Chapter 2

Practice supervision

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By the end of this chapter, you will be able to:

1. Explain how to conduct an initial meeting with a learner.
2. Describe at least three statutory apprenticeship requirements.
3. Discuss the challenges and opportunities of transitioning to practice supervision.
4. Evaluate the application of facilitative approaches to learning.
5. Explore the role of emotion in the formation of professional identity.

Introduction

In this chapter, we will explore the key facets of the role of the Practice Supervisor and Practice Educator in the support and supervision of students, trainees and apprentices within a range of health and social care settings. The socialisation of newcomers within the clinical practice or therapeutic area is critical and requires practice supervisors and educators to ensure that the learner, trainee, student or apprentice has not only completed, but also understood the key areas contained within formal and informal induction programmes. We will explore the theoretical basis of practice supervision and support of learners with reference to the application of adult and facilitative learning theories and the impact of emotion within workplace learning environments. Additionally, we will identify the needs of apprentices with reference to the role of practice supervisors and educators in meeting statutory requirements that ensure that apprenticeship standards are met to enable the apprentice to learn and be assessed fairly and successfully.

Activity 1

Think back to when you were a trainee, student or apprentice and commenced your first placement experience:

- What thoughts, feelings and emotions did you have leading up to the start of the placement?

- How did you feel on your first day? To what extent did the staff make you feel welcome?
- What challenges did you encounter before you were able to participate in caring for patients or working with clients and service users?

Pre-placement student visits

Hopefully, this first activity will have brought back some positive experiences as well as vivid recollections of feelings and emotions as a student and trainee during a significant life event.

How students, learners, apprentices and trainees are welcomed into clinical and therapeutic areas is critical to ensuring that the placement or practice learning experience starts positively and is more than just ensuring that the learner feels welcomed. Where at all possible, learners should be encouraged to contact their placement area to arrange either an informal visit or hold a short online meeting or phone call with their allocated practice supervisor/educator. This is useful for the following reasons:

i. It provides an opportunity for the student and placement area to confirm that the placement has been arranged, that the student is expected and that a practice supervisor/educator and practice assessor has been allocated.
ii. To confirm the start date, time and length of the placement as expected by the student and practice partner.
iii. For the student to be informed of how to gain access to the placement building and who to report to on their first day and at what time.
iv. For the student's duty roster or 'off-duty' to be shared with the learner so that any travel or childcare arrangements can be organised well in advance of the start date.
v. For the student to receive any pre-reading or preparatory work to complete in addition to or contained within a student welcome pack.

Additionally, an informal meeting may be an opportunity for the student to ensure that any reasonable adjustments disclosed prior to the placement are put in place in accordance with university documentation, such as a Clinical Practice Learning Agreement (see chapter 15).

Students may undertake an informal visit to confirm their travel route or to ensure that there is safe, convenient and accessible car parking and allay any anxiety associated with visiting a new department, building or hospital site. Such an opportunity also enables the student to locate staff restaurants, cafes, rest areas, chill-out zones, or places for prayer.

Initial placement meetings

Students should have an allocated and suitably prepared Practice Supervisor or Practice Educator who is assigned to work with the learner on their first day or shift. It is critically important that learners are made to feel welcome and that their identity and name are confirmed on arrival before being given the opportunity to store and secure their belongings. There are three types of induction processes that learners are required to complete:

i. **Organisational induction**: this normally covers the organisational values, mission statement of the NHS Trust or employer and additional training, or the confirmation that mandatory training is completed in the areas of basic life support, manual handling, confidentiality, safeguarding (child or adult), health & safety, raising concerns, infection control and the use of information technology and governance. Mandatory training is normally completed before the student starts their actual placement within a ward, team, department, clinical or therapeutic area.

