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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Facilitating person-centred learning between nursing students and clinical supervisors in practice: guideline and programme development

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Abstract

Background: Current literature is silent regarding the steps required to facilitate person-centred learning in practice between students and their clinical supervisors. This participatory person-centred inquiry was undertaken to address that gap and was underpinned by the theoretical perspectives of transformational learning and person-centredness.

Aim: This research study aimed first to identify the essential steps for effective facilitation of person-centred learning between nursing students and clinical supervisors in the practice context, and second, to develop a guideline as the basis for a person-centred education programme for clinical supervisors.

Methods: The study methodology was aligned to the principles of person-centred research, which are participatory and transformational in intention. The associated methods were embedded in critical dialogue and critical creativity, including the use of art to explore the experiences of the clinical supervisors. The information gathered was synthesised using a creative hermeneutic approach.

Findings: Seven steps were identified: crafting healthful relationships; meet and check-in process; daily interaction and supervision; feedback in the moment; critical conversation; group debriefing; check out; and completion of the placement. Finally, to embed the guideline in practice learning, a person-centred educational programme for clinical supervisors was developed.

Conclusions: Embedding guidelines for person-centred facilitation of learning in practice provides a basis for the education and practice of clinical supervisors. Further research is required to include the student voice in this process.

Implications for practice:

- The person-centred facilitation of learning between nursing students and their clinical supervisors in the practice context is a shared responsibility
- The seven steps to person-centred facilitation of learning enable person-centred learning for both nursing students and clinical supervisors
- Further research on the impact of the seven steps is required, with a focus on the voice of nursing students regarding their role

Keywords: Clinical supervision, facilitation, person-centred curricula, clinical placement, practice-based learning

Introduction

The impetus for the person-centred inquiry presented here came from the findings of a participatory literature review entitled 'How do we consider the impact of clinical supervisor education?' (Mackay et al., 2019). That review identified a gap in the literature regarding what constituted the essential elements (or steps) required to facilitate learning between nursing students and clinical supervisors in the practice context. Both the earlier review and this person-centred inquiry were undertaken in the exploratory phase of a larger PhD research study, entitled *An Exploration of How Healthful Relationships between Students and Clinical Supervisors Influence Transformational Learning: A Person-Centred Inquiry* (Mackay, 2020).

Following completion of the participatory literature review, a further search of grey literature was undertaken for any 'how to' guides for clinical supervisors on effectiveness in their role (Mackay et al., 2019). Although there were models of clinical supervision and practice support (Bradley et al., 2012; Health Education and Training Institute (HETI), 2013; Jack and Hamshire, 2019) describing overarching principles, no evidence was found of a guideline that explained the 'how to' or the essential elements (skills and actions) required for the role. This contributes to the current inconsistency and uncertainty around what is required to prepare nursing students for the realities of practice (Mackay et al., 2021). The research presented here has resulted in the development of a guideline that outlines seven steps for facilitating learning in clinical practice for nursing students and their clinical supervisors. The guideline also provides a framework for the development of learning and teaching resources to prepare clinical supervisors to be effective in their role.

Background

Context

The context of this person-centred inquiry was a metropolitan university in New South Wales, Australia. The pre-registration nursing degree is offered across six geographically disparate campuses on the state's south coast. Nursing students at the university undertake 840 hours of clinical practicum throughout their three-year degree. In accordance with Australian accreditation requirements, all clinical practicum must be supervised and assessed by a registered nurse, referred to at this university as a clinical supervisor (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2019).

The significance of the role the clinical supervisor in supporting nursing students to achieve optimal learning is recognised in the literature (Levett-Jones and Lathlean, 2009; Courtney-Pratt et al., 2012; Needham et al., 2016; Cooper et al., 2020; Rosina et al., 2021). In the Australian context, the role is largely undervalued (Mackay et al., 2014; Needham et al., 2016). Clinical supervisors are registered nurses who are employed on a casual basis, resulting in a lack of consistency in the operationalisation of the role. Each individual institution manages the education and support of clinical supervisors and currently there are no consistent approaches (Giddens and Eddy, 2009; McAllister and McKinnon, 2009).

