



ERA+ Clinical Leadership in Nursing Education



Clinical Leadership in Nursing Education Inspirational good practice

“Clinical simulation in a clinical placement context”

This example shows practical leadership skills that are applied in educational settings. These practices were identified and collected during the Erasmus+ KA220-HED project “Clinical Leadership in Nursing Education,” co-funded by the Erasmus+ programme of the European Union. The content is based on existing practices, with good examples submitted by project partners and stakeholders, recognized as validated examples from professional practice.

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Content

1.	Contact Information.....	3
2.	Short description of the teaching method.....	3
3.	Why should colleagues use this method to strengthen clinical leadership?.....	4
4.	Competencies related to clinical leadership.....	4
5.	Timeline	6
6.	Student guidance.....	7
7.	Required materials / Conditions	7
8.	Evaluation / Follow-up	7
9.	Results / effects on students	8
10.	Tips for colleagues.....	8
11.	Practical example / anecdote (optional).....	8
12.	Visual material (optional)	9

1. Contact Information

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2. Short description of the teaching method

This teaching method is based on structured team-based learning, using realistic nursing clinical cases with some degree of clinical urgency, which escalates in complexity as time progresses, focused on clinical decision-making and task delegation. Students work in small groups and receive, during an initial briefing, basic information about a critical patient scenario that includes clinical data, set within a hospital environment where some of the materials required for data collection and intervention to resolve the clinical case are available. Students, as a group, must choose a leader, who should afterwards be easily identifiable by the teaching staff. The student who assumes the leadership role must coordinate the team's efforts, delegate tasks, and uphold principles of communication, patient safety, and appropriate decision-making. They must also reflect on the limits of their own scope of practice and seek collaboration from another professional when necessary, conveying information in a structured and adequate manner using the ISBAR method. At the end, students participate in a debriefing session, initially describing step by step all the decisions made, and later reflecting on them. The teachers act solely as facilitators of this shared reflection process. This process takes place twice over a period of fifteen days. The method emphasizes respectful interaction, shared decision-making, and patient safety communication.

3. Why should colleagues use this method to strengthen clinical leadership?

This method strengthens clinical leadership because decision-making, communication, task delegation, confidence, and collaboration are core competencies for safe nursing practice and effective patient outcomes. It helps students practise leadership and decision-making behaviours, such as coordinating care, delegating tasks, and ensuring shared understanding within the team. Furthermore, it trains students who are not in the leadership role to fulfil a collaborative part, to intervene, to assist, and to be active participants rather than mere observers. Students learn to make and share decisions, to listen to the input of all team members, and to formulate confident judgements, owning them and taking responsibility for the entire team leadership process in decision-making.

Collaboration skills are strengthened as students negotiate priorities, resolve disagreements, and work toward common goals. This method presents challenges related to the specific case, exposing students to constant uncertainty, prompting them to collect data before deciding, and ensuring they have the best available information to support their decisions. It also allows them to understand the complexity and responsibility of the leadership role, and the need, as a leader, to share actions, delegate tasks, and assume a central position in the patient care process.

As it is directly embedded within a clinical placement curricular unit, it enables students to draw on experiences from practice, to recognise themselves in the process, and to see their clinical placement supervisors reflected in the assigned roles — allowing them, within the safety of clinical simulation, to develop competencies that are immediately useful both in their placement and in their future professional lives.

4. Competencies related to clinical leadership

Primary competences – **secondary competences** addressed by this good practice

Domain – ethics

- ❑ Ethical competence (*ethical principles and values; professional integrity and accountability*)

Domain – professional nursing

- ❑ **Clinical competence** (***clinical competence in specific clinical area; nursing process; health promotion***)

- ❓ Quality management competence (**quality of care; patient safety**)
- ❓ Evidence based practice competence (**evidence based practice**)
- ❓ Decision making competence (**critical thinking; decision making; problem solving**)
- ❓ Self-development competence (**continuous professional development**)

Domain – innovation and change

- ❓ Visioning competence (**future-oriented thinking; understanding the big picture; finding innovative approaches; questioning**)
- ❓ Change management competence (**initiating change; advocating change; implementing change**)

Domain – influencing and advocacy

- ❓ Influencing competence (**influencing others; motivating others**)
- ❓ Patient advocacy competence (*patient advocacy*)

Domain – team leadership

Team leadership competence (**team formation, team coordination, positive working atmosphere**)

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- ❓ Guidance competence (**supervision, mentoring**)

