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The Student-Led Groups Program Model of Practice Education: Pilot Evaluation from the Perspective of Service Provider and University Stakeholders.

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This study was approved by the Metro South Human Research Ethics Committee, project number HREC/12/QPAH/318 committee and all participants provided informed consent.

Abstract

Background: There is a need for innovative models of student practice placements to accommodate increasing numbers of occupational therapy students while providing quality learning experiences. The Student-Led Groups Program model is a new approach, which involves multiple students in continuous overlapping placements taking responsibility for leading a group program.

Aims: The aim of this study was to explore service provider and university stakeholder perceptions of the Student-Led Groups Program model of professional practice education in a brain injury rehabilitation unit.

Method: A participatory action research approach was utilised and this paper presents the findings from the first cycle of research. Data were collected using focus groups with service provider and university stakeholders and analysed using a qualitative descriptive approach.

Results: Five key themes emerged in the data analysis, 1) positive practice placement experience for students, 2) positive practice placement model for clinicians, 3) improved occupational therapy services for patients, 4) essential components of the program, and 5) wider influence and reach. **Conclusions:** Findings indicated that the Student-Led Groups Program model was effective in providing quality student experiences and enhanced patient services in an inpatient setting from the perspectives of service providers and university representatives. Recommendations for subsequent research cycles are presented.

I INTRODUCTION

Professional practice education is an integral component of all occupational therapy training curricula, providing occupational therapy students with opportunities to contextualise their theoretical and university-based learning in a clinical practice context and develop professional practice skills with support and supervision (American Occupational Therapy Association, 2009; Bonello, 2001). Furthermore, professional practice education facilitates student exposure to different clinical settings, teams and modelling of professional behaviours by different clinicians (Bonello, 2001). In Australia, increasing numbers of occupational therapy programs and increasing cohort sizes have resulted in an ongoing challenge to provide students with sufficient hours of high quality practice placements to meet World Federation of Occupational Therapy (WFOT) minimum standards for education (Bonello 2001; Farrow, Gaipman & Rudman, 2000; Hamilton et al., 2015).

The traditional placement model, in which one practice educator supervises one student in an apprenticeship style, has long been used in occupational therapy settings and is the most commonly used model in Australia (Gustafsson et al., 2017). In recent years however, in response to the challenge of providing adequate hours of high quality practice placements for increasing numbers of students, a variety of innovative professional practice placement models have been developed (Copley & Nelson, 2012; Rodger et al., 2009). These include the collaborative or 2:1 model of placement in which two or more students are placed with one practice educator (Fisher & Savin-Baden, 2002; Martin et al., 2004; O'Connor, Cahill & McKay, 2012), the role emerging model where students work to establish and implement an occupational therapy role in an area of emerging practice (Fisher & Savin-Baden, 2002; Overton et al., 2009), project-based placements where students complete a work-based project (Overton et al., 2009), and the multiple mentor model where two or more students are supervised by two or more practice educators (Copley & Nelson, 2012; Farrow, Gaipman & Rudman, 2000;). Student-led services are another model of professional practice placement in which students lead health service delivery (Beck, 2005; Kent et al., 2016). This model, which relies upon ongoing student presence in the practice setting, not only provides opportunities for contextually based training for students but can also benefit clients, for example, by providing additional occasions of service (Beck, 2005; Kent et al., 2016).