Internationally, there is no agreed model of clinical supervision for nursing students in clinical practice (Needham et al., 2016; Rosina et al., 2021). The school of nursing where this person-centred inquiry was based uses the term 'clinical supervisor' for all registered nurses who take on supervision and assessment of students in practice. There are two models in place. The first is 'clinical facilitators', registered nurses who are casual academics employed by the university and have a role in supervising and assessing students in practice. Each is allocated eight nursing students. The second model is referred to as 'preceptor' – registered nurses who work for our host health provider organisations and provide the overarching supervision of students in practice. The university reimburses the host provider for the hours of clinical supervision. In this model, a designated preceptor is assigned to each student for the duration of their clinical placement and the students' supervision and assessment is generally shared between the preceptor and buddy registered nurses who work with students at the point of care. The buddy in both models is the registered nurse who works at the bedside with the

student in practice for a designated shift allocation. This nurse may change on a shift-to-shift basis and the role may include some assessment of students in practice. For this study, the collective term 'clinical supervisor' was used to describe the registered nurse who holds the role of supervision and assessment of student nurses in the clinical practice context.

Theoretical underpinnings

Three key theoretical perspectives underpin this person-centred inquiry: the Person-centred Practice Framework (McCormack and McCance, 2017); solution-focused nursing (McAllister, 2003); and Facilitation on the Run (FoR; Hardiman and Dewing, 2014; 2019).

There is a move in the development of pre-registration curricula towards person-centredness (Dickson et al., 2020). In the Person-centred Practice Framework, it is underpinned by the principles of human freedom, choice and responsibility, holism, different forms of knowing and the importance of time, space and relationship (McCormack and McCance, 2017). The definition of person-centredness has been broadened to consider humanising healthcare as:

> *...an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by the values of respect for persons, individual rights to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development* (McCormack and McCance, 2017, p 3).

Healthful relationships in this context are evident when decision making is shared, staff relationships are collaborative, leadership is transformative and innovative practices are supported. They are seen as the ultimate outcome in developing workplace cultures that are person-centred (McCormack and McCance, 2017). The understanding of healthful relationships between students and their clinical supervisors was the focus of the larger research project, which found that knowing self to enable belonging and respecting personhood are fundamental. The ultimate outcome of crafting healthful relationships is persons experiencing a sense of being in practice together while encouraging each other to reach their full potential (Mackay, 2020). The creation of healthful relationships requires a level of emotional literacy and Brackett (2019) discusses the concept of emotional intelligence as having a self-awareness of our emotions and our response to those emotions. The concepts of person-centredness have been woven through the research process, the development of the guideline and the development of an education programme.

Solution-focused nursing provides the platform for working in strength-based ways with students. In this model, clinical supervisors work with students through authentic engagement and consider them as the experts in their educational journey (McAllister, 2003). Underpinning the principles of solution-focused nursing is an emphasis on the person rather than the problem; language is hopeful and future focused, and issues identified are seen as temporary (McAllister, 2003). Believing that people have the capacity for positive change and that a small change can bring about a profound difference is a fundamental premise of this model. McAllister (2005) argues that solution-focused ways of working are supported by transformational learning. Within the practice context, transformational learning includes seeing and doing in effective ways, noticing the overlooked, seeing strengths and possibilities and acting with, rather than for, people. Being future focused and providing positive solutions in our ways of being enables nursing students and clinical supervisors to be person-centred in their approach to creating healthful relationships and in person-centred learning.

