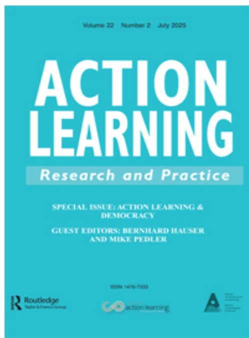

Action Learning: Research and Practice

ISSN: 1476-7333 (Print) 1476-7341 (Online) Journal homepage: www.tandfonline.com/journals/calr20

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To cite this article: Andrew Clark, Lorna Chesterton, Melanie Stephens, Siobhan Kelly, Susan Walker & Angelina Chadwick (05 Oct 2025): Facilitating an action learning community of practice in the delivery of an interprofessional education programme in care homes, Action Learning: Research and Practice, DOI: 10.1080/14767333.2025.2557916

To link to this article: https://doi.org/10.1080/14767333.2025.2557916

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Published online: 05 Oct 2025.

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ACTION LEARNING: RESEARCH AND PRACTICE
https://doi.org/10.1080/14767333.2025.2557916

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Facilitating an action learning community of practice in the delivery of an interprofessional education programme in care homes

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ABSTRACT

This paper presents insights into the experiences of supporting Action Learning Communities of Practice to deliver an interprofessional training scheme in care homes for older people. It draws on original interview data with facilitators in which they discussed their experiences of taking part in Action Learning Community of Practice sets held over separate cycles of a longitudinal study. The role of facilitators on interprofessional education programmes delivered in the care home sector receives little attention despite its potential to build capacity, resilience and the sustainability of interprofessional education. This paper presents novel insights into how care home staff, supported by academics, can successfully transition into facilitator roles through legitimate peripheral participation to ensure the long-term sustainability and resilience of interprofessional training schemes. Used in the delivery of student training in the care home sector, and with appropriate facilitation, Action Learning Communities of Practice can be beneficial to care home staff, service delivery and care quality.

ARTICLE HISTORY
Received 13 February 2025
Accepted 29 August 2025

KEYWORDS
Community of practice; facilitation; care homes; social care; student placements;

Introduction

Care homes are a fundamental part of the UK health and social care system, providing a home to almost 300,000 older people (ONS, 2021), a number projected to rise by 127% over the next 20 years (Devi et al. 2021). Care home staff are a dynamic and highly skilled workforce, adept in navigating complex physical, mental and emotional health needs amidst rising resident acuity, multimorbidity and poly-pharmacy (Barker et al. 2021; Skills for Care 2021). As such, the UK care home sector presents a valuable setting for Action Learning Community of Practice (ALCoP) facilitation, enabling students from multiple disciplines to engage in interprofessional and collaborative learning.

Interprofessional Education (IPE) is a process whereby students of different professions learn from and with each other to improve communication, collaboration and the quality

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of care (WHO 2010). Delivering IPE within care home settings offers a practical and impactful opportunity to strengthen health and social care systems (WHO 2010), support effective multidisciplinary working and enrich student learning experiences (Kelly et al. 2023; Stephens et al. 2023). There are multiple ways of facilitating collaborative learning in IPE, including problem-based, case-based, and team-based learning; simulation; student-led clinics; small group tutorials, large classes; and self-directed learning. Common to all is that students are active learners. IPE can enhance engagement, increase accessibility, foster critical thinking and aid reflection as well as teamwork and communication (Hammick et al. 2007). However, the delivery of high-quality care requires synthesis of professional and technical knowledge along with the skills of care-givers in the care-delivery processes (Wilcock, Janes, and Chambers 2009).

In this paper we examine the role of ALCoP facilitators involved in the development and delivery of IPE in the older age care home sector. The paper offers new insights into the experiences of facilitation in IPE in care home settings, though we contend that there is wider learning to be gained from understanding how ALCoP recalibrates power dynamics between academics, staff and students in any environment where IPE is delivered. ALCoP has the potential to build longevity and sustainability into student learning opportunities that might otherwise be funding dependent and time limited. It can contribute to clearer structures for the support and development of clinical/social care-based staff involved in placement education and prevent practice learning from becoming mere uncritical repetition of the observation of practices during placements.

Conceptual context and existing research

Action Learning can support experiential learning, foster critical reflection, and promote peer-to-peer learning (Winterburn, 2022). It has been deployed for quality improvement within the UK's National Health Service (NHS) since at least the 1960s (Brook 2010). Action learning initiatives have contributed to advancements across various areas of healthcare, including improved management of polypharmacy among practitioners (Brooks et al. 2022); the development of leadership and management skills for planning, supervising, implementing, and evaluating healthcare services (Edmonstone 2018); and the promotion of person-centred care in medical emergency wards (Dellenborg, Wikström, and Andersson Erichsen 2019).