The Student-Led Groups Program model was identified as an opportunity to apply a student-led approach to practice education in an inpatient brain injury rehabilitation clinical context. It was seen as an opportunity to offer a greater number of professional practice placements on a continuing basis, with concurrent students providing peer support to each other and to enable the brain injury rehabilitation unit to consistently provide a group therapy program. Consistent with student-led, or student-resourced placement models as described by Beck (2005) and Kent et al. (2016), in this Student-Led Groups Program model students were to assume responsibility for the facilitation of an existing group therapy program. This paper describes the planning, development, pilot implementation and evaluation of this newly developed student-led practice placement model. Recognising the need for ongoing evaluation and modification of the new program, its embedded nature within a healthcare service, and the integrated roles of the authors within the program, we adopted a participatory action research approach to guide the development process. Understanding the impacts and outcomes of the newly developed model from the perspectives of key stakeholders was considered essential for the evaluation and refinement of the model. It was also considered an important step in the contribution of evidence regarding the effectiveness of this approach to practice education. The aim of this study was to explore service provider and university practice education stakeholder perceptions of a Student-Led Groups Program model of professional practice education in a brain injury rehabilitation unit.

II METHOD

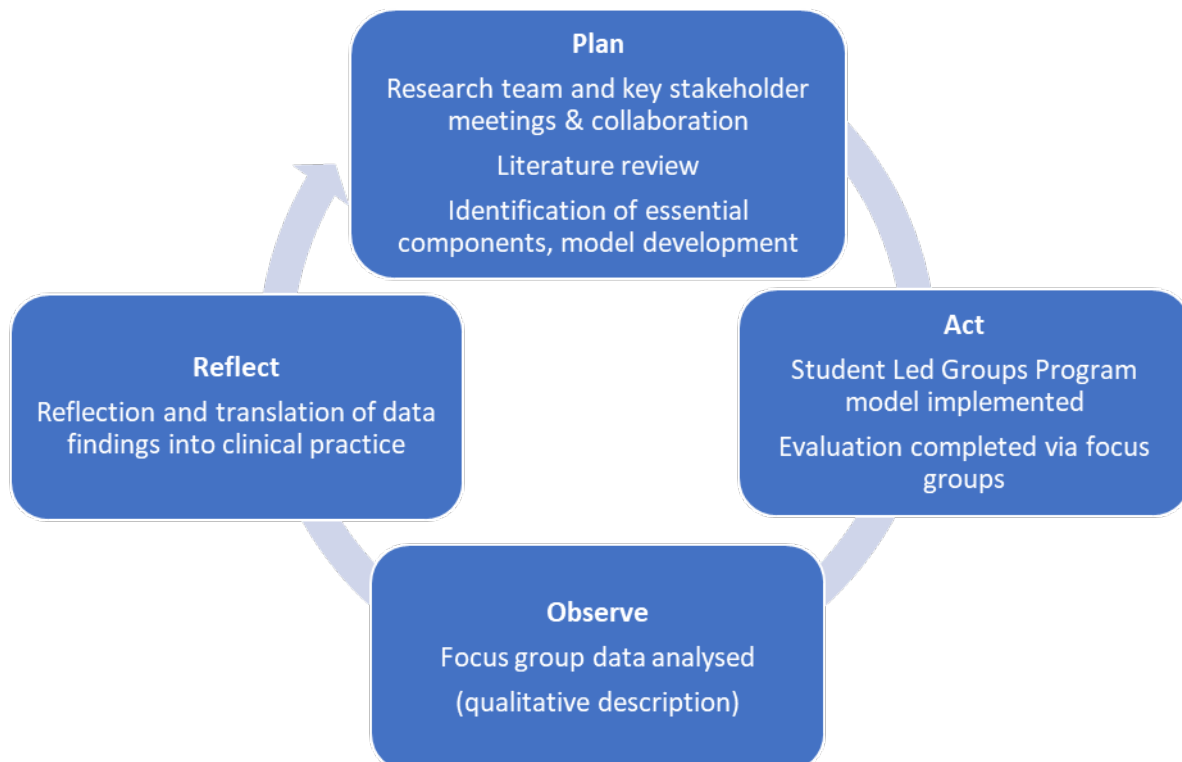
A Study Design

The present study was a qualitative study that utilised a qualitative descriptive approach to data collection and analysis (Neergaard, Olsen, Andersen & Sondergaard, 2009). A participatory action research approach was employed which involves a self-reflective, collaborative approach by researchers and participants to understand and improve practice while engaged in the action of making change (Baum et al., 2006). The action research team consisted of two occupational therapists employed at the Princess Alexandra Hospital (a practice education coordinator and a practice educator from the Brain Injury Rehabilitation Unit occupational therapy team), a university practice education representative and a research fellow with a conjoint appointment at the hospital, in consultation with other key stakeholders. Action research involves cycles of planning, acting, observing and reflecting followed by re-planning, acting, and so on (Kemmis & McTaggart, 2000). Figure 1 presents the first cycle of participatory action research and key actions completed in this project.

The model was evaluated from the perspectives of the following key stakeholders: patients; students; service providers (clinicians and practice educators); and university practice education representatives. The perspectives of patients and students are reported elsewhere and provide support for service provision using this model from the perspectives of students (Patterson, Fleming, Marshall & Ninness, 2017), and present essentially positive patient experiences of participation in the groups program (Patterson, Fleming, & Doig, 2018; Patterson, Fleming, Doig, & Griffin, 2017).