FoR (Hardiman and Dewing, 2014; 2019) is underpinned by the Person-centred Practice Framework (McCormack and McCance, 2017) and describes a process for person-centred learning in clinical practice. It aligns with strengths-based (solution-focused) ways of working through an emphasis on identifying strengths and valuing the person as an expert in their learning. The FoR model has been

developed as 'stepping stones' for the development of facilitation skills from a novice to an expert critical companion (Hardiman and Dewing, 2014). There are two key elements in FoR: Critical Ally and Critical Friend. Clinical supervisors and nursing students need to work together collaboratively and determine the level of their relationship by considering how to establish the prerequisites of creating facilitative learning relationships outlined in the Critical Ally model. This ensures there is an intentional and facilitative basis to establishing the relationship. Once the prerequisites have been established, the FoR model provides guidance for the appropriate strategies to bring about person-centred outcomes and help create person-centred learning (Hardiman and Dewing, 2019). The Critical Ally model has been chosen as the best fit for this research study as it focuses on novice learning relationships (Hardiman and Dewing, 2019). The learning relationship between nursing students and clinical supervisors is a short-term one and would rarely, if ever, reach the maturity of a Critical Friend relationship.

Much is known about transformational leaning in the classroom setting, but comparatively little about this concept in the context of person-centred learning in practice. Mezirow's research and evidence (2009) supports transformational learning in the form of curriculum and takes this to a teacher-based educational setting. Transformative learning theory as described by Mezirow (1978) is realised when a learner transforms their understanding (or learning perspective) with a new awareness of their existing understanding (meaning schemes) and creates an awareness of their current assumptions (meaning perspectives). The reality and complexity of clinical practice presents disorienting dilemmas to nursing students and clinical supervisors. Transformation of understanding occurs when a person is faced with such a dilemma; new perspectives are created through critical reflection and critical dialogue exploring the dilemma (Mezirow, 1990). Person-centred learning is argued to be transformative in its intention (Dickson et al., 2020). The wider research in which this person-centred inquiry sits aims to add evidence to person-centred transformative learning in the context of clinical practice.

Aims

The aims of this research are to:

1. Identify the essential elements (or steps) required for the effective facilitation of person-centred learning between nursing students and clinical supervisors in the practice context
2. Develop a guideline as the basis for a person-centred education programme for clinical supervisors

Methodology/methods

Ethical approval

Ethical approval was granted via the university's human research ethics committee. The research was approved as low-risk for ethical issues. Power was considered as a significant ethical issue due to the first author (MM, PhD candidate) and second author (CJ) holding leadership positions in the school of nursing and providing governance for the clinical placement portfolio (Polit and Beck, 2017). Clinical supervisors who work for the university could perceive the academic staff as having power over their employment, as they work on a casual basis. To mitigate this, the authors were not present for information collection during the person-centred inquiry process. To gain consent for participation, the two authors left the room while a third academic (who was not an investigator in the research) provided information to the group, and clinical supervisors were given time to leave the room before the authors returned.

The researchers have purposely chosen not to be insiders or outsiders but rather researchers who find the space within the research in a way that is right for themselves and for the study participants (Kerr and Sturm, 2019). It is argued that all persons have the right to determine their own personhood, and that collectively, all persons have the right to participate in research in a way that is right for them. The researchers' commitment was to undertake the study in an authentic way.

Methodology

This person-centred inquiry was embedded within the concept of critical creativity (McCormack and Titchen, 2006) through practice development. Practice development considers the use of critical creativity through active learning to raise consciousness of issues that require people to contemplate and problem solve (Dewing, 2010). It has been argued that the use of person-centred and action-oriented approaches to research brings about enlightenment and emancipation of communities (McCormack and McCance, 2017). Person-centred research is participatory and transformative in nature and therefore the inclusion of critical creativity, with clinical supervisors as experts in their practice, was fundamental to unlocking the steps required for the facilitation of learning between nursing students and their clinical supervisors in the practice context (McCormack et al., 2017).

The inquiry was conducted over a six-month period. The timeline (Figure 1) included the collection of information from the workshops and the development of the guideline for facilitating learning between nursing students and clinical supervisors in clinical practice.

