Clinical Supervision for Transition to Advanced Practice

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PURPOSE: This reflective paper offers a conceptual framework of clinical supervision that assists supervisors to create supportive relationships necessary for advanced practice development.
CONCLUSIONS: Combining established concepts of clinical supervision with systems psychodynamics enhances the supervisory experience. It is useful to supervisors to understand role transition as it sensitizes them to what their supervisees experience.
PRACTICE IMPLICATIONS: Nurses require support in role transition, especially when the systems into which they are introduced can struggle with new advanced roles. This framework offers a broadened lens that allows for the richness and complexities that go with the development of advanced practice to be explored and better understood.

Clinical supervision and its contribution to practice development has received significant attention in the nursing literature (Cutcliffe, Hyrkas, & Fowler, 2011; Freshwater, 2008; Lynch, Hancox, et al., 2008). However, while clinical supervision is considered an essential support for nurses progressing into advanced practice (Christensen, 2009; Doerksen, 2010; Gilfedder, Barron, & Docherty, 2010; Sullivan-Bentz et al., 2010), there is little guidance to assist clinical supervisors on how to supervise for this purpose. The aim of this paper is to share the experience of three advanced practice nurses in the development of a clinical supervisory space within which to reflect on transition into advanced practice. To provide a platform for this reflective piece, an overview of the theoretical framework utilized by the supervisor is provided.

Theoretical Framework

Clinical supervision has its origins in psychoanalytical therapy training in the 1920s (Lynch, Happell, & Sharrock, 2008; Yegdich & Cushing, 1998). It emerged in the nursing literature in the 1970s (Yegdich & Cushing, 1998) but despite this, no single definition or theory has been adopted within nursing (Lynch, Hancox, et al., 2008). For the purposes of this paper, the definition offered by Hancox and Lynch is used:

Clinical supervision is a formal process between two or more professionals. The focus is to provide support for the supervisee(s) in order to promote self awareness, professional development and growth within the context of their professional environment. (2002, p. 6)

Given that the origins of clinical supervision are in psychotherapy and counseling training, the focus of clinical supervision is on the work of the supervisee with his or her patients. Case material is brought to the supervision session for discussion. Despite the use of the word *supervision*, the supervisor does not necessarily directly observe the work of the supervisee with the patient but reviews the case retrospectively through formal meetings with the supervisee.

Clinical supervision is an educational strategy that incorporates adult learning principles that value experiential and reflective learning (Benner, 2009; Burnard, 2002; Knowles, Holton, & Swanson, 2005; Kolb, 1984). The concept of reflective learning is thought to be as old as Socrates (Freshwater, 2008) but was developed by Dewey as an educational modality in 1933 (Duffy, 2007). Dewey proposed reflective learning as a rigorous and intelligent thinking exercise applied to analyze complex situations in order to make meaning and gain a deeper understanding of the experience (Duffy, 2007). Applied to nursing practice:

Reflective practice is an active and deliberate process of critically examining practice where an individual is challenged and enabled to undertake a process of self-enquiry to empower the practitioner to realize desirable and effective practice within a reflexive spiral of personal transformation. (Duffy, 2007, p. 1,405)

The capacity to reflect on practice is a desired aspect of nursing, particularly for advanced practice (Freshwater, 2008), and was observed by Benner (1984) to be a key characteristic of the expert practitioner. Creating a structure and process to develop reflecting skills within the supervisee can be considered a goal of clinical supervision.

Despite efforts to the contrary, the international literature is inconsistent in the use of the term advanced practice (Australian Nursing Federation, 2005). In this paper, the term is a description of expertise that develops, not a regulated status. Advanced practice is experienced, knowledgeable, and competent nursing practice in any setting where the nurse uses evidence for practice, takes responsibility for complex situations, shows leadership in clinical and professional settings, contributes to effective teamwork, and focuses on improving the health of individuals and groups (Australian Nursing Federation, 2005, p. 35).

Role transition can be exciting in that it precipitates many opportunities. At the same time, it is also uncomfortable with feelings of vulnerability and uncertainty (Bridges, 2004; Cusson & Strange, 2008). When a person takes up a new role, he/she is in a process of change from *what was* to *what is* (Duchscher, 2009); it is a process of losses and gains, of letting go old ways of being and developing new ways of being, of adapting old skills and learning new ones (Bridges, 2004; Holt, 2008; Spoelstra & Robbins, 2010), and of building new role identities and self-images (Holt, 2008).