Figure 1

The participatory action research cycle (Lewin, 1946; McNiff, 2013) and key actions completed in the first action research cycle



This paper reports on the first cycle of the action research process in the development of the Student-Led Groups Program model, and presents findings from the perspectives of service providers and the university practice educator stakeholders.

B Setting and Participants

The present study was set in an inpatient brain injury rehabilitation unit at a large tertiary hospital in Brisbane, Australia. The Brain Injury Rehabilitation Unit (BIRU) at the Princess Alexandra Hospital is a specialist brain injury rehabilitation unit providing multidisciplinary rehabilitation to people of working age following brain injury. Occupational therapy services are provided on an individual basis as well as through participation in an existing group therapy program. The group therapy program has been running in the BIRU for many years in varying formats; typically multiple groups are facilitated each week including meal preparation, community access, upper limb function, and cognitive rehabilitation groups (Patterson, Fleming, Doig & Griffin, 2017). The groups are client-centred and based on current evidence from occupational therapy, brain injury rehabilitation and groups literature (Patterson, Fleming, Doig & Griffin, 2017). Opportunities for maximising intensity of practice for clients (Turner-Stokes et al., 2011), as well as cost-efficiency and resource management underpin the rationale for the use of groups (Drum, Swanbrow Becker & Hess, 2011; McCarthy & Hart, 2011).

Participants who were invited to participate in the focus groups were: (i) practice educators involved in the pilot program; (ii) clinicians (not practice educators) in the BIRU team during the pilot; (iii) BIRU occupational therapy team leaders; (iv) directors of the Occupational Therapy Department; and (v) university practice education representatives. An email from the research team was sent to the above groups, and participants were recruited from responses to the email. The email emphasised that participation was voluntary and written consent was obtained prior to the focus groups. Inclusion criteria included that participants needed to have worked in the BIRU during the pilot implementation period of the model (with the exception of service directors and university stakeholders).

C Planning (Phase 1)

The first phase refers to the stage of planning a change (Kemmis & McTaggart, 2000). The challenge being addressed by the research team was to introduce the Student-Led Groups Program model without compromising student learning opportunities or patient care, and without placing excessive demands on clinical occupational therapists who would provide the student supervision. Through a series of meetings, email correspondence and review of literature on practice education, the research team and the key stakeholders decided upon a course of action. The Student-Led Groups Program model was proposed, involving pairs of students working together to facilitate the existing BIRU occupational therapy group program.

