International Journal of Evidence Based Coaching and Mentoring
2021, Vol. 19(1), pp.44-60. DOI: 10.24384/9w4f-wx91

Academic Paper

Peer Coaching and Health Science Practicums: Best Practices of Experienced Clinical Educators

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Abstract

The health sciences sector uses work integrated learning to prepare professionals for practice and has done so predominately using a traditional apprenticeship model. Over the past two decades there has been an increasing focus on integrating peer coaching into this learning environment. While peer coaching can occur informally, failure to formalize the process and train participants can negatively impact rapport-building, trust and learning outcomes. Hence, clinical educators often need some guidance in supporting this placement model. As a result, this research examines the best practices of 31 highly experienced clinical educators within a peer coaching placement model by capturing their explicit and tacit supervisory knowledge.

Keywords

peer coaching, work integrated learning, clinical education,

Article history

Accepted for publication: 14 January 2021
Published online: 01 February 2021

Introduction

Work integrated learning placements have been a cornerstone of training for learners in the health sciences. Typically, an apprenticeship model of learning occurs where one learner is assigned to an experienced clinical educator who supervises the learner's practice. However, there has been an increasing focus on integrating peer coaching into the learning environment and many clinical educators have moved to supervising two or more learners at the same time. This change in supervision often requires some training in order to ensure a positive learning outcome. This purpose of this research, therefore, examines the best practice of 31 highly experienced clinical educators within a peer coaching placement model by capturing their explicit and tacit supervisory knowledge through semi-structured interviews.

This research reported here is organized in the following manner. The literature review was used to inform the research and to assist in preparing interview questions. This leads to the methods

section which describes the qualitative research process used in this interpretive study. In the results section, supportive quotations from clinical educators are embedded to support the findings of the study which are organized in to categories of best practice. As is common in the reporting of qualitative research there is some discussion and interpretation in the results section. A discussion section notes the significance of the study and key outcomes. Lastly, the conclusion offers a summary, specific limitations of the study and implications for practice and further research.

Originally used to build the capacity of teachers in education (Joyce & Showers, 1982; Joyce & Weil, 1996) peer coaching has been adopted in the health sciences sector to facilitate professional development. The coaching dimension that occurs between peers is very specific and has been defined and differentiated from other interactions (D'Abate, Eddy, & Tannenbaum, 2003). These authors postulate that coaching is about building skills and using open ended questions to challenge the person receiving the coaching. It is a short-term experience.

Peer coaching is a subset of peer learning (Lincoln & McAllister, 1993). Hagen, Bialek, & Peterson (2017) denoted a need to ground peer coaching in theory and reviewed 55 scholarly references in management/human resources, health care and psychology. They concluded that peer coaching is a process that is linked to training and offers personal and professional development outcomes. In this process, there is no hierarchical authority between peers but rather, a sense of shared mutuality. Honesty and trust are important underlying psychosocial requirements. It is usually voluntary, non-competitive and non-evaluative although in most educational contexts learners are assigned as pairs. Clear goals and objectives guide the learning experience which is about increasing learning and providing support. Hagen and colleagues provide a formal definition of peer coaching.

> “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” (WIL) has recently become popularized to describe situations where learners go to organizations to apply their learning in real life work contexts (Billett, 2015; Brown, 2010; Cooper, Orrell, & Bowden, 2010). Other term that are used include fieldwork, placements, practicums, apprenticeships and internships. There are also a variety of terms used to describe the person who supervises the work of the learners. They are often called educator, tutor, supervisor, coach, facilitator, mentor or preceptor. In this research we use the terms clinical educator and learner (instead of student), because the primary objective of working with learners in the health sciences sector is to support them through learning to become a competent professional.

One comprehensive overview article provides a detailed summary of what needs to occur in a peer coaching 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. What is clear from the literature is the importance of the university providing training to educators on alternative models of supervision and how to encourage peer learning (Bartholomai & Fitzgerald, 2007; Briffa & Porter, 2013; Flood, Haslam, & Hocking, 2010; O'Connor, Cahill, & McKay, 2012). The literature review that follows, therefore, is limited to the operational aspects of the peer coaching model. Studies which describe the general benefits and challenges of this learning model are not included but readers wanting this information are referred to other reviews (Briffa & Porter, 2013; Lekkas et al., 2007; Martin, Morris, Moore, Sadlo, & Crouch, 2004).