Many stresses occur during transition to advanced practice (Fleming & Carberry, 2011). Nurses who take up the pioneering work of developing new advanced practice roles often move into uncharted territory (Paniagua, 2010) and they do not necessarily have well-worn paths to follow. Roles may be poorly defined with unclear lines of accountability, functions, and authority, resulting in unrealistic or unclear expectations from others that can create systems that are ambivalent, unwelcoming, or even hostile (Cashin et al., 2009; Sullivan-Bentz et al., 2010). Taking up the authority and associated tasks of advanced practice is not automatic just because the nurse is given that authority in his/her position description. An internal psychological change needs to occur; the image of oneself as an advanced practice nurse needs to be internalized or introjected—what we have termed *stepping into advanced-ness.*

A systems psychodynamics perspective supports exploration of the challenges of transition in that it facilitates the supervisee to expand awareness and understanding of con-
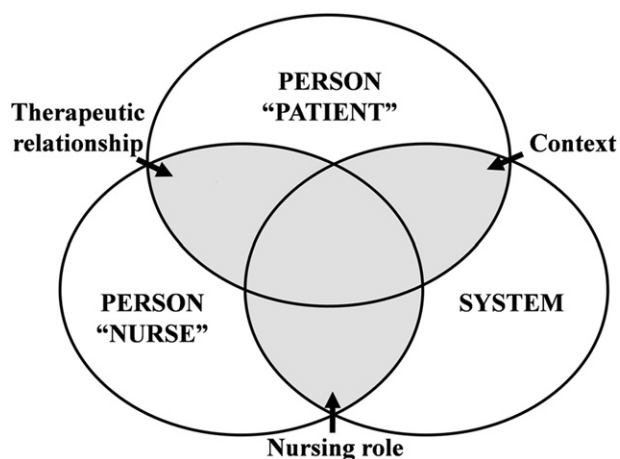

Figure 1. Conceptual Framework for Clinical Supervision

scious and unconscious forces within his or her organization and the complex interplay between an individual in role and within the system (Newton, Long, & Sievers, 2006). This includes interrelationships of anxiety, task, role, authority, boundaries, and identity (Cilliers & Terblanche, 2010).

There is little reference to this perspective in the nursing literature on clinical supervision (Lynch, Handox, et al., 2008). However, an organizational strategy called professional coaching, which is a strategy to improve the performance of staff, has been referenced (Cilliers & Terblanche, 2010; Driscoll & Cooper, 2005; Karsten, Baggot, Brown, & Cahill, 2010; McNally & Lukens, 2006), and it has been argued that the knowledge base of coaching can be useful to the clinical supervisor (Driscoll & Cooper, 2005). The coaching relationship is similar to the supervisory relationship in that it ". . . creates conditions for reflective learning by providing safe psychological spaces that allow coaches and clients to stand back from the workplace in confidential but challenging environments" (Driscoll & Cooper, 2005, p. 19). Like clinical supervision, coaching does not explore the character or personality of the individual. Some exponents of coaching take a systems psychodynamics approach which has at its focus exploring and understanding the individual's role that is grounded in the system in which it is imbedded (Cilliers & Terblanche, 2010; Newton et al., 2006). Increased awareness and understanding of the work system supports the coaching client (or the supervisee) to become less reactive and act consciously and more responsively. The client makes sense of the work environment and can anticipate how he/she will interact with it (French & Hughes, 2007).

A conceptual framework for clinical supervision that incorporates this perspective is represented diagrammatically in Figure 1. The material that can be brought to clinical supervision for exploration is represented by the gray area. This material includes the supervisee's work with the patient who

exists in his or her own context and within a system they both share. In addition, the supervisee brings issues regarding the nursing role in relation to the system.

The next section of this paper presents the experience of the authors in creating a reflective space with the aim of supporting transition into advanced practice utilizing this conceptual framework.

Context

The first author (JS) is an experienced mental health nurse working in Consultation-Liaison Psychiatry in a tertiary teaching hospital who provides clinical supervision to both mental health and general nurses.

The second author (SM) is an experienced surgical nurse who took up a newly introduced advanced nursing role as coordinator of surgical care for head and neck cancer patients. SM was interested in accessing clinical supervision from JS to support, explore, and develop her practice (which is not a common practice for nurses outside psychiatry). Two years specialist experience was a requirement for this position.

JS accepted a request from the third author (LJ) for clinical supervision. LJ had taken up a generic senior clinician position within a Primary Mental Health Team (PMHT), a multidisciplinary team providing primary and secondary consultation and education services to primary healthcare providers in the community. Specialist mental health nursing education and 5 years of specialist experience were a requirement for this position, but it could also have been filled by a range of other mental health professionals.