However, the implementation of Action Learning in the care home sector remains under-explored (Penney et al. 2017), though it has supported the development of end-of-life care initiatives. Dewar and Sharp (2006) found it a useful collaborative mechanism to help people working in care homes articulate issues in relation to changing practice, and Booth and Nash (2013) reported that Action Learning can empower managers to take an active leadership role. Hewison, Badger, and Swani (2013) suggested that its use can lead to more consistent use of care plans, increased involvement of residents and their families in planning end-of-life care, more training for staff, and the use of events and techniques to create opportunities for discussing end-of-life. Indeed, Action Learning can also enable care home staff to think differently about how they care, spending more time with them and doing small things that can make a big difference to quality of life (Kelly et al. 2023; Penney et al. 2017; Stephens et al. 2023). Action Learning can thus enable care home managers and staff to value the care they deliver whilst identifying areas for change.

IPE has been used more frequently than Action Learning in care home settings, mostly in one-off activities such as the development of care or treatment plans (Svensberg et al. 2021), shadowing staff and residents (Laukner et al. 2018; Seaman, Bulsara, and Saunders 2015), attending or participating in case conferences, home rounds or information sessions (Damsgård et al. 2018; Mason, Hunt, and 7 Kane 2021; Seaman, Bulsara, and Saunders 2015), or attending end-of-life care programmes (Weisse and Melekis 2021). IPE schemes are more often designed to evaluate the student experience, overlooking the experiences of care home staff and residents, and rarely considering the facilitation of IPE (Kelly et al. 2023). To the best of our knowledge, there are no published accounts explicitly examining the experiences of those facilitating Action Learning to promote IPE in care homes, though there are allied studies (Penney et al. 2017).

Underpinning the Action Learning approach we developed are Communities of Practice (Wenger 1998). A Community of Practice brings together people who have a common concern, set of problems or passion for a topic to deepen knowledge and expertise around the issue by facilitating ongoing interaction. This facilitates knowledge sharing, increases the likelihood of changes in practice, and in some instances improved clinical outcomes (Ranmuthugala et al. 2011). In our Action Learning Community of Practice (ALCoP) approach knowledge creation is socially produced through interactions between members who share the same goals, interests or expertise. The communities we aspired to facilitate went beyond 'practice' in the direct sense of focusing on student learning, to grow a shared vision of improving care for residents as facilitators and cultivate a climate of trust in which members could learn together and develop best practices for care (Wenger 1998).

When developing a framework for a Community of Practice, Wenger (1998) highlights the need for facilitation of engagement, imagination, and alignment to allow participants to use and build upon their existing knowledge, foster commitment to each other, reflect on self, others and new situations, and overcome differences to achieve 'reification'. We developed ALCoP to create a learning environment to improve communication, collaboration and the quality of care for care home residents. We created 'activating events', to help students and care home staff to articulate and challenge their own and others' assumptions, develop skills in self-reflection, and open participants to alternate points of view by encouraging academic and professional discourse (Lonie & Desai, 2015). Thus we strove to influence community members' reactions and behaviours to change practice and resident outcomes (Read et al. 2023).

Finally, we aimed to create a sustainable placement model. Once the evaluated part of the work ended, students from across multiple professions would be still placed in the care homes so the design of a sustainable IPE placement model that could be facilitated by care home staff was essential. This would be supported by a process of legitimate peripheral participation (Lave and Wenger 1991) where care home staff would initially observe academics skilled in facilitation of ALCoP to learn research-based forms of pedagogy and move to more participation (co-facilitation), and finally take on the role of facilitator.

Study context and delivery of action learning communities of practice

Following a successful feasibility study, a longitudinal project was developed to assess the impact of an interprofessional student training scheme in 5 care homes. Over two study

periods, fifty-four students from a range of health and social care professions (including Nursing, Sports Rehabilitation, Dietetics, Occupational Therapy, Podiatry, Prosthetics and Orthotics and Physiotherapy), were drawn from 3 Higher Education Institutes in Northwest England. In each cycle, between 2 and 5 students formed an ALCoP set in one of each of the participating care homes as part of their placement cycle or volunteered to join as part of a spoke or satellite learning opportunity. There was a mix of full-time and part-time students, with placements spanning from 6 weeks to 16 weeks. IPE activity occurred during the 6-week 'overlap' period when students were on placement within the home at the same time. In total, 5 cycles of the scheme were completed. Each ALCoP comprised of students, care home staff, residents, and facilitators and met weekly to work on the residents' individual goals. With the help of the set members, the residents identified a goal they would like support with. For instance, one resident aimed to work on her confidence and mobility, and another focused on improving his diet. Set members then engaged in a cyclic process of action and reflection to consider different approaches to addressing these goals.