Literature Review

What appears to be a gap in the literature are the pragmatics of how to achieve positive peer coaching outcomes, particularly in the early phases of the WIL experience where considerable pre-planning and preparation is required (Blakely et al., 2009; Claessen, 2004; Flood et al., 2010). However, capturing these pragmatics, or clinical educator best practices is not easy. Experts, or those with extensive experience, often find it difficult to describe their best practice because it comes intuitively to them in the moment. This 'know how' is referred to as tacit knowledge (Polanyi, 1966). Polanyi describes two types of knowledge: explicit and tacit. Explicit knowledge can be declared and documented. Tacit knowledge, however, is difficult to articulate and one needs to capture it in the moment when it is taking place. This is often difficult to achieve because it can be intrusive and impractical in the workplace. However, retrospective accounts of action can be facilitated through a recall process even though they may not have the same purity as accounts captured in the moment (Ericsson & Simon, 1993; Yinger, 1986). By asking a person to recall situations they encounter frequently, in this case supervision during a peer coaching learning model, one can extract some of this knowledge, particularly if the person is prompted. This is often referred to as introspective research and has been used to capture the cognitive processes of educators engaged in practice (Peterson & Clark, 1978).

There are specific planning stages and operational tasks central to the peer coaching model. One of the most central is the progressive delegation of the caseload of the clinical educator to the learners. This then enables the clinical educator to devote more of their time to supervision and management of the learning experience. Preplanning is critical to ensure a quality experience. Timetables, orientation folders, administrative tools and site-specific educational experiences need to be preplanned to help structure the work and to prepare for the learners' arrival. These structural elements of the peer coaching learning experience are reported consistently in the literature (Blakely, Rigg, Joynson, & Oldfield, 2009; Claessen, 2004; Flood et al., 2010).

In the peer coaching model learners must set specific learning objectives for themselves, in addition to those set by the university/host agency. These objectives become the focus for the self, peer and instructor directed feedback and are used in midway evaluations so all parties can be 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).

Learners often need some guidance on how to ask open ended and probing questions as part of the peer coaching experience. This process was facilitated by having learners share some of their caseload and engage in reflective clinical reasoning together (Claessen, 2004). Learners need to develop this capability to support one another as there was a tendency to want to rely on the clinical educator for feedback since there was a belief that the quality or depth of learning was greater when it came from a more experienced practitioner (Tai, Molloy, Haines, & Canny, 2016). Both clinical educators and learners therefore, would benefit from further education and training on placements that involve peer learning in order to optimize supervision and learning outcomes (Briffa & Porter, 2013; O'Connor et al., 2012).

Managing time was a concerned expressed by clinical educators in several studies. The clinical educator tends to provide individual and group supervision to best manage their time, often using a schedule for feedback and evaluation sessions (Blakely et al., 2009; Claessen, 2004; Flood et al., 2010). While this did not create an unmanageable supervision workload, the clinical educator needed to know when to balance the needs for learner autonomy and supervision on individual and group levels (Bartholomai & Fitzgerald, 2007; Blakely et al., 2009). While the educators felt the peer coaching model offered greater learning experiences, it did pose more organizational challenges to ensure learners received equal and robust clinical experiences (O'Connor et al., 2012). Learners preferred the peer coaching model early in their experience because of the benefits of peer learning but in the latter stages of their experience preferred one learner to one

clinical educator so they could demonstrate autonomous practice and have more direct contact with the Educator (O'Connor et al., 2012).

A more recent review on peer assisted learning in clinical education by Sevenhuysen and colleagues involved 28 studies representing five allied health professions (Sevenhuysen, Thorpe, Molloy, Keating, & Haines, 2017). They found bias in the articles to be high, with only nine studies actually measuring the effects of peer assisted learning on learners. There were inconsistent results about learner satisfaction, amount of learning and performance. Only four of the studies actually described how learning was facilitated demonstrating the paucity of research in this area. As a result, evidence is still non-specific in the literature and as the researchers noted in this paper, lacking in 'comparative rigour'.

