PEER COACHING AND WORK INTEGRATED LEARNING

Richard K Ladyshewsky and Brooke Sanderson

With Acknowledgments to Michelle Quail

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Authors

Dr. Richard K. Ladyshewsky is Professor of Managerial Effectiveness at the School of Management, Curtin University. He is a Fellow of the Curtin Academy and the Higher Education and Research Society of Australasia. He is also a Physical Therapist and previously an Academic Coordinator of Clinical Education.

Brooke Sanderson is a Senior Lecturer and Director of Fieldwork – Speech Pathology at Curtin University. She also oversees several student operated University Clinics. She is also a Speech Pathologist.

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Preface

The purpose of this book is to provide an overview of the peer coaching model in work-integrated learning. The book provides a detailed set of practice guidelines for Clinical Educators who are supervising students in this model. While much has been written on this work-integrated learning model, much of it describes the advantages and challenges of the model, describes the model in detail, or provides some theoretical support (or not) for the model. What appeared to be missing from the literature was a comprehensive perspective on how to actually lead and manage this type of placement from the Clinical Educator's perspective. While there have been snippets of this in the literature, and in some online resources, nothing we could find covered the 'how to' aspects of leading and managing this work-integrated learning model from beginning to end.

This book therefore provides an overview of the model and explains some of the different terminology used to describe this model. In addition to Clinical Educator perspectives who have experienced the peer coaching model, a review of the literature is also provided for those wanting to read about the evidence behind the peer coaching model. Some key theoretical principles the authors believe are central to the evidence supporting the peer coaching model is also provided.

What makes this book unique is that the practice guidelines in this book come from a research project to capture the tacit knowledge or 'know how' of experienced Clinical Educators who lead and manage the peer coaching model in practice. These best practice guidelines will provide both the novice and advanced educator with some great information and tools to make the peer coaching model in work-integrated learning successful.

To fully capture the breadth of the peer coaching model and how it can be used in work-integrated Learning we encourage you to work through the book from beginning to end. While the 'how to' sections in Chapter 4 are tempting for those who want to jump in and get started, it is important that you understand the background evidence in support of this

model which is captured in Chapters 1 to 3. Chapter 5 outlines some specific strategies for dealing with specific issues that might arise between students and also offers some guidance to Clinical Educators on how to build your effectiveness in this model. There is also a comprehensive reference list and additional resources and links at the end.

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Introduction

I (Richard Ladyshewsky) first started to manage the fieldwork program for the Physical Therapy program at the University of Toronto 30 years ago. At that time the demand for rehabilitation services was increasing and there was a call for more graduates. Entry level Masters and Doctorate programs were starting to emerge in the therapy professions and the demand for work-integrated learning placements to support these programs was increasing. Private practices were increasing and allied health professionals were beginning to expand into a range of community based services. To manage this demand for allied health professionals (occupational therapists, physical therapists, speech pathologists, diet therapist/dieticians - collectively known as 'therapists') universities started to ask Clinical Educators if they could host two students at a time.

Aside from the increase in placement availability when taking two students, what I found interesting about these 'two students to one Clinical Educator' (2 to 1) placements was that both the students and Clinical Educators enjoyed the experience. Over time I found that these '2 to 1' placements, as they were called at the time, had less problems than those placements that used the old apprenticeship model of one student and one Clinical Educator, or the '1 to 1' model. I became very interested in this 2 to 1 model of learning and thus began investigating, writing about and promoting this peer coaching model of work-integrated learning as I refer to it now.

Fast forward several decades later and we find that the concept of peer coaching has expanded greatly, beyond the clinical environment. Today, organizations outside of healthcare are recognizing the value of peer coaching. For example, peer coaching is being used in the corporate sector to enhance human capital and to build executive leadership skills (Corporate Leadership Council, 2011; Korotov, 2008). It is being used in business education (Ladyshewsky, 2006b; Parker, Hall, & Kram, 2008; Vilkinas & Ladyshewsky, 2011) and in the higher education sector to build academic leadership capabilities (Jones,

Ladyshewsky, Oliver, & Flavell, 2008; Ladyshewsky, 2006b; Vilkinas & Ladyshewsky, 2011). It also has a long tradition in building the capacity of teachers in the education sector (Joyce & Showers, 1982; Joyce & Weil, 1996). While much has been published on the peer coaching model, we still felt that what was missing was a useful 'how to' resource guide for busy Clinical Educators and students that could support them throughout the work-integrated learning experience.

So we hope you find this resource helpful, regardless of what industry or organization you might work in. You can go straight to the sections on how to manage a peer coaching model as part of a work-integrated learning experience if that is what you need. Alternatively, you can read the evidence supporting this model of education or have a quick read of the advantages of peer coaching in work-integrated learning settings if you are still unsure.

We do encourage you to at least give this model a try once or twice. Clinical Educators, after some experience in supervising an individual student, often find that they prefer the peer coaching model after they give it a try.

Terminology

Over the decades peer coaching has been described using a range of terms. One manuscript provides an excellent overview of terms associated with peer learning in education (Lincoln & McAllister, 1993). They note that peer learning is a process and within it, there are many different procedures. For example, peer tutoring, peer teaching, peer group learning, peer assisted learning, and peer consultation. The notion of peer also has to be defined within the context of each situation. For example, in peer tutoring, both parties may be students in a course, however one may be in their senior year whereas the other may only be in the junior year. While they are 'peers' given that they are both students enrolled in a course, they are not 'peers' when it comes to the body of knowledge they possess.

Another useful review is one that explores the range of learning terms that are used in adult developmental interventions. This review explores the differences and similarities between coaching, mentoring and tutoring (D'Abate, Eddy, & Tannenbaum, 2003). These terms are often used interchangeably but in fact are quite distinct. Coaching for example is about building skills and uses open ended questions to challenge the person receiving the coaching. It is a short term experience. Mentoring is more holistic, and while it can be about skills, it often covers many other things as well, some of which might be quite personal. Usually a very experienced mentor guides the mentee. It is a top down approach with the mentor advising and guiding. It can be a very long term experience. Tutoring on the other hand, is about instructing someone on how to do something. The tutor has greater knowledge and/or experience usually than the person receiving the tutoring. Therefore, we like to use the term peer coaching.

Initially the peer coaching model was referred to as the 2 to 1 model in some places because two students were assigned to one Clinical Educator (Ladyshewsky, 1993; Ladyshewsky & Healey, 1990). But the model is more than just assigning two students to one Clinical Educator. There are specific learning dynamics that are unique to this model of learning

(Ladyshewsky, 2006a). As a result, because of the way peers interacted and supported one another, some started to call it a collaborative learning model while others a cooperative learning model. Collaborative learning, when one explores the early literature, defines it as an unstructured or organic learning experience that forms spontaneously (Bruffee, 1993; Tang, 1993). Cooperative learning, on the other hand, is more structured, with specific pre-set group tasks, group accountabilities and integrated reward systems (Johnson & Johnson, 1991; Johnson, Johnson, & Smith, 1998; Slavin, 1983, 1995). The peer coaching model actually sits somewhere in between collaborative and cooperative learning.

Peer coaching started to creep in to the vernacular because we realized that in order for students to work together productively, they needed to learn how to give non-evaluative feedback to one another (Ladyshewsky, 2018; Showers, 1984). This ensured they remained peers and had security and confidence in the learning partnership. Giving non-evaluative feedback is what coaches do. They ask open ended and probing questions to make the coachee (the person receiving the coaching) think about what they are doing rather than just evaluating them and telling them what they need to do (Zeus & Skiffington, 2000). This forces the coachee to self-reflect, re-examine their knowledge, skills and behavior, and to consider better ways of improving their practice. This has a greater impact on future performance than just telling someone what they are doing wrong, particularly if they are not sure why they are doing it incorrectly. Hence, the peer coaching model evolved and was thus named to describe this learning strategy. Even though you can still call it peer assisted learning, as is done so extensively in the literature, this term is vague and doesn't describe what occurs between the students. For this learning model to be successful the learners must understand how to coach one another, and for this reason, peer coaching is a more appropriate term.

A recent review of the peer coaching literature has further denoted a need to ground this term in theory (Hagen, Bialek, & Peterson, 2017). In this review, a total of 55 scholarly references in management/human resources, health care and psychology were examined as a result of meeting the study's inclusion criteria. Hagen and colleagues concluded from the

literature that peer coaching is a process that is typically linked to training and offers personal and professional development outcomes. In this process there is no hierarchical authority between the peers but rather a sense of shared mutuality. Honesty and trust are important underlying psychosocial requirements. It is usually voluntary (although in most educational contexts students are assigned as pairs for their work-integrated learning experience), non-competitive and non-evaluative. Both group and dyadic peer coaching is described in the literature. Clear goals and objectives should guide the learning experience which is about increasing learning and providing support and help. Based on this review Hagen and colleagues offer this formal definition of peer coaching which is one the authors of this book support.

> "Formal peer coaching is the process of formalizing a voluntary, mutually beneficial relationship between two or more hierarchically equal peers in an effort to reach a clearly stated goal, particularly related to performance improvement, through the use of the specific coaching processes and mechanism of learning, helping, and support (Hagen et al., 2017), p. 553.

The term work-integrated learning has recently become popularized to describe situations where students (usually from colleges and universities) go to organizations to apply their learning in real life work contexts (Brown, 2010; L. Cooper, Orrell, & Bowden, 2010). We use the term work-integrated learning throughout this book although we may occasionally refer to some of the other terms as appropriate that are used in workplaces to describe work-integrated learning such as fieldwork, placements, practicums, apprenticeships and internships.

There are also a variety of terms used to describe the person who oversees the work of the students. They are often called Clinical Educator, Tutor, Supervisor, Coach, Facilitator, Mentor or Preceptor. In this book we will use the term Clinical Educator, because the primary objective of working with students is to support them towards becoming a competent professional, whatever field that may be. However, this is not to say that at times this Clinical Educator may have to provide some tutoring, facilitation, mentoring, supervision and/or coaching during the work-integrated learning experience. These are

specific educational interventions that fit nicely under the Clinical Educator label and are defined more deeply in this excellent reference (D'Abate et al., 2003).

The peers who learn from each other in the peer coaching model are referred to as students. This, however, doesn't mean the material in this book is only relevant to students. This guide is relevant to any type of individual learning from another peer in a workplace setting. For example, managers can peer coach other managers, staff members can peer coach other staff members, volunteers can peer coach other volunteers, and of course students can peer coach other students.

Why Peer Coaching?

> Exercise:
>
> Spend a minute writing down the names of all the famous pairs of individuals you know, real or otherwise. For example, (1) Fred and Wilma Flintstone, (2) Sonny and Cher. (3) …

When Clinical Educators are asked to complete this exercise independently during workshops, they run out of ideas fairly quickly, get a bit frustrated and struggle to remember names that are circulating in their head. When they are asked to repeat the exercise with another person they find they experience more valuable and enjoyable. They learn the names of new pairs, get help with some of the pairs they were struggling to remember and feel less frustrated at the end of this experience. In this simple exercise they have just learned as a pair, they have peer coached each other and have increased their level of knowledge. The expression, 'two heads are better than one' rings true. Imagine if we could structure a learning experience for students in this way? Well we can, by incorporating peer coaching into work-integrated learning experiences.

Just before we move forward with the material in this guide, it is important to note that the promotion of the peer coaching model does not by any means lessen the value of traditional apprenticeship models of education where a Clinical Educator works with only one student. We do hope, however, that after reading this guide, you see the added benefits of incorporating the peer coaching model in to your practice as a Clinical Educator.

Chapter 1

Over the past five years, work-integrated learning has taken on a renewed focus in universities given the demand by employers for competent graduates. For example, the authors' own university has made industry linkages a strategic priority by emphasizing this in its strategic plan. This plan states that it will develop "deep collaborations with industry to help our students develop the skills that will be so important to their ongoing professional and personal development." https://strategicplan.curtin.edu.au/themes/learning-student-experience/ accessed February 2019.

The health sciences field has incorporated work-integrated learning in to its curriculum for decades, but over the past 10-15 years there has been an increasing focus on integrating peer coaching into the learning environment. These peer based learning experiences, however, still need to be managed by Clinical Educators. While these Clinical Educators are highly trained in the technical aspects of their discipline, they often need additional support in managing a peer coaching model. Even though there are many papers exploring peer coaching models within work-integrated learning, there is still a research gap in identifying the best practices of those experienced in supervising this model across the duration of the work-integrated learning experience.

Peer coaching can be implemented at several points over the course of a work-integrated learning experience. These points guide the structure of most work-integrated learning experiences that take place over several weeks and are represented in the conceptual diagram below.
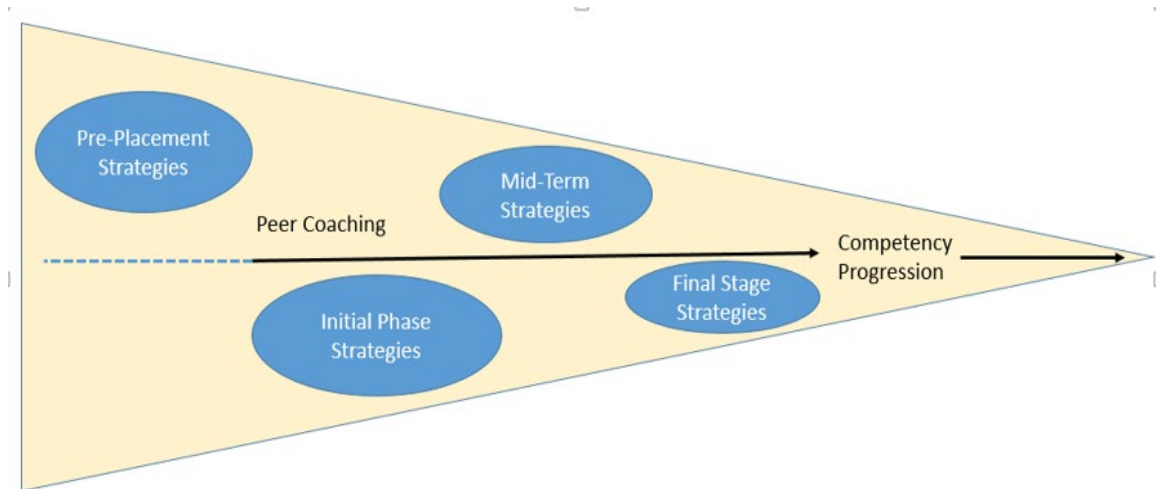
Distinct Points of a Work-Integrated Learning Experience

Each of these points require the Clinical Educator to undertake specific planning, supervision, teaching, coaching, evaluation, and at times, remediation strategies to support the success of the students. Inherent to this work-integrated learning lifecycle is the use of students as strategic learning partners. Through specific peer coaching practices across the different stages, the students are enabled to transfer their training (Baldwin & Ford, 1988) towards higher levels of competency that support their employability. As they become more competent in the work-integrated learning placement, the level of peer coaching may reduce as evidenced by the reduction in the size of the triangle in the image above.

Another peer coaching model that has been described in the literature is described as having five stages: forecasting; training with demonstration of new practice behaviors; opportunities for practice; non-evaluative feedback; questioning and self-assessment (Waddell & Dunn, 2005). While this model is situated in the health care sector, it is applicable to any peer coaching experience in a work setting.

There are several studies that have reported on the costs and benefits of the peer coaching model in work-integrated learning experiences (Baldry Currens & Bithell, 2003; Claessen, 2004; Dawes & Lambert, 2010; Harris, Jones, & Coutts, 2010; Ladyshewsky, 1995; Ladyshewsky, Barrie, & Drake, 1998), including one randomized controlled trial that

explored its efficacy (S Sevenhuysen, M Farlie, J Keating, T Haines, & EK Molloy, 2015b). Evidence in this randomized controlled trial suggested that students benefit from the support offered in this model, achieve higher levels of competency and provide service back to the institution that is often greater than traditional models.

In our own research, we have demonstrated positive productivity outcomes for workplaces that use the peer coaching model (Ladyshewsky, 1995; Ladyshewsky et al., 1998). Other studies have found that students tend to provide positive productivity gains to organizations that take them (Dillon, Tomaka, Chriss, Gutierrez, & Hairston, 2003; Emery & Nallette, 1986). Further, we have demonstrated positive gains in clinical competency (DeClute & Ladyshewsky, 1993; Ladyshewsky, 2010) enhanced clinical reasoning (DeClute & Ladyshewsky, 1993; Ladyshewsky, 2002, 2004; Ladyshewsky & Jones, 2008) and specific forms of clinical reasoning when using peer coaching as part of a reflective blogging assignment (Ladyshewsky & Gardner, 2008; Tan, Ladyshewsky, & Gardner, 2010). An overview of our research and our thoughts on the peer coaching model is summarized in a recent article summarizing decades of research (Ladyshewsky, 2017). It is available at the following open access link. https://radar.brookes.ac.uk/radar/items/26da9f5c-0271-439c-8437-2fa7afe5823d/1/

Peer coaching models in Practice

While peer coaching can occur naturally, failure to formalize the process and train participants can negatively impact rapport-building, the development of trust, confidentiality, status and power and final learning outcomes (Sevenhuysen et al., 2015b). Therefore, it is important that Clinical Educators understand how to manage this type of placement across the life cycle.

There are many variations to how peer coaching might work in a work-integrated learning experience. The most typical model involves one Clinical Educator and two students. However, in some cases there may be three or more students, but not usually more than six

if there is only one Clinical Educator supervising them. In some models, the supervision may be distributed across two or more Clinical Educators. In the case of health care, students may be based in hospitals, clinics, community agencies, public or private settings or non-traditional work settings. A key factor that must be in place is that the students are required to coach and learn from one another in supportive ways throughout the work-integrated learning experience, in addition to any coaching/teaching/supervision from the Clinical Educator(s). Having two students working on separate wards in a hospital with no contact with one another and the Clinical Educator travelling between the two wards to provide teaching and learning support is not a peer coaching model as it does not benefit from the shared power of learning from a peer. Table 1 describes three common peer coaching models that emerged from our interviews with experienced Clinical Educators.

Table 1 - Three Different Examples of Peer Coaching Models in the Healthcare Context

Peer coaching model	Practice Environments	Features
Two students and one Clinical Educator*	Commonplace in hospital wards, outpatient clinics, community care environments etc...	Students have shared and non-shared client caseloads. They provide support, observation and coaching to one another throughout the placement, in addition to that provided by the Clinical Educator. *In some cases there may be two Clinical Educators supervising the students if they job share. In this case, communication, documentation and information sharing systems need to be in place to ensure the supervisors are aligned in their observations, feedback and guidance given to the students.
Three to six students and one Clinical Educator	Commonplace in outpatient clinics in hospitals and university environments.	The students all work within an outpatient clinic that may be based in a hospital or university environment. The students run the clinic and provide observation, support and coaching to one another. The Clinical Educator may work full time in this role (particularly when numbers of students exceed 3) and organizes teaching and learning sessions, evaluations and onsite support.
Two students and two distinct Clinical Educators • One an onsite Non-Discipline Clinical Educator • One an offsite Discipline Clinical Educator	Commonplace in new and emerging workplaces that don't traditionally employ that discipline, or in environments that can use the talents of the students to create new programs and services and potential new areas of employability.	Two students, usually at the end of their training and highly mature and independent, work together at an agency/workplace to create new programs and services that benefit the client base. They work cohesively as a partnership. An onsite Clinical Educator from the agency/workplace provides support, coaching and advice. The offsite Clinical Educator, from the students' discipline, provides support, coaching and evaluation about specific professional competencies and practices. The off-site Clinical Educator usually visits sporadically or as needed although they are always available by phone/email.

Within all of these models there is an expectations that the students will work together, observe the practice of one another, and ask fair and honest open ended questions that stimulate learning. Through this practice they build their confidence and competence together by testing the application of their academic knowledge and practice to the work environment. Where they find themselves challenged as a team and can't resolve practice issues and/or questions, they can approach their Clinical Educator for support and guidance. This brings the 'bigger' issues to the attention of the Clinical Educator whereby they can provide answers and/or support. Bringing this bigger issue to the Clinical Educator feels safer for the students because they realize that they both can't answer the question. When students are alone on a placement and don't understand something, it can feel threatening to bring these big questions to one's Clinical Educator for fear that they might evaluate you in a negative way (Tai, Haines, Canny, & Molloy, 2014). There is safety and power in numbers. Minor issues, on the other hand, are easily addressed by the students, which leaves the Clinical Educator time to attend to other matters, plan teaching sessions, spend time observing and giving individual feedback, and collecting data for evaluation. While some Clinical Educators have expressed concerns that students might be giving other students the wrong feedback or advice, this did not occur when students were asked to work through a simulated case (Ladyshewsky, 1999). In fact, the students were very good at recognizing where practice could be improved in the moment, but were challenged from the perspective of not knowing how to give this feedback during the client encounter to their peer. Again this denotes the importance of preparing students for this model of education. Two studies found that well trained students were very effective in the teaching of specific clinical skills although this was more akin to peer tutoring (Burke, Fayaz, Graham, Matthew, & Field, 2007; Tolsgaard et al., 2007).

There have been some studies which detail the actual strategies Clinical Educators use to ensure the peer assisted learning placement is effective. An excellent overview article by Rindflesch and colleagues provides a detailed summary of what needs to occur in a multiple student single Clinical Educator model (Rindflesch et al., 2009). Detailed operational steps

are laid out although it would appear that more informal peer to peer learning opportunities would add to the formal ones that are part of the model.