In practice, the ALCoP sets were referred to as 'multi-disciplinary team' meetings as some stakeholders voiced uncertainties around the complexity and meaning of the terms 'Action Learning' and 'Community of Practice'. In this paper though we retain the term ALCoP, for while the preferred terminology shifted, the core approach remained aligned with ALCoP principles outlined by Pedler, Burgoyne, and Brook (2004) and Lave and Wenger (1991).

Four university-based academics and 5 care home staff were trained to facilitate ALCoP sets. All facilitators participated in training sessions about ALCoP and were provided with a training manual on the application of concept and approach. In Cycle 1, an academic facilitator led the ALCoP sets while the care home staff observed. In Cycle 2, care home staff began taking a joint role with the academic, gradually assuming more responsibilities in facilitating the sessions. By Cycles 3 and 4, care home staff took on lead facilitation roles with the academic only providing support and guidance as needed. This phased approach ensured that staff gained confidence in facilitating ALCoP and had the time to develop their skills and knowledge. In sum, the ALCoP meetings featured:

- A person centred, and resident focused problem, concern or opportunity that requires action taken by a group.
- Four to 6 individuals who care about the issue, have the power to address it and collaborate in peer sets.
- A commitment to learning through practice and action.
- Limited formal instruction.
- Questioning to help the define the problem, goal or opportunity and then investigate, experiment and reflect on actions taken.
- Reflection and feedback on the testing of actions, reframing of assumptions, and review of learning.
- A commitment to personal learning and development.
- A facilitator who acts as coordinator, catalyst, observer, communication enabler, learning coach and critical friend (McGill and Beaty 1995).

This paper considers the final point. It presents insight into the experiences of 9 ALCoP facilitators who participated in the scheme. Insights are based on reflective interviews

with 5 care home staff facilitators and 4 academic facilitators. Interviews covered the experience of facilitating ALCoP; the positive and challenging aspects of facilitation; the impact on students, residents, other care home staff and facilitators themselves; and how the process might have been improved. Adopting a conversational approach, interviewees were encouraged to share their in-depth experiences of facilitation across the 5 ALCoP. All interviews were transcribed verbatim and anonymised. The data were thematically analysed using Braun and Clarke's (2006) six-phase approach. Transcripts were repeatedly read and re-read to ensure familiarity with the data. Anonymised transcripts were uploaded into NVivo software, and researchers identified patterns and themes from the data. Initially, researchers identified interesting features and made detailed notes on individual elements, situating these observations within the context of the entire dataset. These notes were shaped and guided by the overarching research question and the data were then coded by identifying text segments with similar meanings, enabling the researchers to organise these codes into patterns which were subsequently developed into overarching themes. The themes were reviewed by the research team to ensure coherence and credibility and were discussed and refined through a process of consensus.

We remained conscious of reflexivity throughout, and integrated discussion of this within team dynamics. In practical terms, this involved reflexive engagement by the researchers, who considered the knowledge they were producing and their own roles in shaping it while understanding that this knowledge is contextual, situated and mediated by the researcher's perceptions, values and experiences. Reflexivity was essential in acknowledging and making transparent the subjective lenses through which the data were analysed and interpreted. To lessen the risk of replicating and mirroring experiences in our discussions, one member of the team (AC) who did not act as an ALCoP facilitator led on data gathering and analysis of facilitators' experiences.

Ethical approval for the full study was granted by the University of Salford in accordance with institutional research ethics guidelines. Explicit informed consent was obtained from all facilitators prior to their participation, and again at the start of each interview that informed this paper. Participants were made aware of their right to withdraw at any time, as well as the measures in place to safeguard their confidentiality and anonymity.

Findings

We present findings around two main themes: (1) Processes of Engagement, that focuses on the initial uncertainties and anxieties of facilitators as they engaged with the ALCoP process. We discuss the learning curve, changes in mindset, and how facilitators adapted to new methods of education and collaboration; and (2) Moving Forward, where we examine the broader outcomes and impacts of the IPE scheme and consider how the project developed capacity, knowledge, and confidence among participants, including ALCoP facilitators, and students.