Students allocated a placement by an approved higher education institute within the United Kingdom will not be permitted to enter practice or start their placement until they have had their occupational health (OH) assessment and Disclosure, Baring Service (DBS) clearance successfully completed. Most universities will have panels comprising of healthcare registrants from practice partners to assess any risks associated with students who need reasonable adjustments, or any entry identified from the DBS process, which signifies a Police caution, recordable or criminal offence.

ii. **Local induction:** Each learner should be provided with a tour of the local department, office, team workplace, clinical, therapeutic or ward area, including where to safely store personal belongings, welfare and rest facilities, meeting and

clinical/treatment and administrative areas. The procedure for summoning help in a medical emergency or cardiac arrest needs to be explained, in addition to the location of resuscitation equipment. Identification of fire alarms, exits/evacuation routes and firefighting equipment should also be included in addition to any essential service points relating to the supply of oxygen, which might need to be switched-off in an emergency. Additionally, any current physical hazards or risks should be identified within the physical environment including clinical areas that are normally 'out of bounds' due to the use of high-risk equipment such a clinical lasers, diagnostic radiographic equipment or cytotoxic drugs.

It is particularly important for practice supervisors/educators to ask learners what experience they have had with particular clinical observation, investigation or manual handling equipment which maybe at variance with what is used within the clinical or therapeutic area, even within the same organisation or Trust, to obviate a patient safety issue.

iii. **One-to-one documented induction:**

Following the successful completion of the local induction the practice supervisor/educator needs to hold a one-to-one meeting with the student to check their knowledge and understanding of the clinical/therapeutic area and complete the induction section of the practice assessment documentation, which normally requires the signature of both parties and the date recorded of the meeting.

Activity 2

1. What is the structure or format of induction provided for learners, trainees or apprentices within your workplace, clinical or therapeutic area?
2. How might a learner, trainee or apprentice be supported to ensure that their induction is successfully completed within your area?
3. What key aspects of patient, client or service user care needs to be included in the local induction of learners, trainees or apprentices that may be distinctly different from other practice areas?

Supporting students to identify learning objectives

Learners should be given the opportunity to identify their personal learning objectives within the first 3-5 days of the commencement of the placement or in accordance with the guidance that accompanies the practice assessment documentation. It is important for the practice supervisor/educator to examine the learner's previous practice assessment documentation or overall achievement record (OAR), to identify any documented areas of development and to get a global sense of the learner's previous clinical experiences. A useful strategy for initiating this conversation is to ask the learner about their previous employment or experience within health and social care, or other work experience and to ask them what has motivated them to choose their particular profession (Wareing et al, 2023). Additionally, the practice supervisor/educator may have identified gaps within the learner's knowledge or understanding from the local induction. If the student has undertaken preparatory work and read the Student Welcome Pack, they may have already identified some broad areas of interest that they wish to explore whilst on the placement which may relate to the following:

- Clinical care and treatment plans and patient/client management
- Patient/client/service user assessment
- Diagnostic reasoning and clinical decision-making
- Clinical and diagnostic procedures and investigations
- Communication, building therapeutic relationships
- Clinical observation, monitoring and investigation practices and equipment
- Treatment, management plans, early intervention strategies
- Therapeutic engagement, assessment, activity analysis
- Development of children, young people and parental support
- Care of the older adult, frail elderly
- Interprofessional, interdisciplinary, multi-professional working

The above list is not exhaustive. The practice supervisor/educator should also ask the student about the stage they have reached in their academic studies, so that learning objectives align with recent or current theoretical study or modular work. Learning outcomes should be written using a range of verbs (action/doing words) preceded by a statement, which clearly indicates the timeframe permitted for the student to complete the learning objective.

For example:

'By the mid-point interview, I will be able to competently perform…'

'By the completion of the placement I will be assessed proficient in…'

'By the time of my summative assessment I will have successfully completed at least…'

The use of a personal goal-setting strategy to help the student to write learning objectives that are specific, measurable, achievable, realistic and timely (SMART) may provide the learner with a transferable skill when working with patients, clients and service users to set goals associated with their care, rehabilitation and recovery.

Supporting apprentice colleagues in practice

The number of healthcare apprenticeships is growing in England. According to NHS Employers (2022), 2.9% of its workforce were employed as apprentices during the financial year 2020/21. This percentage of the workforce had grown from 1.2% for 2017/18, and these latest figures exceed the 2.3% target set by the Government for organisations with greater than 250 employees for the period 1st April 17 – 31st March 2021. The variety of healthcare apprenticeships on offer has been slowly increasing. Early adopters were healthcare support workers and healthcare science associates which were approved for delivery in 2016, nursing associate and registered nurse in 2017, later followed by midwifery (2018), and during 2018-19, a wide range of allied health professions regulated by the Health and Care Professions Council (HCPC) including occupational therapy, physiotherapy, podiatry and dietetics were approved.