Bartholomai and colleagues provide information on their experience evaluating three consecutive 3 to 1 placements in a traditional hospital setting (Bartholomai & Fitzgerald, 2007). In this experience they expand the role of supervision beyond the primary Occupational Therapy Clinical Educator. They involved other members of the multi-disciplinary team and other occupational therapists. Other studies describing this clinical education model, where more than one student is being supervised by a Clinical Educator, also indicate the importance of departmental support for this initiative (Blakely, Rigg, Joynson, & Oldfield, 2009; Dawes & Lambert, 2010). For example, the department supervisor, other clinicians, professional staff and other health disciplines may become involved in supporting the learning of the students. The caseload of the primary Clinical Educator was delegated to the students so they could devote their time to supervision and management of the learning experience. Preplanning was critical to ensure a quality experience and was coordinated by the university and site coordinators. The importance of the university providing training to Clinical Educators on alternative models of supervision and how to encourage peer learning was essential (Bartholomai & Fitzgerald, 2007; Briffa & Porter, 2013; Flood, Haslam, & Hocking, 2010; O'Connor, Cahill, & McKay, 2012). Timetables, orientation folders, administrative tools and site specific educational experiences were preplanned to help structure the work and prepare the students on arrival. This is consistent with others who have reported on using a peer learning model during work-integrated learning experiences (Blakely et al., 2009; Claessen, 2004; Flood et al., 2010). The other colleagues were given information on their roles as secondary supervisors and a private space created for the students. This private space was critical to encourage an open and safe space to encourage peer learning and collaboration and students were given explicit instruction that they were accountable to work together as a peer learning team (Bartholomai & Fitzgerald, 2007). The supervisor provided individual and group supervision to best manage their time often using a schedule to set these times as well as feedback and

evaluation sessions as is echoed in other studies exploring the same multiple student single Clinical Educator model (Blakely et al., 2009; Claessen, 2004; Flood et al., 2010). This did not create an unmanageable supervision workload but the Clinical Educator needed to know when to balance the needs for student autonomy and supervision on individual and group levels (Bartholomai & Fitzgerald, 2007; Blakely et al., 2009).

The importance of helping students develop the correct self and peer-critiquing skills is noted in a project where two speech pathology students worked alongside a Clinical Educator in a Speech Pathology setting (Blakely et al., 2009; Claessen, 2004). It was noted that students needed some guidance to develop their self-critique or self-evaluation skills and that their peer needed guidance on how to ask open ended, probing questions (peer critiquing). This process was facilitated by having students share some of their caseload and engage in this reflective clinical reasoning exercise as they could both relate to the case in question (Claessen, 2004). It was important that the students set specific learning objectives for themselves in addition to those set by the university/agency as this then became a focus for the self, peer and Clinical Educator directed feedback/critique. It also facilitated a group midway evaluation as all parties were involved in this formative evaluation process even though a preference for a one on one evaluation was preferred at the end for the summative evaluation (Claessen, 2004).

This chapter has provided an overview of the Peer Coaching Model and some of the key concepts that are important. The next two Chapters delve more deeply in to the theoretical support for the peer coaching model.

Chapter 2

Theoretical Support

Professional Reasoning and Situated Learning

To understand the power of the peer coaching model we need to first explore the nature of professional reasoning, or clinical reasoning as it called in the health sciences sector. When students arrive at the work-integrated learning setting for their first practical experience they are novices (Oldmeadow, 1996). As a result of their study they have a good knowledge base but need to apply this learning to real life experiences. This is called situated learning (Lave & Wenger, 1990). Situated learning increases employability and work ready graduates because it places the learning directly in the environment where the students need to practice. It challenges the students' cognitive abilities of synthesis, evaluation and problem solving in real life situations. They have to be able to evaluate the effectiveness of their thinking and performance based on the outcomes of their actions and make judgements about how to change their thinking and action. This high level reflection-about-action and reflection-in-action (Schon, 1991) is called metacognition. These three elements, knowledge, cognition and metacognition are the components of effective reasoning that are challenged in situated learning experiences.

When novices start to solve problems in the work-integrated learning setting, many of the things they experience do not necessarily match what they have learned in the educational setting. They have to try things out, modify their actions, deal with externalities, and make decisions and move forward hoping they got it right. In the case of health science students, this transfer of academic knowledge to clinical knowledge takes time and is fraught with error as novice reasoning is different from experts (Higgs & Jones, 2000, 2008; Schwartz & Elstein, 2008). This is due to novices employing a thought strategy called backward or

deductive reasoning. It is much more laborious, time consuming and error prone than what experienced or expert practitioners employ which is termed forward or inductive reasoning. To best illustrate backward or deductive reasoning in a novice the following example is provided.

A Novice Reasoning Example using Backward or Deductive Reasoning in a Client with Shoulder Pain	Deductive or Backward Reasoning
	When a student is presented with a client with shoulder pain, they have to generate a series of hypotheses and test these out to see which hypothesis has the best fit to the case. In the case of shoulder pain, there could be several hypotheses (rotator cuff tear, bursitis, bicipital tendinitis, partial subluxation, labral tear, acromioclavicular sprain, cervical spine referred pain, capsulitis). The student has to go back and test each one of these hypotheses using a series of observations, questions and tests. After doing this for each hypothesis a massive amount of data is collected and this often challenges the working memory of the student which is only able to maintain a certain amount of information at one time (Miller, 1956). The student then has to deduce what is the best 'fit' by going backward and reviewing all of the data.

Because there is a lot of data, combined with the fact that some of their questions or tests may have not been done correctly, yielding false-positives or false-negatives, the likelihood of making a reasoning error early in their fieldwork experience is very high. Studies in medicine, for example, have found higher rates of error leading to morbidity and mortality in surgery rotations at the start of the academic year (Englesbe, Pelletier, & Magee, 2007) Similarly, increases in hospital mortality and decreases in hospital efficiency have also been reported during end of year medical student changeovers and this is referred to as 'the July effect' (Young et al., 2011).

With time, and as the weeks progress, the novice moves towards advanced beginner and competent status (Oldmeadow, 1996) only by repeating experiences over and over again with numerous other clients with similar presentations and learning from their successes and failures. Over time, and repeated exposure to clients with similar problems, the student begins to see patterns in the presentation of these clients and begins creating cognitive scripts which enable them to deal with these clients in the future more quickly and more accurately (Boshuizen & Schmidt, 1995; Elstein, 1995; Higgs, Jensen, Loftus, & Christensen, 2019). This is the shift to forward or inductive reasoning.

Expert or experienced practitioners when faced with a new client with shoulder pain, observe carefully and ask very specific questions and do very specific tests which they have learned point very accurately to specific problems. If these observations, questions and/or tests yield immediate positive results, they induce what the problem might be and go forward with their specific cognitive script. They undertake very specific actions which quickly confirm that this case mirrors that of the many cases they have seen before. They do this quickly and effortlessly and it appears to others as intuition. Quite the opposite of the novice who has not had the benefit of seeing multiple cases of the same problem over several months and/or years.

To move from novice to advanced beginner to competent (Oldmeadow, 1996), which is where we want students to be when they enter the workplace, takes time and practice. Clinical Educators can be very valuable at this stage of learning by demonstrating what they do with common cases that present frequently in their practice area. By 'talking aloud' about their thinking (Ericsson & Simon, 1993) during this demonstration, the students can tap in to the Clinical Educators inductive reasoning strategies or cognitive script. This process of enhancing clinical reasoning can be accelerated by peer coaching because each party can ask key questions during work-integrated learning activities that challenge each other to think about their practice (Ladyshewsky, 1999, 2002, 2004, 2010). This can reduce reasoning errors because each party shares their body of knowledge and experience with one another.

Experiential Learning, Reflective Practice and Coaching

To accelerate the progress and accuracy of developing reasoning through peer coaching, it is important to understand some additional theoretical frameworks. The first is experiential learning. This concept was developed by David Kolb and talks about a cyclical framework for learning. This is depicted below.

| | The Experiential Learning Cycle

To maximize learning structure a concrete experience is needed. For example, interviewing a client about their medical history. After it is done, reflect on how well you did, on what you observed, on what you could have improved. Then make some conclusions from this experience. What concepts might you need to review or learn or practice further? Then set up another experience where you can actively experiment with this new knowledge, skill or attitude. Then repeat the cycle until you get it right. |

Experiential Learning Model (Kolb, 1984)

In work-integrated learning settings, students are given a range of tasks that challenge their professional reasoning, leading to competence. However, to maximize learning, it is important to reflect on these experiences afterwards. For example, asking yourself what went well, what did not go well, and what did you not understand about the event. After this review, conclusions have to be made about what you need to do to improve your performance. What new information do you need to get, where do you need to practice further? The student then applies this learning to a new experience and the cycle begins again. As we will discuss further, having a trusted peer who can coach you through this experience can be invaluable, particularly if there are things the student is unaware of that they are doing incorrectly!

Reflective observation is what reflective practice is all about. Those embarking on professional careers need to engage in this practice if they are to improve their competency and most academic programs insist that their students engage in this practice during their work-integrated learning experiences. Students can reflect-in-action and reflect-about-action during and after these experiences (Schon, 1991). The problem with doing this in isolation is that sometimes the student does not know what they do not know. As a result, these errors of reasoning can continue and impede progress towards competent performance. However, during peer coaching, the peer coach can observe their peer coachee in practice. They can ask their peer coachee key questions during and after the experience. This requires the peer coachee to think about what they are doing and to reconsider what they know and don't know.

Knowledge and practice gaps may be revealed through this peer coaching, and in collaboration with their peer coach, improve practice and professional reasoning of both parties through vicarious learning and modelling (Bandura, 1997). Because peers are doing this, in the absence of evaluation, students are more likely to engage with one another in what is known as structured controversy (Johnson & Johnson, 1978, 1987; Johnson, Maruyama, Johnson, Nelson, & Skon, 1981). Structured controversy is a phenomenon that drives student engagement. When something emerges that one or both of the students is not sure about (perhaps a skill, or some specific knowledge) this creates cognitive unease. Students want the answer and will debate, discuss, research and even argue in a positive way to get to a sound outcome. Once this answer is achieved, either through their own efforts or by eventually consulting with their Clinical Educator, the students can relax and move forward, until the next controversy. This structured controversy results in enhanced reasoning and performance and increases competence. Structure is important here as the dialogue must be non-evaluative, positive and fair and not used to score points or make the other person feel inferior.

Peer Coaching, and Non-evaluative Feedback

It is important that peers remain peers during the work-integrated learning experience, otherwise, competition, conflict or withdrawal may occur and cause the interpersonal conflicts between students that Clinical Educators worry about. The peer relationship can be maintained by ensuring that the feedback being given to one another remains non-evaluative, at least in the early stages of the relationship until trust is in place. If feedback becomes evaluative then the peer relationship changes due to changes in status. For example, if one of the students always tells the other student what they are doing wrong, then this student becomes an evaluator, much like a supervisor. The student receiving this evaluation-laden information may find it difficult to digest and may withdraw or withhold information from the other student, get angry resulting in conflict, or compete by doing the same to the other student. This is unproductive.

To maintain equal status, students must learn to ask questions. These questions should be based on the objectives the other student is trying to achieve. Open ended questions are best, and the peer coach needs to be comfortable waiting for answers and to probe further with more detailed questions if necessary. To ensure the peer coach and coachee understand what is being shared they should also paraphrase back and forth what they have heard to cross check clarity. This ensures there are no misunderstandings. Table 2 provides some example open ended question formats that can be used in peer coaching. The 'Why' questions are in italics and bolded because they have to be used with caution because they can make people defensive because they force a person to justify their actions.

Table 2 - Coaching Questions (Zeus and Skiffington 2002).

How	What	When	Where	*Why*
How did you think/feel/act when....? How does that fit in with what you know about...."	What might you do differently next time when...? What did you learn from that when...?	When did you notice it starting to happen...? When did you realise that...?	Where can you start to make a change? Where did you feel it started to go wrong?	*Why did you do that?* *Why do you think they responded that way?* *Why is this happening?*

Asking questions instead of just giving feedback about what is 'good or bad' is important for the development of competence. By asking the peer coachee open ended questions about their practice, you are forcing them to go back to their long term memory where all of this information is stored. The peer coachee must bring this information forward to working memory, and restructure and reframe it with the new knowledge that is being generated through the processes of coaching, structured controversy and reflective practice. The reframed learning can then be used to modify their cognitive scripts and schema, and sent back to long term memory where it will be used more effectively in the next situation where this knowledge is needed. Telling a person what they did wrong is just information, it doesn't create the same kind of knowledge restructuring that peer coaching and reflective practice can create when dealing with complex and challenging work situations.

Social and Constructivist Learning Theory

We learn from each other, and much of how we model our professional practice is based on how we observe others in social and professional environments. We also test our knowledge and practice to ensure it is accurate and valid by discussing it with others. However, engaging in this kind of observation and dialogue with a Clinical Educator can be stressful

for the student because of the continued presence of evaluation. The Clinical Educator is always looking for evidence of their student's competence because the Clinical Educator must provide formative and summative evaluation about the student's progress and determine in many cases whether they pass the practicum. They also need this knowledge to know when it is safe to progress the student to more complex professional tasks.

This evaluative pressure can create certain dynamics in the student – Clinical Educator relationship and is best explained by the Johari Window below (Luft & Ingham, 1955).

	Known to Self	Known to Others
Known by Others	**Open Window** *Known by both you and others*	**Blind Spot** *Unknown to you but known by others*
Unknown by Others	**Hidden Window** *Known to you but not by others*	**Unknown** *Unknown by both you and others*

(Luft & Ingham, 1955)

The Johari Window

When the student and Clinical Educator have a fully developed relationship that is based on openness, trust and confidentiality, the largest pane in this window is the open arena. However, if the relationship is strained due to interpersonal dynamics or is highly evaluative, as opposed to more coaching in nature, the student may elect to hide certain elements of their performance in order to 'look good' in the eyes of the Clinical Educator and only reveal things that they know they are good at. The hidden window would then become the largest pane in this window.

If the Clinical Educator finds out about this practice of hiding things, then of course, the relationship becomes more strained. Lastly, if the Clinical Educator has poor supervision skills or feels intimidated by the student, the Clinical Educator may choose not to give the student feedback until the midway (formative) and final (summative) evaluation. In this case the Blind Spot Window becomes the largest. Keeping the student in this blind spot until the midway and final evaluation can upset the student. This is due to not being kept in the loop about their performance and not given feedback at the time when they could use it most.

The benefit of the peer coaching model is that the students who are working together are not responsible for evaluating each other and making decisions about their competence. Instead, they are equals, learning together, trying to embed their academic knowledge in to clinical knowledge. As a result, it is much safer to cooperate and self-disclose things to one another and work within the Open Window. If the students cannot figure something out jointly, it is safer to then seek the advice of the Clinical Educator for assistance, which moves the issue in to the Open Window a much more productive learning space. The social dynamics have a powerful influence on learning, and peer coaching changes the evaluative nature of a placement to one of coaching and learning.

The discussions that the students have with each other about their practice and knowledge engage some powerful social learning dynamics. When students discuss or observe their practices jointly, they often discover that what they know does not align with what their peer knows. This creates energy between the two students to find the correct solution. As a result of the discussions that occur between the students, they are able to construct new meaning which enhances their practice, something that may not have occurred if alone on a practicum. As a result, the constructivist learning (P. Cooper, 1993) that occurs through the joint dialogue and practice between peers leads to accelerated and heightened levels of clinical reasoning and competence (Ladyshewsky, 2002, 2004, 2010; Ladyshewsky & Jones, 2008).

This is illustrated below. The cones contain the knowledge, skills and attitudes of the student when working individually or as a reciprocal peer coaching partnership under the supervision of a Clinical Educator. When a student is part of a peer coaching model, this partnership, alongside the Clinical Educator, increases the capacity of the cone (as evidenced by the larger size of the cone on the right) and thus a greater level of knowledge, skill and attitude ensues. Knowledge, skills and attitudes (Kraiger, Ford, & Salas, 1993; Quinones & Ehrenstein, 1997) are the three components of clinical competence. Clinical reasoning, represented by the spiral inside both cones is comprised of knowledge, cognition, and metacognition (Higgs et al., 2019). The peer coaching model requires students to engage

with their knowledge (metacognition) and to test it (cognition) against the frameworks of their peer coach. By doing this, it confirms what the students need to do, if anything, about their skills, knowledge base, or affective/attitudinal behaviors to yield greater levels of competence. Individual students working alone with a Clinical Educator don't have this student partnership. Hence, this is why the cone on the right is larger, demonstrating the greater capacity for clinical reasoning.
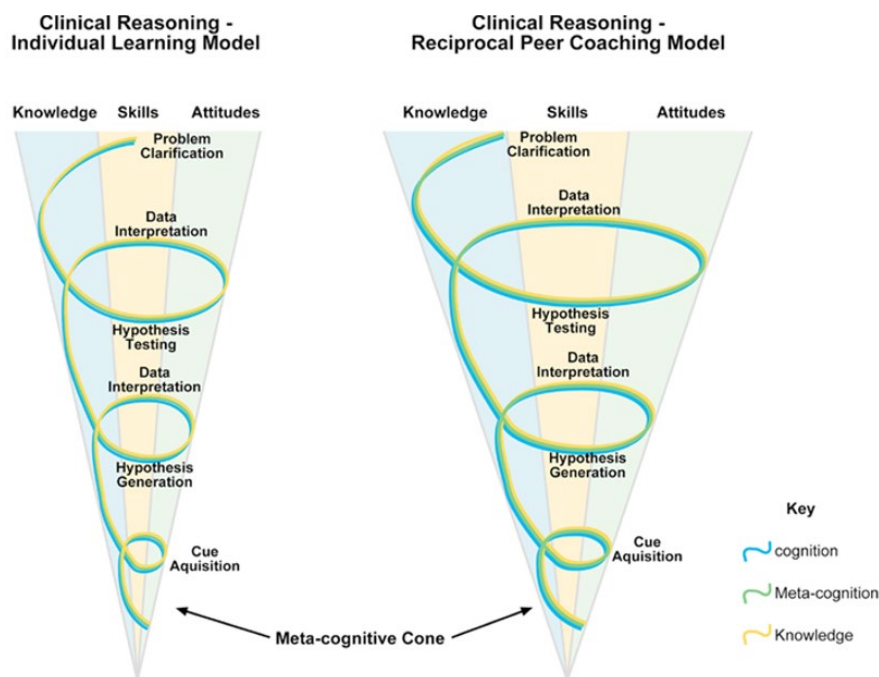
Competence and Clinical Reasoning in Individual vs. Peer Learning

Broaden and Build Theory and the SCARF Model – The Neuroscience of Learning

The last theory that is linked to this section flows from the neuroscience of learning. As noted in the section above, the pressure of evaluation the student experiences when under the watchful eyes of the Clinical Educator can at times create anxiety, fear and behavior that may not be productive for learning. As humans we have more negative emotions than positive ones because the former serve to protect us. Negative emotions such as fear, anxiety, disgust and hate activate fight and/or flight reactions which protect us from harm. However, these are not productive emotions for learning because they interfere with working memory and access to knowledge. The role of positive emotions, such as love, creativity, curiosity

and joy, however, expand the cognitive capabilities of the student by expanding the thought-action repertoire (Fredrickson, 2001). As noted above, the peer coaching model offers a supportive colleague to share ideas and practice with, and can assist the student to feel safer and less threatened. Anxiety is significantly reduced and confidence significantly increased as a result of the support received in this educational model (Ackland, 1991; Baldry Currens & Bithell, 2003; Hemming, Weidner, & Jones, 2006; Ladyshewsky, 1999; Lincoln & McAllister, 1993; S Sevenhuysen, M Farlie, J Keating, T Haines, & E Molloy, 2015a; Sevenhuysen, Thorpe, Molloy, Keating, & Haines, 2017; Zeus & Skiffington, 2000). This reduction in anxiety and and a boost in confidence enhances the power of positive emotion and the learning and development needed for professional growth.

David Rock's SCARF model demonstrates how the peer coaching model can facilitate these positive emotional states, thus lessening the influence of negative emotions which impact learning.

https://conference.iste.org/uploads/ISTE2016/HANDOUTS/KEY_100525149/understanding theSCARFmodel.pdf

This model is based on research within neuroscience on how people interact socially and has three central ideas. The first is that the brain treats many social and physical threats and rewards with the same intensity (Lieberman, & Eisenberger, 2009). Secondly, the ability to make decisions, solve problems and collaborate with others is increased under a reward response (Elliot, 2009). Lastly, the threat response is more intense and more common and needs to be carefully minimized in social interactions (Baumeister & Leary). In other words, strategies to maximize the beneficial power of positive emotions should be put in to place to support learning, growth and development. The peer coaching model is one such strategy.

These five domains of the SCARF model (status, certainty, autonomy, relatedness and fairness) have been shown in studies to activate the same reward circuitry that physical rewards activate, like money, and the same threat circuitry that physical threats, like pain, activate (Rock, 2009). Understanding that these five domains are primary needs can assist

students and Clinical Educators to maximize their learning experience by focusing on things that increase positivity. The SCARF model and how it relates to the peer coaching model is laid out in the Table 3 below.