Processes of engagement

Dealing with apprehension

All facilitators expressed some uncertainty about engaging in ALCoP, particularly during the project planning phase and at initial meetings. They shared their concerns about how

the meetings would go and voiced some apprehension around how students would react in an environment they were unfamiliar with:

> *I'm not actually sure what I first expected when we were facilitating the meetings. I wasn't sure of the format or how the students would come forward, because it's quite ambitious for students to be involved in this, in their emerging leadership roles, when they probably haven't had any exposure to anything like this. So, I suppose my thoughts were, I don't know how people will react in this situation, because it's something that's very new to them.* (Academic Facilitator 1)

Care home staff who became facilitators reflected on their early uncertainty and the resulting anxiety they experienced:

> *I was terrified [of facilitating], if I'm honest, but only because I'm always a bit nervous of everything until I know what I'm doing.* (Care Home Staff Facilitator 6)

Despite attending workshops designed to support all groups involved in the project, facilitators still felt a degree of apprehension in the early phase. These feelings lessened with successive IPE cycles:

> *At the beginning of it, I think we were all a little bit nervous, because it was something new, we were a little bit 'how is all this going to work?', 'What will the meetings be like?'. [We were] … a little bit vague on our understanding of it all. But then when we actually did the first [ALCoP meeting] it sort of clicked, like 'oh right, this is how it's going to run'. So we got into the swing of it then.* (Care Home Staff Facilitator 7)

All facilitators were briefed ahead of each ALCoP meeting, but their initial worries remained about becoming involved in an unfamiliar process. However, their confidence grew as the project progressed, and this led to more active engagement and a deeper understanding of the process.

Developing a different mindset towards education

We observed a step change in the way that education was delivered to students, by moving from primarily didactic to student-led learning. While academic facilitators were largely familiar with and, in some cases, experienced in this approach, care-home managers encountered a form of education that differed from their expectations or previous experiences:

> *In practice, I've always loved teaching the students, so telling them all about diabetes for instance, but I had to learn to do things differently, I had to ask them questions, challenge them to find information about the resident, their condition and so on, so a really new way of doing things. To be honest I was constantly surprised by what information the students came back with every week.* (Academic Facilitator 2)

Enabling such processes meant that facilitators had to trust the ALCoP process and let go of some of their own temptations to lead the groups, as well as develop a new confidence in their own abilities as educators:

> *I've really enjoyed it, absolutely enjoyed it, in terms of being in a different environment, working across professions … And actually, you know, I'm a bit tough on myself sometimes and I think 'oh, I don't think I can do that'. But I'm proud of the work I did and the outcomes the students achieved and also the recognition … It doesn't matter people's backgrounds or what they've come to learn, if we've got a common goal which was the goal the resident chose, then you can facilitate learning in so many different ways.* (Academic Facilitator 3)

A care home staff facilitator noted that the students integrated into the staff team by working in new ways and contributing their professional expertise to the care home:

> *When we first started, there was a little bit of managing them, but they just took off. They're really good. They've become part of the team, and kind of like the staff now, because they're used to them all the time coming; there's no barriers.* (Care Home Staff Facilitator 8)

Understanding how to support student learning through ALCoP brought facilitators new skills, where they challenged and questioned the students to find information themselves and look at the latest evidence-based practice.

Facilitating collaborative working

The students involved in the project had not previously experienced working interprofessionally. ALCoP enabled them to learn about and question other students' professional scope of practice and share their own experiences with the support of facilitators. Facilitators observed how students' perceptions of each other's roles changed over time as they began to work together and think about how their individual and collective knowledge and skills could help meet residents' goals:

> *It reminds me of the novice to expert scenario, where you've got students who really were out of their comfort zone totally. All they had to rely on were their own professional values and what their remits have always been. We had a mental health nurse student who, I thought, may stick to his own comfort zone and say: 'Well, I'm only going to be interested in people's mental health and their emotional welfare', things like that. But actually, that wasn't what happened. They all came together and looked at different aspects, with a more holistic viewpoint.* (Academic Facilitator 2)

Others reflected on how the students worked collaboratively to provide holistic person-centred care:

> *The students work with the residents and set goals together. They did a full assessment of everything. [One student] did a physiotherapy assessment to see how [a resident] was moving, how he was sitting, postural, you know, things like that, and they looked into his medical history. [Another student] looked into his medications … all aspects of his care. They even looked into his sleeping care plans, or position he slept in bed* (Care Home Staff Facilitator 8)

ALCoP facilitation was shaped by a range of factors, including the structural dynamics of student placements. For example, part-time students, some of whom were present in the care home only one day per week, had fewer opportunities to engage with peers or the ongoing collaborative work outside scheduled sessions. These patterns did not reflect a lack of engagement but rather pointed to the need for facilitation approaches that could adapt to varied rhythms of participation. Engagement was influenced by a range of contextual factors beyond full or part-time student status including placement timing, competing academic demands, and prior experience. Recognising this complexity, facilitators worked to adopt flexible and responsive strategies to create inclusive opportunities for contribution and connection across the group. For example, a part-time physiotherapy student based in an Emergency Room for 4 days a week and 1 day in the care home felt that their involvement would be limited in what they could bring to the ALCoP. The facilitators supported the student to negotiate one of the days in the Emergency Room as a study day to undertake some ALCoP work in preparation for

the next meeting. The groups also set up a 'What's App' group to communicate between meetings and receive feedback on the impact of their actions as the weeks progressed.