Domain – communication and collaboration

- ❓ Communication competence (**effective communication, dialogical competence**)
- ❓ Collaboration competence (**interprofessional collaboration; professional collaboration**)

Specific behaviors practiced:

(e.g., giving feedback, speaking up, handling conflict, setting priorities, situational awareness,)

- Structured communication using ISBAR
- Active listening and clarification techniques
- Giving clear and concise patient updates
- Handover communication and documentation clarity
- Closed-loop communication to confirm understanding

- Speaking up about patient safety risks
- Conflict management and respectful disagreement
- Delegation and prioritization in team decision-making
- Interprofessional communication (team communication)
- Feedback exchange within the team

5. Timeline

This method takes 2 lessons; approximately 4–5 hours total.

Structure: briefing, clinical simulation, debriefing.

The simulations follow the same structure; the leaders may remain the same or students may switch roles. It is expected that, in the second session, facing a different clinical case, performance will improve, drawing on the contributions discussed and acquired during the first training session.

6. Student guidance

Feedback is provided at the end of the debriefing process. Until then, teachers act solely as facilitators in the development of the clinical scenario.

Following the initial briefing, in which basic information is provided, students perform the clinical scenario. At the end, they are prompted to recall the entire process they went through — the actions performed, the tasks delegated, the communication carried out, and the progression of the scenario.

After this, students reflect, on their own initiative, on what they could have done better, conducting a SWOT analysis of the process undertaken.

Finally, drawing on the students' account of all the actions taken, the teachers guide the students by identifying appropriate behaviours and suggesting changes to those that require improvement.

The entire process concludes with students identifying different take-home messages to incorporate into future simulated or real clinical scenarios.

7. Required materials / Conditions

- Manikin
- Clinical materials (syringes, needles, medication, medication prescription charts, stethoscope, sphygmomanometer, glucometer, thermometer, pulse oximeter, oxygen therapy equipment, nebulisation equipment, telephone, etc.)
- Computer to simulate vital signs
- Chairs and table for final debriefing

8. Evaluation / Follow-up

Students are assessed on their performance in the second simulation session, their capacity for critical analysis during the debriefing, their ability to reflect on the actions taken, and their ability to incorporate those reflections into subsequent actions in the second clinical simulation session. All of these aspects are part of a checklist designed to ensure proper assessment. The roles assessed relate to both leadership and collaboration behaviours. Particular emphasis is placed on students' critical thinking capacity and their ability to incorporate into subsequent practice the insights generated during the debriefing, as well as the guidance provided by the teachers.

9. Results / effects on students

A clear evolution in behaviour is observed both in the clinical simulation scenario and in the placement setting. Students, having been exposed to simulated situations that they encounter in clinical practice, shape their behaviours in accordance with their own reflections and with the suggestions provided by the teachers. Both in the second simulation and in the clinical context, they are noticeably more competent, assertive, and clear in their communication. They assume the leadership role without difficulty, coordinate actions effectively, and fewer unnecessary, disorganised, or uncoordinated actions are observed. Furthermore, a clearer and more collaborative thought process is evident. An improved ability to communicate critical situations to clinical supervisors and the multidisciplinary team is also identified. It is worth highlighting that even students who do not assume the leadership role in the simulation adopt a noticeably more respectful attitude toward the leader, which is reflected in genuinely effective collaboration.

10. Tips for colleagues

Groups may be composed of five to six students, due to time constraints. It is believed that this would be optimized if groups were smaller, with three students, in order to better distribute the protagonism among participants.

It is important that the scenarios are not suggestive, as this drives students toward a rapid resolution. This is a concern when students focus on the outcome rather than the process. It is therefore essential that, prior to the initial briefing of the case, students are encouraged not to rush, to trust the process, and to avoid making suggestive readings of the clinical scenario presented.

11. Practical example / anecdote (optional)

A student with a shy profile kept a very low profile during the first clinical simulation session. She remained almost entirely beside the manikin and did not actively participate, being overshadowed by the pace and confusion of her peers, and by the chaotic leadership of the situation. This, however, placed her in a highly privileged position of observation of the clinical scenario. The same student, during her clinical placement, was able to lead a situation involving severe hypoglycaemia in a patient, coordinating actions with a fellow student, calling the nurse and the doctor at the right moment, and conveying all relevant information in an appropriate manner. We believe this would never have been possible without objective training in a simulated context, particularly for a student nurse with a shy profile. This example clearly illustrates the importance of simulation-based training in developing clinical leadership competencies within the scope of professional nursing care.

12. Visual material (optional)

N/A