Sevenhuysen and colleagues also 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 (Sevenhuysen, Farlie, Keating, Haines, & E, 2015; 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 learners, both clinical educators and learners preferred the more traditional peer assisted learning model. The research emphasized the importance of strategies that need to be in place to ensure adequate feedback, observation of the clinical educator's practice and opportunities for learners to observe and learn from one another. However, this research also indicated that a peer coaching model cannot be so structured that the learners and the clinical educator are stymied from developing their own informal learning strategies. Specific skills and preparation were also needed by the clinical educator to manage the placement effectively and to ensure the learners worked together cohesively. Otherwise, educators may feel 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 educators are well-suited to this model. This has been suggested in research which suggests that educators with experience supervising learners adjust to the peer coaching model more readily (Flood et al., 2010; Rindflesch et al., 2009).

One of the challenges inherent in the peer coaching model is the tension between how learners perceive the value in learning from an expert versus learning form a peer. One study found that junior learners, 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). Learners felt the primary purpose of a clinical placement was to learn from experts and that time spent in peer assisted learning, while valuable, detracted from this primary purpose. Learners, 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.

Methodology

The aim of this qualitative research was to understand and describe the best practice of clinical educators who supervise learners in a peer coaching model as part of a WIL experience. Specific objectives were to capture examples of best practice of the clinical educators during six specific points in a WIL experience: before the learners arrive; the first day; the first week; subsequent weeks leading to and including the midterm evaluation; the final weeks leading to and including the final evaluation; and after the learners leave.

Sample

A purposive sampling approach, sometimes known as an expert sample, is a nonprobability sample (Lavrakas, 2008). Expert knowledge is applied to select in a non-random way, a sample of

individuals that represent a cross-section of the population (Lavrakas, 2008). The experts used in this study were university and agency-based coordinators of clinical education at Australian and Canadian universities. They were the most suited to identify clinical educators with known expertise in supervising learners in a peer coaching model. Once a list of experienced clinical educators was identified, they were invited by the researchers to participate in the study, following which participants were given information about the study. The research was approved by the Human Research Ethics Committee of the university. Informed consent was received by all participants.

Philosophical Approach

The research was suited to the qualitative paradigm and followed a constructivist ontology, with interpretivism as the epistemological lens (Guba & Lincoln, 194). Constructivism is, “an approach to learning that holds that people actively construct or make their own knowledge and that reality is determined by the experiences of the learner” (Elliott, Kratochwill, Littlefield Cook, & Travers, 2000), p256). Clinical educators learn how to be effective supervisors through education and practice in the field, and through this experience, construct their own best practice. To capture these perspectives, the theoretical frameworks of phenomenology and symbolic interactionism were used to structure the interpretive inquiry (Zeegers & Barron, 2015). Phenomenology concerns itself with describing the experience of the person whereas symbolic interactionism concerns itself with the meaning the person attaches to this experience. Both of these perspectives were important to the capture the essence of the clinical educators’ best practice. The researcher represented the perspectives of the subjects through an interpretive lens, by asking them to describe these experiences and associated meanings.

Participants were advised that they would be asked a series of questions during an interview that would last up to an hour. The interviews were conducted by one of the researchers and a research assistant. After the first interviews, the research team compared their field notes, the reaction to the questions, and any other issues to ensure similar approaches to each interview. Any questions that were unclear were modified. New questions that needed to be asked as the research progressed were also included. The interviews were all recorded and then transcribed by an external transcription service and checked for accuracy.

Data Reduction and Analysis

The researcher works to limit their own subjectivity in reporting the results by applying specific practices when analyzing the data (Guba & Lincoln, 194). These practices involve reading through the pages of data captured through the interviews with the clinical educators and then organizing the data in to specific categories. Within each of these categories the data is interrogated further, and through a process of content analysis, constant comparison and coding verbal sections of the text, the data is organized in to themes and sub-themes that best describe the experience (Cresswell, 1998; Lewis-Beck, Bryman, & Futing Liao, 2004).

The research assistant organized the data into specific categories, in consultation with the researchers. Following this, the data within each category was further analyzed using the content analysis and constant comparison coding practices identified earlier. Through this approach, the common best practices of the clinical educators at each of the six specific points of a WIL experience using peer coaching were highlighted.