The growth in the numbers of apprentices has implications for practice supervisors, assessors, educators and managers as there may be some employed in your team who you are required to support, or you may receive an apprentice from another employer or part of your organisation to gain practice experience. It is important that you are acquainted with the 'apprenticeship funding rules' issued by the Department of Education (2023) as these set mandatory standards that employers and apprenticeship providers receiving funding for apprenticeships must adhere to. These standards are revised on an annual basis, and many healthcare employers employ apprenticeship leads who will be up to date in their knowledge of current requirements, so will be able to advise you of your

obligations. Of key importance to all educators and managers are the mandatory requirements to:

- Allow the apprentice to attend weekly 'off the job' training. The types learning activities included and the minimum weekly time allowance has changed over time, but it usually includes time to attend theoretical sessions delivered by the apprenticeship provider and practice experiences which may be delivered by the same provider or within a variety of placement providers. Apprentices must also be granted time to undertake their written assignments.
- Attend 'progress reviews' at least four times per a year. The aim of this meeting is to discuss the progress of the individual apprentice against their training plan. This meeting may also include discussion of any concerns, changes of circumstance that impact upon the apprentice's progress, amending the training plan in light of these issues and signing off the off the job training. While this formal meeting is led by the training provider, employers have a mandated obligation to attend meetings along with their apprentice. The meeting needs to be documented and signed by all attendees and kept for evidence in case of inspection by external bodies. Although the apprenticeship funding rules do not stipulate specific job roles that are expected to attend, as you can see, the focus of the meetings lend themselves to individuals who work closely with the apprentice in their workplace and are involved with their progress i.e. the apprentice's manager or practice supervisor.

While the apprenticeship training provider will support your apprentice, particularly with theory and academic assignments, it is important that your apprentice colleague also receives encouragement and assistance in the workplace to ensure that they develop satisfactorily, and are able to put the theory they have learned into practice during their day-to-day role. Support that managers, practice supervisors and assessors can offer is varied and can include:

- Offering a 'buddy' who is a newly qualified apprentice of the same profession. If this is not possible within your organisation, you could try and partner your apprentice with someone from an outside organisation in the same profession, or someone within your organisation with a similar role who has personal experience of being an apprentice.

- Organise meetings and shadowing opportunities with colleagues who will play a key role for the apprentice to help them develop a working relationship and see where their role fits in with the wider organisation.
- Providing the apprentice and their colleagues with information regarding the apprentice's job role and objectives and articulating the expectation that all must respect this so that all parties are clear of what is expected of the apprentice. This is particularly important in cases where existing staff are accepted onto an apprenticeship, as many colleagues might be tempted to continue regarding them in their previous role and thus hinder their role transition.
- Providing learning opportunities in the workplace that will help develop the apprentice's skills and knowledge.
- Work closely with apprenticeship providers to ensure seamless development and support is provided.
- Raising any issues and concerns in a timely manner with the apprentice and apprenticeship provider so that the training plan can be amended as soon as possible, along with an action plan if needed.
- Performance reviews – offering regular performance reviews helps the apprentice with their development and reduces the chance of them failing to meet key developmental points in their training plan. Many healthcare apprentices will have a 'practice assessment document' provided by the apprenticeship provider where you can agree the skills and knowledge needed within your clinical area, the timeframes that guide development and progress in performance against these. In review meetings you can discuss how well your apprentice is doing, and agree an action plan in cases where development might not be going as well as anticipated.
- Wellbeing - holding regular review meetings also offers an opportunity for practice supervisors and assessors to get to know their apprentice better and it is important to also to discuss wellbeing as your apprentice might be struggling with their physical or mental health and need support and signposting to support services within your organisation. Also, note that many apprenticeship providers also have support services that apprentices can access should they prefer.