Table 3 - SCARF Model and peer Coaching

Status	When status is equal, negative emotions are reduced because there is no power differential. When a status difference emerges, then negative emotions may be activated to protect oneself. Impact on learning: Because peers are equals, they are more likely to share knowledge and practice with each other in the open arena because there is no evaluation pressure. This activates positive emotions and leads to creativity, joy, curiosity and love of learning. Clinical Educators need to make sure they also treat each student equally (overtly and covertly) to ensure status remains equal between the students.
Certainty	When uncertainty is present, fear and anxiety increase and activate protective mechanisms which interfere with learning. Impact on learning: The presence of a peer helps to reduce uncertainty because students can resolve basic issues jointly, observe others' practice, and get clarity on questions without involving the Clinical Educator all the time. This enables inquisitiveness, exploration and love of learning. The certainty of being able to approach the Clinical Educator with questions that both are not able to answer also adds to certainty, particularly it is a shared question and not one that can be used against the individual.
Autonomy	When we lose control over events, our autonomy suffers and we become more vigilant, anxious and fearful. Having autonomy is important for feeling in control. Sometimes in a traditional placement, the individual student feels observed and monitored all the time by the supervisor. This can reduce a sense of autonomy. Impact on learning: During the peer coaching experience, students bring their own issues and challenges for discussion with their peer. This keeps the peer in control of what they want to learn and helps them to manage what they need help with. This gives each partner a sense of autonomy in the relationship while maximizing the support of their partner. The Clinical Educator can also support autonomy by being very clear about what are individual versus shared roles in the partnership of students.
Relatedness	During the peer coaching experience, students bring their own issues and challenges for discussion with their peer. This keeps the peer in control of what

	they want to learn and helps them to manage what they need help with. This gives each partner a sense of autonomy in the relationship while maximizing the support of their partner. The Clinical Educator can also support autonomy by being very clear about what are individual versus shared roles in the partnership of students. Impact on learning: In the peer coaching partnership, provided the students are working together appropriately, a trusted support person is present where they can bounce ideas off. Because this relationship is peer based, there is a sense of affinity which increases relatedness and maximizes the opportunity to capitalize on the positive emotions in the learning relationship.
Fairness	This relates to how fair we see the exchanges between people. When we sense unfairness, defensiveness and anger emerge, which again, shut down the opportunity to maximize positive emotions for learning. Impact on learning: In a peer coaching relationship, there are the students and the Clinical Educator. It is harder to do things that might be unfair because there is always a third party to make a comment. This makes the feedback that occurs between students and the Clinical Educator fair because of this third party presence. Similarly, during evaluation sessions, the opportunity to benchmark oneself against one's peer(s) helps to moderate any feedback about one's performance. For example getting negative feedback about your performance from a Clinical Educator may seem fairer because you have observed better performance in your peer. Clinical Educators need to be mindful of how they give feedback or assign duties to their student(s). The student(s) might see things but not understand underlying reasons. Hence, if decisions are being made which seem unequal in the eyes of the student(s), it is important to share the underlying reasons for this decision. For example, why is one student given a more complex task and the other one is not?

Chapter 3

The Peer Coaching model: A Review of the Literature & Clinical Educator Perspectives

In this Chapter, we review the Health Sciences literature on the peer coaching model. We also summarize what Clinical Educators note are the advantages of the peer coaching model from their direct experience and/or thoughts during the many workshops that have been run for them on this supervision approach. First, the literature.

Literature Review

Several systematic reviews of the peer learning/peer coaching literature have been done over the years. These are presented in chronological order.

One early review focussed on peer assisted learning in health sciences education and noted that more evaluation was needed on this educational model even though there was considerable evidence in support of its effectiveness in childhood education (Lincoln & McAllister, 1993). In this review they provide examples of structured and unstructured approaches to peer learning in clinical learning environments, and offer many different examples of models that can be developed to support peer learning. For example, unstructured experiences may include senior students peer tutoring junior students, or just creating opportunities for peers on a placement to come together to reflect and observe learning experiences. Structured approaches might include student run clinics where four to six students work together to provide the service yet support one another educationally. Another structured approach may involve senior peers working collaboratively on a project within an agency with offsite supervision, or quality circles which involve groups of students coming together to enhance their practice through discussion, reflection and problem solving. The review notes several potential advantages of the peer assisted learning model.

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These include increased student competence through knowledge confirmation, greater confidence, enhanced collegiality, deeper approaches to learning, less reliance on the Clinical Educator and a greater focus on learning from others, particularly through enhanced reflection.

Another early review explored the origins of peer coaching in teacher staff development and presented the theoretical concepts underlying this educational model (Ackland, 1991). This review touted many of the benefits which appear in later reviews of peer coaching, in particular, collegial support, problem solving and sharing, and the opportunity to observe one another to provide feedback and assistance. They noted the importance of using non-evaluative feedback when sharing information based on the observation of teaching practice. The feedback had to be specific, accurate and non-evaluative with the aim to improve instructional technique.

One review of 10 manuscripts in physical and occupational therapy explored how the peer based learning model was developed and/or evaluated (Baldry-Currens, 2003). Five of the studies were comparative and the other five only descriptive. While sample sizes were small in each of the papers, and the number of authors and institutions limited, the credibility of most of the findings was increased through confirmation in two or more separate studies. The advantages were increased time for supervision by Clinical Educators and greater student independence. Students valued the support and companionship in the model. One concern expressed by Clinical Educators was the potential for student competition and conflict. Concerns about a lack of rigour and breadth of studies in the literature was expressed in the review and no conclusions could be made about whether the peer coaching model was better than the traditional apprenticeship model (Baldry-Currens, 2003).

The question of whether the traditional or apprenticeship model of clinical education was inferior or superior to a peer coaching model has been explored in the literature. A systematic review of the scholarly literature on undergraduate clinical education models found that there was no one superior model of clinical education (Lekkas et al., 2007). This

review focused on a range of allied health disciplines (physical and occupational therapy, speech pathology and social work). Given the evidentiary quality of the quantitative and qualitative literature that was reviewed, no solid conclusions could be made regarding a superior model. Six different models were reviewed including the one Clinical Educator to two student model. Each offered advantages and disadvantages. For the one Clinical Educator to two student model, advantages included positive effects on service delivery, increased number of placements, enhanced clinical competence, greater sharing, cooperation and support between the students (Lekkas et al., 2007). Students positively regarded this model although they had fears that they might not get adequate supervision. In some cases the model was restrictive where space or client variety was lacking. Concerns about students being incompatible, the extra work for the supervisor and the potential for student competition were also noted in this review. However, one study which surveyed medical students working in teams on clinical rotations using peer assisted learning strategies were reported to have no problems with competition (Tai et al., 2014).

Another high quality and comprehensive paper reviewed the peer coaching literature from the perspective of business education (Parker et al., 2008). Central to the effectiveness of peer coaching was ensuring there was equal status between partners, a focus on the development of both peers, reflection on practice, and an emphasis on the process, particularly non-evaluative coaching questions, to ensure partners remained connected and respectful of each other (Parker et al., 2008). In their survey of 209 Master of Business Administration students, who used peer coaching to accelerate career learning, they felt more success in dealing with change, felt supported in the pursuit of their personal and professional goals, had more confidence, improved self-image and improved delivery of feedback that fostered empowerment (Parker et al., 2008). Overall, 49 percent were satisfied with the peer coaching experience, 26 percent partiially satisfied and 25 percent dissatisfied. The degree of satisfaction appeared to be impacted by how much time and effort was invested in the peer coaching process with greater investment leading to greater satisfaction (Parker et al., 2008). These results again note the importance of properly preparing students

for the experience and suggest that the peer coaching model may also be appropriate for students in Post-Graduate entry programs and in programs outside of the health sciences.

One pragmatic review explored peer teaching in clinical education (Secomb, 2008). Citing a lack of consensus and clarity on how to implement this practice, 12 articles involving both quantitative and qualitative methodologies spanning five countries and four health science disciplines were reviewed. The study concluded that peer teaching and learning is effective for undergraduates on clinical placements. The authors noted that peer teaching increases student confidence in clinical practice and improves learning in psychomotor domains (Secomb, 2008). Personality and/or learning style clashes were potential issues associated within this model of learning as was the potential for having less individual time with the Clinical Educator. Other issues, specific to the studies in this review identified other advantages and some challenges but these require more research to make any broad conclusions (Secomb, 2008).

Similar findings to these earlier reviews were also reported in a review of 17 studies in clinical education across several allied health disciplines several years later (Briffa & Porter, 2013). In this review of the two student to one Clinical Educator model, learning from peers was noted as an advantage. The peer support led to greater opportunities to practice skills with one another, and reduced reliance on the Clinical Educator except for complicated questions. An interesting conclusion from the review was the positive perspective that Clinical Educators had for this clinical education model. One of the disadvantages noted in the review was reduced time for individual supervision of the students. This is commonly noted in the literature from both perspectives – as the Clinical Educators have to split their time across the two students and the students want more time with their Clinical Educator. Much of this concern stems from a belief that the quality or depth of learning will be greater when it comes from the Clinical Educator (Tai, Molloy, Haines, & Canny, 2016). However, as noted in several reviews of this model, peers can offer each other many things that can enhance competency and success (Baldry-Currens, 2003; Briffa & Porter, 2013; Lekkas et al., 2007).

Another review of peer assisted learning focussed on undergraduate clinical medical education, with 43 qualitative and quantitative manuscripts meeting quality inclusion criteria (Tai et al., 2016). This study focussed on same level peers learning from one another during clinical education. They found that that peer assisted learning increased the students' ability to reflect, increased confidence, increased motivation to participate, enhanced problem solving, increased feedback and provided support during clinical education. Of note was the importance of the Clinical Educator. While students can learn from each other, they still desire teaching and feedback from the Clinical Educator and this is more highly valued (Tai et al., 2016).

A more recent review on peer assisted learning in clinical education involved 28 studies representing five allied health professions (Sevenhuysen, Thorpe, Molloy, Keating, & Haines, 2017). The review found bias in the articles to be high, with only nine studies actually measuring the effects of peer assisted learning on students. There were inconsistent results about student satisfaction, amount of learning and performance. Only four of the studies included in the review actually described how learning was facilitated. As a result, the researchers noted in this paper that the literature is lacking in 'comparative rigour' which is a fair comment given what has been described in the systematic reviews presented in this chapter. Nonetheless, there is a common stream of advantages and challenges that come out of these reviews.

There have also been a number of individual studies evaluating the peer coaching model as part of a work-integrated learning experience. These individual studies can be very helpful in understanding how to best implement this model in practice and what challenges and advantages surfaced. Again, these are presented in chronological order.

One study of 37 Clinical Educators and 61 students, following 34 actual peer coaching model placements found that the majority (35) of the Clinical Educators would repeat the same model of supervision (Baldry Currens & Bithell, 2003). The students in this study were very supportive of the model as well, with 98 percent valuing the peer discussions and 81 percent

valuing the peer support. Many of the concerns expressed by Clinical Educators about potential student competition and other challenges did not emerge, which is consistent with earlier research (Tiberius & Gaiptman, 1985).

Martin and colleagues evaluated a 1:1, 2:1 and 3:1 model of practice education in Occupational Therapy (Martin, Morris, Moore, Sadlo, & Crouch, 2004). This qualitative study involved six Clinical Educators and 11 students whom were interviewed about their experiences. While each of the models had advantages and challenges, the 2:1 model was most preferred by the Clinical Educators as it offered more opportunities for peer support which enhanced the quality of the educational experience. While the 1:1 model offered a more connected experience between Clinical Educator and student it carried the potential risk of the student becoming dependent on the Clinical Educator. The 3:1 model was more complex to manage, access to the Clinical Educator by students was more limited, and it was harder for the Clinical Educator to keep track of all of the students. A shared perspective by all, regardless of the model, was the importance of planning the experience (Martin et al., 2004).

Hemming and colleagues explored the impact of peer assisted learning and surveyed 138 athletic therapy students at various levels in their education programs (Hemming et al., 2006). They found that almost 20 percent of students learned a moderate to large amount of their skills from other students. Two thirds of the sample practiced a moderate or large amount of their skills with other students. A third of the students also reported that they got advice from other students greater than half the time when in the clinical setting. As noted by these authors, students do learn a lot from one another and can do so with less anxiety when compared to practicing skills and asking the same questions of the onsite Clinical Educator. While the role of the Clinical Educator is still very important, the authors suggest that peer assisted learning strategies be embedded in training programs to expand learning opportunities.

Another study using qualitative methodology interviewed 12 students and eight Clinical Educators on their experiences in both the one student to one Clinical Educator model (1:1) and the two student to one Clinical Educator model (2:1) (O'Connor et al., 2012). The Clinical Educators felt the 2:1 model offered greater learning experiences but had more organizational challenges including ensuring students received equal and robust clinical experiences. There was also some suggestion that some placements were less suited for a 2:1 experience suggesting that pre planning and assessment be made regarding suitability before student assignment. Students preferred the 2:1 model early in their experience because of the benefits of peer learning but in the latter stages preferred 1:1 so they could demonstrate autonomous practice and have more direct contact with the Clinical Educator (O'Connor et al., 2012). The authors stated both Clinical Educators and students would also benefit from further education and training on placements that involve peer learning in order to optimize supervision and learning outcomes respectively (O'Connor et al., 2012).

An interesting study on medical students and peer learning found that students engaged in this practice even though it was not formally emphasized in their curriculum (Tai et al., 2014). Medical students in this study were sent out to clinical placements as a team, and had a range of people supervising and educating them. General objectives like team work and working cooperatively were noted as guidelines for their work-integrated learning. After surveying students about their experience it was found that they learned equally from near peers as well as others, but still preferred to learn from experts. However, they liked the support, extra time and practice they could offer each other. Whilst they liked the feedback which came from a person who wasn't evaluating them, they found it difficult to give negative feedback to a peer.

Sevenhuysen and colleagues conducted a randomized control trial of a highly structured peer assisted learning model in a clinical setting and compared it to a traditional peer assisted learning model without these imposed structures. The results of this work are summarized in a range of publications (Sevenhuysen et al., 2015a; Sevenhuysen et al., 2013; Sevenhuysen, Keigaldie, Molloy, & Haines, 2016; Sevenhuysen et al., 2014; Sevenhuysen,

Thorpe, Molloy, Keating, Barker, et al., 2017; Sevenhuysen, Thorpe, Molloy, Keating, & Haines, 2017) While both models were found to produce positive educational benefits for the students, both Clinical Educators and students preferred the more traditional peer coaching model. What this high quality research suggests is that there needs to be strategies in place to ensure adequate feedback, observation of the Clinical Educator's practice by the students, along with opportunities for students to observe and learn from one another. However, it can't be so structured that students and the Clinical Educator are stymied from developing their own informal peer coaching learning strategies.

Sevenhuysen and colleagues also found that complex facilitation skills and preparation were needed by the Clinical Educator to manage the placement effectively and to ensure the students worked together cohesively (Sevenhuysen, Thorpe, Molloy, Keating, Barker, et al., 2017). Otherwise, they may feel frustrated or overwhelmed by the experience and may not opt to continue with this model of learning in the future (Dawes & Lambert, 2010). It may also be that more 'experienced' clinical Clinical Educators may be more well-suited to this model. This has been suggested in other research which suggests that more experienced clinicians with some traditional one student to one Clinical Educator experience adjust to the peer coaching model more readily (Flood et al., 2010; Rindflesch et al., 2009).

The research by Sevenhuysen and colleauges also found that the peer assisted learning model reduced student anxiety and increased the students' sense of safety (Sevenhuysen et al., 2015a). This is consistent with other quasi-experimental research which found the same outcomes (Ladyshewsky, 1999) and is commonly reported in the literature and reviews of peer assisted learning (Ackland, 1991; Baldry-Currens, 2003; Lincoln & McAllister, 1993; Sevenhuysen, Thorpe, Molloy, Keating, & Haines, 2017).

One of the challenges inherent in the peer coaching model is the tension between how students perceive the value in learning from an expert versus learning from a peer. This issue has surfaced in several of the reviews and individual studies report thus far. One study found that junior students, about to start their first clinical attachment using peer assisted

learning, felt tension between learning from experts and time spent in peer assisted learning (Bennett, O'Flynn, & Kelly, 2015). Students felt the primary purpose of a clinical attachment was to learn from experts and that time spent in peer assisted learning, while valuable, detracted from this primary purpose. Another study found that preparing students for assessement through reciprocal peer coaching helped them self-regulate their learning through increasing motivation, time management, goal setting and enhanced metacognition, all which in turn increased self-efficacy (Asghar, 2009). This type of experience, which could be integrated in to the academic curriculum, could use this social learning framework to prepare students for a peer coaching model when they start their first work-integrated learning placement. This would help to address some of the tension about the value of learning from peers and not just experts (Bennett et al., 2015). Students, as a result, need to be prepared for peer assisted learning and to understand this tension. They must understand the value of both learning strategies (expert and peer based) as part of an overall educational strategy to support the development of clinical competence.

The systemic reviews and individual studies that have been described in this chapter have described numerous advantages of the peer coaching model for students, Educators and Agencies. While some challenges have also been expressed, they don't appear to be significant or frequent issues when explored in the literature. What is clear is that with adequate preparation and training, things tend to run smoothly in the peer coaching model.

The evidence that has been reviewed in this chapter has included a randomized control trial (level 2) through to the opinions of experts and authorities on the topic (level 7) (Ackley, Swan, Ladwig, & Tucker, 2008). By far the most studies and reports cited in this chaper are situated between controlled studies without randomization (level 3), well designed case control or cohort studies (level 4), and systematic reviews of descriptive and qualitative studies (level 5) (Ackley et al., 2008).

Advantages of the peer coaching model: Clinical Educator Perspectives

The next section describes what Clinical Educators have noted as advantages about the peer coaching model. Clinical Educators from around the world have shared their thoughts on the peer coaching model in the numerous workshops that have been delivered on this supervisory approach. Some of these Clinical Educators have direct experience. Others, have reflected on what they see would be the benefits. The advantages are organized in to categories relevant to the different parties that are involved in this work-integrated learning model. While these are not necessarily exclusive to the peer coaching model, they are often touted as advantages within this model (Martin et al., 2004).

Advantages for Students

- Students feel safer and less threatened and because of this, their fear/anxiety is lessened and they are able to experience more positive emotional states in the placement.
- Students can practice and try out their skills with each other before trying them out on clients. They can then observe/experience how successful they were with the client. This enables them to model best practice.
- Having to work with a peer builds other generic skills such as communication, active listening, conflict management, assertiveness and emotional intelligence. All of these skills are important for successful team participation which is necessary in the workplace.
- Talking through one's thinking with a peer about what one is going to do with a client, or how one is going to solve a problem reduces reasoning errors because of the heightened metacognition that takes place. This accelerates competency development because students are more likely to tackle the issues they are facing more effectively through discussion.
- When learning new things, students like to benchmark themselves against other peers to assess progress. This is difficult to do if you are working alone with a Clinical Educator

because their skills are so advanced. By working alongside peers, it is much easier to model behaviors and skills that are observed to be effective and benchmark capabilities. This can be particularly effective for international students who are placed in work-integrated learning settings that create culture shock. They can learn through observation and modeling culturally sensitive ways about improving their practice.

- In community based settings there may be situations where going out to the location by oneself is not secure or safe. Having a peer to accompany the other peer is good for safety.

Advantages for Clinical Educators

- Supervising within a peer coaching model can give staff an opportunity to diversify their role. For example, an experienced clinician may find that they can do their clinical duties quite easily. They have reached expert status and aren't 'cognitively' challenged anymore by their caseload. They can do many of their tasks intuitively. By taking on a couple of students, they can enrich their role to that of Clinical Educator and increase their engagement and motivation with these new challenges. Job enrichment can increase ones motivation and engagement within their role and this may be one of the reasons more experienced Clinical Educators elect to supervise within the peer coaching model.

- Clinical Educators can give the students a majority of their caseload to manage as time progresses during the placement. The Clinical Educator can then use their time to improve their teaching and evaluation efforts. They may also use the time to give students more feedback and catch up on any other administrative duties.

- Clinical Educators, by supervising multiple students at the same time, can transfer these skills to more senior roles where supervision of staff is needed.

- In rural or international placements, having a pair of students also helps to reduce social isolation for the students and gives the Clinical Educator space. Clinical Educators often feel they need to engage socially with their student if the student is alone in the small country town or in a new country. This can cause issues with supervision if a friendship

role emerges between the Clinical Educator and student and the student starts to have difficulties in the work-integrated learning placement. Having another student present gives the other student a social companion and helps to maintain a more appropriate relationship between the Clinical Educator and student(s).

Advantages for Educational Institutions

- Of course one of the major benefits for educational institutions is that the peer coaching model increases the number of available placements. Not only does it increase the number of placements but it also increases capacity for educating students in key areas of the discipline. For example, if there is a shortage of clinicians who work in respiratory areas, by having two or more students at each respiratory placement, the likelihood of some moving in to this specialty area might increase.
- There is also a positive evidence base for the peer coaching model and this elevates the quality of the fieldwork education program.
- The peer coaching model creates less administration for the academic institution because it expands the capacity of quality work-integrated learning placements. The institution can work with and manage less locations with higher quality learning environments.

Advantages for Organizations

- Organizations that adopt the peer coaching model can experience many benefits. In certain environments, having several students in the organization can alleviate waiting lists for service or offer some short term reprieve where they may be a staff shortage. While it is acknowledged this is not the purpose for having students in an organization, it is also acknowledged that students do provide service to organizations with respect to productivity.