Moving forward: using ALCoP to develop a future placement model for interprofessional education

Students from different professional disciplines came together to share knowledge, skills and experience. The benefits of this structured approach were not confined only to the students, but also experienced by residents, care staff and facilitators.

Building capacity

Building capacity was integral to the success of the project. At the commencement of the project facilitators arguably had the best vantage points from which to observe the changes in their own role, and in care home staff who were mentored into the facilitator role. They noted how over time, and with successive cycles, care home staff began to engage more proactively in guiding students and managing meetings:

> *This [initiative] has got to have longevity and resilience, hasn't it. This project is not something that parachutes in, you do your bit, and then come out. This is about giving the skills that the care home manager can continue to use on their own, so that they can [continue] to have placements for students.* (Academic Facilitator 3)

A transition in roles ensured the project's sustainability and established a foundation for ongoing benefits. After the research concluded and academic staff were no longer directly involved, the skills and practices developed through the project continue to benefit the care home environment, fostering long-term improvements and sustaining the positive impacts achieved.

Building knowledge

Facilitators built on their own knowledge base to support student learning. One facilitator felt that they needed to ensure their knowledge base was up to date so that they could discuss residents care and treatment with the students and academics:

> *It sparked my thinking again, you know, because once you're in practice you can get quite bogged down by your daily tasks and your daily routine … And obviously we revisited some clinical and some medical stuff and when [the academic facilitator] was there and she was talking to the students, we were talking about any systemic or clinical aspects, medical aspects, you know, that was nice to revisit those things … I didn't know too much about podiatry, so I got some new learning from that. And I am not a mental health nurse, so listening to the mental health nurse was insightful.* (Care Home Staff Facilitator 6)

The ALCoP meetings provided a safe space for students to bring knowledge from their individual disciplines and professions to tackle issues and work on resident goals. As facilitators gradually stepped back, students took the lead in sharing their insights and collaborating effectively:

> *It's seeing [students] coming from their own discipline knowing their own personal identity, professional identity in many ways, but not understanding other professional identity and professional roles and remits, and I think that's the beauty of it. Students start to understand where their role finishes and another one starts … When these students are emerging professionals, they go and work in clinical practice this gives them a grounding of you know,*

> *how you could involve other people and how valuable other people's resources are.* (Academic Facilitator 2)

> *My students have been brilliant for the whole [care] home. from the physio[therapist]s and sports rehabilitation students I've got exercise plans, … I had one resident with a rare condition, so they did a big plan on that to pass on to the staff … we've got an OT student, so, she's shown the care staff how to move residents, how to help them up and get their balance, to practice their steps … I listen to them because it's all new information. They're up to date on everything.* (Care Home Staff Facilitator 8)

Facilitators were motivated to enhance their own knowledge by engaging in discussions about residents' health and learning from students who introduced new professional insights and skills.

Building confidence

Facilitators observed how students used their professional skills to teach others and implement evidence-based practice into the care home setting, and with their support, ALCoP members took on more responsibility. This initially proved intimidating for facilitators who were more accustomed to being more proactive in directing student learning:

> *On the second cycle, I could very much sit back and because the students were interacting very well with each other and problem solving … [As an educator] you're very much used to telling people what to do and having to sit and enable students to sort of come up with their own solution … It's very much a different way from being prescriptive for students … This was about them taking the lead. It is about them problem solving.* (Academic Facilitator 2)

Care home staff felt daunted by this, fearing they might not facilitate effectively:

> *I remember when I saw [academics] name I was like 'gosh [they] will be there, as well'. I remember asking her: "What do you want me to do?" She went: "It's okay, I'll do this and this but I don't want to take over" … I didn't really do as much as I should have done in a way. I tried to speak and give input but I wasn't always sure if I was sticking my nose in when I shouldn't, and I think that's me lacking confidence.* (Care Home Staff Facilitator 6)

Another reflected on how she reconciled her initial perception of the academic's role with the recognition of her own contributions:

> *I wouldn't like to be letting [the students] down. They set their own goals and I make sure they are OK … because I'm nowhere near as good as [the academic facilitator], but I'm all right with the hands-on stuff.* (Care Home Staff Facilitator 8)