Review of practice education literature identified a number of factors that contribute to high quality practice placements including a welcoming learning environment, the provision of a detailed orientation, regular and timely constructive feedback, practice educator experience and skills, clear student expectations of their role during placement and a successful partnership between the university and practice educators (James & Prigg, 2004; Kirke et al., 2007; Rodger et al., 2011). These factors were perceived by the research team and key stakeholders to be essential components for the proposed model and subsequently were built into the design of the new model during the planning phase and reflected in both planning documentation and resources. The essential factors integrated into the Student-Led Groups Program model were:

- Multiple student placements offered simultaneously (i.e. at least two students during each placement period) and continuously throughout the year, with the students taking responsibility for facilitating the groups program;
- Overlapping placements whereby one pair of students orientates the next pair (involving students on placements of varying length with an overlap of one week);

- Team support (i.e. multiple team members providing timely feedback based on their observations of the student-led groups) in addition to a practice educator allocated to each student;
- Peer learning and support, with students providing each other with a higher level of feedback, joint reflection on practice, and peer support than expected in traditional placements through formal processes integrated into the model;
- Clear expectations and roles (manualised and presented to students in orientation with other supporting resources);
- Ongoing key stakeholder engagement and consultation particularly regarding management of risks associated with implementation of this new model.

The proposed model involved pairs of students facilitating 15 groups per week and completing a service development project over the course of their practice placement. In the first week, students participated in an in-depth orientation program with the preceding pair of students and with clinicians. Resources were developed to support this process (e.g., orientation checklist, timetable, weekly guidelines, etc.). Students were each allocated one therapist to be their practice educator, as opposed to the collaborative model where both students are supervised by the one therapist (Fisher & Savin-Baden, 2002; Martin et al., 2004; O'Connor, Cahill & McKay, 2012). Students also received regular feedback from other team members, which is consistent with multiple-mentor models of practice placement (Copley & Nelson, 2012), the difference with this model being that feedback from members of the occupational therapy team would be provided to the allocated practice educators as well as directly to the students.

D Acting (Phase 2)

This phase of the action research cycle refers to the implementation (or acting) of the planned interventions (Kemmis & McTaggart, 2000). For this study, the phase involved a pilot trial of the Student-Led Groups Program model over a seven month period including both the implementation of practice placements using this model and formal evaluation of the pilot outcomes. Six students were approached by a university representative and consented to participate in the pilot (no students declined to consent). These students were identified as suitable by the university practice educators based on a number of factors including home address, clinical focus of previously completed placements, interest and availability for set dates. Ethics approval was obtained from the Metro South Hospital and Health Service Human Research Ethics Committee (HREC Reference Number: HREC/12/QPAH/318).

Following completion of the placements, qualitative data were collected using focus groups to understand the perspectives of key service provider and university stakeholders. Focus groups enabled an in-depth understanding of the features of the model that were useful and could generate strategies for improvement (Liamputtong & Ezzy, 2005; Hennink, 2007).

The purpose of the focus groups was to explore service provider and university stakeholder perceptions of the pilot implementation of the Student-Led Groups Program model of occupational therapy practice placement in the BIRU. Questions to guide the focus group were developed based on the literature, the research team's experience and the key components of the model of practice placement. The questions were designed to facilitate in-depth exploration of issues and perceptions of this placement model. Table 1 presents focus group questions.

Table 1
Focus group questions

Focus group questions
<ul style="list-style-type: none"> • What's been your overall perception of the student-led groups program? • How do you think the student groups program in the BIRU could be improved? • What do you think are the benefits of the student-led groups program in the BIRU and do you have any examples? • Are you aware of the risk management strategies identified with this project? [If any no responses, a copy of document provided] • Do you feel the risk management strategies that were developed at the start of the pilot have been implemented in practice? • Do you feel these risk management strategies effectively manage the identified risks?

Focus groups were facilitated by a member of the research team (NN) who was not a member of the clinical team. Clarification and probing by the facilitator enabled topics to be explored in more detail and encouraged participation by all participants. Written field notes were taken by the facilitator during and immediately following each focus group. Focus groups were audio-taped and transcribed verbatim. Participants were provided with a copy of transcripts from their group for checking and advised they could make amendments; no amendments were requested.