Figure 1: Research process timeline

Methods

The methods used in this research include critical creativity (McCormack and Titchen, 2006) and critical dialogue (Harbermas, 1987) in a workshop setting. The research had three stages, as outlined in Figure 1: participant recruitment and information collection; guideline development and validation with participants; and development of the education programme.

Participant recruitment, and information collection and analysis

The recruitment and the collection of information occurred as part of the regular twice-yearly educational workshops for clinical supervisors. Participants, as described above, were all registered nurses who worked in the capacity of clinical supervisors with nursing students in practice. During the workshop, information on the research process and requirements was provided, and clinical supervisors who did not wish to participate were able to leave temporarily. In total, 110 clinical supervisors agreed to participate in information collection from six workshops. One workshop was held at each of the six campuses where the nursing degree is offered, and the participants included clinical supervisors from rural, regional and city areas.

The term information collection is being used rather than data collection as this is consistent with person-centred qualitative terminology (Mackay, 2020). Collection was undertaken using critical creativity (McCormack and Titchen, 2006) to create a shared understanding of the optimal clinical

supervision experience from the perspective of the clinical supervisors. The researchers invited the participants to paint their individual experiences of optimal clinical supervision on a large white sheet. Once all had completed their contribution, time was given for the group to stand back and consider the collage of artwork as a whole canvas. The participants then wrote words on sticky notes and placed them on the canvas. These words represented their initial feelings in regard to the optimal clinical supervision experience from viewing the collective artwork (Figure 2).

Figure 2: Collective artwork

Artwork shared with the permission of the participants

The second part of the workshop was information analysis with the clinical supervisors. This was undertaken initially using a hermeneutic analysis approach where the participants created a shared understanding through their experiences of practice (Boomer and McCormack, 2010). Hermeneutic analysis was chosen as this valued the embodied knowing of practitioners, who were able collectively to create a new understanding of the art of clinical supervision through the creative exploration of their practice (Boomer and McCormack, 2010). The unpacking of the creativity was facilitated using critical dialogue (Habermas, 1987). The clinical supervisors used the learning from the first part of the workshop as they stood around the painting and participated in critical dialogue. The second author took notes from the conversations on a whiteboard and the group validated the information collected. The validation was an essential part of the process, to ensure the understanding of the salient points of clinical supervision were captured accurately in the words of the participants.

Guideline development and validation with participants

Once the information was collected, the two academic researchers developed the guideline entitled 'Facilitating learning between students and clinical supervisors in practice'. The clinical supervisors attending the research workshops validated the descriptions of the seven steps by offering advice and comments. The term 'subject coordinator' is used in this guideline; this is an academic staff member at the university who coordinates the workplace experience subject the student and clinical supervisor are enrolled/employed in.

Development of an education programme

The essential elements or steps that emerged from the information collection were then used as the guide for the education of clinical supervisors during the two compulsory workshops they attend each year.

Findings

Education programme development

An education programme that included two workshops was established following the development of the guideline. The first workshop was an introduction day for all new clinical supervisors. This workshop starts with a plain language exploration of the theoretical underpinnings of the guideline: person-centred practice (McCormack and McCance, 2017); solution-focused nursing (McAllister and McKinnon, 2009); and FoR (Hardiman and Dewing, 2019). It then uses practice development principles and creativity to explore each of the seven steps of the guideline individually.

The second workshop is an update day and was designed in consultation with clinical supervisors. Prior to this workshop, the clinical supervisors are presented with eight topics related to issues that have arisen between workshops and asked to number them from 1 to 8, with 1 being the topic they view as carrying the highest need for learning and growth. The issue of highest need is collectively agreed and aligned to one or more of the seven steps used to create the workshop (Mackay et al., 2014). This workshop is for all clinical supervisors, including those who are new to the role, and aims to update them with information to support their role in the upcoming clinical placements.

Guideline development and implementation

The words that the clinical supervisors shared following their reflection on the artwork as a whole have been put into a wordle in the shape of a key. The words provide the key to the effective facilitation of learning in practice (Figure 3).