- By taking more students into the organization, leaders can also observe the quality of the students and recruit those who they see as being a good fit for the workplace.

- More senior members of staff can also observe the quality of the organization's Clinical Educators, and groom those Clinical Educators for potential leadership roles in the organization.

- When students have excellent experiences in an organization, they also tell their peers, and this in itself elevates the 'magnet' status of the facility, making it easier to recruit people because of the organization's reputation.

- The peer coaching model can also create more breaks for Clinical Educators who might have 'student fatigue' as a result of a constant flow of students throughout the year. For example, if a Clinical Educator traditionally took one student for each placement, and there are six placements year (n=6), they could still increase the number of students they take but also have a break. The Clinical Educator could take two students for four of the six placements (n=8) and still have two placement timeslots free (for vacation, attend an educational program, or just get back to enjoying clinician time).

Advantages for Clients

- Clients who experience services within the peer coaching model may find themselves more engaged with this team. While one student is deep in thought collecting

information from the client or carrying out the service, the other student, who is there to coach and observe, can engage with the client on a more social level.

- For difficult or more complex cases that might be too much for a single student, having two students focus on the case gives the client an opportunity to receive care by this team.

- In the peer coaching model clients often get more care and education because the student(s) have more time to spend with them. For example, a clinician may need to provide care to 20 clients a day when they don't have the students in the setting. In a 7.5 hour working day, this amounts to 22.5 minutes per client. With the clinician now in the role as Clinical Educator, and two students present, over the course of 7.5 hours, these 20 clients are spread amongst the triad. Each client could receive up to 67.5 minutes of care by a team member. Of course there are other things that need to occur or might eat in to this time as part of a clinical day, but the capacity to expand care to clients is greater in the peer coaching model.

Challenges and the Peer Coaching Model

There are of course a range of things that could create challenges for a Clinical Educator in the peer coaching model, for example, insufficient caseload, not enough space, extra paperwork and teaching/evaluation time, student conflict/competition. Research suggests that many of the anxieties or fears that Clinical Educators have about the peer coaching model don't actually manifest when they actually engage in the experience (Baldry Currens & Bithell, 2003; Tiberius & Gaiptman, 1985). Most of the challenges arise from not having the right strategies or preparations in place during the peer coaching model. As a result, the chapters that follow provide a comprehensive guide on how to successfully structure the work-integrated learning experience using the peer coaching model, so that these challenges do not occur or can be effectively managed.

Chapter 4

Clinical Educator Perspectives – Research Findings

The fourth source of information for this book is from recent qualitative research conducted by the authors of this book where we explored the tacit knowledge of experienced Clinical Educators who supervise students in the peer coaching model. There are Clinical Educators who supervise students in the peer coaching model with extensive experience. These Clinical Educators receive outstanding feedback and are known to University Fieldwork Coordinators for their excellent practice. By tapping in to the tacit knowledge of these Clinical Educators, much can be learned on how to effectively manage the peer coaching model within the work-integrated learning setting.

Tacit knowledge in the workplace, as defined by the Cambridge Dictionary, is "knowledge that you do not get from being taught, or from books, etc. but get from personal experiences, for example, when working in a particular organization."

https://dictionary.cambridge.org/dictionary/english/tacit-knowledge

Tacit knowledge is in the subconscious and is very difficult to capture accurately as the person may not even be aware that they have it buried away (Tagger, 2005). This is in contrast to explicit knowledge which is declarable and consciously accessible by the individual. Experts typically use tacit knowledge to guide their actions and decisions without necessarily having to directly reference this declarative knowledge (Tagger, 2005). Capturing this tacit knowledge is important because we can use this information to inform best practice in supervision within the peer coaching model. Facilitation is one strategy for extracting tacit knowledge from individuals as it can reduce the effort needed to externalize the knowledge (Tagger, 2005). By asking specific questions about what they do at key points of a peer coaching model, this helps to stimulate recall (Ericsson & Simon, 1993; Fonteyn,

Kuipers, & Grobe, 1993; Mast, Feltovitch, Soler, & Myers, 1985; Yinger, 1986). This information can then be captured, usually via a recording device, transcribed and then summarized in a way that the knowledge becomes useful to others who need this information to do their work.

In this qualitative research, 31 Clinical Educators from Australia and Canada shared their experiences of supervision in the peer coaching model through a semi-structured one on one telephone interview. Tables 4 and 5 provides specific information about this group of Clinical Educators. It is important to note that the number of students that have been supervised overall, and the number of students that have been supervised in peer coaching placement are estimates that were provided by the clinical educators during the interview. The abbreviations for the different clinical educator disciplines are; physical therapy (PT), occupational therapy (OT), speech pathology (SP), dietetic therapy (DT).

Table 4 – Canadian Clinical Educators

Unit Type	Role	Years of Experience	Years of Experience in Clin. Ed.	Students Supervised (n)	Students Supervised (Peer Coaching) (n)
Critical Care	PT	19	18	32-36	32 (16 pairs)
Inpatient Rehab Neurosciences	PT	14	13	25-30	28 (14 pairs)
Cardiorespiratory Cardiac Care Unit	PT	12	11	30	18 (9 pairs)
Cardiac/Surgical Wards & Intensive Care Unit	PT	14	13	34	28(14 pairs)
Outpatients Musculoskeletal	PT	26	25	65	60 (12 x 5:1)
Inpatient Care - Medicine	PT	6	5	15-20	8 (4 pairs)
Outpatients Musculoskeletal	PT	19	6	17	12 (6 pairs)
Outpatient Musculoskeletal	PT	27	26	60	20 (10 pairs)
Intensive Care & Critical Care Units	PT	20	19	56	46 (23 pairs)
Outpatient Neurology	OT	14	13	67	62 (31 pairs)
Community	OT	30	12	80	70 (35 pairs)
Outpatient Neurology	OT	8	8	22-25	10 (5 pairs)
Outpatient Musculoskeletal	PT	36	22	24	6 (3 pairs)
Long Term Care/Home Care	OT	22	20	35	20 (10 pairs)
Primary Care	OT	30	15	35	24 (12 pairs)

Table 5 Australian Clinical Educators

Unit Type	Role	Years of Experience	Years of Experience in Clin. Ed.	Students Supervised (n)	Students Supervised (Peer Coaching) (n)
Acute hospital (inpatients)	SP	10	7	15	10 (5 pairs)
Public Hospital - Mix inpatients and outpatients	SP	7	3	40	38 (most 4:1)
University clinic	SP	8	7	1000	1000 (6:1)*
School	SP	5	2.5	48	20 (10 pairs)
School/Private practice	SP	4	3	6	2 (1 pair)
Acute hospital	SP	8	5	12	10 (5 pairs)
Hospital (adult)	DT	13	12	>40	30 (15 pairs)
School	SP	4.5	3	25-30	8 (4 pairs)
Adult hospital clinic	SP	28	20	>50	>40 (>20 pairs)
Aged Care Facility	OT	15	13	~30	(15 pairs)
Aged Care Facility	DT	24	7	1000	800 (10:1)*
Acute hospital	SP	4	4	13	10 (5 pairs)
Tertiary hospital	SP	24	4	6	2 (1 pair)
Hospital outpatients	PT	21	13	600	100 (20 x 5:1)*
Tertiary hospital	DT	15	8	40	24
Aged Care/Community Clinic	SP	5	3	80	80 (6:1)*

* There are large number of placements recorded here as these are university run clinics which place large cohorts of students through this program.

The mean age of our Clinical Educator sample was 40. There were 15 clinicians from Canada and 16 clinicians from Australia (31 in total with 30 female and one male). We had 11 Speech Pathologists (SP), 11 Physical Therapists (PT), six Occupational Therapists (OT), and three Diet Therapists/Dieticians (DT) participate. The average number of years they have practiced as a clinician was 15.88 years. The average number of years they have worked as a Clinical

Educator was 11 years. As a whole, the clinicians had a lot of experience supervising students. Of the 31 Clinical Educators interviewed, only seven had supervised 20 or less students. The remaining 24 Clinical Educators had supervised up to 80 students in total, and for those involved in clinical education programs that take more than two students at a time, the numbers are in the hundreds. The Clinical Educators worked in a range of organizations (hospitals, outpatient clinics, community based health care, schools) and with a range of different clients across the lifespan with acute and/or chronic illnesses or other health care needs.

The Clinical Educators ran a range of different types of peer coaching models. Most of them involved one Clinical Educator supervising two students, or in some cases two Clinical Educators sharing the supervision of the two students. Other models had one Clinical Educator supervising anywhere from three to six students. In some of the University run clinics the supervisor/coordinator to student ratio could be higher (1 to 10). In these larger models there are other clinicians who provide supervision and the supervisor/coordinator oversees the group. The supervisor/coordinator is often paid for by the academic program in part or full. Peer coaching within these larger cohorts would usually have smaller peer coaching teams embedded within them.

The last model tended to be more project based and had two supervisors. The students were usually senior and selected carefully for the project. One supervisor was based in the agency and was not necessarily a clinician. The other supervisor was an external Clinical Educator of the same discipline as the students. The supervisor that was based in the agency provided day to day supervision. The external Clinical Educator provided once a week face to face supervision and was available through telephone contact as needed.

The information on best practice that was shared by these Clinical Educators is summarized in the following sections. These sections lay out the practicalities of making a peer coaching model successful in a work-Integrated Learning setting. Given that there is a specific lifecycle to a placement, semi structured interview questions were designed to capture the

best practices and any underlying tacit knowledge of the Clinical Educators as they reflected on their practice at the following key points.

1. Before the students Arrive
2. The First Day
3. The First Week
4. The Weeks Approaching the Midway
5. The Weeks Approaching the Final Evaluation
6. After the students Leave

The Clinical Educators were also asked what made them want to try the peer coaching model and to continue to use this in their educational practice. They were also asked if they had any challenging situations to manage between the students and how they managed them.

Before the Students Arrive

One of the most important things to do for a peer coaching work-integrated learning placement is preparation. This is clearly noted in the literature and from Clinical Educators who supervise this model of learning. The following preparations will ensure the placement runs smoothly and will prevent some of the challenges that may arise in this peer coaching model.
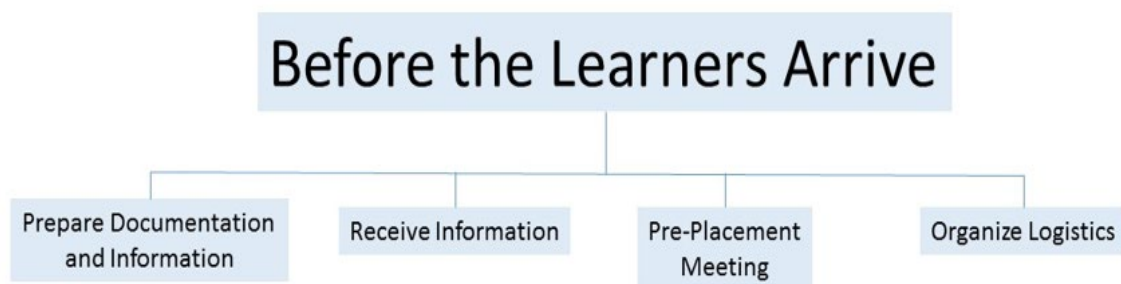
Prepare Documentation and Information

Having necessary documentation prepared in advance allows the agency to ensure all students get the same important information. The Clinical Educator should develop specific placement information for the students and review it at the end of each placement, ideally with feedback from the students on how it might be improved. An orientation package should be developed and reviewed regularly with important information such as the service model, staffing structure and key individuals, the Organization's mission and values, department information and the professional role of the discipline in that agency. Specific placement expectations should be clear, along with information on how to perform the clinical assessments at the site. This can be a documentation binder, or a set of resources that are online and perhaps stored in a secure software application on the cloud such as Dropbox ®, and shared with the students so they can read the information in advance of the placement.

Specific placement information may also include meeting schedules, dates of assessments, a calendar of events and the clinical focus for each week. If there are any inter-professional activities these should be clear along with any other deadlines and/or project delivery dates. Included in this information should also be expectations for how the students should work together as peer coaches over the duration of the placement.

Some of the more specific information that was specified by Clinical Educators is outlined below.

- Organization's website for review
- Pre-reading – articles, topics, online courses and training
- Policies and procedures
- Discharge information for clients
- Information on documentation specific to site
- Information related to specific projects and presentations
- Maps and parking information
- Example assessments
- Working hours
- Preparation required for first day
- Food arrangements for breaks if available at agency
- Peer coaching model information sheet

All of this information can be provided to the students, if available, on a software site via a welcome letter with a link to the site that is sent to them prior to the placement. If not, then the students can be told it will be available to them on the first day. If email is used to communicate with the students, it is important that all of the students are copied into the email if it is information that will benefit all of them. It is important to remind them that it is a peer coaching model in case they have not been informed prior to their arrival. In this correspondence it is also important to briefly note the expectations for learning from one another in the peer coaching model. This can alleviate any anxiety associated with the work-integrated learning placement and peer coaching. The following two quotations illustrate this point.

> *"I generally do mention that initial bit that it will be a peer placement model and that we do have a generic information sheet that we send them. It's nothing fancy but it*

does explain from that onset that they'll be working together and that there will be an expectation that they kind of go to their peers first and then to their Clinical Advisor and that they have that opportunity to really learn from their peer." SPFA002

"... just lay out the expectations for the first week, and sort of outline, day by day, what the students can expect. Their feedback, that I've gotten, is that that is the most helpful thing, prior to starting the placement. Cause, it just sets the expectations, and calms some of their anxieties as to what they're coming into." OTFC0011

Receive Information

One of the benefits of writing to the students in advance of the work-integrated learning placement with information about the upcoming experience is that the Clinical Educator can also ask the students for specific information that will assist with supervision. For example, asking the students to specify if they have any interests related to the placement, what experience they have to date and any strengths they can bring to the experience, what their preferred learning style is and whether they have any specific goals they want to achieve during their time at the organization. In some cases this request for information can be set up as a standard questionnaire that is sent out to all students that come to the agency as noted in the quotation below.

"... we get an information questionnaire from the student and it has things about what they're worried about, what their strengths are, what type of student they are." SPFA002

All of this information can be very helpful, particularly in peer coaching placements where there are more than two students. This may assist with matching or pairing students so they have complementary learning styles and also give the Clinical Educator information about how to divide up caseload based on individual learning goals. It also gives a 'heads up' to the Clinical Educator with respect to how much supervision they may need to give the students as a group and/or individually as noted in the following quotation.

"I tend to have a look at them individually and then I do look at them side by side just so I get a bit of a feel of what they're going to look like in a pair and who might need to be watched and generally they end up in not only the same learning style preferences and things like that." SPFA002

Pre-Placement Meeting

In some cases it may be necessary to have a pre-placement meeting, particularly for a work-integrated learning placement in a non-traditional setting that has not had students before. During this meeting it may be important to introduce the students to key people at the site, talk about what the site needs from the students in terms of any projects with the Clinical Educator present. The following quotation from a clinical educator describes this point.

> *"I let them know this is kind of an unusual placement that requires a lot of independence and a lot of collaboration between the two students...   ...I describe to them what I expect of them in the placement in order to help make that placement successful."* [OTFC0012]

If work-integrated learning placement independence or risk is high, it may be appropriate that the students are interviewed prior to assignment or given this information so they self-select in to this type of experience. For non-traditional placements where students are working a lot of the time with off-site supervision a high degree of maturity and ability to work independently as well as part of a team is very important. Hence, for these types of work-integrated learning placements, having pre-placement processes to ensure the correct students are assigned can be very important, particularly if the academic institution is wanting to build a new placement opportunity within that agency. This is expanded upon the following quotation from a Clinical Educator.

> *"... so the students that are in these placements are just students that really feel like they can handle this. And that helps with being able to make sure that they can do well at these placements."* [OTFC0012]

Organize Logistics

Other important tasks associated with preparing for a peer coaching work-integrated learning placement include organizing logistics in advance so these are in place when the students arrive. What work spaces do the students have to work and to do their documentation and have peer coaching meetings in private? What meeting rooms have to be booked and/or prepared so they are ready for the arrival of the students? If there are any forms to fill out, or processes to complete, to ensure the students have access to information technology and electronic medical records this should be done in advance so they are not waiting for this to occur while the placement progresses. If there are specific things that have to be coordinated and booked in advance with other professionals this should be done as well, e.g. safety training, infection control training, institutional orientations, operating room access.

The Clinical Educator should also start to plan the caseload for the students and decide how to allocate the clients based on the students' learning needs. Is there adequate variety and volume for the students so they get good exposure to a range of cases? Do new clients need to be booked in? Which cases will be shared by the students and which will be individual? What projects might the students undertake when not engaged in client services? What training and/or educational sessions will the Clinical Educator organize for the students to get them up to speed in the service?

As is evident from the information in this section, doing your preparation prior to the arrival of the students will make the first week of the peer coaching work-integrated learning placement proceed very smoothly.

The First Day

The first day of any new work-integrated learning experience is exciting and stressful for many students and some Clinical Educators. Throw multiple students in to the mix and the energy and excitement and anxiety can certainly increase. The first day, as a result, is an important one as it sets the tone and begins the establishment of important relationships that will endure throughout the placement. On this first day orientation typically takes place, meetings about expectations are held, relationships start to be built and some clinical work may even start. This section details how to make the first day a success.

The First Day

Orientation   Build the Relationship   Clarify Expectations   Provide Information On Peer Coaching   Starting Clinical Work

Orientation

If an orientation document hasn't been made available to the students in advance, then typically this is provided to the students on the first day. As students progress through the various placements that are part of their academic program, it may be that some aspects of the orientation are relaxed or not included because of the increasing knowledge and competency of the students. However, for students who are just starting out, or who have not been in the kind of agency that they now face, a more detailed orientation is recommended. Tailoring the orientation to the students' needs are described in this quotation from a Clinical Educator.

> "I probably base the extent of the orientation and easing in to it based on their experience at an acute hospital environment. So if it's their first adult acute placement, then I'll probably spend a bit more time, I'll be a little bit slower and a

little bit more gentle, 'cause I find sometimes even just the tour through the hospital can be quite overwhelming to people" [SPFA012]

The content of the orientation manual should include:

- An overview of the site – organizational mission and value statements, department information and scope of services provided.

- Contact details for important people associated with the placement, including processes for calling in sick.

- Key dates and timings for important meetings and events and planned activities.

- Specific processes or procedures that need to be followed in the agency, especially around client prioritization systems and bookings, referral management, discharge processes.

- Specific tools, forms and assessments, progress note formats that need to be undertaken, with some examples if possible.

- Information on caseload, expectations for managing caseload and key objectives for achievement associated with the caseload. Any other expectations should also be clearly laid out.

- Password information and information on how to access any electronic information necessary for performing duties, along with processes to ensure confidentiality and security.

- A template for the students to write out any specific learning goals and objectives along with a questionnaire on learning styles. Two online sites that are free to determine learning style preferences are noted below.
    - https://www.webtools.ncsu.edu/learningstyles/
    - http://vark-learn.com/the-vark-questionnaire/

- Information on how to secure ID badges and any uniform requirements including dress codes.

- Important safety and security information and information on any training they need to complete and how to access this.

Some organizations have students sign off on each section of the orientation manual to ensure they have read the information and can be particularly useful if there is a disagreement about what was provided or not to the students. This document can be retained by the Clinical Educator.

The orientation itself should include:

- A tour of the agency and the department along with any working areas the students will be performing their duties.
- Introductions should be made to key people the students need to know.
- Transportation and parking information, where they can lock bicycles in a secure area.
- Lockers and change rooms, bathrooms and where valuables may be stored securely.
- Where they can obtain food within or around the agency.
- How to use pagers, and any other telecommunication devices in the organization.

The Orientation can also be made fun with ideas integrated in to the process to increase integration and retention as structured by one Clinical Educator in the quotation below.

"I send the students on a scavenger hunt, so that they can figure out where things are situated, and begin to learn who some of the people in the building are...   ...If we have both OT and PT students starting at the same time, we'll either do it as a competition or we'll pair OT and PT together. So that they can go off and do it, and there's a bit of a prize at the end, for whoever gets the most right answers... ...The students find that, if they're trying to go out and find the information themselves, it sticks a lot more than if we tell them things." OTFC0011

Build the Relationship

As noted earlier, building the relationship starts right from the beginning. Hence it is important to make the students feel welcomed, safe and to allay any anxieties. The initial days of a work-integrated learning placement send many covert and overt signals to the students about the quality of the placement that is going to occur. A rushed orientation and an ill prepared Clinical Educator may signal negative signals to the students and place them

on edge. Saying something will happen, and it doesn't, also can signal issues about trust, authenticity and reliability to the students. These issues can lead to interpersonal conflict between Clinical Educator and student and between students. Clinical Educators had several suggestion on how to set the tone and get relationships off to a good start. Introductions are particularly important as these set the tone between parties as noted in the quotation below.

> *"I usually introduce myself and how much I love to teach. I really want to make this for them and I want them to get the most out of it. Then I give them information about my background."* [PTFC002]

A general conversation can also follow about the placement and any previous placement experiences, learning styles, how they like to receive feedback and what their goals and objectives are (generally) for the placement. This is illustrated in the following two quotations from Clinical Educators.