Results

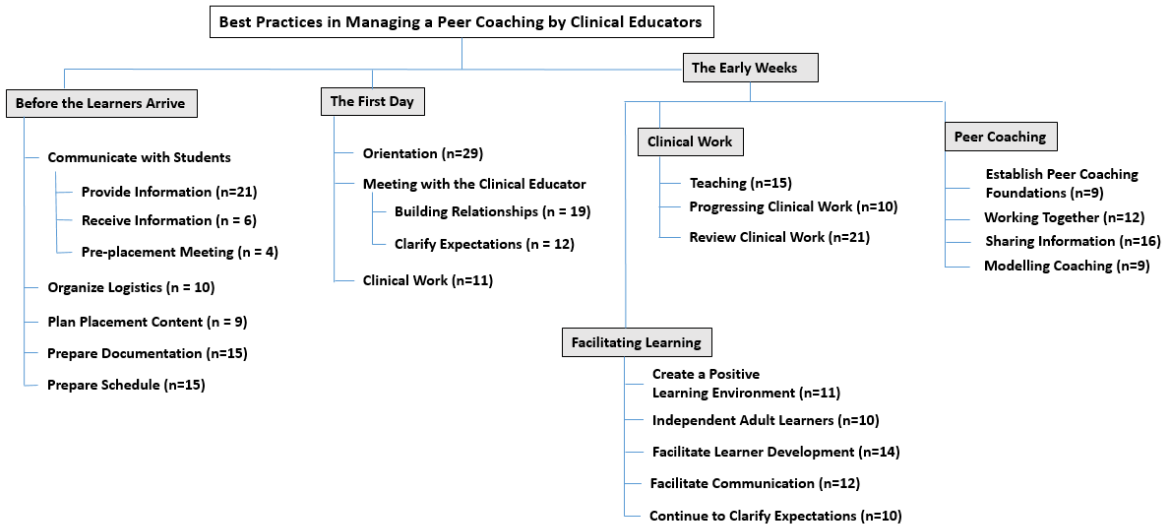
The mean age of the clinical educator sample was 40. There were 15 Canadian clinicians and 16 Australian clinicians (n = 31). There was only one male in this sample. Breaking down the sample further, there were 11 Speech Pathologists, 11 Physical Therapists, six Occupational Therapists,

and three Diet Therapists/Dieticians. The average number of clinical practice years of the sample was 15.88 years. The average number of years as a clinical educator of the sample was 11 years. Of the 31 clinical educators interviewed, seven had supervised 20 or less learners. The remaining 24 clinical educators had supervised up to 80 learners in total, and for those involved in clinical education programs that take more than two learners 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 peer coaching model varied depending on the site and the clinical educators. Most of them involved one clinical educator supervising two learners. Other models had one clinical educator supervising anywhere from three to six learners. In some of the University run clinics the clinical educator to learner ratio could be higher (1 to 10). In these larger models there were other clinicians who provided more episodic supervision whereas the clinical educator had more of a coordinator role and was responsible for overseeing the group. Peer coaching within these larger cohorts would usually have smaller peer coaching teams embedded within them. One other model tended to be more project based and had two supervisors. The learners 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 learners. The supervisor that was based in the agency provided day to day supervision whereas the external clinical educator provided once a week face to face supervision and was available through telephone contact as needed.

Given the enormous amount of data that is generated in qualitative research only the preplanning and early implementation activities of the WIL experience are reported here: before the learners arrive: the first day; and the early weeks. Further, important information about ‘evaluation’ and ‘the progression of the peer coaching partnership’ are noted because of their salience. Figure 1 provides a map of the overall categories, themes and sub-themes along with the number of clinical educators that made comments within each themes/sub-theme. Providing numbers serves to provide a measure of density or representativeness within each theme/sub-theme (Hannah & Lautsch, 2011). Only data that represented the best practice views of at least a third of the clinical educators are reported. However, in some cases, given the importance of the theme in relation to this WIL model, some themes/sub-themes are reported with fewer clinical educator reports. Reporting themes with fewer representative numbers is still important in qualitative research as these insider perspectives can still be very important for understanding the depth of the research question(s) (Hannah & Lautsch, 2011). Note that while we use the term ‘learner’ in this research, clinical educators typically described them as students.