E Observing (Phase 3)

This phase refers to observing the consequences of the change or actions that have been implemented (Kemmis & McTaggart, 2000). Meetings continued through this cycle between the research team and the service provider and university stakeholders.

Data from the focus groups were analysed using a qualitative descriptive approach (Neergaard, Olsen, Andersen & Sondergaard, 2009) following the analytic strategies proposed by Miles and Huberman (1994). Transcripts and field notes were reviewed separately by the focus group facilitator and a second reviewer to become familiar with the data and to develop initial codes for the data. These codes were then discussed and refined to ensure consistency. Subsequently the codes were collated into potential themes which were reviewed by the research team, including a third independent reviewer to enhance the trustworthiness of the emerging themes. This led to further refinement and defining of the final themes. Strategies to enhance methodological rigour and trustworthiness included member checks, reflection on research bias, peer review and reaching of consensus on key themes, audit trail, and following established research methods (Lincoln & Guba, 1985; Milne & Oberle, 2005; Lincoln & Guba, 1985). The themes that emerged as part of this observing phase are presented as Results below.

F Reflecting (Phase 4)

The final phase involves reflecting on the processes and consequences, and then re-planning (Kemmis & McTaggart, 2000). The reflecting phase involved the research team examining the findings and considering them with respect to the literature, and then using this information to plan further refinements for further research cycles. The reflecting phase of the cycle is described in the Discussion section below, along with the plan for the next action cycle.

III RESULTS

Two focus groups were conducted with a total of twelve female participants. Clinical experience ranged from new graduate to more than 10 years of experience. Focus group

participants comprised practice educators ($n=4$), clinicians who were not/had not been practice educators ($n=3$), BIRU occupational therapy team leaders ($n=2$), directors of the Occupational Therapy Department ($n=2$), and university practice education representatives ($n=1$). Of the 12 participants, two were not currently working in the BIRU team but had been at the time of the pilot implementation. Clinicians and team leaders described that whilst they were not practice educators they did provide clinical supervision to students/groups and feedback to students and practice educators about student performance and group outcomes.

Five key themes regarding the pilot implementation of the Student-Led Groups Program model emerged from the data analysis. These were: 1) positive practice placement experience for students, 2) positive practice placement model for clinicians, 3) improved occupational therapy services for patients, 4) essential components of the program, and 5) wider influence and reach. The themes are described below along with illustrative quotes where P represents the participant number and FG represents the focus group number (for example, P4, FG2 refers to participant 4 in focus group 2).

Theme 1: Positive practice placement experience for students

All participants strongly agreed that this placement model provided a positive practice placement experience for students. Two key reasons that were identified for making this a positive experience were first, the amount of patient contact the students were exposed to; and second, the level of autonomy students experienced during the placement.

The substantial amount of patient contact involved in the program was seen as an important contributor to the value of the placement for students. Participants described the physical environment of the placement as being a communal therapy space, which meant that students were surrounded by clinicians and patients each day. This benefit was described as, *“for the students it gives them a huge variety of different patients that they get to see and work with...”* (P4, FG2). This provided opportunities for direct patient contact, observation of clinician behaviours and skills, and patients. One participant described, *“...the amount of patient contact that they have, they are in that treatment area for the vast majority at every single day and for the times where perhaps they’re not facilitating or supporting a group, they’re still observing groups, having opportunities to observe individual therapists”* (P3, FG2).

The second positive aspect of the Student-Led Groups Program model identified by participants was the autonomy it fostered in students. Participants explained that the placement facilitated a sense of empowerment and ownership of the groups program for students, reporting, *“They (students) felt really empowered!”* (P7, FG1) and *“They did! And they felt ownership, total ownership.”* (P5 FG1). Participants also described how students were supported to develop skills to manage the groups as independently as possible and that students were observed to respond well to this responsibility. For example, one participant reported, *“They’ve really enjoyed the opportunities and the autonomy and the trust that they feel is placed in them in running groups and I’ve only had positive feedback”* (P2, FG2).