> *"You know how all the students know about how they learn best these days. I make sure I am familiar with that and I go over how they learn best, how I teach, how I teach to how they learn, and that strategy might work differently between the two of them"* [PTFC002]

> *"I ask them what's worked well in the past on their placement, and what could've gotten better and how we can implement that in this placement."* [PTFC002]

Built in to this introductory conversation is an opportunity for the students to ask any questions. This is important to reduce any anxieties and fears. Having them ask these questions in the presence of the other students is also valuable as it gets them used to being comfortable expressing things they may not know or understand. The answers that are provided are also helpful as everyone then gets the same information as noted in the quotation below.

> *"If there's any questions, that they be addressed as a group, because we all know that we learn from each other, well and truly."* [SPFA003]

It is also particularly useful to have a group discussion at the end of the first day to just overview what has occurred and to determine where the students are at and allaying any

other concerns before they leave for the day. This group discussion and how it works is described by a Clinical Educator in the quotation below.

> *"So we usually ask for the students to meet with their peer first off, and just talk through with them what their experience for the day's been like ... And then we'll come together with the supervisor and the students and just talk through how that day's been. Identify if there's anything that perhaps needs to be problem solved .... I've had some examples where students have been quite confronted by being in a hospital environment and, you know, sometimes they're being on a hospital ward brings up issues that they didn't know were issues until they're there. So it's a good opportunity to be able to talk about some of those things and work out how we're going to be able to manage that"* [DTFA007]

In some cases, depending on the philosophy, resources and time available within an organization, a more formal welcome function may be organized. This may be particularly beneficial in organizations that take many students. A welcome activity like a morning tea, a 'getting to know you' function can be very welcoming as noted by one Clinical Educator in the quotation below.

> *"We have a philosophy as well around making people feel welcome and trying to bring anxieties down so that students are open to learning. So we spend a bit of time making them feel welcome. Like doing a 'get to know you', and some kind of thing just to make sure that people are in the right space to learn."* [DTFA0011]

Clarify Expectations

Students typically have an enormous number of questions and concerns on the first day. Having an opportunity to sit down and clarify what the expectations are for them is extremely valuable in allaying any anxieties. Many of the issues they will have will be answered if the orientation and documentation information presented earlier is thorough and accessible to the students. Usually one of the big fears students have is around how many clients they will need to see, which clients they will see individually, and which will be shared, what they need to do before an assessment or session in terms of planning and review with the Clinical Educator, and how accessible the Clinical Educator is for feedback or help. This can be done as a group but it is also useful to have a one on one meeting with

the student as well, particularly on the first day as they may be nervous to share certain things with the other student(s) present as the relationship is still not firmly established. The Clinical Educators had a lot of suggestions on how to clarify expectations as noted in the quotations below.

> *"I do meet with students one on one during that day as well so I can clarify my responsibilities one on one if the discussion as a group is not clear to anyone. I find that this naturally leads to that explicit discussion regarding who is responsible for what over the course of the term. I do find that once that is all understood you can visibly see the students relax in to the placement. I try to communicate the expectations regarding the different roles very explicitly."* SPFA004

> *"I'm going to ask you a lot of questions. It's just for my learning to understand where you guys are at so I can better support you, but I don't want you to feel overwhelmed or if you don't know the answer, that's okay."* PTFC006

> *"I just give them a rough structure for the entire placement as well. So, by the end of week one I want you to be doing X, Y, and this... ...I think that's quite nice, because it gives the students a very clear guideline as to where they should potentially be at in each week. And I think students really appreciate that, because they quite like that really, this is what you need to do and this is where you need to be."* SPFA006

> *"... we have this document that basically says over the six weeks, this is what it's going to take to go from being fully supervised, independent in terms of treating patients, using equipment"* PTFC0014

Provide Information on Peer Coaching

As the work-integrated learning placement involves peer coaching, it is important to provide the students with information on how this works, particularly since they may be disappointed that they don't have the Clinical Educator all to themselves. An acknowledgement of this and some of the challenges associated with peer coaching can be noted but all the advantages should also be shared with the students. An explanation on how non-evaluative feedback works is very useful. They should also discuss how they will work together on shared tasks and on other tasks where one is just observing and offering feedback. Students may need strategies on how to act in an observation session so the client stays focused on the student that is actually assessing and treating the client, and not the

observer. The peer coach can have a signal, for example, which they display outside the client's visual field when they want to provide some input to their peer coachee. Alternatively, the peer coachee might stop during specific parts of the assessment and treatment and ask if the peer coach has any comments. These are two ways information can be given to the student clinician in the moment – where it is most useful.

As most academic programs do not have anything specific on their evaluation forms about how students perform in a peer coaching model, the Clinical Educator will need to be clear about their expectations for peer coaching. The students can be reminded that peer coaching is considered part of professional behavior and will be evaluated against that criteria in the placement evaluation tool.

Because Clinical Educators often do multiple offerings of the peer coaching model, some have generic information already prepared for each group that arrives or a standard explanation on how things will work. These two concepts are described in the following two quotations from Clinical Educators.

> *"We have a very generic Power Point about peer placements and just the expectations of that. It has a little bit of conflict management and a few things like that"… …generally they have had a 1/1 placement prior to coming so there's obviously really big changes between the two models … We do acknowledge the things that can be seen as the negatives of it. Like, not giving as much one on one time and things like that but we do try and explain to them all the really great things that come out of them. We have a few articles in there so it does have a few references"* [SPFA002]

> *"Then the collaboration, part of that self-directed learning and that teaching model is that they learn with each other, they learn from each other, they learn about each other … So I really sort of explain that student run clinic model and outline the expectations that they are going to be collaborating not only with themselves but also with the other disciplines"* [OTFC0013]

Starting Clinical Work

Students are excited to be in the agency as they can start to apply their learning that they have acquired in the academic setting. Giving them an opportunity to see the clinical areas

and perhaps even engage in some simple tasks is a great way to alleviate some anxieties the students may have about the setting as noted in the quotation below from a Clinical Educator.

> *"And then, best case scenario, we try and see a patient, so they feel like they've done something on their first day clinically"* [PTFC004]
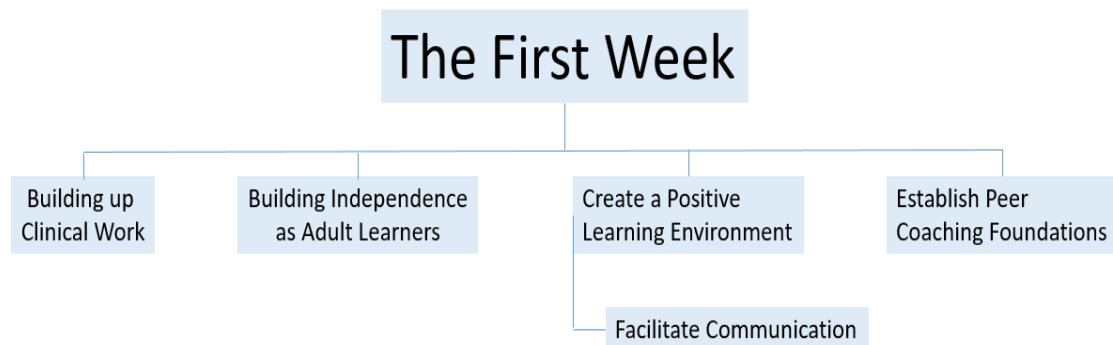
In the first day it may be just observation with the Clinical Educator undertaking a new assessment and/or a repeat treatment. This can involve discussions before and after the encounter with the client. Observation is an important learning tool and Clinical Educators should make these opportunities available. Modelling best practice is a great way to prepare students about what you expect when they work with your clients. Some ways to build observation in to the placement include:

- Observation of the Clinical Educator engaged in assessment and treatment activities.
- Observation of other clinicians engaged in assessment and treatment activities.
- Observation of other students further along in the academic program who are on placement as well.
- Observation of other professionals for inter-professional learning and understanding.
- Observation of each other undertaking assessment and treatment activities followed by a peer coaching discussion.

Otherwise, depending on how the other aspects of the first day have progressed, the students may be given specific tasks to complete such as a chart review, an assessment or treatment as a pair. The Clinical Educator can use this opportunity to see how the students communicate, how safe they are, and how they handle equipment and/or clients. This may alert them to some things they need to pay attention to during the first week of the placement as the students start to take on more responsibilities.

The First Week

The first week of the peer coaching work-integrated learning experience is the busiest week. It is during this time that the Clinical Educator needs to ascertain the knowledge, skill and affective behavior competencies of the students. This then determines how much independence and supervision each student requires. From here, the Clinical Educator can start to allocate tasks, clients and work to the students independently and as a team and balance their supervision across these activities to further determine safety, skill and competency. The focus of this first week is to get the students comfortable by immersing them in to the environment.

The First Week

- Building up Clinical Work
- Building Independence as Adult Learners
- Create a Positive Learning Environment
  - Facilitate Communication
- Establish Peer Coaching Foundations

Building Up Clinical Work

The importance of observation cannot be underestimated as a learning strategy for the students. Observation captures many of the learning style inputs preferred by individuals – it is visual, it is auditory, it is kinesthetic and involves reading and writing in the chart. It is also an excellent way to model best practice and to demonstrate standards that the Clinical Educator is looking for. Even though students are there to 'do' clinical activities, having the Clinical Educator demonstrating a full assessment and treatment and talking about one's thinking gives the students access to the reasoning capabilities of the experienced clinician. Since modelling is such an important part of learning, Clinical Educators should try to demonstrate how they assess and treat some of the more common cases that the students

will see a lot of in that clinical specialty. One Clinical Educator describes this process in the quotation below.

> "But before and after every, patient I go to, I usually try to do just like a, session with them just about talking about, you know, let's review the chart together, what information am I pulling out? Why is that that information that I pulled out important? Why that stuff versus not other stuff? What my plan is going to be in terms of what I'm going to do, with the patient... ... So after the assessment, then they have an opportunity to ask a question, any questions, and I kind of do a debrief about, what I did, why I did it, what I picked up on, what I'm looking for, things like that." *PTFC006*

As the week progresses, each student starts to build up the amount of clinical work they will be responsible for managing. During this week, the Clinical Educator observes the students undertaking various tasks, assessments and treatments. The students may also 'shadow' other clinicians, if available, to see how other professionals conduct these tasks. Typically there is a pre and/or post session discussion with the Clinical Educator to assess preparation and reasoning. Through this moderation, the Clinical Educator gains knowledge about each student so they can further tailor supervision, education and discussion with the students. This initial client contact may involve co-management where one person is the 'leader' and the other an 'assistant. The Clinical Educator may lead and have the student(s) undertake specific tasks. Case discussion, planning and documentation are also part of this experience. This paces the experience for the students as they slowly start to gain confidence in communicating with clients, handling them and implementing treatments. This is explained in more detail in the two quotations below offed by Clinical Educators.

> "I warned them like the first day, 'The first week is gonna feel a little bit overwhelming, I want you to just try, and take it all in. We're gonna work with patients. I won't put you in a position that I think it's unsafe. If there's something I ask you to do that you really don't want to do, just say I'll wait and I'll try it next time'." *PTFC002*

> "It's a slow progression, and to them, it usually happens before they know it that they have taken over a treatment session." *PTFC002*

During this first week the Clinical Educator is also testing the student's knowledge through quizzing, case discussion, and analyzing their skills. A review of written documentation is also carried out by looking at client notes and the student's reflective learning journal (if appropriate and the student gives consent). Professional behavior is assessed by how well the students manage administrative tasks such as recording statistics, dealing with orientation tasks and attendance and performance at meetings. With this information in hand, the Clinical Educator can start to give focused feedback to the students and ask more directed coaching questions to make the students think more deeply about their practice. One Clinical Educator shared an example of how they do this in the quotation below.

> *"Then I'm providing my feedback. I use an observation deck called Shape. I put in thoughtful answers according to each section depending on the day then I email that through to them to look at ... [then] after we have a talk about it as well."* [SPFA004]

Building Independence as Adult Students

As the students start taking ownership of their learning (e.g., selection of clients, independent management of tasks, asking questions, taking notes, building networks) they are more likely to be in a place where they can start to consider establishing some specific learning goals and objectives. From here they can set up a learning contract which they can establish in partnership with the Clinical Educator and if appropriate, their peer coach. Two Clinical Educators describe how they work with the students to establish a learning goals and objectives and a contract in the quotations below.

> *"We always go over goals by the Friday of the first week, so that they've had a bit of a chance to experience the clinical areas, to be able to make their goals appropriate to the experiences they're likely to have, but also just to get them hammered out in the first week."* [PTFC004]

> *"So that's really important to see the contract, and then I would need to add my part to the contract in terms of how they want their feedback, and in terms of the time frames and how they like to receive that, what mode of feedback they prefer"* [SPFA013]

The students also have to start demonstrating independence by using each other to answer questions and for observation of practice. Where they are not able to find the answers, or

need further input about their practice, they need to approach the Clinical Educator directly. These expectations are clearly laid out as noted by the quotations from Clinical Educators below.

> "... my expectation is they're adult students and they come to me if they've got questions or if they've got issues... ... my expectation of them is that they're driving their placement, as far as I'm concerned" [DTFA007]

> "... and what I ask them to do is to make sure that they make themselves very useful, to get to know as many people as possible, ask lots of questions, make themselves really helpful to build relationships and develop alliances." [OTFC0012]

> "... I'm really firm with them that if you want more time, if you're not coming and asking for individual time, we're assuming you're going along well." [SPFA002]

The students are also expected to start demonstrating independence in administrative tasks and behaving professionally. They should be more competent as the week progresses in time management (starting and finishing client sessions on time) and completing all tasks appropriate to daily schedules as noted by the Clinical Educators below.

> "They're obviously expected to turn up on time and we always aim to leave on time at the end of the day, just trying to focus on sort of work-life balance or model that for them, and taking regular breaks during the day" [SPFA001]

> "I book in all of those things on their shared calendars, and then the expectation is that they're checking their calendar to see what they have going on that day, in order to manage their own schedules during their placement." [PTFC004]

The students should also be demonstrating an eagerness and interest to learn individually and in the team. This learning oriented mindset is important for the success of the peer coaching model. As noted in the literature review earlier, students often feel they don't get enough one on one time with the Clinical Educator and may not see the value in learning from a peer who has equal knowledge. So if this learning oriented mindset is not manifesting in that first week then the student(s) may need to be taken aside and reminded of the purpose of the peer coaching model. These expectations are clearly noted in the example quotations from two Clinical Educators.

"I think I would define it more around attitudinal, so to make sure that they're in the right space to be learning. So interactive and participating in the team, those type of expectations." [DTFA011]

"I expect them to come ready to learn. I don't expect them to have all the knowledge, but a desire to want that knowledge. Come with a good theoretical background and then trying to be open to feedback and also encourage them to generate questions themselves to get the practical skills to improve that." [DTFA015]

Create a Positive Learning Environment

In the first week it is also important for the Clinical Educator to be available and approachable in person, and via an agreed alternative communication method. The Clinical Educator is so central to the students having a positive learning experience. Hence, it is critical that the Clinical Educator demonstrate excitement and commitment to their learning. Otherwise, if students feel they are a burden, or are being treated harshly, the negative consequences on brain learning discussed in the SCARF model earlier in this book start to occur. However, the Clinical Educator also needs to set clear boundaries around their availability and set specific times for feedback sessions, group meetings and evaluations. This is particularly important where the Clinical Educator is off-site in some of the non-traditional placements or in peer coaching models where they have four to six or more students. Examples of how the Clinical Educators set the stage for a positive and open learning experience are noted below in the quotations.

"... encourage really open communication between the students and the supervisors in terms of being really approachable and letting them know that they can ask questions at any time and we will let them know if it's not an appropriate time." [SPFA001]

"Often times, with students, it can be all, very overwhelming. They often don't have questions in the moment, but maybe the next day...   ...So they need a bit of time to process what they saw, too. It's really ... I'm just making clear that, whenever they have a question, they can come and chat with us at any time. Our door's always open." [OTFC0011]

"and I'll be really encouraging them to be asking as many questions as possible so they can try and make sense of our processes and where they fit in, in terms of the patient's journey. It's largely information gathering for them" [SPFA013]

Facilitate Communication

In addition to creating a positive learning environment and being available and accessible, there are specific meetings that help to facilitate communication and learning. Having set meetings regularly, such as the beginning and end of each day and more formally once a week helps support learning, reflection and developing competency. The focus of these meetings can very general or focused on specific cases and/or projects. The agenda can be set by the students and/or the Clinical Educator depending on developmental needs. There may also be additional meetings that the students set up for peer coaching. One Clinical Educator provided an example of how they structured their meetings with the students as noted in the quotation below.

> *"Every Friday morning, we set aside time to review objectives, individually with the students. Then, at the end of each day, there's a debrief time set aside. But, we also, at the end of every session, try to do just a mini debrief about their observations about the client. What their impressions were; if they have any questions about what they saw."* OTFC0011

The Clinical Educators also had some specific ideas for facilitating communication. These included giving student shared access to a cloud based document storage program such as Drop Box ®. This enables the students to share and work on documents or plans collaboratively. In another example a continuous handover document is prepared by the students which they handover to the next group of students coming to the agency. This binder contains information on how groups were managed, ongoing individual cases and progress on specific projects. This is particularly important for larger peer coaching models in student run clinics. The following quotations illustrate how some of the Clinical Educators facilitated communication.

> *"I have a drop box account for the placement. I provide access to students for each term and they use that, not just as a bit of a backpack for documents, but also to refer to each other's work when they start to plan collaboratively for whole class sessions."* SPFA004

"The students will develop a binder and they'll say these are the groups we're running or these are the conversations we had. This is the project we did, can you check to see how it's going? And solidify it or change it if it's not working ... And then the binder gets left behind for the next set of students. So that helps ensure quality communication so that each set of students isn't starting from ground zero... ...There's a really huge sense of empowerment that they are responsible for this." OTFC0012

"I will do a weekly E-mail summary, so at the end of every week I'll just summarize both to myself and to the student's what has been done and what's coming up in terms of deadlines and so on and that's where I do my little reminders" SPFA008

Establish Peer Coaching Foundations

Of course the last thing that needs a specific focus in this first week is to ensure the establishment of effective peer coaching foundations. The students need to be reminded and given feedback that the purpose of engaging in peer coaching practices is to enhance problem solving and build clinical reasoning. Many of the Clinical Educators have information on how they see the peer coaching model working and share this with the students in a formal education session as noted in the two quotations below.

"We start to introduce the concept of peer coaching and what it looks like, what it sounds like. We give them a run through with documentation on possible question ideas and how it might look in the sessions." SPFA005

"What they're given is a bit of a structure in terms of what it looks like, also a bit of a diagram outlining the three domains of coaching. So they're asked to use dialogue to open up in how they might have that discussion with their peer, with their CE, about looking to the placement demands, accountability, their knowledge and whether there might be gaps in their knowledge. And also, from a personal level, how they're going about doing their skills and well-being therapies. So we try and look at fostering peer coaching around three domains as opposed to just the knowledge of the skill sets. We think that's more beneficial and the students definitely start to form more relationships with one another as well. We found that beneficial." SPFA005

Because it is so important that the students understand the peer coaching model, many of the Clinical Educators offered information and resources to the students about working together as a team (powerpoint slides, information sheet, expectations, pre-reading). The

Clinical Educators try to frame the experience for the students so they embrace the opportunity to have this experience even though many of the Clinical Educators interviewed didn't necessarily understand or call the placement model 'peer coaching'. They just saw it as students working together to ensure each other can build their competencies to be successful at their profession. This is noted in the two quotations below.

> "... and the concept of peer coaching I haven't actually thought about the collaborative placement in terms of peer coaching, I've only thought about it as the three of us together" [OTFC0015]

> "... peer coaching is a new term for me." [PTFC001]

As a result, even the Clinical Educators have an opportunity to build their knowledge on the peer coaching model. However, they had very useful ideas and thoughts on how to define the experience for the students. Some of the concepts include reminding the students that in life they will have to work with many other people so the peer coaching model is a good example of developing competencies in this practice. Others reminded the students about the importance of being able to work in a team and to understand how to work with others who have different learning styles. Several Clinical Educators shared how they framed the peer coaching experience with their students as described in the quotations below.

> "Trying not to pretend that a peer placement is all smiles and wonderful. Sometimes there are personalities that clash and I always take everything with a job attitude though. I always say to them with that hat on that you're not going to get to pick who you work with, you can't pick what your team is, you can't pick who your boss is, you're going to have to work with people that aren't your style. That whole ... it's going to give you a really great experience from that level too. That's the way I always try and- -phrase it to them so that they're kind of thinking about the end." [SPFA002]

> "On that first day, I do talk about the- I don't know, I do a sort of back reference to the research around the benefits of peer learning. And it's interesting, most of them will say, "Oh, we've always been close with a peer", so I think actually we're moving towards a time where more and more students are actually- that's their main experience, is working with someone else. So they're sometimes a bit surprised when I indicate that they're supported by research" [SPFA009]

> "I set it up in the first interview that obviously there's two of them and one of me, I'm going to try my best to make sure that everything, you know, fair between the

two of them...   ... we're going to be a team and working together, and you guys are going to be here to support each other. So sometimes I might start out, with you us all three going in and the two of you might go in together. When that happens, you know, we're going to give open feedback to each other and throughout this process." PTFC006

"But I reinforce to them that it's preparing them, also, for mentoring, which is a component of the fourth year program. And it also helps, most definitely consolidate their learning, when they're reading rationales and what have you that are written by other people, it helps to cement a different way of presenting information. And importantly, in most cases, they're reviewing session plans relating to clients that they've seen in clinic, that they've observed from the observation room. So it's very much a collaborative process and the students are encouraged to most definitely be supportive of each other because in doing so they help achieve better outcomes for the clients most definitely" SPFA003

"we also get them to do self-learning questionnaires and we find that's really quite helpful before they go in just to see how similar their learning styles are. And, if need be, we might give them a little bit of rundown on how you approach different learning styles and what kind of things and what kind of feedback might be best for the other peer in order to prepare them for that kind of coaching style." SPFA005

One way Clinical Educators found they could support the peer coaching model is to bring the group together when debriefing about each student's experience. They would have open meetings with all of the students present so everyone becomes involved in everyone's work. How much of this, compared to individual sessions, is up to the Clinical Educator to decide. Some examples of how the learning team worked together is described by three Clinical Educators in the following quotations.