Figure 3: Key to effective facilitation of learning in practice

The initial information collection resulted in the development of a six-step model that was used with clinical supervisors in practice in the academic session following the workshops. They provided feedback at the educational workshop following the academic session. The experience of the clinical supervisors in practice and the outcome of the larger PhD research project added a further step, which has now become Step 1 – Crafting healthful relationships.

Feedback from clinical supervisors following the implementation of the education programme and their trial of the guideline in clinical practice resulted in their identifying enablers and barriers to its use in the reality of the practice context. The enablers and barriers identified in Table 1 were shared by clinical supervisors. Overall they rated creating relationships with students as the most important part of enabling the facilitative or healthful (supervisory) relationship, which became the additional step in the guideline.

Table 1: Enablers and barriers to the effective facilitation of learning in clinical practice

Enablers	Barriers
• Planning: preparedness for facilitators; planning with students; student's motivation; communication; recognition of benefits using the steps in practice; be with the student; plan beforehand; be mindful with the student in clinical activities; role model • Personality: personal values of respect; the desire to build trust and a relationship with the students and to remind them we are around for them; knowledge, be well informed of what you're required to do; principles of working, understanding your role and value • Education: feeing better informed to follow the university guidelines; developing, skills and knowledge, experience; workshops on current issues; experience; transfer knowledge, confidence, preparation; being more informed about how to help students in setting goals/expectations; developing skills in critical thinking; being aware of guidelines • Support: meet and greet; establish the ground rules first then ask what they expect of me; seeing that all students have increased their tool kit • Communication: agreement with students; patience; individualisation; increased skills in conducting critical conversations; group debriefing, getting each student to talk and have them start first or second; belief in the learning process; clarity of expectation of guidelines; knowledge, communication, reflection, ability to speak the truth with tact; have a plan to start the facilitation process; appropriate resources, sufficient time; student/facilitator motivation; supportive ward environment • Trust: time management; empathy; support from nursing staff; willingness of students to engage; communication from university and facilities, accessibility; availability; appropriate resources, time; motivation from myself and students; appropriate space	• Communication: lack of communication; different mentality; personalities; lack of student's cooperation; failed relationship with students; poor planning • Knowledge: lack of knowledge; updated knowledge; communication; students don't understand guidelines • Priorities: competing priorities; having to spend more time with one or two students • Personalities: peer pressure i.e. bullying; not trusting own ability; unpreparedness; lack of engagement with the student; students who do not engage in the conversation; students want to leave early; lack of experience; challenging students • Facility: group debriefs are not well organised at times due to wards; facility resistance, available space; privacy and environment; having different placements and not seeing all students together; lack of space environment; lack of time; unmotivated student/facilitators; finding a suitable talking space • Time: appropriate time; time to support/work with; time poor; preparation; workload; check out and completion of placement barriers; taking a long time with some students and then not having enough time to spend with others

Following the consideration of enablers and barriers, the outcomes for students and clinical supervisors were considered, and the clinical supervisors, from their perspective, believed learning was enhanced for the students and themselves.

Table 2 – Outcomes from the guideline implementation

Outcomes that were realised in practice from the perspective of the clinical supervisor	
For nursing students Feeling more motivated • Motivated, enthusiastic, confident, relaxed, engaged • Feel more an active part of the nursing team • Fosters creativity Valued and respected • Feel more valued and respected • Trust is improved Increased learning • Willingness to learn • More reflection • Courage to ask questions • Take ownership of their own learning • Improved problem solving • More critical thinking and clinical judgement • Better decision making and clinical analysis • Promotes lifelong learning • Feel like they belong • Fosters interest in career in that area	**For clinical supervisors** Better able to undertake role • Job satisfaction • Courage to ask • Professionalism • Preparedness • Knowledge about assessment Improved communication • Open channel of discussion • Broaden support networks • Supports relationships with the ward

The final seven-step guideline is as follows. Its intent is to offer considerations and guidance for good practice when working with students in clinical practice.