Theme 2: Positive practice placement model for clinicians

Participants emphasised that the Student-Led Groups Program model also had benefits for clinicians, for example, *“I feel like it’s been a really good opportunity in terms of team building that ... there is a big element of team feedback”* (P3, FG2). Opportunities that the model provided to support new practice educators were also highlighted by participants, with one participant explaining, *“I think that it probably lends itself to be quite a good first supervision kind of opportunity for a supervisor because there’s so much structure, the expectations are set, it’s quite clear, and there’s so much support from the team as well you’re not on your own supervising someone, the team are really supportive”* (P1, FG1). This participant went on to describe additional benefits to the existing therapy service including that the students *“... bring great ideas, new ideas to the program so the therapists are being inspired as well so it gives a lot of fresh ideas ...”* (P5, FG1).

Theme 3: Improved occupational therapy services for patients

The third theme was that the program resulted in improved occupational therapy services for the BIRU patients. Participants attributed improvements in occupational therapy services to increased therapy time for patients overall and improved consistency of the groups program. First, patients were receiving more daily therapy from the combination of individual therapy sessions with their therapist complemented by consistent group therapy sessions facilitated by the students. This was described by participant P5 (FG2) in, *"I think it provides more opportunity for therapy so you get your one-on-one individual but you've got more sessions available to continue to practice the skills, so I really think that's a great benefit"*. Students facilitating the groups allowed clinicians more time for individual therapy sessions with their patients. The groups also provided patients with additional opportunities for practice and repetition of task and strategies and so overall, *"...from a patient perspective they're getting more therapy..."* (P3, FG1). Second, participants highlighted that during the pilot implementation the existing group therapy program was run with greater consistency and intensity, *"We would have at least triple the number of groups compared to what we used to have, and the therapist used to have to run it, you had to do it as well as your caseload, so you just couldn't run that many groups in the week"* (P5 FG2).

Participants reflected that patients seemed to enjoy the contact with the students, with one participant describing, *"I find it incredible because some of the patients won't remember what you've done every day for the last week, but they'll remember and be asking about the students when they leave, they're always asking about 'where's that girl or that boy in the green shirt?' (student uniform)"* (P3, FG2).

Theme 4: Essential components of the model

Participants identified four components perceived as essential to the success of the pilot, and to address potential risks associated with the introduction of the new model. These were: clear expectations and structure, team support, peer learning, and feedback.

The importance of clear expectations and structure was highlighted for both students and clinicians. For example P1 (FG1) described, *"The expectations of when they have to do documentation or how they run the groups, how much supervision they get so the first week they're just shadowing, the next week they've just got someone watching them, it's pretty clear where they need to be at and when"*. Another participant described, *"The other benefit is that those clear expectations for students you know the weekly guidelines"* (P2, FG2), and their role in managing expectations, supervision and feedback.

A high level of team support for the students was the second essential component of the model identified. One participant explained, *"I think all the clinicians are really supportive and open to being approached by the students to clarify questions and talk through groups planning which was part of the concept"* (P3, FG2). Further examples of support provided by the team identified by participants included that clinicians other than allocated practice educators were happy to supervise students facilitating the groups and provide feedback directly to the students regarding group facilitation. This also addressed a potential risk with the model of part-time practice educators being unable to observe their students every day. Specifically, the team support assisted with this, *"...you get the feedback from the other therapists in the room..."* (P5, FG2).

The presence of an occupational therapist in the vicinity of the group was equally important to maintain patient safety and manage potential risks, as one participant highlighted, *"so I suppose having the systems whereby there is another clinician in the room at all times, whereby we have a groups planning meeting where we'll review referrals especially for example for things like community access, if students are going out, are those patients appropriate to be addressing that particular goal with students?"* (P3, FG2).

