Abstract
Clinical supervision has been an aspect of nursing practice in various forms for several years; however, it remains challenging to ensure its widespread implementation across healthcare organisations. There is an increasingly evident need for formalised support in nurses' busy practice settings, so it is important to improve the quality of clinical supervision in healthcare. This will also assist nurses in providing evidence of their continuing professional development as part of revalidation. This article provides an overview of clinical supervision, outlining its features and functions in healthcare practice. It includes three case studies related to group clinical supervision, discussing how this was implemented in each case and the various methods of group-working that were used.

Aims and intended learning outcomes
The aim of this article is to review the development of clinical supervision, with an emphasis on examining methods for healthcare practitioners to engage in group clinical supervision. It explores the purpose of clinical supervision, as well as its benefits and the likely challenges to its implementation. After reading this article and completing the time out activities you should be able to:
» Describe the main characteristics of clinical supervision and how it differs from other forms of supervision in practice.
» Examine the functions and relevance of clinical supervision.
» Identify the benefits and common challenges that may be experienced when implementing clinical supervision.
» Understand some of the forms of group clinical supervision and the potential for implementing these in your practice.

Introduction
Professional support mechanisms for healthcare practitioners include local induction programmes, peer support groups, preceptorship and mentoring schemes, coaching and clinical supervision. The idea that nurses require clinical supervision throughout their career is well established. The emergence of formalised clinical supervision in the early 1990s (Department of Health (DH) 1993, Kohner 1994, United Kingdom Central Council for Nursing, Midwifery, and Health Visiting 1996), and its adoption by the health regulator in 2013 (Care Quality Commission (CQC) 2013), have been partly in response to concerns about failings in care, as well as issues related to patient safety and care quality (Clothier 1994, DH 2013, Francis 2013).

Clinical supervision is not a mandatory requirement for most UK nurses; however, The Code: Professional Standards of Practice and...
Clinical supervision is a form of professional supervision that is distinct from formal line management supervision and is supported by organisational policy and guidelines.

Clinical supervision is a regular process of support and development, which is legitimised by the healthcare organisation and valued as a work-based activity.

Clinical supervision involves a clinical supervisor and supervisee, or group of supervisees, reflecting on practice in a safe space, with the intention of improving care delivery and offering support.

Clinical supervision is a practice-based form of reflection that can be used as evidence for revalidation.

Clinical supervision is a confidential process, in which a supervisee periodically reflects on their practice with a clinical supervisor.

The supervisee ‘owns’ the process, leading the discussion on what aspects of practice they wish to talk about.

Ideally, the supervisee will have a choice of clinical supervisor, but this person will need to be endorsed by the supervisee’s line manager.

It is expected that supervisors will engage in their own clinical supervision.

(Adapted from Driscoll and Cassidy 2013)

Engaging in clinical supervision on a regular basis can initially be challenging for healthcare practitioners. In the authors’ experience, first-time supervisees may have reservations about beginning the process, making time in their busy practice and identifying a suitable clinical supervisor who will provide them with the confidence to begin reflecting on aspects of their practice. Having committed to the process, clinical supervision should begin with the supervisor and supervisee agreeing roles and responsibilities, discussing what is going to take place during the sessions and clarifying what clinical supervision is, as well as what it is not. Additionally, the practical arrangements should be addressed, for example where and how often clinical supervision will take place.

There will be differences in how clinical supervision sessions are structured depending on whether they take place on a one-to-one basis or in a group, as well as the expertise of the clinical supervisor. However, whatever format is used, there is broad agreement on the functions and purpose of clinical supervision (Pollock et al 2017).

**TIME OUT 1**

Reflect on how clinical supervision is implemented in your clinical area. If you are involved in the process, how does it support your practice? If you are not yet engaging in clinical supervision, approach your line manager and ask if there is an organisational clinical supervision policy and how you could become involved.

**Functions of clinical supervision**

Proctor’s (1986) Interactive Framework of Clinical Supervision is widely used in nursing practice (Sloan and Watson 2002, Driscoll and Townsend 2007, Cassidy 2010), and outlines three areas that might be discussed during a clinical supervision session:

- Formative (learning) – the continued development of the skills, abilities and understanding of the supervisee in their clinical practice.
- Restorative (support) – how the supervisee responds emotionally to the stresses and demands of clinical practice.
- Normative (accountability) – maintaining and monitoring the effectiveness of the supervisee’s clinical practice.

The role of the clinical supervisor is to assist the supervisee to reflect on these perspectives and the options for moving forward, rather than advising or telling the supervisee how to proceed.