"When they start to get to the point where one of them is the lead therapist and we're observing, then I would expect the lead therapist to provide feedback on themselves, and their co student to provide feedback on their peer, and then I would provide the feedback third" PTFC004

"Apart from talking about their performance, all the meetings we have are together, so they're still learning about what each of the other students are doing." OTFA010

"I tried to create it like a team. It's the three of us, we have this case load, we need to get through it, we're going to be working together. You'll have your caseload, I'll have mine, they'll each have their own. But ultimately we worked together, so I think that helps" PTFC009

During this process the Clinical Educator can also test how well the students are working together by modelling the coaching practice themselves. Students will always want the answer from the expert so may bypass their peer coach. In joint learning sessions the Clinical Educator may also ask the other student to offer feedback in the moment, to again, model and encourage this practice. Some examples of how the Clinical Educators guided the students to learn from each other are provided in the quotations below.

> *"... when those questions do come to us, we'll always ask how'd you go when you chatted to your peer about that? And it becomes very evident, very quickly whether they have actually chatted to their peer about that or whether they haven't."*[DTFA007]

> *"We do encourage it, if we're not seeing enough of it. ... "Well, maybe you should talk to that physiotherapy student, and ask them what they're doing with respect to that area, and bring up your concerns, or the clients concerns, with respect to that.""*[OTFC0011]

> *"One of them will do something and then I'll give them a chance to reflect on how they did it, and then I ask their peer, "Could you give him some feedback?" Or in the moment, if they're doing something, I'd say, "See a person from where you're standing." Or like, "Could you make some observations? How could we help this person do it better? ""*[PTFC002]

> *"And I find that it's important for me to demonstrate what it means to be peer coaching... So, I think that, from the very first day, if they see that ... I'm somebody that is willing to ask questions, share information ... they can feel comfortable about sharing information, asking questions, relating experiences, discussing cases. So, it's almost like you are modeling that behavior, so they know from the beginning, this is the excepted way of performing."*[PTFC008]

Students should be advised that they should be sharing knowledge, explaining new terminology to their peers, providing non-evaluative feedback to each other, participate in meetings, and complete joint learning activities. They should plan and manage their group tasks, talk about their peer coaching expectations and map out the logistics for how they see this relationship evolving. The importance of this peer support system was echoed by the Clinical Educators as noted in the quotations below.

"... that's part of why they're together so that they can support each other and problem solve." [OTFCoo1o]

"... they [students]... realize they probably have more availability than I do for those quick questions that pop up during the week. That in turn starts the working relationship rather than always sending everything to me as well." [SPFAoo4]

"I think that's an opportunity for them to really build on their communication and work on their teamwork and think about, you know, how duties and responsibilities will be delegated and how they'll report back to each other to make sure it's fair and all of those sorts of things." [DTFAoo7]

Even though the students are given space to create their peer coaching relationship, the Clinical Educator needs to ensure that roles, resources, clients and experience are being shared equally between the two students so each has the opportunity to build their respective competencies. As a result it is still important to have a conversation to clarify expectations within the peer coaching model. What are the expectations of the Clinical Educator and of each student and how to they all work together within this model. Things that should be discussed include how they see themselves working with one another with respect to quality observation and communication. It is also important to review the importance of providing non-evaluative feedback so that status remains the same between the students. Several of the Clinical Educators provided the students with a template to structure their feedback to one another as described in the quotations below.

"... we actually give them a sheet that says what they think went well in the session, what would they do differently if they were running the session from their observation and anything that they would take away and use themselves next time that they might be in that situation" [SPFAoo1]

"I give them a little feedback template where they're expected to watch their peer and they have to be honest with what they think their peer did really well and one thing that they think they could improve on with that idea of coming together over the discussion and make a plan of how that's actually going to happen." [SPFAoo2]

"... the observation and feedback templates have been really helpful when students are giving feedback to each other, early on in the placement, because they know what kinds of feedback to provide." [SPFAoo8]

Set times for reflection and discussion between the students should be established. Lastly they need to think about how they work together on shared clients, how they work together when one is observing only, and how to give feedback during sessions with clients. Roles around documentation also need to be discussed so that omissions around client reporting don't get overlooked.

The Clinical Educator also needs to note their expectations with respect to evaluation and what professional behaviors related to peer coaching are being assessed. They need to ensure that the students are relying on each other for support in the first instance as noted in the quotations below.

> *"... my first lecture is allocation of responsibilities and the go-to people and what to do if they have an issue, if there's professionalism issues or they have questions for their supervisors and that sort of thing. So that's ironed out in the very first lecture"* DTFA015

> *"We talk a lot about the fact that that is their little mini team...   ...So we'll always have them ask their peer any clinical questions before they'll ask their supervisor"* DTFA007

One Clinical Educator who usually supervises a peer coaching model even reported that when they only have one student assigned to them for a placement they ask the University to provide a student contact in another placement so their student has a peer support mechanism in place.

> *"... they can be a pair or they can be single. If they're single, I'll always ask the university to give me a peer at another site for my student to contact." DTFA007*

The Following Weeks

The following weeks are marked by students gaining more confidence and working on tasks with more independence. The role of the Clinical Educator becomes more of a monitor role and direct supervision reduces. The students are working more cooperatively with each other as they get to know one another further. During this time, their specific individual strengths and development needs emerge. Each student must work with their peer(s) and Clinical Educator(s) to get the support and experience to round out these development needs so they can achieve expected competencies. So while the Clinical Educator may be reducing their direct supervision and observation time during the following weeks, the time the Clinical Educator does spend on direct supervision is focused on supporting the specific development needs of each student. Support may involve offering demonstrations and/or teaching, giving developmental feedback and also confirming strengths. Reviewing the student's objectives is important to ensure they are on track. Direct observation is more strategic, focused on the specific development needs of the students and for the collection of evidence for evaluations.

The following five strategies for these following weeks were consistently identified by the Clinical Educators as noted in the figure below.

The Following Weeks

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The Following Weeks
├── Facilitating Communication
├── Facilitating Student Development
├── Student Centred Learning
├── Extending Learning
└── Monitoring the Peer Coaching
        └── Review the Student Work
                └── Gather Subjective Data
                        └── Shifting to Independent Practice
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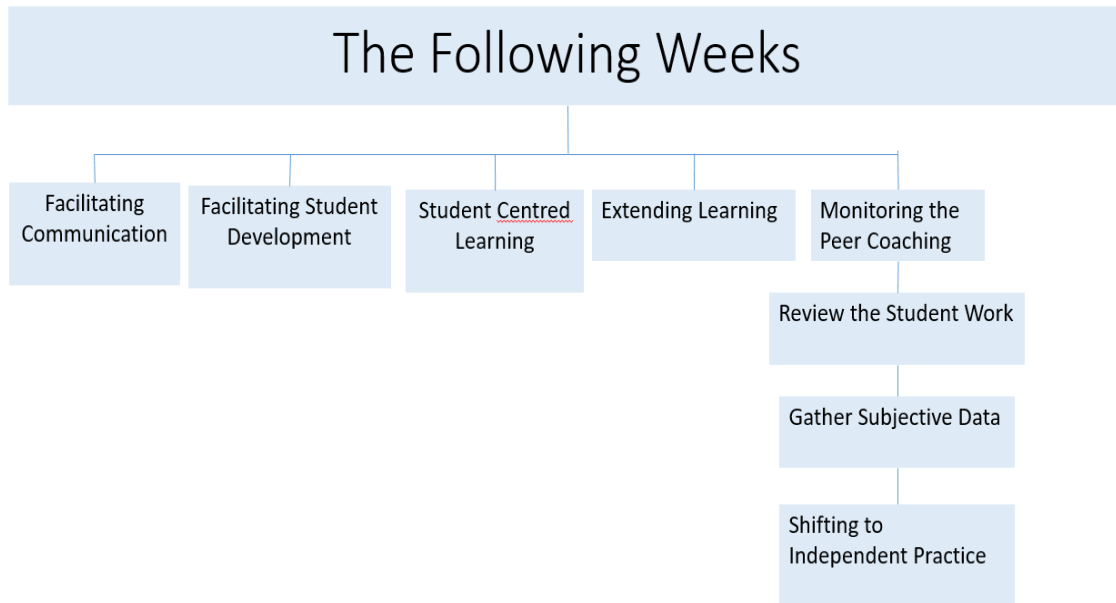
Facilitating Communication

Regular discussions continue with the students both as individuals and as a group. There are still clinical brainstorming sessions and reviews of workload and these are scheduled so there is dedicated time for these conversations about practice to occur. It is important that the Clinical Educator observe and debrief with the students about what they are seeing so there are no surprises when the midway evaluation occurs. The discussions that occur during this time have more depth and are occurring between Clinical Educator and student(s), between students, and with other professionals in the workplace as networks are created. The following two quotations from two Clinical Educators provide examples of how the supervision is working during these middle weeks.

> *"At the end of every day, we have feedback about how the day went, and I tell them, I don't want any surprises at midway. I'm gonna take care about them as they come up, and you shouldn't have any surprises from me at midway."* PTFC002

> *"I find that that checking in week three is really helpful because it's a couple of weeks before mid-compass and it allows us to just check in with each student, see how they going, talk about caseload workload, how they're managing that, but it also gives an opportunity for us to receive feedback but also for us to provide any feedback or really air any concerns that we have with the student progression. And even though it is only week three, it's kind of that opportunity to see if we do have any real red*

flags. So we've got a couple of weeks until mid-compass to see some change from the students." SPFA016

Facilitating Student Development

As the Clinical Educator becomes more aware of each student's strengths and development needs, they can work more specifically with the students. In the earlier part of the work-integrated learning experience the Clinical Educator is more directive. As the weeks progress, however, the Clinical Educator shifts to a coaching role and uses more open-ended questions in order to probe the student's thinking and clinical reasoning. Questions starting with "who", "what", "where" and "how" are excellent as it makes the student have to think about their thinking (metacognition) and encourages reflection about practice. The following two quotations from Clinical Educators describes this practice.

> *"I'm taking more of the observational role and they're starting to take on more independence, for the actual session with the client. I may step in if they're not on the right track with something. Or, I may ask them questions if they're doing things with the client to elicit what they're, sort of, thinking. Where they're thinking is at, and where their clinical reasoning is at."* OTFC0011

> *"Whereas if they're in phase two they're in that assistance partnership phase. It's probably about those open ended questions, asking for a little bit more information in terms of their problem solving or reasoning. ... when they're leading up to Mid-COMPASS, they're usually between coaching and assistance. So we do try to direct our feedback around what level of assistance they're needing."* SPFA005

As the students become more confident, workload also changes, with the students taking on more responsibility and caseload. Discussions with the student regarding their capacity to take on more work occurs. With this increasing responsibility comes the need for the Clinical Educator to check-in regularly on progress to ensure the student is meeting targets, on track for longer term tasks and will meet deadlines. The following quotations from Clinical Educators describe this practice.

> *"... by mid-placement, I'm wanting to see a lot more independence starting to happen, so I'm tapering back my directive sessions, and trying to set them up to "Okay, so what are you going to do? How are you going to approach this?" rather*

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than giving them so much guidance, and trying for it to be more student directed learning." SPFA013

"... it would just be checking on, just asking them how they're going. I wouldn't look at what they're doing, just asking if they think they're going to make their dates, and if they're not, that's when we'll re-look at the dates or re-look at what they're doing to manage their time."OTFA010

In the latter weeks, when the students' caseload is increasing and they are taking on more complex clients, the Clinical Educator role shifts towards a more advisory role. In this role they probe the students' knowledge to test for clinical reasoning and problem solving as well as assisting them with more complex questions. The provision of direct feedback reduces as the students will get this from their clients and their peer(s). The Clinical Educator at this point of the work-integrated learning experience can be considered akin to a consultant role. This change to a more advisory role is apparent in the following quotations which illustrate how the Clinical Educator works with the students.

"I'm asking so why are you doing that or how could you achieve that in a different way or what direction would you take this? Or what are you gonna do when this happens, so I'm getting a direct feel of their clinical reasoning and their planning." OTFC0013

"... you'll find that I've giving you less daily feedback because you're going be getting more feedback from your clients." PTFC0014

Student Centered Learning

The Clinical Educators noted that they emphasize reflective practice and encourage students to take ownership of their learning. Given that the students set their own personal learning objectives early in the work-integrated learning experience, along with any specific objectives set by the learning environment, they must take responsibility for managing their learning. Not only is this important for ensuring they meet expected competencies, it also is an effective strategy for reducing any anxiety the students may have. By reflecting on their practice, they can get support from their peer coach and/or Clinical Educator and mitigate

any concerns or anxieties. To create this student centered focus, two Clinical Educators offered these following ideas/strategies.

> *"I'll ask the students to identify anything that they feel ... where they might be falling short or. If there are areas that they are falling short, I'll ask them to have a think about what might be some opportunities that we could provide ... that you will be able to demonstrate those particular skills or whatever it might be. If they really struggle, I'll share some ideas with them, but my preference is really that they come up with those sorts of things themselves."* [DTFA007]

> *"I also do, encourage them to do weekly self-reflections, so written self-reflections on how they feel the week went. And I feel like that helps their ability to reflect on their own performance and that of their peers as well."* [SPFA012]

With this increased self-direction and ownership of learning, the students are more directive in the kind of feedback and support that they want from their Clinical Educator(s). They have taken on board the rich feedback that typically occurs in the first half of the work-integrated learning experience, and through reflective practice, have embedded it into their daily practice. If they do need support, and have not been able to get the answers they need from their peer(s), this emboldens the peer coaching team to approach the Clinical Educator. As a team, it is less threatening to approach the Clinical Educator as it is less about something an individual doesn't know versus something the team is trying to figure out. The following quotations note how feedback from the Clinical Educator changes and a greater emphasis on student self-evaluation increases.

> *"... because we fostered a lot of self-reflection in the first half of the placement, I find that by the end of the placement, I need to give a lot less feedback, because the students are already reflecting what feedback I would provide for them about a particular session."* [SPFA008]

> *"With my students who have been performing at or above expectations, I start to rely more and more on their self-assessment. That's where my evaluation of their ability to evaluate themselves in the first couple of weeks, becomes really critical, ... because they're doing things more independently. But I still expect them to come when they've done a treatment session, or a new assessment, come back to me and say, "This is how the patient did, this is how I did, and this is something I wanna continue to work on.""* [PTFC004]

> *"I suppose I like to take a bit of more of a back seat and get the student to approach me in terms of what feedback do you have the need from this session. Or, what they need from me. I would like them to have the confidence and competence to say, "Hey, I'm not quite sure about this patch. What do you think or how do you think I'm going? So, I want them to. I can't think of the right word. Take more ownership over their learning."* SPFA006

Extending Learning

As the Clinical Educator gains a better understanding of the student's strengths and development needs through observation and discussions, they can strategize ways of extending learning for the students. In some cases it may be to set some homework, or organize a set of scheduled educational sessions. Given that the Clinical Educator knows the environment very well they can find specific opportunities where the student(s) can gain more practice. They can also respond to student interests by assisting them in achieving their learning objectives or by providing them with specific experiences of interest. Students can also be given opportunities for working with others to see different approaches to care.

> *"Everybody is just constantly communicating so I'm always asking "hey think about what you guys want to achieve next week or what haven't we achieved that you really want to tackle?" I have an ongoing fluid understanding of where they are at and what they want to continue to work on. So by the end of the placement, I still know how to challenge them and where to take it."* OTFC0013

Extending learning activities may also be undertaken because the Clinical Educator needs to see the student performing a certain task to assure safety or to collect information for evaluation and competency assessment. Again, the Clinical Educators noted the following ways they extended learning in the following quotations.

> *"Once a week I do, sort of, a breakout education session. So, an hour on a specific topic, pertinent to the placement. The students are given a list of topics at the beginning of their placement. They chose however many, depending on how many weeks in their placement …They're led by myself but we do a lot of, sort of, hands on practice and questioning, in those sessions as well. So they're providing the answers, in a way. I'm just, sort of, facilitating that teaching."* OTFC0011

"... encourage them to shadow other clinicians in the team to make sure that they, usually just feel comfortable that they can see somebody else do something maybe slightly differently but ultimately get the same outcomes."^{SPFA012}

Monitoring the Peer Coaching

It was noted by Clinical Educators that making sure the students were peer coaching effectively was something they had to monitor even though they didn't have to necessarily 'teach' them how to work collaboratively. Whilst setting clear objectives and expectations for peer coaching at the start is imperative, the Clinical Educators noted that they did monitor this even in the middle of the work-integrated learning experience. Clinical Educators continued to provide students with shared tasks and reminded them to spend time together and to observe each other and offer feedback. This is outlined in the following quotations from Clinical Educators.

"It's a bit of explicit reminding as well to make sure they are working collaboratively."^{SPFA004}

"I do prompt that joint reflection after a session, so the session will finish and I'll say, "Let's get you guys to reflect on how the session went", and then I'll come back in 10/15 minutes and we can talk about"."^{SPFA009}

There is always the temptation to ask the Clinical Educator to solve a problem as students value expert input. As a result, Clinical Educators noted the importance of sending questions and some learning tasks (based on student development needs) back to the students. Students were encouraged to 'figure it out' or to get input on a question or technique by having the other student observe and offer feedback. Some examples of how this is done by a Clinical Educator is noted below in the quotations.

"... if they come to me for a question, I will tend to say to them, "what has your peer said about that?""^{SPFA002}

"I also do really direct them if patients are similar or if someone's done something similar to make sure they are seeking the other student out."^{SPFA002}

*"I get quite strict on the providing their feedback to each other. Making sure they're giving really great examples and ones that they haven't said the week before because we do written feedback so I will say to them, "No, no. You said that one last week. Let's think of something different.""*SPFA002

Review the Student's Work

One way Clinical Educators were able to assess whether the students were working together effectively and coaching one another was to review their work and how they problem solve as a team. During ad hoc or scheduled education sessions or meetings, the Clinical Educator can observe how the two students are working together. These observations can be used by the Clinical Educator to address any concerns that might be surfacing around how the students are collaborating. The following quotation by a Clinical Educator demonstrates this practice.

"... there is that opportunity for me to observe how they are problem solving and how they're conversing and how they are kind of coaching each other. So, I feel like I get a pretty good sense when we have our group reflective supervision session. Who maybe finds it a little bit easier to offer suggestions or direct their peers to resources and who struggles a bit more with that." SPFA008

Gather Subjective Data

The Clinical Educators also collected specific information on how the students were coaching each other and working collaboratively. They needed this information to ensure the work-integrated learning experience was progressing well and that there were no issues. They also needed this information as it is linked to the professional behavior and communication section of the evaluation as there usually isn't a specific measure to evaluate peer coaching on institutional evaluation forms. Clinical Educators would discuss how they are finding the peer coaching arrangement with the students directly as a team and also privately as noted in the two quotations below.

"... what we do is we ask the students to reflect on how they think the peer coaching is going and whether or not they find it beneficial moving forward or not. And it's

shown often enough they do find if very beneficial, so that's a key indicator that it is moving in the right direction." SPFA005

"... so we'll actually ask each of them separately how the peer relationship's going. Obviously if there are any issues in that relationship, I'll ask that earlier, but I do find that midway there are formal opportunities to ask how is it going, do you think that the workload is equally shared, and that gives them the chance to say, "Actually, it's not going so well," and we can then work on that." SPFA009

Other strategies to collect this information included asking other staff who may have observed the students working together and having the students write a reflection on their peer coaching experience. What was good to hear from a Clinical Educator is that if there are issues, the students raise these issues directly. The Clinical Educator doesn't even have to ask.

"If there were issues, I don't even have to ask. They really come and tell me immediately." PTFC001

Shifting to Independent Practice

As the work-integrated learning experience moves in to the latter phases with the final evaluation near, the students have shifted in most cases to more independent practice. Given that all students at some point are going to become independent practitioners, it is not unreasonable for them to want to test out their skills in this manner. Hence, the early and middle parts of the work-integrated learning experience rely on peer coaching and collaborative engagement more so than the latter part. The Clinical Educators were very aware of this shift in practice and supported it, even though they still encouraged the students to debrief with one another as part of the collaborative practice model. This shift in practice is noted in the following quotations from Clinical Educators.