Reflections of the Supervisor (JS)

Both supervisory relationships began in much the same manner as my previous supervisory relationships. At first meeting, it is my practice to explain the frameworks that inform my approach to clinical supervision. My grounding education is in general and psychiatric nursing, and therefore the biopsychosocial model of care provides a basis for clinical practice. Gestalt psychotherapy is a relationally based and holistic approach that is the cornerstone of my psychotherapy practice. This is supported by psychodynamic theory, particularly in relation to developmental and relational concepts. The structured approach of Hancox and Lynch (Lynch, Hancox, et al., 2008) best describes my clinical supervisory model, and this incorporates adult and reflective learning theory. Combining these theoretical approaches provides a solid framework for understanding humans, therapeutic relationships, the helping process, and clinical supervision.

In my work with SM, we discussed clinical cases seeking to understand the patient, and how SM might work with the patient after a diagnosis of cancer. My existing theoretical framework supported me to observe, listen, question, and reflect comfortably on these situations. However, as our work progressed I became increasingly aware that I was struggling with the role development issues that were challenging SM. I raised this with my supervisor who is both a Gestalt psychotherapist and an organizational consultant. He assisted me to shift my focus from SM as an individual with intrapersonal struggles related to her work to SM as a person who takes up a role that is in relationship with a system. Improving my understanding of the dynamic process of how roles develop in relation to the system (Tyson, 2004) assisted me to facilitate SM to gain an increased awareness of her role in relationship with the broader system in which it is imbedded.

I was also becoming increasingly aware that as we develop as advanced practitioners, our self-perception changes. Even though nurses in advanced practice roles may be given authority and tasks consistent with advanced practice, initially they may not take up that authority or undertake the expected tasks. There seems to be a transitional process where nurses *step into their advanced-ness*. By this I mean gradually internalizing images of themselves as advanced practitioners, holding that image as part of their professional self-image, and as such, feeling enabled to take up the role, authority, and tasks as expected.

SM and I started to talk about how she understood the expectations and tasks of her role, how she enacted her responsibilities, the knowledge and skills she drew on and needed to develop, and her relationships with individuals and groups within her system of work. In particular, SM identified the loss of security in leaving the safety of the ward and the collegiate support of the nurses by moving into a much more autonomous position. The security of being "one of the nurses" was hard to relinquish but as confidence built within SM, as she began to *step into her advanced-ness*, she was able to take up her authority.

Almost at the same time I found myself floundering without a suitable frame from which to work with LJ, who was grappling with the belief that her nursing skills were inadequate to undertake her role in the PMHT. She was searching for the "right" course to give her the "right" set of skills and credibility to take up the role in the team, particularly in relation to providing psychotherapy. I discussed the possibility of taking a career counseling approach to her problems with my supervisor. (I realize now what a fantastic example of parallel process this was; LJ was not feeling skilled and knowledgeable enough to take up her role in her team and I was not feeling skilled and knowledgeable enough to provide supervision to her.) During my supervision, I was shocked that within my struggle I was unwittingly falling back into the very familiar therapist mode. Again, I was focusing on the individual and her difficulties and less on her in a role within a system. My supervisor suggested I need to "take my therapist hat off" and concentrate on having "my supervisor hat on." As I thought

some more about this, I realized I was not as clear about the differences between therapy and supervision as I thought I was. To assist me to understand my supervisory role, my supervisor again linked our work to systems psychodynamics. To support this learning we did an organizational role analysis (Newton et al., 2006). By exploring how I take up my own advanced practice role, my understanding of the dynamic process of how roles develop in relation to both the individual and the organization was heightened.

I took these insights into my work with LJ. We could both see that our sessions were starting to feel like therapy. Putting this on the table made a significant difference to our work. I began to listen to LJ with an ear for her role as she was experiencing it within the system and to explore the systemic forces that were contributing to her self-doubt with less emphasis on her intrapsychic experiences of insecurity. The increased awareness of our need to focus on role and my regular reminders to myself to utilize a systems psychodynamic framework helped me from slipping back into therapist mode. LJ explains the impact of this work later in the paper.

Reflections of the Supervisee (SM)

I came to reflective practice during a transition from acute surgical nursing to autonomous advanced practice surgical cancer nursing. I found myself faced with the demands of an advanced role coupled with having left behind the familiarity and safe space of the acute surgical ward environment. I felt like a nurse who was holding the title of an advanced practice role but on the inside I was overwhelmed and alone.