Facilitative learning

Learning within practice-based environments is underpinned by a pedagogical approach which promotes the workplace as a legitimate site of learning in its own right, where students and trainees can not only be assessed but contribute to the generation of new knowledge. Work-based and workplace learning is closely associated with the concept of andragogy, which is the theory of adult learning. Malcolm Knowles (2005) argued that adults' conception of themselves develop as a result of maturity, enabling the adult to become more self-directed in their learning; that adults draw on experience when engaging in learning; that their readiness to learning helps in the accomplishment of tasks which must be personally relevant; that problem-solving strongly orientates the adult learner as it can help them to better perform in their particular roles; and that internal rather external motivation drive adult learners to obtain and refine their skills. A particularly effective approach to the support of adult learners is facilitative learning, as described by Rogers (1969), where the role of the supervisor is to create a learning environment that best supports the learner to be self-directive. This learner-centred approach contrasts with traditional forms of learning based on a teacher/instructor-pupil relationship where the expectation is for learners to receive direct formal teaching. Rogers argued that what the student did was more important than the role of the teacher as the learners' background and experience was essential to how and what was to be learned. Fundamental to effective facilitative approaches to learning is where the facilitator is able to recognise the role of ontogeny (Billett, 1998), a concept that describes the accrued variety of practice and learning experiences that creates the biography of the learner. This requires the practice supervisor/educator to identify the previous placement, practice, training and educational experiences that the student has successfully completed and to build from the known to the unknown, using a facilitative approach to support the development of the learner in a safe and effective manner.

Once a relationship has been established the practice supervisor/educator can begin to explore how best to involve the student, learner, trainee or apprentice in the care, treatment and management of patients and service users utilising a participatory approach. Vygotsky (1978) described the zone of proximal development where an instructor sets the level of challenge for a learner based slightly above what the learner is known to be able to practice. This pedagogical approach ensures that the learner is provided with an appropriate

level of challenge when introduced to an area of practice that maybe new or unknown. Allied to this approach is the need for a learner to engage in learning which is scaffolded (Bruner, 1960) where the practice supervisor surrounds the learning experience with a framework, which permits participation in practice or to undertake a procedure, but under close supervision. Bruner argued that when a student is supported whilst learning a new skill, they become better able to use their newly acquired knowledge or skilfulness independently. Vygotsky's theory was based on observations of children, where it was observed that the assistance of a more knowledgeable other enabled a child to learn skills that went beyond their actual developmental level. As the student gains confidence and proficiency the scaffold can be removed as a result of the learner being able to expand their competency, which in turn, leads to the proximity of supervision being reduced from 'close' to arms-length or indirect. The provision of participatory learning where students are able to participate in episodes of care underpins the learning and assessment strategy of contemporary practice assessment documentation and requires the learner to demonstrate increasing levels of competency or proficiency towards a progression point, typically at the end of each academic year.

Consequently, practice supervisors and educators need to be able to identify and enable the student to access a range of learning affordances, which Billett (2001) described as opportunities within the workplace environment to engage in a range of learning activity whilst receiving direct and indirect supervisory support.

Activity 3

Think about a particularly vivid learning experience that you have had where you have been supported to learn within a workplace or practice setting:

1. What strategies were used to encourage you to be a self-directed learner, participate in episodes of care delivery, patient/client assessment and management?
2. What if any, barriers and enablers did you experience when seeking to identify learning opportunities?
3. What learning affordances were you able to access in order to engage in learning activities?

4. To what extent did previous working and practice experiences enable you to be a more effective practice-based learner?

Practice supervision

All students and apprentices studying on professionally regulated health and social work courses are required to have a practice supervisor and assessor or practice educator in accordance with the professional standard regulatory body guidance (NMC, 2018; HCPC, 2015; CODP, 2021). It is critical that the allocation of practice supervisors, assessors and educators is completed in advance of the arrival of each student; not least, as the learner may contact the practice area to arrange an informal visit and to request their roster or off-duty.

Placement capacity

The traditional approach to the allocation of students to supervisors and educators is based on the placement capacity identified within the educational audit that will have been completed by a university to determine the numbers of students by study pathway and academic year. For example, a critical care or emergency department within an acute hospital may agree to take adult nursing and paramedic students, but may request that only 2nd and 3rd year students are placed within the department, given the acuity of the patients and service users. One of the challenges of this approach is that the placement capacity becomes fixed at the point that the educational audit was completed, which can present challenges for clinical staff during periods when there are high staff absence periods or a department is struggling to recruit new staff. Therefore, a more effective approach is when placement capacity and the allocation of students to practice supervisors, assessors and educators is aligned to the staffing establishment within each clinical or therapeutic area (NHS Employers, 2019, 2022a). The approach recognises that potential capacity exists wherever and whenever health and care services are being delivered sufficient for at least one learner to be supported during daily working hours (Borwell & Leigh, 2021). Additionally, this enables students to be allocated to staff present throughout the working day or shift leading to an equitable 'spread' of students throughout the year. We will explore the process of educational auditing, which involves the establishment of placement capacity, in chapter 8.