Figure 1: Thematic Categories of Clinical Educator Best Practice



Before the Learners Arrive

Five themes emerged within this category. Communication with learners was the most broadly represented theme encompassing three sub-themes: provide information, receive information and pre-placement meeting. The remaining four themes were: organize logistics, plan placement content, prepare documentation and prepare schedules.

Communicate with Learners

Provide Information

Clinical educators made sure learners received specific information to help them prepare for the WIL and peer coaching. This included website links to the organization, assessment and documentation information, maps, parking, hours of work, food availability and pre-reading. They would also share any online courses or training that might help, caseload information and policies and procedures. They were available to answer questions. The clinical educators, as noted in the following quotation reminded learners that the WIL experience involves peer coaching and also laid out the general expectations for the first week or so of the placement.

> *"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 CA and that they have that opportunity to really learn from their peer."* SPFA002

Receive Information

Clinical educators also asked learners to share their interests, learning styles, learning goals, concerns and strengths. They also asked the learners what specific experience they were interested in - *"we get an information questionnaire from the learner and it has things about what they're worried about, what their strengths are, what type of learner they are."* SPFA002

Pre-placement Meeting

For very specific placements that were new, or required very senior learners working independently within a non-traditional agency, a pre-placement meeting was organized. This allowed for introductions to be made, to identify specific needs of the agency and to determine if the fit was going to be a good one. This is noted in the following quotation.

> *"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

Organize Logistics, Plan Placement Content and Prepare Documentation and Prepare Schedules

The clinical educators reported a range of things they had to organize and prepare. For ease of reporting, these four tasks are described together in this one section. Tasks included booking meeting rooms and workspaces, and setting up information technology access so the learners use electronic medical records when they arrived. They also had to organize mandatory training (e.g. infection control, fire safety) and book any specific inter-professional activities.

Planning placement content and experiences included identifying appropriate clients for the learners' caseload and methods for allocation of these clients to the learner(s) so each had adequate variety. Within this caseload, determining shared versus individual responsibility for clients was also necessary.

A review of the placement documentation took place to ensure it was up to date, with appropriate orientation information appropriate to the site. For example, service models, organization mission and values, department information, professional responsibilities, assessment and treatment protocol and any other expectations. One clinical educator had, "created a 'virtual binder' of resources on Dropbox ® PTFC007

Preparing schedules for teaching, feedback and evaluation sessions were important to establish, along with a calendar noting key events such as rounds or inter-professional learning experiences, and any specific project deadlines or presentations the learners might need to complete.

The First Day

Orientation

The importance of a good orientation the first day was emphasized by nearly all of the clinical educators. This involved an explanation of professional roles, caseload, and a physical site tour (large scale and specific department), introductions, essential onsite training, ID badges, security, information technology systems, safety and patient administration systems. With respect to clinical work, clinical educators also ran through assessment protocols, documentation, specific clinical tools, patient prioritization systems, and also spent time discussing learner learning styles, supervision preferences and expectations. Clinical educators also made the orientation fun, and adjusted it based on the learners' previous experiences as noted in the following two quotations.

> *"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…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."* OTFC001

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

slower and a little bit more gentle, because I find sometimes even just the tour through the hospital can be quite overwhelming to people" SPFA012

Meeting with the Clinical Educator

Of course, the first day involves getting to know the clinical educator that will be supervising the pair or group of learners. This involved steps to immediately start building the relationship and to discuss expectations.

Building Relationships

There were several things that the clinical educator reported they did to build the relationship with the learner. These include introductions, talking about learning styles and feedback preferences and learning goals. The clinical educators were also interested in the learners' past experiences and how they could use these to further accentuate learning. Quite often the clinical educators had a welcoming 'tea' so the learners could meet the other staff. And of course, time for the learners to ask questions, ideally in the group so everyone gets the same information. The following quotations illustrate these actions.