Academic facilitators noted that they tried to recalibrate the power dynamic at times, to ensure that care home staff didn't feel intimidated or lacking in knowledge and skills:

> *I was very aware that care home staff felt comfortable in the meetings. I didn't want them to feel that I knew more, or that they couldn't contribute. I have a clinical background, which probably helped, but I know how highly skilled nurses have to be in care homes, as they deal with really complex care. I saw the care home staff blossom in confidence as the project went on, and it was great to see the students tap into their expertise.* (Academic Facilitator 2)

In this way the project fostered confidence building among students and care home staff, as students learned to take the lead and problem-solve independently, while care home staff, perhaps initially intimidated by the academic facilitators, became more confident in their own contributions.

Discussion

The focus on IPE is 'almost always on IPE outcomes pertaining to student learning rather than its impact on the organisation, staff, or residents' (Laukner et al. 2018, 4); While there is evidence about the positive impacts on staff and residents (Kelly et al. 2023), our focus here has been on individuals who facilitate ALCoP to enable IPE delivery. The process influenced facilitators and brought benefits for students and residents, contributing to redressing a wider issue of care home staff feeling under-valued from negative stereotyping and possessing limited inadequate training, knowledge and skills (Spilsbury, Hanratty, and McCaughan 2015).

Building capacity and cultivating change among care home staff who were mentored by academics offers a novel approach to bridging the theory–practice gap that aligns with Lave and Wenger's (1991) work on Communities of Practice. Collaboration can facilitate information sharing, knowledge translation, the dissemination of best practices, and the development of both professional and interprofessional capacity (Ford et al. 2015). Through role modelling, academics demonstrated nursing expertise, professionalism, and a commitment to reflective practice (Foster et al. 2015). Role modelling offers an effective method for fostering professionalism, and a sense of belonging in nursing (Vinales, 2015) and is a valuable way to teach professional behaviours beyond the formal curriculum.

Effective ALCoP facilitation can contribute to addressing broader systemic issues, and particularly the persistent undervaluing of care home staff who are often affected by negative stereotypes and may have limited access to adequate training, knowledge, and professional development opportunities (Spilsbury, Hanratty, and McCaughan 2015). The hours that care home staff offered supporting the ALCoP could be recorded as Continuing Professional Development and contribute towards Nursing and Midwifery Council (NMC) revalidation requirements. However, we did not credentialise (seeking a qualification) work of the care home staff facilitators in ALCoP and we acknowledge this as a valuable future recommendation. More formal recognition of the skills and competencies developed through facilitation could enhance professional status, create clear pathways for career progression, and contribute to workforce retention within the care home sector. Credentialising may also align with national health and social care workforce strategies, and support standardisation of facilitation practice.

Operationalising ALCoP in care homes introduced a student-led, applied learning model. It enabled students to critically appraise and apply research in partnership with care home staff under the long arm supervision of their clinical/practice supervisors, directly improving standards of care and enhancing staff knowledge and skills, especially for those who might otherwise struggle to stay current with evidence-based practice (Leonard, McCutcheon, and Rogers 2016). However, variations in student engagement, especially among part-time students, brought the need for facilitators to adapt their approach. In some cases, reduced time on site meant part-time students risked feeling less connected to the team, less aware of ongoing discussions, and less able to contribute to decision-making. Effective facilitation required a flexible intentional strategy that actively sought to integrate those learners, for example by providing structured opportunities to update them on progress, encouraging their direct input on specific aspects of resident goals, helping to negotiate study days to complete actions on their other

placement and fostering peer support within the group. Such targeted inclusion helped maintain continuity of learning, ensured different professional perspectives were represented, and strengthened the overall group dynamics.

The ALCoP model we developed was reliant on the formation of respectful relationships between students and care home residents, care home staff and facilitators (McCormack et al. 2017). Successful delivery is central to this. Developing respectful relationships requires an openness from facilitators about their anxieties as well as a flexibility towards IPE environments and programmes, and trust across and between all those involved (Edwards et al. 2003; Penney et al. 2017). Building knowledge and confidence among facilitators does more than improve the ALCoP experience for students. It has the potential to grow understanding and awareness of professional identities among student learners by demonstrating how their own and other professional's roles, values and behaviours interact in the care setting.

The development of professional identity is often shaped through a socialisation process with others from the same profession (Joynes 2018). As health and social care practice settings become more integrated, it is essential that professionals can work effectively together and understand each other's roles and remits. While professional identity cannot be easily *taught*, it can be *crafted* through working in a multi-disciplinary team (Joynes 2018) and, we argue, by facilitators nurturing a culture open to learning from others regardless of status or hierarchy as with legitimate peripheral participation. To achieve this, ALCoP facilitators should be supported and if necessary trained in pedagogic practice including group facilitation and student-centred learning alongside updating clinical and social care knowledge (Leonard, McCutcheon, and Rogers 2016).