Step 1: Crafting healthful relationships
The process of crafting healthful relationships is a continual one that starts as students and clinical supervisors prepare for the context of practice and proceeds throughout the placement period. In the knowing or learning phase of person-centred transformational learning, students and clinical supervisors should be prepared to consider the 'knowing self' prerequisite from the Person-centred Practice Framework (McCormack and McCance, 2017) from the perspective of their values and beliefs. They should also be challenged to accept differences and respect individual personhood. Consideration of creating healthful relationships also requires students and clinical supervisors to be exposed to emotional literacy skills and be challenged to consider their reactions and responses to differences. Critical reflection and critical dialogue provide the conduit for learning to take place amid the turbulence of practice and for this learning to be transformed into purposeful turbulence where learning occurs.

Step 2: Meet and check-in process
There is no requirement for students or clinical supervisors to contact placement facilities before the start of the placement. Day 1 instructions are outlined in the facility information (online) for both groups. The provision of orientation is the health provider's responsibility and should be carried out before students undertake clinical care wherever possible. Clinical supervisors are responsible for ensuring students receive orientation at the start of their clinical practicum or as soon as possible on the first day of the placement. It is expected that the clinical supervisor will be present at the orientation process for students.

Within the check-in process, students and supervisors are expected to establish the prerequisites of their facilitative healthful (supervisory) relationship. It is at this stage of the guideline that the student and supervisor consider the establishment of the prerequisites of the Critical Ally model (Hardiman and Dewing, 2014; 2019): mutual respect, shared values, preparedness and authentic presence, as a minimum. Healthful relationships are to be explored in terms of acknowledging shared leadership and joint responsibility to learn from each other. Students should initiate a conversation with their clinical

supervisor in which they will share their values, feelings and expectations to establish ways of working. It is important to undertake conversations that cultivate trust and respect by being authentic and inclusive of individuality. The initial conversation should include a strengths-based approach to self-assessment, where the student identifies their strengths and their opportunities for improvement against the Nursing and Midwifery Board of Australia's registered nurse standards for practice (2016). Following this conversation, the student's individual learning objectives should be completed, using the identified strengths and opportunities for improvement. Students should be encouraged to identify a learning outcome they would like to address, related to their clinical context. This process is embedded within a strengths-based approach that enables the student to develop strategies to address the issue that are measurable and help them meet their individual learning requirements.

Step 3: Daily interaction and supervision

The daily interaction between students and clinical supervisors should include a conversation with the registered nurses they are working with. Students should have the opportunity to identify their goals for the day with their clinical supervisor and buddy RN. Conversations should include critical questions and seeking examples of practice to explore. It takes courage to provide honest feedback; this feedback should be sought regularly – daily if possible – in conversations with the both the student and the buddy. The conversations should respect the personhood of others and try to see the person behind the title.

Clinical supervisors should role model and articulate person-centred practice. The use of gentle language, with consideration of tone and body language, is encouraged. The focus of the strategies that clinical supervisors implement in daily interactions and supervision should be on achieving the outcomes of the FoR (Hardiman and Dewing, 2019) and the Person-centred Practice Framework (McCormack and McCance, 2017). Consideration should be given to ensuring the prerequisites of the Critical Ally are still in place or deciding if they need to be revisited. The strategies for the FoR model that best suit the relationship should be agreed between the clinical supervisor and the student.

The daily interactions should support challenging what is known about oneself to enable supervisor and student to have the courage to be authentic in their actions and behaviours. As with the initial conversation in Step 2, daily conversations should take a strengths-based approach to self-assessment. The student's individual learning objectives should be included in the daily review of progress. Any issues identified are to be raised straight away with the subject coordinator, who is to be seen as an internal stakeholder in supporting students to be successful within their placement.

It is essential to provide formal documented feedback at the midpoint of the placement experience. Person-centred feedback should be given using a strengths-based approach. Issues must be raised in advance of the assessment with the student – in consultation with the subject coordinator if they are to be included in the assessment.