"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 might work different strategy between the two of them" PTFC002

"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

Clarify Expectations

The other important part of getting to know the clinical educator was a discussion of expectations. Expectations of site staff, learners and clinical educators were all discussed. This ranged from simple operational things like dress code, calling in sick, to attendance at meetings and how feedback sessions would work. Caseload management expectations were important discussion topics as well as how to ask for help from the other learner(s), or the clinical educator. The importance of clarifying expectations is revealed in the following quotation.

"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

Another important part of clarifying expectations at the outset involved discussing how the peer learning or coaching experience was going to work. Clinical educators made a point of explaining how the learners were expected to support each other.

"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

Clinical Work

A third of the clinical educators talked about the importance of at least introducing some clinical work on the first day - "we try and see a patient, so they feel like they've done something on their

first day clinically" PTFC004 . This typically involved having the learners observe clinicians or other learners who may be there nearing the end of their WIL experience, with a pre and post session discussion about the case and perhaps some direct contact with the client(s).

> *"I actually like to sit down with them, and have them create the template based on their own clinical reasoning. We would do one with steps to preparing patients, like going through a chart review, what assessment techniques they need to do, what equipment to bring. We would see a patient and then do another one related to documentation, and the different sections of the documentation. The reason I do that is to kind of get them independent with these two tasks immediately" PTFC003*

The Early Weeks

The best practices that were shared by the clinical educators were particularly dense in relation to the first week, with many themes emerging. Many of these best practices were focused on ensuring a positive learning experience, progressing clinical work, and ensuring the learners understood how to work together as peer coaches.

In this section the clinical educators ensured that a range of processes were put in to place to ensure they were facilitating learning. They did this by focusing on the learning environment and putting in to place strong communication practices.

Create a Positive Learning Environment

The clinical educators noted the importance of creating a positive learning experience by being available and approachable to the learners. This could be face to face but also via email, text messages, phone calls or a group chat via social media depending on the nature of the WIL experience. The clinical educators, however, made a point of noting when they were not available and set clear boundaries around contact. The clinical educators also ensured they discussed the learners' preferred learning style as well as the best way to give feedback. All of these practices were in place to build trust with the learners. These practices are illustrated in the following quotation.

> *"… 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*

Independent Adult Learners

Clinical educators viewed their learners as adults and expected them to take ownership of their learning. They expected them to take initiative, manage their time, ask appropriate questions, and seek help when needed.

> *"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*

They also ensured that the learners had clear goals for the WIL experience and that they had mapped out a strategy or learning contract to achieve these goals.

> *"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 clinical educators were also sensitive to the learners and recognized that the experience could also be overwhelming at the start of the WIL experience. They supported the learners by using reflective supervision which emphasized to the learners the importance of them taking ownership of their learning and to reflect on what was going well and where they were feeling challenged.

> *"I'll ask the students to identify anything that they feel, you know, in terms of where they might be falling short of. 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

Facilitate Learner Development

With the ongoing review of the learners' work, clinical educators were then able to facilitate learner development by gradually increasing their responsibility. This would progress from the learner(s) shadowing the Educator, then co-treating a client with simple needs to eventually working more independently with clients with complex needs. This progression is done so the learner can develop their own professional approach. In this process around facilitating development, the clinical educators are actually reducing their support while increasing the learners' responsibility to perform and to support their peer(s).

> *"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

The other aspect of best practice that the clinical educators emphasized in the early weeks of the WIL experience related to ensuring the learners understood how to peer coach each other

Facilitating Communication

An important best practice of the clinical educators was to ensure strong lines of communication were established early. This meant having regular informal meetings at the beginning and end of each day with to discuss objectives and progress, as well as a more formal session once a week. The learners were also expected to initiate communication with the clinical educator regularly and any other stakeholders that were important in the WIL experience.

> *"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."* OTFC0011

Continue to Clarify Expectations

As the initial weeks progressed, clinical educators made a point of continuing to clarify expectations. This was to ensure quality observation and communication. It also enabled the clinical educator to check that learners were following policies and procedures. The clinical educators also need information on how the learners are progressing and following schedules so they can increase their responsibilities. They also use this information for evaluation and feedback. Hence, continued discussion on why the educators are asking questions, why they are wanting to observe the learners' practice, and why they need to give feedback is reinforced.