Creating an ALCoP-supporting environment focused on person-centred care was embraced by care home staff facilitators who reflected on the importance of spending time with residents and setting goals through a joint decision making with the residents. Here, our findings mirror those of Svensberg et al. (2021, 7) where such an environment 'expanded most students' educational horizons'. With supportive and confident facilitation, ALCoP environments can contribute to this, . not simply as the locations where ALCoP takes place, but rather as facilitators 'make space' (Schot, Tummers, and Noordegraaf 2019) for the uncertainties and opportunities interprofessional learning might provide. Away from the structured learning of a clinical setting or lecture theatre, ALCoP can arguably provide safe environments for learners and facilitators to come together to share experiences and explore possibilities.

Finally, alongside the experiences of students and care home residents (Kelly et al. 2023; Stephens et al. 2023) ALCoP facilitation offers a future structured placement model for health and social care. There have been other models implemented in clinical practice to bridge the theory-practice gap and increase placement capacity such as STEP (Supervising, Supporting Learning and Coaching) (Wilson, Cooper, and Hodge 2020) and CLIP (Collaborative Learning in Practice) (Hill, Woodward, and Arthur 2020), though both are nurse education focused. The model we developed, with ALCoP at the heart, serves many health and social care programmes whilst attending to other drivers such as the UK's NHS Long Term Plan (NHS England 2023), the Department of Health and Social Care (2023) workforce pathway for adult social care and future proofing learners to be fit for purpose for future of health and social care and the roles within integrated care.

Reflections on delivery

At the commencement of the project, care home managers appeared apprehensive about their ability to facilitate ALCoP. Many expressed concerns about 'not being academic enough', and hesitated to participate when terms such as *action learning* were introduced. They initially perceived ALCoP as something grandiose or beyond their capacity and skill-set. In reality, however, facilitation mirrored practices they already engaged in daily with their staff; they simply had not recognised these as transferable skills acquired through everyday working routines.

To ensure a supportive and developmental process, the research team facilitated the first ALCoP cycle with more experienced facilitators. The second cycle evolved into shared facilitation, and by the third cycle, a care home manager took the lead. Reframing the skills required to deliver ALCoP through the lens of legitimate peripheral participation (Lave and Wenger 1991) enhanced both confidence and competence. For future iterations, a simplified Facilitator's Booklet and opportunities to observe an ALCoP will be offered to alleviate initial concerns.

Facilitators also supported students and care home staff in recognising and confidently applying their existing skillsets in facilitation roles. Some perceived research involvement or facilitation leadership as outside their scope of practice; reflecting broader systemic challenges around the professional parity of social care nurses. Facilitators worked intentionally to address these barriers, which proved key to fostering confidence and participation.

Conducting research within care homes requires close collaboration with staff, residents, and families. These environments are inherently dynamic and fluid, demanding flexible and responsive methods that respect daily care routines and individual resident preferences. Genuine partnership was essential to ensure that the research respected the fact that it was taking place in someone's home and that it complemented, rather than disrupted, care.

Several lessons emerged from us addressing these challenges. Early and ongoing facilitator support, through mentoring, observation, and constructive feedback, was essential for building confidence and competence, particularly for those new to interprofessional education. Clear role expectations, combined with flexibility to accommodate operational realities, helped sustain engagement and continuity. Creating inclusive spaces where all participants felt able to contribute, regardless of confidence level or professional background, was vital to the quality of the ALCoP experience. Finally, securing organisational buy-in from the outset, including explicit endorsement from senior leadership and protected time for facilitation, proved decisive in sustaining momentum and embedding ALCoP into routine practice.

Practical guidance for implementation

For organisations and educators seeking to implement ALCoP in care homes or similar health and social care settings, several practical considerations are recommended:

Start with joint facilitation by experienced academic and care home staff, gradually transitioning leadership to the latter to build confidence and sustainability.

Provide structured training in facilitation, group dynamics, and student-centred learning, alongside opportunities to update clinical and social care knowledge.

Secure organisational commitment early, ensuring senior leadership endorsement, protected time for facilitators, and integration of ALCoP within the organisation's learning culture.

Create genuine reciprocal partnerships: academic staff were cognisant that to conduct the study they were visiting both a place of work and a place of residence. This proffered an opportunity to be part of the care the residents received and the service the homes offered, creating an environment of personal and professional development for all involved.