Being and becoming

Two concepts that are useful in describing the experience of students as they progress through their studies ahead of registration with a professional healthcare regulatory body are being and becoming. Being a health and social work student and becoming a professional are highly emotive and complex experiences shaped by the many and varied practice learning experiences that students, learners and apprentices are exposed to during their study programmes. Hannah Arendt (1958) described labour, work and craft as a key characteristic of the human condition and regarded work as 'the labour of life' that positions human beings within the world. Being a worker and engaging in work adds to the 'worldliness' of human experience. Arendt (1958) argued that every occupation has had to prove that it is useful to society at large and that work rather than labour, authenticates human activity. Health and social care work is regarded as increasingly important to the functioning of modern societies, which increasingly face the challenge of balancing the needs of an ageing population with the concomitant demand for advances in medicine to treat long-term conditions and meet the care needs of the frail elderly. Jarvis (2009) describes the concept of 'becoming' where learning and our progress through stages of the life cycle enable us to *become* and shape our sense of self or our 'personhood'. For Jarvis (2009) 'becoming' is about lifelong learning which is described as a type of learning that develops and transforms us through our engagement with the world so that we fulfil our human potential.

Activity 4

Read the vignette below that features Mica and work through the questions.

Vignette: Mica, a medical student, reflecting on his first cardiac arrest

Following a difficult day where Mica had experienced his first cardiac arrest while working alongside Fernando the Foundation Year 2 (FY2) on a ward, Mica returned home and sat down to complete her learning log as agreed with Fernando. After a few minutes of staring at the screen of his iPad, Mica decided to describe what had happened by recalling the events that had led to Fernando and him being called to the patient, the arrival of the crash team and his observation of the cardiac arrest. The events of the day were very clear in Mica's mind and he had no difficulty describing his feelings and what went well and not so well. One of things that Mica realised when analysing the situation was how helpless he felt towards his patient. Although he felt pleased that he had been able to

observe what went on during the cardiac arrest; albeit at a safe distance, Mica wondered whether there should have been something he could have done. In fact, while the patient was being resuscitated a patient's relative had approached Mica and said "excuse me doctor, is he going to be alright?" Mica felt awkward being addressed as a doctor within earshot of his colleagues and had not known how to respond. Although Mica was not able to complete his learning log he decided to take what he had done into work to discuss it with Fernando as he felt he needed advice on how best to support his colleagues' other patients and relatives following a cardiac arrest.

Questions:

1. What impact has this learning experience [in general] had on Mica?
2. Why might he be struggling to reflect on his experience?
3. What has he realised about his identity?

The vignette suggests that 'becoming' (in the case of Mica, becoming a doctor) is characterised by how we learn inwardly whilst fulfilling outwardly, a professional role. How learners, students and apprentices utilise activities and tools within clinical, therapeutic and working environments shape identities before patients, clients and service users as 'being' is concerned with how learning within the world leads to the development of new identities before the world. Jarvis (2009) describes how learners are given an ascribed identity prior to being exposed to a range of experiences that lead to the acquisition of knowledge and skills enabling the novice to eventually gain an 'achieved' identity. In the vignette, we saw that Mica appeared to have the identity of a doctor as perceived by one patient when in fact his professional status had been ascribed to him, ahead of graduation and professional registration when his identify would become achieved.

Values and beliefs in practice

Practice supervisors and educators fulfil an important role in supporting learners, students and apprentices to develop their professional identity. In addition to inquiring about students' motivations to care, as discussed in chapter 1, this can be achieved by asking learners to explore their personally held values and beliefs; not least as values-based recruitment is often a feature of the interview process used by universities. Additionally, the formal assessment of professional values may feature within practice-based assessments.