> *"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"* SPFA001

> *"I will say, do a weekly E-mail summary, so at the end of every week, I'll just summarize both of 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 my due little reminders"* SPFA008

The next three themes fall under the category of 'Clinical Work'. These best practices were focused on ensuring the learners were providing safe and appropriate care to their clients.

Teaching

The clinical educators also did a lot of teaching in the early weeks of the WIL experience. They made presentations on specific topics related to the caseload and clinical areas associated with the placement. They also did explicit teaching of clinical tasks - focusing particularly on practical tasks to help the learners get started. Observation of the clinical educator's practice was also an important part of the instruction so learners' could tap in to the clinical reasoning and experience of the clinician, particularly for those cases that were common in that WIL experience.

> *"I find placements go better if it's really heavy in the teaching and observing in the beginning."* PTFC009

Progressing Clinical Work

The first week involves the learners observing and 'shadowing' the clinical educator with pre and post session discussions often occurring. This helps to demonstrate to the learners some of the practice standards in the setting.

> *"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? … What my plan is going in 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

During this first week the learners also start to get clinical responsibilities and may observe each other managing a case. They may also share a case, with one of them nominated as the 'lead'. These sessions are often staggered throughout the day so the clinical educator can still observe the learners' practice. These observations help the clinical educator make decisions progressively about how ready the learner(s) may be for an increase in responsibility.

> *"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 going to 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

Review Clinical Work

In addition to the intensive teaching that the clinical educators did in the early weeks of the WIL experience, they also put a lot of time and energy in to observing the learners' practice. They would review this work directly, or via video recordings, and then discuss it during team conversations and one on one meetings. This helped the clinical educators to make decisions about how to pace, progress and support each learner.

> *"I do ask them a lot of questions and I use that … part of the way that I understand their mindset…just to kind of know where their learning is. So I find that's one of the most helpful, ways because it really tells me the depth of their ability"* PTFC006

> *"and I feel like they can talk me through exactly what they're doing, and afterwards give me a really coherent, well thought out summary of how the session went … and then I feel like they understand what they would do if something were to go wrong in the sessions and how they would fix that, is probably when I would feel like they were ready."* SPFA012

Establish Peer Coaching Foundations

Clinical educators from the start made sure that the learners understood that peer coaching was a fundamental part of the WIL experience. They laid the foundations for peer coaching by reminding learners that they were to share knowledge, provide feedback and support to one another and complete assigned joint learning activities. They would leave the learners to plan and delegate group project tasks, discuss peer coaching expectations and logistics.

> *"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

Working Together

Learners were given some freedom to map out how they would like to work together, however, the clinical educator still put in place a range of experiences to ensure they were working together. They would set up specific shared tasks such as group projects, co-writing patient notes, co-running specific sessions where one of the learners would be the 'lead, and maximizing opportunities for the learner to observe each other. For placement models that had multiple learners, the clinical educator would break them up in to pairs so they could work more appropriately on tasks. The educators would have the learners practice clinical tasks on each other as a simulation, and would build in to the learners' schedule dedicated meeting time for the learners to plan and reflect together.

Sharing Information

Clinical educators mentioned that the learners already knew to a certain degree how to work together. As noted in the quotation below, they didn't have to necessarily prepare them for the peer coaching experience.

> *"I think by the time they are at that point they know what we expect in terms of collaboration and supporting each other and I find it, that tends to evolve organically. I'm trying to think if I've ever had a situation where they needed more guidance about how to work together and that hasn't really been an issue."* OTFC0010

In contrast, just over half of the clinical educators did note the importance of encouraging the learners to share information and to provide feedback to one another. This is not something learners normally do, particularly when they are in a more traditional placement model where the feedback typically comes directly from the supervisor. So again, laying out this expectation to the learners was something that the clinical educators undertook as part of their best practice.

> *"… they will be reviewing each other's session plans following the feedback that I provide them in week one, from week two onwards they send session plans to each other. And they rotate through the course of the placement, so they all have an opportunity to read each other's work, and they cc me in the process. So I get to see the feedback that's provided by different students. Which I guess that lends accountability to the students."* SPFA003

Modelling Coaching

Some of the clinical educators were also very aware of their own role in modelling coaching to their learners. Learners look towards their supervisors to see how they perform, and then adopt these behaviors as part of their own practice if they see that it yields positive results. As noted in the following quotations, the clinical educators were aware demonstrating good coaching practice by being good coaches themselves.