"... initially it's a lot of stuff together and then they go off and do their individual part of the project in week four and five."OTFA010

"... students are showing less interest in participating in sort of peer observation from sort of midterm onwards, and they're really hungry to complete sessions on their

own, and would rather have more patient interaction that they're leading, rather than observing." SPFA001

"... it does tend to drop off and I tend to let it. I let it drop off as long as they are still working collaboratively and utilizing each other." SPFA002

"... in the latter half of that placement I encourage them not to be conjoined twins and to do everything all together. That I encourage them to find times and places where they might do a treatment session with an individual on their own. And then come and debrief it with their partner still." OTFC0012

While the tendency to shift to more independent practice occurs with respect to some of the clinical duties the students must complete, this is not always the case. There are still other dimensions of the work-integrated learning experience that will benefit from peer coaching and collaborative practice. As students progress through a work-integrated learning experience the complexity of the placement also increases. Students take on more complex clients, acuity levels may increase, caseload and administrative tasks increase. Hence, students may still struggle and would, therefore, benefit from the support and coaching a peer may offer. This was also apparent in some of the comments made by Clinical Educators as noted below.

"I find it does vary. ... I do find, however, generally ... that support right through the placement. Where, I might get the odd student who is working a bit more autonomously towards the end, as a whole I'd say that the peer coaching is still present. Perhaps slightly less of a degree." SPFA004

"We find that the students work more collaborative as the placement progresses, because actually that's what we're encouraging. They tend to develop a bit of that discipline ... So the collaborative communications, the working with, from, and about each other, is actually what we're promoting. And it's also assessed. So if the students are doing less and less of that then actually translates to a fail." DTFA011

"I would say even towards the end of the internship, there's always at least one or two patients that they are seeing together, just because things might be a little bit more complicated, or they might need two people to transfer. It might just be a good learning opportunity." PTFC003

"The process of observing each others' sessions, and participating in those group section sessions, continues right through the placements. There are always opportunities for peer coaching even as some of those students might be working a

bit more independently towards the end, the opportunities are there right through the placement." SPFA004

Evaluations – Midway and Final

Two thirds of the Clinical Educators noted that the practices involved in preparing for the midway (formative) and final (summative) evaluations are much the same. As a result, strategies for successful evaluation will be considered the same for both time points. Any specific strategies that might be important to a specific time point, however, will also be included.

For any evaluation, it is important that the Clinical Educator be aware of the established competencies required for successful completion of the work-integrated learning experience. These should be discussed at the outset with the students, along with any expected competencies for peer coaching. This moderation exercise ensure all parties are clear of the competency expectations at the outset for midway and final performance evaluations.
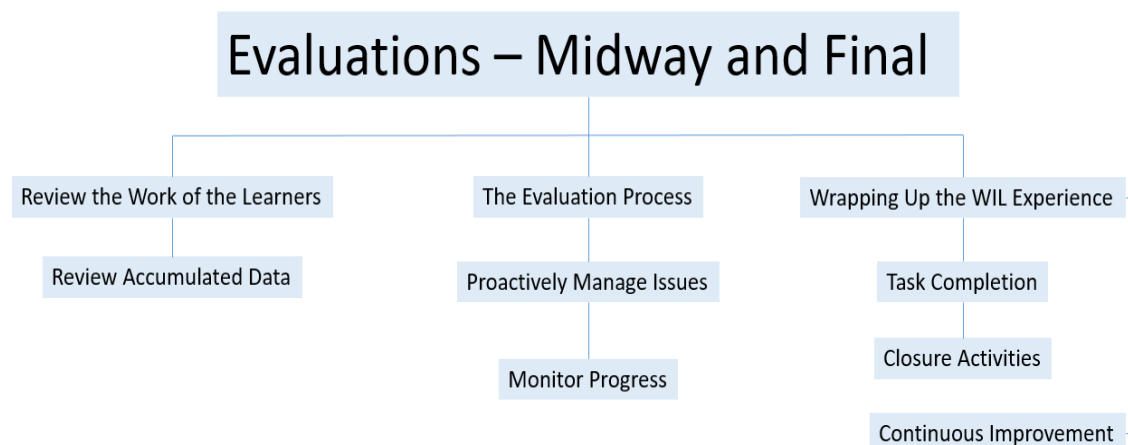
Review the Work of the Students

For each evaluation it is important to observe the student(s) directly or indirectly when completing clinical work. This allows the Clinical Educator to make a fair and informed decision about competency. It is also important to observe the depth and complexity of the thinking that is demonstrated by the students during discussions. This provides insights

with respect to how they are applying their knowledge and learning. Specific areas of concern that are developmental needs should be given particular attention to see if feedback is being actioned. Lastly reviewing written documentation (assessments, chart notes, letters, etc.) and in some cases reflective journals (if the student consents) provides further information helpful for evaluation.

In some peer coaching models, other members of staff may be asked to provide feedback on the students' performance, particularly in non-traditional sites where the students are working on a project in an agency with only off-site supervision by their Clinical Educator. Another reason for doing this may be to get another opinion on a specific student's performance if the Clinical Educator is not sure.

Review Accumulated Data

The observation and review noted in the section before yields a lot of data. This must be maintained in a journal for each student and team so that it can be used as information and evidence for the midway and/or final evaluation. This ensures that the evaluation is written objectively. If there are any disagreements, the Clinical Educator can refer to their journal notes with the date(s) and specifics of what they observed. Some strategies specifically noted by Clinical Educators are noted below.

> *"I do also have a document on my computer with compass comments that I am finding relevant for individual students. So, I'll just pour bits and pieces into there and evidence into there at the end of a clinical day or when I am next back in the office to keep track of how they're going."* [SPFA008]

> *"I keep a list of things that I've seen them do and things that need improvement, on both of them."* [PTFC002]

> *"I think being able to give them individual examples ... gives them faith in that 4 to 1 peer coaching model. If you can talk about that student ... how they work with their peers but some individual things that they have done, I think that really gives them that confidence and that faith in that kind of model. I tend to collect my thoughts in a really easy word document about some examples."* [SPFA002]

By having a rich database of examples which have been observed and/or discussed, this ensures that there are no surprises at midway and final evaluations. Where there are two Clinical Educators supervising the students, it is important that they meet to discuss their accumulated data and collectively make decisions on how to evaluate the students as noted in the quotation below from a Clinical Educator.

> *"... it's sort of a bit of a planning meeting between the two supervisors in terms of the feedback we're going to provide and sort of summarizing all of our notes from the placement so far and then putting that together before we sit down with the student." SPFA001*

The Evaluation Process

Clinical Educators repeatedly noted the importance of ensuring the students provide a self-evaluation prior to the formal evaluation meeting. This then enables the Clinical Educator and student to focus on items where there is disagreement. It is very important that the meeting is a two-way conversation. This ensures that any performance issues can be discussed, with strategies for improvement. Evidence should be provided for each competency measure as an example of excellent practice or an area needing further work. The Clinical Educators also noted the importance of conducting the evaluation with the individual student and not as a team. The following comments from Clinical Educators reflect these evaluation processes.

> *"I ask them to do their self-evaluations before I give them their evaluation so that I can have a look at where they're at and if I feel like my perception of where they're at is congruent with their perception, and what they've identified as their learning needs, and so I try to give more feedback on the areas they've identified as their areas for growth so then I give it to them ahead of time to read." OTFC0010*

> *"... if the student feels I've marked them a failure on competency, I do give them the opportunity to talk about why they think they have reached that, whatever it is they have to support them." SPFA008*

> *"It's putting the ownership on them as well, just to show us what they've improved on." SPFA001*

Proactively Manage Issues

With the midway evaluation complete, Clinical Educators noted the importance of setting new goals in collaboration with the students, particularly for developmental needs. This may involve tailoring a student's caseload so that they can work on specific competency items. This set of goals and accompanying action plan then enables the Clinical Educator to check in at regular intervals on progress.

> *"So I think if I have any issues that were raised in the mid-term, then I kind of don't leave the mid-term unless we've got some clear kind of goals or really clear strategies of how we're gonna work towards meeting those goals. So then that's a nice opportunity, kind of regularly after mid-term to catch up and be like, "Okay how are you going with this, this, and this?" Instead of leaving it quite broad I help them to kind of, we'll scaffold to make sure that they've got a plan of how they're going to get there. And then we regularly touch base about it."* SPFA012

Clinical Educators also noted that these specific areas needing development can be a focus for peer coaching. The student can focus on these new goals with their peer coach in the latter part of the work-integrated learning experience.

> *"... if there are particular things that they need to work on, they should share that with their peer. Obviously that's something that I can disclose to their peer, but I encourage them to share that so they can support each other in their learning goal."* SPFA009

Monitor Progress

For the remaining weeks leading up to the final evaluation, it is important that the Clinical Educator monitor progress. The Clinical Educator needs to monitor how the student is changing with respect to new goals and actions plans established at the midway evaluation.

> *"I'm certainly observing and ensuring that the students are taking in the constructive feedback that was given to them, and making those changes to practice. In our debrief sessions, I'll often bring up, "How are you changing your practice, in order*

to reflect that feedback?", if I'm not seeing the changes happen in a more natural way." OTFC0011

For the most part, the students do well if these evaluation practices are carried out. As noted by one Clinical Educator below, with expectations clearly laid out at the outset and again at midway, the students naturally work towards meeting the objectives and competency standards.

> *"To be honest, I don't often come across situations where I have to be very critical or very overt. I think partly, that's because the expectations are laid out so clearly at the beginning of the placement. That it just, sort of, naturally flows out of that. That the students start to take on more and more, and can begin to self-reflect and change their practice."* OTFC0011

Wrapping Up the Work-integrated Learning Experience

Task Completion

The most significant tasks the Clinical Educators needed to complete at the end of the peer coaching experience was ensuring that all administrative tasks were complete. As the students prepare to leave the work-integrated learning experience, Clinical Educators had to ensure that treatment summary reports were complete and home programs were set up for clients being discharged. Handover documents ensuring continuity of care also had to be in place for the Clinical Educator and other clinicians who would be picking up the students' caseload. Signatures on all relevant documents also had to be checked along with all relevant statistics entered in to databases. Clinical Educators noted that they had to be on top of this and not assume it would just happen as noted in the following quotation.

> *"So getting the students to, sort of, thinking about that closing of the treatment process. It isn't something that just happens. You need to put some work and preparation into that, in order for it to happen, in a way that the client feels quite supported through."* OTFC0011

For students in project based work-integrated learning experiences it was important that the Clinical Educator check in on the progress of any long term tasks as well as smaller tasks. Information storage and due dates were all important considerations to discuss with the students.

> *"Talking to them about everything that's going to be needing to wrap up and putting the ownership of them but me prepping them for all the little things they need to do."* SPFA002

Closure Activities

At the end of the work-integrated learning experience a range of activities were described by the Clinical Educators to bring closure to the experience. Quite often, students were required to give a presentation on their work-integrated learning experience. This might include how they contributed to the service, training on a specific topic or skill, presentation of data on clients they have collected, or, in the case of project based placements, a summary of the project outcomes. They were also interested in what the students found challenging, rewarding and what they might be taking forward in to their next work-integrated learning experience or career if at the end of the program.

> *"... what were the things that excited them the most? Or, where did they learn, or, how did they learn? How can they take that, moving forward, with them, either to their next placement, or into their careers, if they're finished and they're beginning to start practice."* OTFC0011

> *"... we will time table some time at the end to just all talk about how the feedback model, how it all went and what they liked, what they didn't like."* SPFA002

It was also noted by the Clinical Educators that acknowledging the students' contributions to the service was important. This involved having a morning tea, a signed card, a thank you certificate or even a small gift.

Continuous Improvement

As the Clinical Educators took their role seriously, they wanted feedback from the students on how they might improve the experience after the final evaluation was complete. They wanted this feedback so they could make changes that would benefit future students and also improve their own competencies as Clinical Educators. In some cases the University offered structured feedback forms that the students completed. Once the term ended, this feedback is then given back to the Clinical Educators. However, Clinical Educators took the opportunity to directly engage with the students to solicit this feedback as noted in the quotations below.

> "... to summarize basically what they've done all term within the classrooms and outside of the classrooms to reflect on how they felt the service delivery model works and to make any suggestions that they think would improve the placement structure for the following term ..." SPFA008

> "We'll always try and improve on the second placement." OTFA010

> "I always reflect on how I feel I went as a supervisor in that placement, because I find each placement teaches me something new or challenges me in a different way." SPFA012

> "... tweaking our service delivery model based on the reflection that the students and staff, in order to prepare for the next placement. SPFA008

> "Just things that they would like to continue, things they think that we should start, and things they didn't think worked very well. Then we review that once they've left." PTFA014

Even though the students on a work-integrated learning experience have dedicated Clinical Educators, quite often many other members of the team are involved in supporting the educational experience. As the peer coaching model involves more students being present in the organization, this can create a new set of demands for staff. As a result, Clinical Educators also recognized the need to debrief with their team following the departure of the students to identify any other systemic issues and actions needed to support the team.

"It's a good time for me to thank my team for having the students because it's amazing having students, but it is also taxing. It's emotionally taxing and it takes time. So we'll have a little bit of a problem solver at that point, you know. Is there anything that you've had to drop over the last few weeks that you've been supervising that we need to support you to be able to catch back up on? You know, was there anything you found particularly challenging? And from that point of view, I'm asking those questions in case we need more training or, you know, we need to be doing some peer support ourselves" DTFA007

"So we do surveys, but we reflect as a team, and all the students that have come for the term, so we have a meeting, we will go through that reflective process with all the students that have been within the department, what went well, what were the challenges, those sort of things. So we can negotiate the issues around space or computer use or any of those." SPFA009

Chapter 5

Special Issues
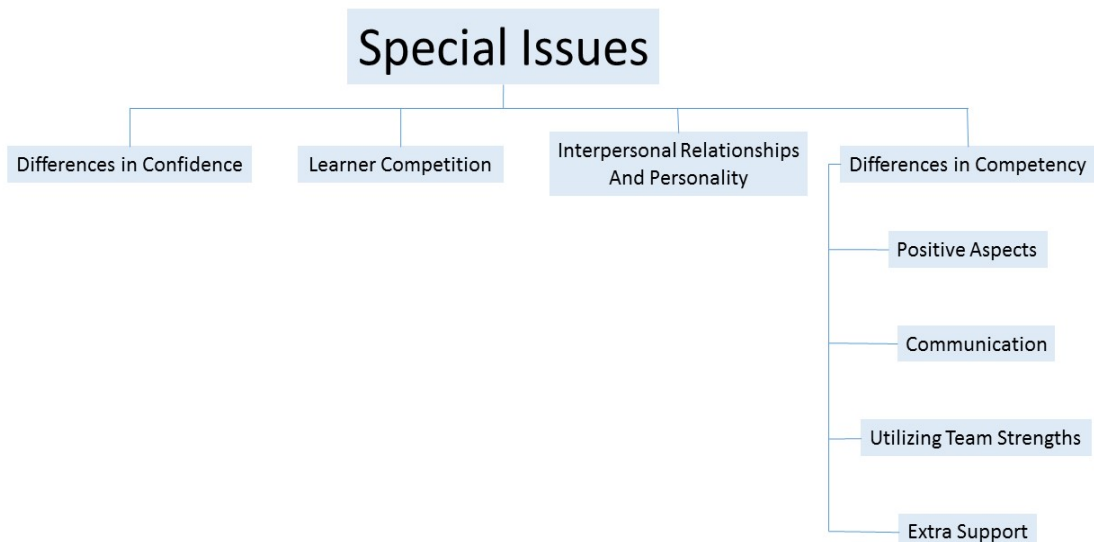
There are issues that surface in the peer coaching model during work-Integrated Learning Placements. Differences in competency was not identified as a significant issue in the peer coaching model and is probably no different from other models. Students either have the required knowledge, skills and behavior instilled in them during their education to be successful or not. But what did manifest in the Clinical Educators comments was how confidence, personality and competition can play out during the work-integrated learning experience.

The Clinical Educators who shared their views in this project raised a number of issues they have experienced, although not all of these were specific to the peer coaching model and could, in fact, occur regardless of whether the site hosted one or multiple students. This emphasizes that taking multiple students doesn't necessarily increase the potential for issues or risks that Clinical Educators may face. What does mitigate these issues is having

appropriate management strategies in place such as those covered here and in the preceding sections of this book.

Differences in Confidence

What was reported frequently by Clinical Educators were differences in the confidence levels between students. This needed to be actively managed as students who are very confident can dominate opportunities and may sometimes appear as very competent when in fact they are not as noted in the quotation below from a Clinical Educator.

> "It turned out the one who wasn't as confident was obviously the one who was more competent... ... I said to her, "I could pass you right now. The rest of this is you just getting as much out of this as possible and how can I help you do that?" Whereas the other one who was more outgoing, I made the mistake of giving too much positive feedback and encouragement at midterm and that day he bombed and it was an unsafe situation with a patient." [PTFC002]

In contrast, those students with low self-confidence require support, particularly if anxiety increases as a result of them comparing themselves to the other student(s). This can be unnoticed initially as evident in the quotation below. However, once these differences are noticed, it is a matter of spending the appropriate amount of time with each student, and assisting them to develop strategies to overcome confidence issues as described by a Clinical Educator in the following quotation.

> "I can think of one instance where one student was just really, really anxious and really not confident. And the other student was the complete opposite, really communicative, really personable, really confident and able to take on more than expected... ... At first, I maybe didn't recognize it as readily ... because the strong student was more vocal, I tended to pay more attention to that student. So I had to really make a conscious effort to make sure that I was spending time helping the student who was struggling more, to develop what they needed to... So I did explain, not that one was bad, or good, or whatever, but just that they're in different places, so I have to pay different attention to each of them." [OTFC0015]

This may require that the Clinical Educator manage how tasks are distributed. The Clinical Educator may also need to discuss with the more confident student the impact they are

having on the other student(s) and provide some coaching on how they can be a more effective peer coach. The student with low confidence may also need more feedback, particularly the impact their lack of self-confidence is having on others as noted by a Clinical Educator in the following quotation.

> *"Some students might need encouragement to be more vocal in terms of discussions and making more contributions. And if I see that there's some that are less confident, then I definitely speak to them about how it's really important in this environment, as well as in any workplace, to be part of a team and that your thoughts are worthy of contributing."* SPFA003

The Clinical Educator should make a point of identifying the student's strengths to boost any lack in confidence. However, feedback and direct questioning may increase the anxiety of the student with low self-confidence. Using self-evaluation may be more effective as indicated by one of the Clinical Educators.

> *"I try not to just specifically ask the more reserved student a specific question because sometimes they don't respond well to that. It depends what they say that they like their feedback, and how open they are to it. So I kind of pick up on those cues throughout the placement, to know how to engage with them best. Sometimes it is not a matter of asking them questions, but just asking them for self feedback ... So I just try to engage them as much as possible, in an individual task and individual questions, just so I can really see how they're feeling and how they're doing."* PTFC006

Student Competition

It is important to note here that a large number of Clinical Educators did not report that student competition was so problematic in their experience that it required a considerable amount of effort and management to prevent it from happening. However, they did offer strategies to deal with the natural tendencies of some students who may be more competitive in nature. In fact, a few noted that competition can be good and fun as long as it doesn't become counter- productive. It may be important to reframe competition so that students who don't like competition don't move away from learning from one another. This defeats the benefits of the peer coaching learning model. As noted by one Clinical Educator, healthy

competition is about challenging one's own thinking. It can be a way of increasing metacognition and self-evaluation of one's own practice.

> *"… really speaking positively about learning from multiple different clinicians, whether that be the two supervisors that you have or your fellow student. Even if you're watching their sessions thinking you would do it completely differently, just thinking about why you would do it differently and why you think that's more successful."* SPFA001

> *"The stronger students tend to be more open to it [peer coaching] and don't have very many issues with it at all. Where its the middle performing students that tend to think that it's more of a hindrance than an opportunity."* SPFA002

If competition does become apparent, it simply has to be named in the context of professional behavior as students are also learning how to be effective team members.

> *"… reiterating that part of their competence is not only clinical, it's also communication and it's teamwork, and competition is, it's, you know, healthy competition is great, but when it goes too far it's counter-productive, and that is actually meaning that they're not competent in those areas. So I will talk to them about that side of their work."* DTFA007

Students need to be reminded to acknowledge the contribution of their peers. They need to be reminded to share equally those tasks assigned to them by the Clinical Educator, particularly around projects and presentations. However, where competition is surfacing, sitting down with the student(s) and reminding them to focus on their own individual learning journey helps to ground them to the purpose of the work-integrated learning experience. An example of how a Clinical Educator has this conversation is provided in the following quotation.

> *"… what we try and do is actually meet with a student individually, to let them know that this is their learning journey, their learning objectives, and that while we can say there's competition, we'd like them just to focus on what they need to learn and let other people do that as well. And we found that once we've actually had that formal conversation with them, things have improved."* DTFA011

Other strategies included being very clear around assigned tasks that are allocated separately and collaboratively to the students. Having regular check-ins with each of the

students on how the peer coaching is going is also useful to see if competition or any interpersonal issues are surfacing. For collaborative tasks, it is important to also be clear what roles each of the students will have (e.g., student A will do the history, student B will do the physical examination).

> *"... so usually I'd give them each a role, "This person is going to lead the session and your job is to be the assistant for the session and so on and so forth." If that's not working, then they are separated and they have their own patients"* *PTFC002*

Actually saying, "this is not a competition" can be also be effective and reminds the students to focus on their competency development.

Interpersonal Relationships and Personality

A few Clinical Educators noted that pre-existing relationships as well as the development of challenging relationships between students on the work-integrated learning experience can influence interpersonal dynamics.