Cuthbert & Quallington (2008) argue that values in health and social care are moral beliefs, principles or rules of conduct that guide social interactions and human relationships. A useful activity to initiate a discussion with a student or group of learners is for a practice supervisor/educator to undertake the following exercise:

Think about the professional values and beliefs that have motivated you to choose a career within health and social care:

*i. What values and beliefs might have been **told** to you**?***

- *These maybe from parents, guardians, family, schooling, involvement in activity, cultural, sporting or faith groups.*

*ii. What values and beliefs might have been **sold** to you?*

- *These maybe from authority figures, social media, art, music, films, literature or key influencers.*

*iii. As a result, what values and beliefs do you **hold**?*

- *These are values and beliefs that you regard as truth and hold within your heart or the core of your being.*

The above exercise has been designed for learners to attempt to establish the origin, roots and foundation of their personal framework of beliefs and values and to assess the extent to which their pre-existing beliefs and values conform with professional values that might be challenged when working with patients, clients, service users and relatives. Additionally, the exercise can be used as the basis of a discussion of a range of clinical situations and scenarios where students can re-contextualise their beliefs and values within clinical practice, ahead of the summative assessment of each students' professional values.

Becoming an authentic professional

Dall 'Alba (pg. 43-44, 2009) argues that re-shaping our assumptions about what it means to be a particular professional, such as a doctor, dentist, nurse, midwife, leads to new ways of being that involve a transformation of students, learners, trainees and apprentices. In essence, their engagement in practise, even in situations that are familiar to them, shape how they become the healthcare professional that they wish to become, but only when they are prepared to see the everyday differently and recognise when experiences arising from the delivery of care are significant to the creation of their professionalism. As we shall see in chapter 4, techniques arising from coaching, such as the utilising of a questioning approach

that leads to 'conversations that matter' can assist learners to utilise everyday experiences as opportunities for learning and development that will help form their professional identity. This type of 'authentic' professional learning (Webster-Wright, pg. 113, 2010) has the following constituents:

- **Understanding** – which leads to a change from what was previously known (the students' prior understanding) through to a transition that changes the learner's understanding as a professional. This requires the learner to know what to do, how to think and to question what is done. The exercise where students were required to identify the origin and root of their professional values and beliefs is perhaps one strategy for developing understanding.
- **Engagement** – this requires learners' to be actively engaged in care and to care about specific aspects of practice while recognising that some aspects of care are uncertain.
- **Interconnection** – authentic professional learning arises from multiple experiences. In order to connect those experiences over time learners' need to harness their imagination to draw together their past, present and future and to engage with others (such as workplace practice supervisors, assessors and educators) in a dynamic way that uses shared experiences to create mutual understanding.
- **Openness** – authentic professional learning requires learners' to be 'open-ended' by developing an attitude that recognises the opportunities and constraints that exist within professional environments and how tension that arise in practice settings can be resolved.

Authentic professional learning is essential to the creation and on-going development of authentic professional practice. Webster-Wright (pg. 171-188, 2010) argues that the way a professional continues to learn is an expression of their way of being a professional in a dynamic interplay with their particular professional context. Professional authenticity arises from learning that is transformative, which will be discussed in further detail in chapter 6. This is achieved when learners are encouraged to seek to face up to situations by weighing-up different possibilities and seeking to understand their professional responsibilities. This requires practice supervisors and educators to support learners to engage in constant cycles of reorientation that are shaped by changing circumstances while maintaining a continuous sense of themselves as professional people.

Activity 5

Think about a recent vivid learning experience that occurred within your clinical, therapeutic or workplace setting:

1. To what extent did the learning experience alter your understanding of what it means to be a health and social care professional?
2. What impact did your level engagement have on what was learnt from the experience?

Powerful and transformative learning experiences; particularly those that shape the health and social care professional that we aspire to be, are often characterised by situations that arouse strong emotions because of their relationship to our identity and the extent that we are personally as well as professional invested in the work that we do.