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

Discussion

The best practices of the clinical educators that were shared in this research reveal the complexity and breadth of the planning and preparedness that is needed to ensure multiple learners have a positive learning experience. Few studies have reported on the actual pragmatics of managing a peer coaching model to support learning in WIL experiences (Sevenhuysen, Thorpe, Molloy, Keating, & Haines, 2017). Hence this research makes a significant contribution to the theory and practice of peer coaching in WIL settings.

It has been reported in the literature that more experienced clinical educators may be better suited to this model of learning (Flood et al., 2010; Rindflesch et al., 2009) and this was apparent in the demographics of the sample. The mean age of the clinical educators was 40 and the mean years of clinical education experience as an Educator was 11 years. Having the best practice of clinical educators documented here may be a valuable asset for those with less experience wanting to supervise learners in this model. It can also be used to assist universities to build resources for their Clinical Education teams.

The findings of this research also supports what is stated in the literature about the importance of preplanning to ensure the structural elements of the peer coaching experience run smoothly (Blakely et al., 2009; Claessen, 2004; Flood et al., 2010). These strategies, which are reported here, focus on the early part of the WIL experience, as it is important to get things right at the beginning of the placement (Rodger et al., 2008). It is also the part of the placement that requires the most planning. This evidence presented here indicates that clinical educators can organize successful peer coaching WIL experiences successfully, without creating an unmanageable supervision workload (Bartholomai & Fitzgerald, 2007; Blakely et al., 2009).

As the placement moves beyond the midpoint, learners typically become more competent and can start to work more independently and this frees up the clinical educator to focus more on teaching, feedback, and evaluation. This outcome is the result of the early strategies implemented by the clinical educators around teaching, progressing and reviewing clinical work. Although not reported in this paper, as the focus is on the early weeks of the WIL experience, a total of 13 clinical educators noted that the learners shifted to more independent practice in the latter half of the WIL experience.

The clinical educators recognized that most learners understood how to work together with their peer as they often do this at University. Nine clinical educators reported that the learners understood how to work together implicitly. They didn't have to do much to support them in developing this skill. So while the learners still needed some guidance on how to ask open ended questions and give non-evaluative feedback (Claessen, 2004), it did not appear to be an

overwhelming activity for the clinical educators. The clinical educators could demonstrate this practice by modelling coaching. Learners observe how the clinical educators work with their own peers and adopt these own practices in to their peer coaching through what is known as vicarious learning (Bandura, 1997). Nonetheless, it was still important to reinforce the importance of peer support to reduce the reliance on the clinical educator as learners often feel that the quality or depth of learning will be greater when it comes from a more experienced practitioner (Bennett et al., 2015; Tai et al., 2016).

Limitations and Future Research

There are some limitations associated with collecting retrospective data through a semi-structured interview as one has to rely on the person being interviewed to give an accurate account of their practice. A different approach, and an area for future research, might employ ethnography (Hamilton, Smith, & Worthington, 2009), where the researcher actually places themselves in the environment and observes actual practice. This direct observation would certainly enrich the theory and practice of supervision in peer coaching contexts. However, by interviewing 31 experienced clinical educators in this study from a range of Universities across Canada and Australia in different disciplines and contexts, issues associated with retrospective recall are moderated by methodological triangulation (Cresswell, 1998).

Conclusions

The aim of this qualitative research was to understand and describe the best practice of clinical educators who have extensive experience incorporating peer coaching in to the WIL environment. The study found that the preplanning and early implementation activities were the most complex and demanding part of the WIL experience for the clinical educators and learners. Many of the best practices reported overlap with what one would expect in a traditional clinical placement (Delany & Molloy, 2009; Rodger et al., 2008), and therefore, the integration of peer coaching might not be as big a challenge as clinical educators might expect. The findings of this research demonstrate that with adequate preplanning, and having best practice clinical education processes in place (Rodger et al., 2008) a WIL experience with peer coaching can progress smoothly.

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