Being someone who finds interest in understanding and learning about me from a psychological point of view, I found it easy to sit down and discuss the way I was feeling. The challenge was linking my thoughts and emotions with the professional issues I was facing. Discussing the intense situations I faced on a daily basis in caring for people with cancer was quite confronting. Learning how to self-critique or reflect "on" practice was equally challenging. It was important for me to understand that I needed to explore the situations I faced in order to work out what I did well and how I could improve.

We spent time working through the different aspects of the advanced nursing role, which allowed JS to gain a greater understanding of the role and the expectations within it. The feelings of being overwhelmed and being alone were explored and we teased out the resultant impact on my work. I expressed a sense of feeling "too full" to give as much of myself as I could to my patients who so needed it. We worked on trying to "empty out" some of the fullness to create a more caring space. We did this by talking through individual patient scenarios, including my reactions to the patient and how this impacted on patient interactions and outcomes. It also became apparent to me that the team I worked with also influenced my reactions and ability to manage each situation.

We then set about working to understand the advanced practice nursing role and its place within the team.

First and foremost, what I discovered from this process was a sense of achievement. I actually allowed myself the opportunity for self-praise in making it to an advanced practice level. From this sense of achievement, I began to appreciate myself within my role. Over time and seemingly just all by itself, one day in a particularly challenging patient situation, I found myself feeling as though I was looking down on the situation from above and reflecting "on" what was happening at the same time as the issue was unfolding. It was an incredibly calming feeling and a feeling of control and confidence—confidence in knowing exactly what to do and how to react in order to achieve the best outcome for the patient. This feeling gave me the sense of being able to offer more to my patients: more time, more emotional support, more "space" for their personal situations and the impact of having cancer and treatment. The overwhelming sense was one of "space." I had not realized before that this lack of mental space had been such a barrier in my work that had been limiting interactions I had with people; I had no idea.

During this time we also explored my reactions to situations, how relationships with the team affected the way I managed in my role and my relationship with the organization. We explored the idea of sitting within a whole organization with its own set of boundaries and expectations, within which was my team and my role. I learned that there is a complicated interconnectedness between my role, the team, and the system. At the center of this web is the patient and the care he or she needs. Through recognizing and understanding the motivations and functioning of the system I worked in, I discovered even more "space" to give to my patients. This understanding was assisted by the awareness I gained through undertaking a role analysis. We explored the roles I take and have taken in various situations throughout my life. We applied this understanding to the context of my work within the team and broader organization. This provided valuable insights into understanding not only some of my conscious processes but also things I was not so aware of. The ability to reflect on my practice with greater depth and knowledge of myself in role was valuable.

I now feel I have more control over my work, more of a sense of calm and also the feeling of confidence to manage any patient situation. This has allowed me to feel as though I can relinquish some of the hold over my role and I am enjoying sharing my knowledge with other nurses as they too prepare to step into advanced-ness. The end result is I now feel like an advanced practice nurse on the inside, too.

Reflections of the Supervisee (LJ)

When I accepted a position on the PMHT in a different organization, my former supervisor suggested I approach JS for

clinical supervision. I did not know JS and had little knowledge of her style and what supervision would "look like." I was worried about the change as I was used to my previous supervisor. I brought along my own expectations and hopes for the sessions. This was a useful experience as I recognized that this is similar to the anxiety that might arise for patients when they attend a new therapist and was therefore helpful for me to remember when I work with new patients.

JS was very clear about her background and style of supervision and I found her flexible in that I could discuss content relevant not only to case studies but also to systems issues. Transparency of approach and openness to a wide variety of material helped to create rapport and set the scene.

My initial understanding of PMHTs was that they were established to provide services to patients with high-prevalence psychiatric disorders. The teams consisted primarily of psychologists and medical staff with a function of providing therapy for the patient and consultation to the general practitioners. I had been keen to apply for a position on PMHT but was informed that there were no nursing positions. So when I was offered a position working as a nurse within a multidisciplinary PMHT, it excited me. However, at the same time this led to some confusion and uncertainty about my role. Essentially the position description was generic (could be taken up by a range of professionals). It encompassed the key responsibility areas of:

• Providing consultation and advice to primary care providers and delivering best practice interventions to patients
• Providing clinical leadership to the team regarding evidence-based practice and the assessment and treatment of high-prevalence disorders
• Applying principles of quality improvement to service development and seeking professional development
• Ensuring information is managed in a manner consistent with legislative requirements and high-quality documentation is maintained
• Ensuring a safe approach is maintained in keeping with occupational health and safety requirements

As time passed, I noticed myself feeling like I desperately needed a model of therapy so I could work with my patients providing therapy. I searched for courses in psychology and cognitive behavioral, Gestalt, and mindfulness therapies. The more I explored, the more confused I became. It became apparent to me that I was very disillusioned with the nursing profession. I struggled to see how I could transfer my nursing knowledge, expertise, and skills into this advanced role. I was not clear where my career path was leading. I could not articulate what it is that nurses do in an advanced role. This formed the focus of my clinical supervision sessions.