Step 4: In the moment feedback

In the moment feedback should be provided on a daily basis in the clinical setting. It is important to do this in strengths-based ways that enable the student to lead the conversation and explore their strengths and opportunities for improvement. Examples of practice should be used to support feedback. Clinical supervisors should ensure they provide critical feedback that identifies where the student is performing well and their opportunities for improvement against the NMBA standards (2016). We would encourage both students and clinical supervisors to have a voice in providing in the moment feedback, which should be given with gentle language that is hopeful, future focused and suggests any problems identified are temporary (McAllister, 2003; Hardiman and Dewing, 2019). In the moment feedback should foster the creation of relationships that are vulnerable and brave and encourage persons to optimise difference.

Step 5: Critical conversations
Individual critical conversations should form part of the daily supervision between the clinical supervisor and student, and take place in a private location. This conversation should encourage the student to think out loud and identify strategies to enable them to develop a deeper understanding of themselves, the nursing profession and the specialist area of practice they are currently experiencing. Critical conversations should be conducted in a way that enables both students and clinical supervisors to have a learning (asking) lens rather than an expert (telling) lens. The use of enabling questioning via the CARE Framework (Martin, 2016) is encouraged to explore the issues raised.

Where concerns are raised regarding the students' ability to meet the required level of knowledge and skills in their placement, feedback is to be documented in consultation with the clinical supervisor using the student performance improvement plan, developed as part of this project. This form should enable the student to identify their own strategies for improvement.

Any concerning issues identified are to be raised straight away with the subject coordinator, who supports the student to be successful in their placement. This feedback should be documented as above and in consultation with the subject coordinator using the student performance improvement plan.

Step 6: Group debriefing
Group debriefing occurs in placements where multiple students attend and should include a group of students meeting to explore practice issues and help each other to develop solutions that are specific to the context of the care environment and inform their future practice. These sessions form an integral part of the facilitation of student learning in clinical practice; their timing needs to be negotiated with the wards/services and should be at least weekly. Students from all year groups should be encouraged to attend. Importantly, in group debriefing, students and clinical supervisors need to enable each other to move towards discomfort by co-creating shared ways of doing and being with each other. The process should use the enabling questions of clarifying, reflecting, challenging and probing and action (Martin, 2016).

Time should be spent creating a safe space for students to share their practice experiences (Brown and McCormack, 2016). Each student should identify a challenge they have faced within practice and then the group should reach an agreement on which example will be explored. Students should lead the enabling questions. The clinical supervisor should provide feedback and ensure that the conversation follows the CARE framework questions (Martin, 2016) and that the students remain safe within the space. Once the conversation reaches a natural closure, a process check should be completed and the students should have the opportunity to provide feedback on how the experience was for them.

Step 7: Checkout and completion of placement
Towards the end of the placement, each student should ensure all relevant documentation is completed. Students are responsible for ensuring all their requirements have been met and all their assessments are completed and signed. Clinical supervisors are responsible for completing all required paperwork and for communicating honestly with the student regarding the placement experience.

Students and clinical supervisors should have a conversation to conclude the placement, with both having the opportunity to provide feedback on their overall experience. This conversation should be in a safe place where both parties can be courageous and honest. It should start with what worked well and then progress to any challenges and barriers. Any issues raised that cannot be resolved by either party should be referred to the subject coordinator for consideration and support. Checkout includes a conversation on the supervisory relationship that is open and honest. A place to start is considering that a healthful relationship is evident when persons experience a sense of being in practice together while supporting each other to seek their full potential.

Discussion

Although many universities have attempted to integrate person-centredness into curricula, the current reality is that it is 'largely sporadic, inconsistent in approach and operating at different degrees of explicitness in terms of the representations of person-centred concepts, theories and principles' (McCormack and Dewing, 2019, p 1). The collaborative approach undertaken in this person-centred inquiry resulted in the development of a seven-step guideline that clarifies and operationalises the requirements for facilitating learning in practice. The development of the guideline has been an iterative process and the document remains live and open to further change. The guideline addresses the first aim of the research by adding a new understanding to what is known about the steps needed for effective facilitation of learning in practice between students and clinical supervisors.