Plan for diverse student engagement, with specific strategies to include part-time or less-present participants so all voices are represented and valued.

Encourage reflective practice within and between ALCoP sessions to consolidate learning and promote continuous improvement.

Consider credentialing pathways to formally recognise facilitator skills, enhance professional development, and align with workforce strategies in health and social care. In the interim, highlight to care home managers that hours can be logged as CPD hours towards future professional body revalidation.

Keep empowerment at the heart of all work conducted within and outwith the ALCoP. This includes empowerment for future nurse and allied health care leaders (students); empowering care homes managers; and empowering residents to collectively deliver quality care through continuous professional development.

These measures can support the successful adoption and long-term sustainability of ALCoP, ensuring it delivers benefits not only to students, but also to residents, staff, and the wider health and social care system.

Conclusion

Developing ALCoP was not without challenges. Unequal participation within learning sets, the influence of dominant perspectives, and occasional interpersonal conflicts all required careful and skillfull facilitation to ensure that every voice was heard and valued. Facilitators had to intervene subtly to rebalance discussions, encourage quieter participants to engage, and prevent the learning environment from being shaped disproportionately by a few individuals. While all facilitators were supportive of the project vision, some required persuasion and/or reassurance about their skills in the early stages, though this diminished as they grew in confidence and began to see some of the impacts that they and their ACLoP sets were making.

Balancing competing demands was another significant challenge. Facilitators, both care home staff and academics, were required to manage ALCoP commitments alongside their primary responsibilities. For care home staff, resident care and day-to-day operational duties rightly remained the priority, which occasionally created scheduling pressures or limited their availability. In rare cases where such conflicts arose, academic facilitators were able to step in, ensuring continuity of the learning process without compromising resident care.

The success of the project relied on participating care homes and universities recognising its potential benefits and investing in a supportive, enabling culture. This included providing protected time for facilitators, valuing interprofessional learning as a legitimate part of care home practice and embracing the shared goal of enhancing resident outcomes through collaborative education. We are mindful that not all settings will enjoy

such organisational alignment or resource availability. In less supportive environments, competing operational pressures, staff turnover, or limited understanding of interprofessional education could pose barriers to implementing and sustaining ALCoP. Recognising and proactively addressing these contextual factors will be critical for replication and scalability across the health and social care sector.

Undertaking ALCoP as part of an IPE initiative in care homes provided enhanced opportunities for learning and reflection for facilitators. The project created new learning opportunities for care home staff to become facilitators, who embraced a new way of working, often outside of their comfort zone. Using an action learning community of practice in interprofessional education in care homes benefits facilitators as well as residents, students, and care home staff. With support, facilitators can enable a sustainable model of ALCoP delivery. There is wider awareness to be gained from understanding how ALCoP recalibrates power dynamics between academics, care home staff and students in the context of IPE, while also building longevity into student learning opportunities that might otherwise be funding dependent and largely time-limited.

Study limitations

This paper is based on the experiences of a small sample of 9 ALCoP facilitators delivering IPE in 5 care homes, which may not fully capture the broader range of experiences and challenges associated with facilitating ALCoP. The study also focused on a specific geographic region (Northwest England) and a defined set of health and social care professions, potentially limiting the representativeness and generalisability (understood in a positivist sense) of the findings. Nonetheless, it provides a first exploration of facilitating ALCoP in care homes and underscores the need for future research to investigate a wider range of experiences and contexts. By including the views of all facilitators involved in the project we are confident in the internal generalisability of the work and the comprehensiveness of our analysis of how ALCoP worked in this particular context. Our ongoing work in this area indicates that our findings are transferrable to different kinds of care homes across the UK, including those that serve different socio-demographic communities; urban and rural locations; and that support residents with a range of health and social care needs. By illuminating the experiences of facilitators, we suggest that our wider findings have relevance and potential transferability across a range of health, social care, and education settings where an ALCoP approach might be implemented. At the time of writing, the ALCoP model we developed has already been adapted and utilised in a variety of contexts, including a paediatric intensive care unit, a large national care home provider, a pelvic health midwifery and physiotherapy service, and early years education settings. The issues we have presented here are likely to occur in different organisational structures, workforce compositions, and service models, making them relevant wherever ALCoP might be being developed and integrated into care delivery.

Acknowledgements

We would like to thank the Greater Manchester Project Management Office for supporting the project and Health Education England's (2022) Targeted Practice Education Programme (TPEP) workstream for funding. Particular thanks go to all students, care home residents, and staff for their enthusiasm for and commitment to the work.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by Greater Manchester Project Management Office and received funding as part of Health Education England's (2022) Targeted Practice Education Programme (TPEP) workstream.

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