**TIME OUT 2**

Watch the YouTube video by Buckinghamshire Healthcare NHS Trust and University of Bedfordshire (2014): www.youtube.com/watch?v=mP0qwah98jk

Examine how the clinical supervisor works with the supervisee in the clinical supervision sessions. How are the functions of clinical supervision managed in the session? What do you think some of the benefits of clinical supervision might be to you as a supervisee?

As well as one-to-one supervision, group clinical supervision can also be undertaken. Charles (2018)
suggested that the development of increasingly collaborative working in healthcare can support increased accountability in practice, which in turn could improve care. This article describes three case studies to demonstrate how different forms of group clinical supervision were implemented to support healthcare practitioners.

Case study I – externally facilitated group clinical supervision for Admiral Nurses

Dementia care is a priority for both NHS England and the UK government. The Prime Minister’s Challenge on Dementia 2020 (DH 2015) was launched in February 2015, and set out the government’s commitment to improve dementia care in England. In addition, one of the ten priorities identified by NHS England (2014) in its Five Year Forward View was to improve the quality of dementia services and increase support for individuals with dementia, and their families and carers.

Dementia UK provides specialist case management for families affected by dementia through the Admiral Nurse service. To achieve the intended transformation of dementia services, Dementia UK has long-recognised the benefits of clinical supervision for individual Admiral Nurses, the healthcare organisations who employ them and families affected by dementia. Smith (2012) emphasised that ‘for patients to feel safe and cared for, the practitioners who care for them must also feel safe and cared for’. Actively supporting group clinical supervision for Admiral Nurses could be a strategy that healthcare organisations adopt to demonstrate that its practitioners are valued (Delgado et al 2017).

It has been identified that using group clinical supervision for nurses working with people with dementia has a positive effect on the nurses’ attitudes and skills, as well as improving nurse-patient relationships (Berg and Welander Hansson 2000, Francke and de Graaff 2012). It is expected that all Admiral Nurses in Dementia UK will participate in group clinical supervision (Dementia UK 2012). A report by Butterworth and Shaw (2017) stated that Admiral Nurses’ model of working is informed ‘by clinical supervision and continuing education’, offering an effective method of working with families affected by dementia. In addition, Admiral Nurses have benefited through the process of sharing knowledge and expertise with their peers and fellow experts (Butterworth and Shaw 2017).

There are more than 25 Admiral Nurse clinical supervision groups across the UK, with an average of seven to eight nurses per group. As the numbers of Admiral Nurses increases, so does the number of clinical supervision groups. This ensures that nurses can attend a local group that is convenient for them, and that the number of participants in each group remains viable. The clinical supervisors are external group facilitators who have expert practice and knowledge in supervisory processes and techniques, as well as a working knowledge of dementia care. When developing the working policy for group clinical supervision among Admiral Nurses in any geographical area, the expected roles and responsibilities of the Admiral Nurses, the healthcare organisations who employ them and the clinical supervisors, are outlined. Each new clinical supervision group undertakes a ‘values clarification’ exercise and develops a values statement, then agrees what will happen in the sessions (Dewing et al 2014). The values statement provides the group with structure, boundaries and a sense of shared purpose (Foundation of Nursing Studies 2015). From this, a group clinical supervision structure is developed to meet the needs of the individual Admiral Nurses and the external facilitator.

Cassedy (2010) emphasised that all group clinical supervision sessions should have a beginning, a middle and an end, and that using a group structure offers a sense of direction and organisation during the session. An increasingly popular format for group clinical supervision among Admiral Nurses is the use of a modified action learning approach (Rivas and Murray 2009, Staniland et al 2011), in which the facilitator focuses on individual supervisee narratives rather than group actions to achieve organisational change and improvement. Haith and Whittingham (2012) asserted that action learning provides a practical framework for group clinical supervision since the main emphasis is on members developing their own practical solutions to workplace issues. Action learning is also a realistic approach that all Admiral Nurses can engage in to support their practice. Box 2 shows the typical structure for group clinical supervision sessions with Admiral Nurses.

In the authors’ experience of the Admiral Nurse approach to group clinical supervision, the format and structure adopted by clinical supervisors may vary slightly, but most use a case presentation approach. The two-hour timeframe of the sessions often enables two case presentations, but some clinical supervisors report up to six cases being explored in one session. All Admiral Nurses are surveyed annually to obtain

Key points

- Clinical supervision is an important method for healthcare organisations to ensure the quality and safety of care, as well as providing continuing professional development (CPD) and support for healthcare practitioners.