JS brought to my attention that with her "therapist hat" on, our discussions had become more like therapy. That is, focusing more on me as an individual and less on me in my role

within the system. We worked on this together, and this allowed us to examine the process of supervision. Through further dialog that incorporated the perspective brought from JS' supervision, we were able to become unstuck. I began to recognize the value of clinical supervision and the understanding it brings not just in clinical work, but also to the complexities of roles, the organization/system, and professional development. I recognized that by JS exposing her own "not knowing," my trust in our relationship increased, and this allowed me to share my own clinical and professional issues at a deeper level. Having the space to be more candid and talk openly about my struggles working in a role that was largely ill defined, and to examine the impact of external influences on my position allowed me to review my practice and expand my understanding of clinical supervision.

I developed a greater understanding that I was striving for perfectionism, believing that this could only be achieved through studying an alternative profession that would provide me with the key to that therapy model and therefore best patient outcomes. In talking these issues through, I was able to hone in on my nursing capabilities, clearly define my skills, and put words to what nurses can do, particularly in advanced practice roles.

Reflecting on the experience of team members from other disciplines that had joined and left the team, I was hit with the realization that their difficulties were similar to my own experience. They, too, struggled with poorly articulated roles and responsibilities. I realized how far I had come, where I had been, and where I was now. I had created a nursing role in which I felt comfortable, I knew what I could do, and I could also see a scope for ongoing development. I can identify how much I have improved and gained further understanding of the system as a whole and where and how I fit within it. I have become clearer about my role and advancedness. I have gained insight into my nursing approach and style of practice and the influences that this has on patient outcomes and on team dynamics. My understanding of clinical supervision and the parallel processes between supervision and therapy has increased. I have been able to learn and grow with my supervisor and I continue to gain further expertise and knowledge that in turn frames my practice and ultimately my future.

Being able to discuss case studies as well as a range of issues pertaining to my career and my role within the team and the organization has been a valuable experience. It has provided me with motivation, encouragement, and positive experiences to reach to a level of satisfaction within my role that has allowed me to be comfortable in my own skin. This has resulted in a strong sense of professional credibility as a nurse and in the work I do for my patients. Simultaneously, JS has encouraged and inspired me to write this piece and to present at a conference, steps in my career that in the past I would never have dreamed of.

I also realized that in terms of furthering my career and professional development, I did not have to study a different discipline. I am currently completing a Master of Advanced Nursing Practice, Nurse Practitioner. I am very excited for the future and where this can lead. For me it is an ever-evolving process where I am learning new skills all the time and enhancing my career, which in turn can only improve patient outcomes and my own functioning within a team.

Discussion

The authors' experiences of role development and transition are consistent with the literature. Common themes have been identified in studies that have explored transitions to advanced practice nursing (Brown & Olshansky, 1997; Chang, Mu, & Tsay, 2006; Cusson & Strange, 2008; Fleming & Carberry, 2011; Holt, 2008; Nicolson, Burr, & Powell, 2005; Spoelstra & Robbins, 2010; Sullivan-Bentz et al., 2010; Woods, 1998). Nurses frequently describe feelings of loss, insecurity, ambivalence, isolation, confusion, and doubt in the early stages of transition with high expectations of themselves and an acute sensitivity to perceived criticism. These nurses have a sense that they are no longer an expert practitioner but instead feel like a novice again (Cusson & Strange, 2008; Spinks, 2009). Lack of policy, well-articulated and conceptualized organizational structures, clear role descriptions and opportunities to robustly debate the role, adequate remuneration, evaluation and feedback processes, and resources compound the difficulties experienced. For those who require additional practice licenses such as nurse practitioners, regulatory requirements add to the pressures.