> *"There's always certain personality types that maybe don't mesh together well. That can create a bit of friction"* *OTFC0011*

It is important to note that personalities themselves don't clash, but rather, clashes can result when a person reacts to a personality dimension that they may not understand and which differs from their own. The Myers Briggs Trait Indicator is a useful tool for understanding personality traits and why clashes may occur across traits. Readers are encouraged if they don't know this tool to explore its concepts on the organization's home page.

https://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/home.htm?bhcp=1

Where clashes seem to be appearing, it may be useful to have a discussion about the differences across the team or students. Is the clash for example between an extreme Extrovert and a strong Introvert? Or, could it be that a strong Feeler who makes a point of acknowledging others and being careful about what words they use when talking to others

is not feeling appreciated by their peer coach who is a strong *Thinker* who communicates in a very direct and blunt manner? What Clinical Educators can do, aside from having this developmental conversation to help the team gel, is recognize the issue early and then sit down with the students to discuss it. A review of learning styles and how to give non-evaluative feedback may be necessary with check-ins to make sure it is working. Having the student's reflect on their relationship is also a useful strategy identified by one Clinical Educator.

> *"We actually developed a peer reflection tutorial which we don't do with all pairs. We only do them if we do sense that there are a few underlying issues and we'll do things like actually get them to actively talk about, describe three positive things that your peer's being in this placement that you found you've learnt from. Particularly if there seems to be a bit of tension, and get them to talk about what's working well, and have there been any challenges, and if so- and to get them to think about how they might have resolved them, or could resolve them. And then actually explicitly each of them identify what's one thing your peer could do to help you improve your learning."* SPFA009

Differences in Competency

Positive Aspects

One of the concerns voiced by Clinical Educators in workshops is that the students will have different competency levels and that this will be a problem. In fact, a large number of Clinical Educators noted that this could be a positive thing on team dynamics and performance as noted in the quotations below. It was positive when a stronger student actually demonstrated the ability to support a weaker student. Not only did the weaker student benefit from the peer coaching but the strong student also improved their performance as a result of coaching. Behaviours that would not normally be seen become evident as the stronger student is demonstrating teamwork, communication, teaching skills.

> *"... it also shows the supervisors other skills that the student might not normally show, as a passing student is trying to support their peer... ... in terms of teamwork and communication and things like that."* SPFA001

> *"... often it was a quite a beneficial relationship because the stronger student actually improved by peer coaching and the weaker student improved by being peer coached"* PTFA014

> *"... the student who was performing well, she was actually really supportive of her peer. And was always kind of like, "Oh, are you okay? What can I do to help?""* SPFA006

Of course, one does need to be aware of the weaker student losing self-confidence. If so, applying the strategies discussed earlier to support student's with low self-confidence becomes important.

> *"I find that the weaker students, particularly if they are working with a stronger team, do become very aware of their own difficulties or the fact that it might be taking them longer than other to pick up on things and they very quickly start to compare themselves with the others in the group. A side effect of that is their self-confidence and their self-care then drops a little bit."* SPFA004

Individual Practice

While the peer coaching model has a lot of benefits for increasing learning, each student is still responsible for demonstrating that they are competent to practice as an individual. As a result, to ensure that differences in competency are recognized, Clinical Educators had several strategies to ensure they could measure this. Some of these were already discussed in the Evaluation section in the latter part of Chapter Four. However, Clinical Educators did note the importance of separating some of the students' duties as part of the work-integrated learning experience. This individual practice could occur more towards the end of the work-integrated learning experience, just before mid-term in order to measure individual competencies, or in response to recognizable performance differences between the students. This doesn't mean the students don't consult with each other, ask each other questions, or seek assistance. It just means that they do have some things they do individually and this takes place to prevent opportunities for dependency to occur. It also enables more the competent student to advance to more complex cases while the more average student continues to focus on standard competencies. Some examples of how Clinical Educators

structured independent practice within the peer coaching model are described in the following quotations.

> "Part of the reason why I now divide the students up earlier, by the beginning of the second week is that, I have had the situation where they have been working together so closely that the areas of weakness, for lack of a better word, of one of the students have been completely compensated by the other student, and we're not apparent about how significant they were until I divided them up. And by that point, you're already almost at the midterm point, and it can come as a shock, because they appear to be at the same level when they're discussing, but you don't realize how much the one is relying on the other." PTFC004

> "... separating them in sessions so they're not always observing each other, ... I think that would be quite intimidating for the one who was struggling to be seeing that I am constantly giving her oodles of feedback, and the other one just very little. So having them do separate sessions allowed me to give them the different level of support that they needed, and the frequency of feedback." SPFA013

> "... they would be on separate cases sitting next to each other, where one could work at a much quicker rate and the other one could spend the time. So the strong student wasn't getting frustrated ... and the other one still had time to actually learn about this case and what was happening and could start to interpret it and then they could, you know, when they had questions they could still bounce off each other. But there wasn't that direct one patient case where they had to do it completely together, which just didn't work." DTFA015

Communication

Students most likely will be astute enough to recognize differences in performance within their peer coaching team as noted by one Clinical Educator.

> "The peer is usually self-aware enough to understand that their co-student is performing better than they are, because they're observing their treatments, and seeing that, that person is doing things that they're not remembering to do, or haven't figured out yet." PTFC004

As a result, it is important to address differences in competency and performance directly within the team as being normal. Some students will come to a work-integrated learning experience with previous experience in that area whereas it may be the first time for the other student. Clinical Educators noted the importance of discussing these differences with their

team so these differences in performance/competency are open. Examples of these discussions are provided in the following quotations. If Clinical Educators are spending more time with the weaker student, the stronger student understands the reasons.

> *"I will meet with them and talk to them about it, and explain that everyone's got strengths in different areas and that some people have got different placement preferences and learning styles, so I try and make them feel okay about it. And then probably just try and be around more for them and just give them that extra support."* OTFA010

> *"... just having that open communication and identifying issues directly with the student as they arrive. I think timeliness is key in terms of raising those issues and giving feedback, because, I guess, if you hold onto them until midway or the end of the placement then the student will be like, "Well, why have you put me at this mark? You didn't tell me about it." So, I think just open communication and transparency is key in that respect."* SPFA006

> *"For me and I say this to everyone coming in that my goal is to give equal time to the students no matter what. If someone is struggling it means it's a lot of one on one more private time ... respecting that confidentiality and then it's a lot of just figuring out ... what's the actual problem .... It's a lot of learning goals, strategies, and trying to get things into manageable chunks and figure out what's going on and if there's a big struggle"* OTFC0013

Utilizing Team Strengths

Given the focus of the peer coaching model is to build a team where support and learning occur, several Clinical Educators noted the importance of using team strengths to support others who might need extra help.

> *"... they [students] often have different strengths or competence in different areas. So I've never had one that's been amazing at everything and one that's sort of hopeless on everything ... So I found it a really nice opportunity for them to learn from each other, because they each have a skill that the other one is really working towards. So I just kind of used that and just got them to really, use it as an opportunity to teach the other one. And they've always found that quite helpful."* SPFA012

> *"It ends up being like a lot of brain storming in an overall topic that I know both of them are still going to get benefits from. I would do that in a situation where each of*

them is going to bring strength and where each of them is going benefit from perhaps the strategies that the other person is doing. They are both getting to productively contribute to the conversation and they are both maybe getting some ideas on some areas they are having challenges with so it's not throwing anyone under the bus." OTFC0013

However, one must be careful not to use the stronger student as a substitute Clinical Educator. The strategies mentioned above deal with performance differences in a productive way. Placing the stronger student in to a role as Clinical Educator changes the status in the relationship and may interfere with the positive aspects of the peer coaching model. As a result, Clinical Educators have to be careful how they use the stronger student to support the weaker student, particularly if the stronger student does not have good coaching skills. As noted in the quotation below this can have a damaging effect as the role of the peer is not to give critical feedback but to provide non-evaluative feedback through the process of asking open ended coaching questions.

"... the theory that the university's has given me from previously is that, the stronger student will help to pull the less strong student up. In clinical practice I haven't had that work ever, because the stronger student feels bad about giving critical feedback to their peer.

Extra Support

Given that a weaker student may need extra help, a large number of Clinical Educators noted that getting extra support is important. This can be done by engaging others to assist such as other Clinical Educators, University Supervisors or others in general clinical education roles. For example, if a weaker student requires more support, and the other student is doing well, then other staff can be made available for that student to consult. This enables the Clinical Educator to spend more time with the weaker student.

"I've had to divide my caseload, so that I was exclusively with a student who was not performing at expectations, and then my other students bounced around between other therapists for the remainder of his placement." PTFC004

"So the one who was struggling, we were needing to meet and talk about it almost daily in the end, and sort of setting very specific tasks daily that she would try and learn and draw on." SPFA013

Chapter 6

Benefits

Education Focus

As noted in Chapter 2, where advantages of the peer coaching model was discussed, a range of benefits were reported by the Clinical Educators who supervise students within this model of education. For the Clinical Educators themselves, they felt they spent less time supervising overall even though the first week or two is quite intensive. This is due to the students supporting one another and being able to answer many questions collaboratively. They enjoyed the model and observing the students working together productively. Several noted it is their preferred model of supervision.

> *"Often times, the students will, sort of, talk through their clinical reasoning or issues on some of the more straight forward topics, and can generally come to an appropriate conclusion amongst themselves... ... So, I find there's a lot of work up front, for me, in terms of setting expectations and providing them with that early education. But, ...moving to the later stages of the placement, I don't have to do as much." OTFC0011*

> *"It's really time consuming initially, but then I find that I have a lot more time to reflect on what the clients are doing with these students and I get more time to myself, than if I had only one student, because then the two of us are always together." OTFC0015*

> *"... you have more time to actually do education with them because your caseload is, more freely covered. So although it's a lot more running around. For me the therapist, I'm not actually doing as many physical treatments so that gives me more time with each student, can engage them." PTFC006*

> *"... it's a lot easier to manage, because you don't have one student vying for your time when they don't have work allocated to them. So, you've always got an opportunity to sort of say, "Oh, you can observe the other student during their session." SPFA001*

> "Just in terms of them being able to ask questions of each other first before coming to the supervisor I think is beneficial, rather than them having to ask you questions continually."[SPFA001]

Learning from One Another

A few Clinical Educators liked the dynamics of having more than one student present. It changes the dynamic of the learning situation in a positive manner as expressed in the following quotations.

> "... a 1/1 student often feels like a shadow from my experience but you have this opportunity [in the 2/1 model] to have some freedom from them and have more group discussions, particularly in terms of giving feedback or things to work on. You can talk about it as a group and it doesn't seem so confrontational often because you can have more group discussions." [SPFA002]

> "I'm inspired by three different minds and they all come at the project quite differently, ... I'll have my idea, and then by the time we're all bouncing ideas off, you actually come up with a different outcome that's much better than I may ever have thought of." [OTFA010]

> "Sometimes students will come up to us, with a solution to a problem or create an amazing resource or come up with a totally new set of delivery ideas, just based on the conversations that they are having and then you go, "I can't believe we didn't think of that. That is such an amazing thought."[SPFA008]

> "For me, I feel like we're more like colleagues and that feels better for adult students. It feels more comfortable. And then once the student graduates and becomes a health professional, I feel like the relationship hasn't changed that much." [DTFA011]

Similarly, the Clinical Educators were clear about the benefits of the peer coaching model for the students. Students are required to use their clinical reasoning skills and to practice more independently. The students also learn more as they are participating in, and observing, the learning experiences of other peers. This also improves their communication skills. The model also creates a more secure environment and gives students some security, particularly around asking questions they may be fearful asking their supervisor. Several Clinical Educators shared their thoughts on the benefits of the peer coaching model as noted in the quotations below.

"But I feel like with two of them without me there they have each other so there's two brains, and instead of trying to do your clinical reasoning in your head it forces them to do their clinical reasoning out loud and to think it through and to be clear, and explain to each other why they're doing what they're doing. So I think it's excellent for the students that way." [OTFC0010]

"Apart from the additional support they get from each other, I find the learning opportunities that they get multiplies astronomically. If we're careful with how we provide those observation opportunities and those group feedback sessions, I think it instantly quadruples the learning experiences that they are able to obtain within the placement." [SPFA004]

"I think there's a beauty to the peer collaboration and support because I'm not around nearly as much or really almost at all, those students, they don't get any quick answers. They really have to struggle through and determine their own answers and I think often when you learn a lesson because you struggled through to get to the other side, if it took you two or three times longer than if they would've just come to me and I could've given them a quick answer, their learning is just so much richer." [OTFC0012]

"I think it just improves their communication in a work team, because when they have to actually provide feedback, then they have to really think about how do I word this and that's something that usually can be difficult to start." [SPFA016]

"I know lots of students come in, and they don't want to ask the stupid question, and I think it's a really great opportunity for them to be able to ask any of those questions without that fear, before they get to know their supervisor and know that it's actually okay to ask those questions to them as well." [DTFA007]

Organizational Impacts

One of the clear benefits that many Clinical Educators cited was the increased output of the team along with a quality service. It made more sense to place students in teams to prevent staff burnout. As well, opportunities to take on bigger projects occurred in some agencies. Students when placed in non-traditional or new agencies, often created services and job opportunities that didn't exist before. Further examples of the benefits associated with the peer coaching model are noted below in the following quotations from Clinical Educators.

"So we try and come up with some project that probably we've been meaning to do, but haven't been able to get around with. Often it's patient documentation, like handouts or something that need revising, or evidence review and exercises rewritten and organized. So that can be of a real benefit to the department. As one student, that can be quite a daunting task to do, but the two of them together can be a much more powerful unit, and they'll bring a different strength to it. One of them might be really computer savvy and the other one really into looking up articles or something...   ...So there's a huge benefit to the organization from that perspective." SPFA013

"... what that has done [placing OT students at a site without an OT] has actually lead to the creation of OT positions because ... we had OT students in some of the primary care clinics ... and then when the MyHealthTeams were discussing what positions to hire when they were given funding from the region, the buzz was out, different doctors were talking about what the OT students had done, so they had a sense of what the OT role was... so in the end lots of the positions ended up resulting in OT positions." OTFC0010

"I do think having two sets of eyes improves the quality of what they're doing with the patients, and of course there's always someone else in the room, even if I'm not there, so I think that peer supervision also increases the safety for the patient too. So if something happened to the patient, for example if I wasn't there, you've still got someone with the patient while the student quickly gets somebody else." SPFA00

"I think from a site point of view is actually the only way to go, as often as well because you have such few supervisors that to try and have everybody individually placed, you just don't have the supervisors and they end up getting burnt out. So from a site point of view, pairing's logically and economically better." DTFA015

Job Enrichment

One way to enrich a job is by giving employees more responsibility (Herzberg, 1968) so that their role expands and they experience the possibility of career progression. Supervising a peer coaching model as part of a work-integrated learning experience moves the Clinical Educator in to more of a coach/manager role and can be a great stepping stone for learning how to manage people. Several Clinical Educators noted however the importance doing one on one supervision initially. This enables the staff member to develop their education, coaching and supervision skills with a range of students – some advanced, some average and some below average. Clinical Educators noted that it is not your clinical expertise that

is central to the success of a work-integrated learning experience, but your ability to learn, self-reflect on your own performance, and facilitate learning.

> *"I'm of the opinion that it's not necessarily clinical expertise that makes you a good supervisor. It's your ability to model, and being open to not knowing something and recording that process. We know that students' experience with placement is around the supervisor relationship, not how great you are as a clinician. Others may disagree with me but I don't think that's what's critical, I think your ability to provide an open and supportive learning environment and being, like I said, on board in relation to being able to admit to the students, "I actually don't know, we're going to need to go and look it up", is more critical."* SPFA009

> *"I think you have to be comfortable with your own strengths and your own skills and your own reflective practice. You have to, in this role, we have to be very self-aware... ...Because you learn with the students as well, but the way that you are, actually does affect the supervision relationship... ... when you're trying to do like a peer model, you're coming across as a peer, but you're also assessing. So it is a fine balance between making sure that you give constructive feedback but also be positive. And you just have to keep balancing that. And so the way that you communicate with the students is very important. You have to keep reflecting on the way that you're being."* DTFA011

> *"So you need to be I would say equally as confident in your ability to provide education to students and not everyone will feel confident in that and have excellent clinical skills."* SPFA016

Developing these skills as a competent Clinical Educator is important because in a peer coaching model you have multiple students and at times you may have students at different levels of competency with varying degrees of confidence. Hence, having these basic Clinical Educator skills in place will assist with having several students and their needs all coming at you at once. While not all Clinical Educators noted that doing one on one supervision is an important pre-requisite before undertaking a peer coaching model, many felt this was important as noted in the following quotations.

> *"I think that you have to learn techniques for one person before you can really apply it to the group. Because although it looks like it's group or team learning, it's still individuals just times 10."* DTFA011

"Firstly, with managing multiple students, yes, you want to be confident that you can deal with a strong student who's going to challenge your clinical skills, but also deal with a weaker student who's going to challenge your ability to deal with a failing student, which is obviously what we always feel very uncomfortable about, having to give negative feedback. So by knowing those, then that helps you deal with when that's all happening at once." OTFA010

"They take a lot of time and they challenge you in the way you think and explain and I think if you're learning your feet as a supervisor, it could possibly be a bit overwhelming having double that intensity put on you. So doing one student with one supervisor for a very new supervisor would be a better system" DTFA015

And of course, being in an agency that values students and recognizes the importance of providing education to the next generation of professionals is important. The peer coaching model does change the way in which traditional apprentice-style training historically took place. Having colleagues and supervisors, therefore, who support the concept of being a learning organization will certainly help Clinical Educators build their competencies as coaches and facilitators of learning.

"I think I'm very lucky because I have a very supportive supervisor of my own in my role, so I've always got somebody to bounce ideas off or talk things through or just feel like the placement that I'm providing the students is the best that it can be. I think ... if you're in a setting that doesn't have a supportive supervisor it may be tricky to navigate. But knowing that I've got someone who can always help and maybe if I need to split the students 'cause I do need to spend more one-on-one time with one student it's, you know I've got that extra person there to help me with that." SPFA012

Chapter 7

Conclusions

This book on peer coaching models in work-integrated learning placements has provided an overview of this model, its supporting literature, and evidence based practice from 31 experienced Clinical Educators familiar with supervising within this model of education. The book started off with clarifying some terms and definitions of the peer coaching model and providing some background on the model.

The next section provided a summary of some theoretical concepts central to the efficacy of the peer coaching model. This included background information on professional reasoning and differences between novice and expert practice and how peer coaching can support the clinical reasoning process. The importance of experiential learning, reflective practice and coaching were noted and how they are central to the peer coaching model. The use of non-evaluative feedback during peer coaching was also emphasized to keep the peer coaching relationship status equal. Social and constructivist learning were also outlined as underlying educational philosophies for work-integrated learning. Lastly, information on the neuropsychology of learning was also overviewed, specifically Broaden and Build Theory and the SCARF model. These neuropsychology based learning theories were applied to the peer coaching model to demonstrate how the model supports brain learning.

The next section in the book provided a comprehensive literature review on the peer coaching model. The literature that was described offers a range of perspectives on the peer coaching model. The main conclusions are that the model can reduce anxiety and increase confidence in students, can increase learning opportunities, can increase clinical reasoning efficacy, provide more opportunities discuss and reflect on practice, and increase productivity for the agency. Some of the challenges noted in the literature are increased planning time required for the placement model, students not having enough access to the

Clinical Educator, potential student competition, differences in competency levels making supervision challenging, increased teaching and administrative workload for the Clinical Educator, and poorly prepared Clinical Educators. In addition to this review of the literature, the perspectives of actual clinicians citing the advantages and challenges of the model in numerous workshops was also shared. These perspectives mirror much of what is in the literature.

The next section offered the perspectives of experienced Clinical Educators with experience supervising within the peer coaching model. The tacit knowledge that was revealed demonstrates that with good preparation and planning, many of the challenges noted in the literature do not surface or are minimized. There are different parts to the peer coaching model as it progresses over several weeks, and specific strategies were shared for each stage, namely, before the students arrive, the first day, the first week, the middle weeks and the midterm evaluation, the final weeks and final evaluation and after the placement. In addition, some thoughts were shared to deal with situations that might arise such as differences in confidence between students, differences in student competence, and interpersonal and personality conflicts. Lastly some benefits for the Clinical Educator, Academic Program and Agencies was offered. The knowledge that was extracted from these 31 Clinical Educators was profound, and offers those new to this model or those developing their own competence within this model some excellent strategies for improving practice as a Clinical Educator.

As the authors of this book, our objective was to put together a comprehensive but digestable resource for busy professionals on peer coaching who have a passion for work-integrated learning. By writing about the background, evidence and experiences of skilled Clinical Educators supervising a peer coaching model, our hope is that more individuals will adopt this model of supervision and learning in to their own practice.

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Preceptor Education Program for Health Professionals and Students

PEP is an on-line program designed to help prepare students and clinical Clinical Educators (preceptors) for clinical placements. PEP consists of eight learning modules (one of them is on peer coaching) and many of the modules are designed so that preceptors and students can work through them together. The learning modules can be used by any health care discipline.

https://owl.uwo.ca/portal/site/!pep

Developing Employability – Clinical Educator Site

EmployABILITY is the ability to create and sustain meaningful work across the career lifespan. This is a developmental process which students need to learn before they graduate. The Developing EmployABILITY Initiative is a collaboration involving over 30 higher education institutions and over 700 scholars internationally. Our goal is to enable and embed employABILITY thinking in the curriculum.

https://developingemployability.edu.au/