Emotion in learning

Students face challenges during their course that may cause distress, or exacerbate mental health conditions. Some studies suggest that students experience poorer mental health than the general population, with those within health professions noted as particularly vulnerable (Lewis and Cardwell, 2019; Kotera el al 2023). Of particular interest for practice supervisors, assessors and educators is to consider when supporting learners is the challenge some face when applying theory to practical situations (Wallace *et al*., 2015). This may lead to feelings of a lack of preparedness when caring for patients, and consequently students may be worried and fearful of making mistakes (King-Okoye and Arber, 2014; Wallace *et al*., 2015). Students have been found to experience empathetic distress as a result of providing direct patient care, and levels may be higher in students compared to registered colleagues (López-Pérez *et al.,* 2013). Other causes of general distress during practice learning include experiencing ethical dilemmas with patient care, experiencing uncivil behaviour from others in placement, and experiencing heavy academic workloads whilst in practice (Suresh *et al*., 2013; Sasso *et al*., 2016; Tee *et al*., 2016). Inadequate preparation for the emotional aspect of practice has also been cited as a key factor in experiencing distress (King-Okoye and Arber, 2014). Stress specifically has been linked to poor academic achievement, reduced life satisfaction, feeling a reduced sense of belonging within clinical practice placements, and increased health risk behaviours such as poor diet, excessive

alcohol consumption and smoking (Nastaskin and Fiocco, 2015; Grobecker, 2015; Pelletier *et al*., 2016; Samaha and Hawi, 2016; Deasey *et al*., 2016). Also highlighted are the challenges faced by those who possess lower levels of personal agency. A propensity to use passive coping strategies, a reluctance to use peer support and possessing lower levels of general self-efficacy and self-esteem have all been found to be risk factors for experiencing stress and other mental health concerns (Edwards *et al*., 2010; Priesack and Alcock, 2015; Deasy *et al*., 2016; Horgan, 2016; Zhang *et al*., 2016). There is also evidence that suggests younger students may be more vulnerable to feeling overwhelmed and stressed in practice (Galvin *et al*., 2015). Illeris (pg. 20, 2011) observes that the harbouring of a negative feeling towards a person or group whose behaviour that we disapprove of can be changed when a learner gains insight into why they have acted in the way they do and signifies the relationship between cognitive reasoning and emotion within the workplace.

There are ways that practice educators can help and support their learners to develop resilience that research indicates helps individuals to manage their emotions and develop coping mechanisms.

This can include:

- Providing time and opportunity through asking open-ended questions at the end of a work session where the learner can share their experiences and emotional challenges. This is particularly important in cases where there has been a distressing incident in practice e.g. a sudden or unexpected death or safe-guarding incident.
- Acknowledging and validating the emotions that are shared with you.
- Support the learner to find positive solutions through asking coaching questions to help them reframe the situation and explore different coping techniques (see Chapter 4).
- Providing an opportunity to see the positive aspects of practice by asking learners to try to consciously identify and focus on the positive aspects of their role and wider work environment, and consider things that they are grateful for at work.
- Start a 'buddying' system where senior students are paired with a junior, and provide them with opportunities to discuss their progress and any issues that have arisen.
    - You might even wish to teach learners some beginners coaching techniques (e.g. TGROW – see chapter 4) and ask them to peer coach.

- Provide 10 minutes of time for learners to write a reflection on their practice at the end of a session.

Summary

This chapter has covered a large range of theoretical and conceptual perspectives that underpin the role and practice of the supervisor, assessor and educator. Practice learning starts before the arrival of a student, trainee, learner or apprentice as we saw with regard to pre-placement meetings and informal visits. The induction process of learners is often characterised by three discreet stages; organisational, local and one-to-one meetings, where preparatory work and mandatory training need to be completed successfully before the newcomer can create, negotiate and agree learning outcomes that should provide the key focus of the practice learning experience. We saw that there were additional statutory requirements necessary for the support, supervision and progression of apprentices, whose experience of practice learning is characterised as much by being an employee as a trainee. Additionally, the requirements provide the practice supervisor/educator with an opportunity to ensure that apprentices are recognised as learners as well as workers in their own right.

The principles of adult learning were examined in the context of the role of the supervisor/educator as a facilitator of learning, who is committed to recognising the experience of being a learner, trainee, student and apprentice, ahead of becoming a proficient, competent and safe practitioner. The vignette featuring Mica illustrated the nature of ascribed as opposed to achieved professional identity as students practice before patients, clients and service users and we explored the impact of personally held values and beliefs and their role in becoming an authentic health and social care professional. Finally, we returned to a theme that started the chapter; the role of emotion within practice and work-based learning, which is not only present prior to, but throughout placement experiences and is central to the role of the practice supervisor, educator and assessor in promoting a compassionate practice learning environment for all.

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