- Clinical supervision is concerned with those subjects the supervisee chooses to reflect on as part of their CPD, and is a source of active support in practice.

- Clinical supervision is not a mandatory requirement for most nurses in the UK; however, The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (Nursing and Midwifery Council 2018) advises that all practitioners should have access to professional development, which could include supervision.

- It is important for healthcare organisations to commit to supporting the well-being of nurses through strategies such as resilience-based clinical supervision, to improve professional quality of life and staff retention.
feedback on their experience of clinical supervision. Similarly, the clinical supervisors report annually on clinical supervision activity and outcomes. Regular evaluation of this approach has demonstrated that Admiral Nurses use clinical supervision to support their practice and place significant value on this method of support. For instance, in an internal evaluation of clinical supervision undertaken in 2017, Admiral Nurses identified the following benefits:

- A safe space for self-care and promoting resilience.
- Peer support and being part of a ‘collective’ learning environment.
- Shared perspectives and rich reflections from a range of care settings.
- The structure and facilitation of group clinical supervision enables all of its members to participate.
- Development of skills and knowledge to enhance clinical practice.
- Use of reflection to ‘unpick’ the complexity of cases.
- Role-modelling for newer Admiral Nurses.

Challenges involved in implementation

Despite the benefits of group clinical supervision, its implementation can prove challenging. There is an expectation that Admiral Nurses will attend 80% of group clinical supervision sessions each year; however, this has not always been met. Lack of attendance may occur when time for clinical supervision is not valued as a CPD activity by a nurse’s healthcare organisation, often because of workload pressures and inadequate planning. Non-attendance at clinical supervision groups can affect the morale of group members. A further challenge is maintaining an adequate skill mix among group members, because the numbers of nurses attending with different skills may change over time, which can affect the make-up of regional groups. Comprehensive evidence for the effectiveness of clinical supervision for patients is not yet available. However, group clinical supervision remains part of the CPD of Admiral Nurses and contributes to integrated methods of working.

Case study 2 – implementing a reflective clinical supervision group via telephone sessions

In 2015, Horizon Health Network in New Brunswick, Canada committed to providing reflective clinical supervision for practitioners who worked on addiction and mental health programmes, including social workers, nurses, psychologists, occupational therapists and counsellors. A working group was formed to establish the infrastructure for organisational clinical supervision across a wide geographical service in New Brunswick.

One significant challenge to the implementation of the reflective clinical supervision group was the use of the traditional ‘expert’ model of supervision in Canadian healthcare, which involves a senior healthcare practitioner or manager supervising the work of junior staff in an administrative and managerial capacity. In contrast to this model, Boyd (2015) used a fire engine as a metaphor to describe how reflective clinical supervision can assist healthcare practitioners to ‘clean their truck, test the equipment and polish the various clinical tools, ensuring they were fit for purpose’, with the equipment and tools referring to the healthcare practitioners engaging in reflective clinical supervision and the various practices they employed. The word ‘reflective’ was used in this model of clinical supervision to describe the type of conversation that would occur between the supervisee and the supervisor.

It was agreed that a reflective clinical supervision working group would be facilitated via a telephone session for one hour each month. The working group was to run for five months. An important element of the working group sessions was the discussion of individual and collective actions undertaken between sessions, for example the wording of organisational guidelines, content of training for new clinical supervisors and how managers could make time for supervision in practice, and reporting back on progress at the following sessions. The main topics for discussion in the sessions included: policy direction; managing change in target areas; recruiting supervisors and supervisees; agreeing the content of training; and how to support new supervisors.

A values clarification exercise was conducted along with a mapping exercise to establish a baseline for the type of supervision that already existed in the target areas before the reflective clinical supervision group was implemented. A force field analysis (Cassedy 2010) was undertaken to identify the driving forces present in the organisation that supported the development of reflective clinical supervision, as well as the restraining forces that hindered its development (Box 3).

For reflective clinical supervision to be implemented, the driving forces must outweigh the restraining forces or substantially reduce these.

Based on the force field analysis, it was identified that supporting new clinical supervisors would be vital to sustaining the implementation of reflective clinical supervision (Dilworth et al 2013). Furthermore, information workshops were required for practitioners and managers on the benefits of reflective clinical supervision and why it was being introduced to complement other forms of clinical supervision in practice.