Nurses also describe processes of questioning, exploring new knowledge and perspectives, skill acquisition and experimentation, linking of theory and practice, and competency development. They identify the importance of having access to skilled clinicians to assist them in these practice and skill development processes. Nurses differentiate between supportive and conflicted relationships in the system, reporting repeated themes of role conflict with medical staff and difficult interpersonal dynamics both with other professionals and nursing colleagues.

Finally, although named differently in various studies, there is a transition to advanced-ness. This is a sense within the nurse of *becoming* an advanced practice nurse (Spoelstra & Robbins, 2010; Woods, 1998), *internalizing the role* (Fleming & Carberry, 2011), developing *capability* (Gardner, Hase, Gardner, Dunn, & Carryer, 2007), *evolving as a confident practitioner* (Nicolson et al., 2005), *making it* (Cusson & Strange, 2008), *legitimacy* (Brown & Olshansky, 1997), and *empowerment* (Stewart, McNulty, Quinn Griffin, & Fitzpatrick, 2010).

It might be that because LJ and SM did not have higher degrees it made transition more difficult. However, the studies cited above were primarily on nurses with formal advanced practice education, and the themes resonate with the reflections of the supervisees in this paper. Role transition is inevitably and by necessity uncomfortable (Bridges, 2004). However, it could be argued that role transition stress might be reduced but not eliminated by education. Not surprisingly, both supervisees have recognized the need for postgraduate education, with LJ currently completing her master's degree and SM exploring her options for further study.

A clinical supervisor that holds a systemic perspective as described in this paper can assist the supervisee to explore these transitional experiences, taking into account the broader systemic forces at play, and provide needed support to the supervisee during the anxiety provoking process of change. The literature on role transition provides important information about these emotional responses, experiences, and systemic forces that may be encountered by the supervisee. Supervisors should familiarize themselves with this literature so they are sensitive to the issues that are faced, so he/she can more readily recognize themes as they emerge and anticipate what might be to come. The value for the supervisees is that they can recognize that they are not alone with these experiences and can utilize the literature to make sense of them.

It is also useful to consider the advanced practice role of the supervisee from a structural perspective (position description, organizational structure, and resources), a process perspective (how the role is undertaken), and an outcome perspective. Data from a range of sources can be gathered and analyzed to assist the supervisee to more fully understand what is done, how it is done, and what impact it has. To further support the exploration and understanding of work role, a role analysis can be utilized (French & Hughes, 2007; Newton et al., 2006). This analysis aims to increase the understanding of how the supervisee takes up roles in life and how this influences how he/she takes up the advanced practice nursing role.

Critiquing the position description can also stimulate meaningful dialog, assisting the supervisee to understand the role and consider how the position description can be adjusted to reflect the changes as the role develops. This gives the supervisee the opportunity to practice articulating what it is he/she does, in preparation for debate within the organization, public presentation, and publication. LJ and SM examined their position descriptions in this way and this helped them become aware of the limitations in these documents that were contributing to their difficulties. SM was able to adjust her position description to more accurately articulate her role.

Another aim of the clinical supervisor is to create a structure and process of clinical supervision that supports the development of reflective skills within the supervisee. SM, in particular, had not experienced supervision previously and her reflection skills developed significantly as is demonstrated in the experiences she describes. Reflecting *on* practice assists in developing reflective skills in general, and in particular

learning to reflect *in* practice (Freshwater, 2008) and *before* practice (Heath & Freshwater, 2000). The ability to reflect in practice and even before practice can result in more carefully chosen interventions in the moment and decrease the risk of being reactive or impulsive. *Practicing mindfully* (Rolfe, 1997), or as Freshwater (2008) describes, *intentionality in regard to practice*, increases the likelihood of helpful interventions. Having access to clinical supervision is one of the "supportive relationships" cited in the literature as necessary for advancing practitioners.

Implications for Nursing Practice

The challenges of role transition have been recognized in the advanced nursing practice literature, and structured support strategies such as mentorship and clinical supervision are cited as necessary (Christensen, 2009; Doerksen, 2010; Gilfedder et al., 2010; Sullivan-Bentz et al., 2010). However, there is little detail in the literature to assist clinical supervisors and advancing practice nurses to create such supportive relationships. This paper offers a framework that combines the established concepts of clinical supervision, adult learning theory, and systems psychodynamics that can enhance the clinical supervisory experience for advanced practice nurses.

This conceptual framework creates a broadened lens through which to view the material for clinical supervision that allows for the richness and complexities that go with the development of advanced practice work within a challenging system, to be explored, appreciated, and better understood. This paper also provides a life example of how creating a reflective space for advanced practice nurses can be transformational for the supervisee and the supervisor.

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