Overwhelmingly participants acknowledged the role and benefits of the peer learning and support opportunities available by having two students on placement simultaneously. One example described by participants was, *"They get to collaborate with someone on the same level"*

(P3, FG1). Other benefits related to the peer aspects of the model included, *“The benefits for the students running the group is that they’re able to support each other and they also challenge each other... So they will have an idea and then they’ll build on that and another student will encourage that idea so there’s lots of that inter-learning and self-sufficiency”* (P5, FG1). Benefits for practice educators were also identified, such as reducing support burden on the practice educator, with one participant explaining, *“I think we have seen through the groups program the evidence for the benefits for having more students at once in terms of their ability to support each other and reducing that support burden on the actual clinical educator (practice educator)”* (P7, FG1).

Lastly, the participants identified the importance of the provision of feedback, including both direct feedback to students about their performance, and to the allocated practice educators about the students. Participants emphasised that these processes were assisted by resources developed for the purpose such as, *“I actually almost found it easier to mark the SPEF-R [Student Placement Evaluation Form-Revised] in that you were getting these checklists back after other therapists had observed them, other therapists were constantly feeding back and giving specific examples”* (P1, FG1). Additionally, participants highlighted the benefits of students receiving feedback from multiple sources or perspectives, for example, *“I think the students really enjoyed having different people they could go to and get different pockets of knowledge.”* (P2, FG1).

Theme 5: Wider influence and reach

The final major theme referred to the broader implications of the model beyond the trial site. For example, clinical handover was identified as a current issue within the broader health service provision context, and participants described that this model provided opportunity for skill development in this area. One participant expanded on this explaining, *“From an organisational point of view I think the clinical handover is a really key skill and that’s something that [name of organisation] as an organisation has really flagged as a big safety and quality issue and that’s something that is really great that the students are getting that experience in terms of clinical handover”* (1, FG2). Another broader scale benefit that was identified related to the use of student-led services in general and the potential for this model be used in other settings. P2 (FG2) described that, *“In a way I think it kind of de-mystifies the whole student run service issue ...and because the outcomes are so positive I think there’ll be a lot more people enthusiastic about trying it”*.

IV DISCUSSION

The aim of this study was to explore service provider and university stakeholder perceptions of the piloting of the Student-Led Groups Program model, with the purpose of informing refinement of the model. The findings suggest that the program was beneficial for students, clinicians, patients and the organisation, and that it was underpinned by key components such as clear expectations and structure, team support, peer learning, and feedback. During the reflection process, the findings of this study were considered in conjunction with perspectives of students (Patterson, Fleming, Marshall & Ninness, 2017) and patients (Patterson, Fleming, & Doig, 2018). Given the positive nature of the experiences reported by stakeholders, it was decided that the Student-Led Groups Program model was a successful approach to providing a high quality practice placement and that it was suitable for adoption on a more permanent basis by the BIRU occupational therapy team.

In the reflecting phase, several recommendations were identified for implementation in the following cycle of research. The first was continuation of the program. The second was providing formal orientation for practice educators who were unfamiliar or less experienced with the model. This included opportunities for co-supervision and participation in a structured tutorial. The third recommendation was to continue with ongoing evaluation from the perspectives of students in the form of surveys and semi-structured interviews to be completed following final practice placement assessment. The results of student feedback (Patterson, Fleming, Marshall & Ninness, 2017) was considered vital to inform further planning and re-action phases. Finally, given this

present study included a small number of final year students, it was considered important to examine its use with a wider variety of students, including undergraduate third year students, and with a broader range of academic and clinical abilities.

This paper reports on the first cycle of an action research project, which involved the development and evaluation of a new model of practice placement. Although the Student-Led Groups Program model has similarities to existing models of practice placement, key points of difference include: having constant students present to facilitate an existing groups program; having practice placements overlap by one week to provide opportunities for direct student to student clinical handover; utilising peer-based learning and support by having at least two students completing practice placement simultaneously; and utilising all members of the clinical team to facilitate student learning experiences. Key findings from the initial cycle continue to underpin the Student-Led Groups Program model, and these are discussed below in relation to existing literature.