Supporting new clinical supervisors

There is no agreed or accredited training for new clinical supervisors

BOX 2. Structure of group clinical supervision sessions with Admiral Nurses

- Check in with each other
- Reflect on presentations from the previous session and follow up on outcomes
- Agree on presentation(s) and decide on who will present, on a rotation basis or prioritising an urgent need to present
- Presentation of a case or issue by an Admiral Nurse
- Group discussion facilitated by the clinical supervisor after each individual case or issue, taking place within an agreed timeframe
- Reflections, summary of learning, application to the Admiral Nurse Competency Framework (Dementia UK 2012) and actions agreed
- Close
in Canada or the UK, and it is unclear what constitutes support or the supervision of supervisors after they have completed their training (Milne 2009, Hawkins and Shohet 2011, Driscoll and Cassedy 2013).

From the outset, it was agreed that soon after completing their training, new supervisors would be expected to participate in externally facilitated, monthly follow-up group teleconference sessions with their supervisor peers. This provided valuable information about the concerns of new supervisors and how they would work with their supervisees following the training workshops, such as: agreeing how clinical supervision would be organised; ensuring sessions began and ended on time; deciding how often reflective clinical supervision should occur; and managing cancellations, lateness and lack of contact with supervisees. The challenges included how new supervisors were to incorporate a more reflective and less directive style of supervision than the administrative and managerial style they were familiar with.

Despite the organisation agreeing to the programme of clinical supervision, some supervisors felt that time for reflective clinical supervision was valued less than their clinical work. They also reflected van Ooijen’s (2000) concerns that supervisees lacked preparation before sessions and incorrectly assumed that the clinical supervisor was responsible for the ‘work’ of supervision. Such a passive view challenges one of the distinguishing features of clinical supervision (Box 1) – that sessions should be supervisee-led.

TIME OUT 3
Consider how you might enhance your preparation for your clinical supervision sessions. For instance, one of the requirements for revalidation as a nurse is to complete five reflective accounts. Could describing an experience in your practice in detail form the basis for reflection on practice with your clinical supervisor?

The challenges of group clinical supervision via telephone sessions include delays in connections, dropped lines and low sound quality; however, the technique has remained a feasible and cost-effective option where geographical distance is a challenge (Driscoll et al 2006, Driscoll and Townsend 2007, Goss et al 2016). Goss et al (2016) suggested that the use of the telephone and other technologies such as video-conferencing in clinical supervision will continue to expand because technology overcomes geographical limitations. However, Martin et al (2017) warned that although technology presents an opportunity to overcome the issues of distance, access and time, care must also be taken to ensure the effectiveness of supervision is not compromised.

**Case study 3 – resilience-based group clinical supervision**

The integration of group clinical supervision into pre-registration nurse education has been established as a positive aspect in any curriculum design (Holmlund et al 2010). The desired outcomes are to provide opportunities for reflection on how nursing theory relates to practice, and to enable ongoing peer support (Sheppard et al 2017). Group clinical supervision also aims to develop nurses’ critical thinking and promote a clear professional identity, which is in accordance with the purpose of delivering nurse education at degree level (Ashmore et al 2012). However, Sheppard et al’s (2017) evaluation of group clinical supervision showed that peer support became the primary focus and the most highly valued aspect of supervision. Thus, the opportunity to challenge and critique nurses’ views and perspectives on practice were limited since a comfortable, co-dependent group dynamic developed.

One implication of this form of group clinical supervision was that nursing students relied on the reassurance of the group delivered in the comfort of the university setting to cope with challenging aspects of clinical practice. When this supportive group structure was no longer present post-registration, newly qualified nurses found the isolation and perceived lack of support from their team and organisation challenging. There

**BOX 3. Summary of the force field analysis undertaken to identify the driving and restraining forces for implementing reflective clinical supervision**

**Driving forces**
- Staff demand for support in practice
- Strong advocates of reflective clinical supervision in target areas
- A collaborative working group and ability to learn from each other’s experiences
- Having a designated reflective clinical supervision coordinator
- Clinical supervision identified as the strategic priority by the organisation
- Method of clinical supervision based on supervisee needs rather than the ‘expert’ model
- Use of external consultancy to oversee the process, including training