Reflecting on the experience of the university that hosted this research, the implementation of a person-centred curriculum is a slow, iterative process that occurs over time. O'Donnell and colleagues (2020) argue for a need to move beyond mediocrity and suggest academic staff are ready and willing to challenge traditional approaches to learning and teaching, and open to embracing person-centredness. In an attempt to grow and embrace person-centred language, the most recent update to the guideline has a name change from 'Clinical supervision of students in practice guidelines' to 'A guideline for facilitating learning between students and clinical supervisors in clinical practice'. The change is subtle but it is critical in the continuing move towards person-centred curricula. The revised name underlines the shared responsibility between nursing students and clinical supervisors for learning in practice.

The second aim of this research was to develop a guideline that would provide the basis for the development of a person-centred education programme for clinical supervisors. The design of the two workshops is now underpinned by the guideline, giving the education a structure and purpose. Universities have a role in preparing clinical supervisors (Needham et al. 2016) and this research proposes that this preparation needs a focus on person-centred facilitation of learning in clinical practice. This consistency with the guideline that they work with would help give subject coordinators and clinical supervisors a shared understanding of the expectation of the roles. This consistency also addresses the prerequisite of being professionally competent within the Person-centred Practice Framework (McCormack and McCance, 2017). Nursing education programmes need the courage to be person-centred and prepare their clinical supervisors and nursing students to be emotionally literate and self-aware so they can engage authentically (McCormack and McCance, 2017; Brackett, 2019).

The limitation and strengths of this research study relate to the messiness and muddiness of undertaking person-centred research (McCormack et al., 2017). The information collected was limited by the individual interpretations of clinical supervisors and their perceptions of their practice (Polit and Beck, 2017). These limitations are also a strength of person-centred research; their experience of practice and context are valued and their expertise adds to the richness of information collected in a person-centred inquiry (McCormack et al., 2017). Person-centred research accepts there is more than one reality, and the learning from this research may enable curriculum development in other contexts (McCormack et al., 2017). Finally, and in line with person-centred research approaches, another limitation of this research is that it represents only the voice of the clinical supervisors. Further research is required to authentically include the voice of the nursing students as equal partners in the guidelines for the facilitation of learning in practice.

Conclusions and implications for practice

The key learning from this research has been that critical creativity holds the key to unlocking clinical supervisors' expertise in their own professional role of supporting students in practice. The participants in this research actively engaged with creativity and used their discomfort to unpack and share their wisdom. Researchers need to be cautious about holding assumptions about participants' ability and believe that all persons have gems within them that are needed for innovative practice improvement. The next step in this process is to gain the nursing student perspective on the guideline and be open to learning from their wisdom and embodied knowing.

The development of the seven steps in the guideline has enabled an understanding of 'how to' enact the role of the clinical facilitator. A comment that is often heard is that the role is ambiguous and that clinical supervisors are unsure of the expectations others have of them. The guideline has the potential to provide clarity for clinical supervisors, host organisations and students. Embedding this guideline requires student preparation for practice so that students and clinical supervisors have equivalent information on how to craft healthful (supervisory) relationships and thus be in the best position for shared learning to occur during the placement.

The developed guideline contributes to what is known about person-centred curricula in the non-classroom setting. Further research is required to enhance these research findings on the facilitation of learning between students and clinical supervisors in other practice contexts and across other disciplines. This research will enable students and academics to embed person-centredness in learning within the practice context.

Finally, being open to feedback from many voices also enables the ongoing development of a person-centred curriculum. Student feedback has challenged the academic researchers to include them in the future consultative process. The researchers have learned from the omission of the student voice in the guideline development, and students will be included in the future development of curriculum learning and teaching resources.

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