Stakeholders highlighted a number of structures and processes that enabled clear communication of student roles and expectations, for example weekly guidelines and the student handover from one pair of students to the next. This is consistent with previous studies about how to provide high quality clinical learning experiences (Farrow et al., 2000; Kirke et al., 2007; Rodger et al., 2011). Service providers also identified benefits of the communal therapy environment that provided students with opportunities for observation, modeling and skills practice throughout their placement. The importance of providing these learning opportunities is supported by existing practice education research (Rodger et al., 2011).

The multiple formats in which feedback was provided to students (i.e., peer to peer, practice educator to student, clinicians to students, and clinicians to practice educators) were seen to be a positive aspect of the model. Peer learning was seen as particularly valuable for students as they were able to support and learn from each other throughout their placement. There is strong support in the literature for peer learning as an effective learning tool (Farrow et al., 2000; Martin et al., 2004). In addition, support from the clinical team and the team's willingness to provide students with feedback on their performance was seen to contribute to the success of the model. This is consistent with previous findings that collaboration among clinicians was a critical element of the group model of practice placement (Farrow, Gaipman & Rudman, 2000).

The Student-Led Groups Program model had a constant student presence facilitating the groups program and as a result there were increased numbers and consistency of patient therapy groups. The dependence of the model on having students all year round also means the university may have the opportunity to provide greater numbers of consistent student practice placements. Conversely, the reliance on students leading the groups program means there is a risk the model may be unsuccessful or may impact on service provision if student placements are not able to be filled, a student underperforms, or a placement is ceased early. The literature on peer learning raises the mismatched level of performance between students as a potential risk in practice education (Baldry Currens & Bithell, 2003). For example, this could result in uneven distribution of the student workload and increased supervision demands on practice educators. These risks did not emerge in the findings of the present study.

Limitations and directions for future research

In qualitative research the potential for bias needs to be considered, and in this case the first and third authors were closely involved in the development of the model and evaluation processes. The first author was also involved in supervision of students during the pilot. The third author facilitated the focus groups and as such there is a possibility that participants may have felt influenced to report positively given the facilitators vested interest in the program. However, involvement of this nature is inherent in participatory action research. Measures were taken to minimise potential for bias including opportunity for focus group participants to provide feedback anonymously, transcript review by and discussion with an independent researcher, and the completion of self-reflections. One challenge with action research is that researchers are

participants and in this case it was important to be conscious that involvement in the development of the model may have positively influenced results. For this reason, consultation with key external stakeholders (including departmental directors and the university) was essential.

The findings indicate that the Student-Led Groups Program model was perceived positively by key stakeholders in this setting, an inpatient brain injury rehabilitation unit. This setting is a highly structured rehabilitation environment where occupational therapy has a specific role. In addition to this, the department has a long history of providing student practice education, the team has experienced supervisors and access to a clinical education coordinator, there are well established local resources for students, and ongoing university support exists for practice education; these factors may have impacted positively on implementation of the model. The Student-Led Groups Program model was specifically designed for this setting and as such may require modification or adaptation to meet the environmental or resource requirements of other settings. Other limitations of the study include small participant numbers at a single site during the pilot implementation and evaluation, with this paper presenting findings of the first cycle of participatory action research. Further research is needed to determine the feasibility of the model in other clinical settings.

V CONCLUSION

In conclusion, multiple benefits of the Student-Led Groups Program model were identified by key clinical service provider and university stakeholders and the model of practice placement has continued to be implemented in the investigated setting. The Student-Led Groups Program model could be a viable model of practice placement in other similar settings to offer greater numbers of high quality practice placements and increased occasions of service to clients.

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Declaration of Interest

The authors report no declarations of interest.

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