**Restraining forces**
- Issues relating to time management and arrangement of cover so that practitioners could attend clinical supervision
- Lack of information about reflective clinical supervision across the organisation and among practitioners and managers
- Negative connotations of the term ‘supervision’ which might suggest practitioners being watched or the surveillance of practice by managers
- Ongoing costs associated with implementation and training supervisors, as well as the time required to engage in the process
- Limited policy direction, since reflective clinical supervision was new and largely unknown in Canada
- Additional responsibility involved in being a supervisor alongside clinical practice responsibilities
- Staff fatigue with change and initiatives being introduced
- Staff familiarity with a traditional ‘expert’ model of clinical supervision, rather than reflective clinical supervision
was a strong theme of self-criticism and doubt among participants regarding their ability to fulfil their roles and adapt to organisational expectations in clinical practice, while the opportunity to explore these feelings in an environment that they perceived as safe was non-existent in most healthcare organisations (Sheppard et al 2017). Furthermore, employers were aware of these challenges and reported a ‘lack of resilience’ among newly qualified nurses, indicating that the message that they needed to ‘toughen up’ was being reinforced. Such experiences were similar to the ‘reality shock’ first described by Kramer (1974), which nurses may experience when they make the transition from nursing student to registered nurse, and remains an issue in retaining nurses following their professional registration (Whitehead and Holmes 2011).

These observations and experiences led to the development of the resilience-based clinical supervision model (Stacey et al 2017). This model is underpinned by Gilbert’s (2010) compassion-focused therapy model, which examines how emotions motivate an individual’s response to a situation and how they can learn new strategies to achieve a desired outcome. The aim of group resilience-based clinical supervision sessions is to enable group members to develop competencies that support self-care and promote compassion, both for themselves and others.

Resilience-based group clinical supervision sessions are characterised by:
» Identification of the unique group conditions required to establish a safe space.
» Integration of mindfulness-based stress reduction exercises.
» An explicit focus on the emotional systems in Gilbert’s (2010) compassion-focused therapy model – threat, drive and affiliation – which motivate an individual’s response to a situation.
» Consideration of the role of the ‘internal critic’ in underpinning an individual’s response to a situation.
» Closing the session with a statement of positive intent or gratitude to the group.

Providing a safe space to discuss practice is an important element when developing clinical supervision groups. If group members do not feel secure within the group, it is unlikely that the group will sustain itself. The integration of mindfulness-based stress reduction exercises as part of the clinical supervision process is intended to assist group members to improve their well-being and reduce stress and subsequent ‘burnout’ (Barratt 2017).

A pilot evaluation of resilience-based group clinical supervision among 120 nursing students and 235 newly qualified nurses was undertaken by the University of Nottingham across trusts in the East Midlands. The groups varied in size and frequency; however, all participants received at least six resilience-based group clinical supervision sessions.

The Professional Quality of Life (ProQOL) scale (Stamm 2010) was administered pre-intervention and post-intervention, and focus groups were conducted with participants and the group facilitators.

The evaluation indicated that participants’ experience of clinical supervision improved because the structure of the sessions was perceived to prevent cycles of participants’ negative storytelling, for example in relation to criticisms of established healthcare practitioners or perceived deficits in healthcare service provision. The nursing students and newly qualified nurses reported that mindfulness was useful in preparing for stressful situations or following distressing encounters. Furthermore, the nursing students and newly qualified nurses prioritised self-care, describing several self-care strategies such as establishing support networks, engaging in critical reflection and positive reframing to challenge the internal critic (Stacey et al 2017).

Wider implementation in healthcare organisations

Wider integration of group clinical supervision into pre-registration nurse education and preceptorship programmes is underway in the UK. Consistent group membership and skilled facilitation are essential conditions for effective group clinical supervision; however, these conditions are challenging to achieve in large healthcare organisations with a large number of newly qualified nurses. Furthermore, nurses require permission from managers to be released from their clinical practice duties to engage in clinical supervision, which may be challenging to obtain.

It is important for healthcare organisations to commit to supporting the well-being of nurses through strategies such as resilience-based clinical supervision, to improve professional quality of life and staff retention. There is a risk that nurses’ dissatisfaction will increase if the priority they place on self-care through clinical supervision is not perceived as being equally valued by their healthcare organisation.

Conclusion

While clinical supervision has been an important element of nursing practice for several years, its potential has yet to be fully realised. However, it is increasingly important for nurses to engage in clinical supervision as a form of individual support and CPD, as well as a strategy for making improvements in practice. Nurses should be aware of the purpose and features of clinical supervision. They should also understand the differing approaches that may be used, including group and face-to-face clinical supervision and over-the-telephone clinical supervision where geographical distance is an issue. There are challenges associated with implementing group clinical supervision, but with the commitment
of healthcare organisations and nurses it can be successfully developed to meet local needs.

TIME OUT 5
Consider how engaging in clinical supervision relates to The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (NMC 2018) or, for non-UK readers, the requirements of your regulatory body

TIME OUT 6
Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: rcni.com/reflective-account

References


University of Nottingham, Creative Connection (2017) Resilience Based Clinical Supervision. www.youtube.com/watch?v=YoQA5scO5U (Last accessed: 9 November 2018.).


Clinical supervision

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Clinical supervision is:
   a) A disciplinary process
   b) A period of structured transition for newly qualified nurses
   c) Concerned with the subjects the supervisee chooses to reflect on as part of their continuing professional development, and is a source of active support in practice
   d) An objective structured clinical examination in which nurses respond to scenarios that they are likely to encounter in practice

2. Which of the following is not a feature of clinical supervision?
   a) It is a regular process of support and development, which is legitimised by the healthcare organisation and valued as a work-based activity
   b) It involves a clinical supervisor and supervisee, or group of supervisees, reflecting on practice in a safe space, with the intention of improving care delivery and offering support
   c) It is a practice-based form of reflection that can be used as evidence for revalidation
   d) The supervisor 'owns' the process, leading the discussion on what aspects of practice they wish to talk about

3. In Proctor's (1986) Interactive Framework of Clinical Supervision, the three supervisory functions are:
   a) Formative, restorative and normative
   b) Authoritative, negotiated and collective
   c) Transformational, transactional and laissez-faire
   d) Clinical, educational and research-focused

4. Which statement is false?
   a) It is expected that all Admiral Nurses in Dementia UK will participate in group clinical supervision
   b) Most Admiral Nurse clinical supervision groups use a case presentation approach, in which up to six cases are explored per session
   c) Each new Admiral Nurses’ clinical supervision group develops a values statement to provide structure, boundaries and a sense of shared purpose
   d) The greater the number of Admiral Nurses in one clinical supervision group, the better, since this enables a broad range of experiences to be discussed

5. When might it be beneficial to incorporate use of the telephone or teleconferencing in clinical supervision?
   a) Where there are resource issues with clinical supervision training
   b) Where the healthcare organisation is unwilling to provide face-to-face clinical supervision
   c) Where group members work in geographically disparate locations
   d) Where maintaining confidentiality is not an issue

6. Which of these is most likely to support the development of reflective clinical supervision in practice?
   a) Staff demand for support in practice
   b) Limited reflective clinical supervision policies in place to work from
   c) Staff fatigue with change and initiatives being introduced
   d) Staff familiarity with a traditional ‘expert’ model of clinical supervision

7. How can group clinical supervision support nursing students?
   a) By enabling them to understand their place in the nursing hierarchy
   b) By encouraging them to ‘toughen up’ before they experience clinical practice as a registered nurse
   c) By providing opportunities for them to reflect on how nursing theory relates to practice, and by enabling ongoing peer support
   d) By ensuring that they follow established routines of care

8. The aim of group resilience-based clinical supervision is to enable group members to:
   a) Hide their emotions in challenging situations
   b) Develop competencies that support self-care and promote compassion, both for themselves and others
   c) Avoid challenging situations
   d) Detach themselves from the emotional demands of healthcare practice

9. Which of these is a characteristic of resilience-based group clinical supervision?
   a) A focus on negative storytelling
   b) Integration of mindfulness-based stress reduction exercises
   c) Encouragement to criticise oneself
   d) Ad hoc group membership

10. One challenge in the implementation of group clinical supervision is:
    a) Difficulty achieving consistent group membership in large healthcare organisations
    b) Lack of skilled clinical supervisors available
    c) Difficulty obtaining permission from managers for nurses to be released from their clinical practice duties to engage in clinical supervision
    d) All of the above

How to complete this quiz

This multiple-choice quiz will help you to test your knowledge. It comprises ten questions that are broadly linked to the CPD article. There is one correct answer to each question.

» You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.

» You might like to read the article before trying the questions. Subscribers making use of their RCNi Portfolio can complete this and other quizzes online and save the result automatically.

Alternatively, you can cut out this page and add it to your professional portfolio. Don’t forget to record the amount of time taken to complete it.

Further multiple-choice quizzes are available at rcni.com/cpd/test-your-knowledge

This multiple-choice quiz was compiled by Alex Bainbridge

The answers to this multiple-choice quiz are:
6. a 7. c 8. b 9. b 10. d

This activity has taken me ___ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent  □  Good  □  Satisfactory  □  Unsatisfactory  □  Poor  □

As a result of this I intend to: