Clinical Leadership in Nursing Education

Teaching material for communication lessons

"Incomplete information, big decisions"

Clinical leadership in a multidisciplinary meeting with conflicting signals and uncertainty

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Content

1. Scenario description

Context

Acute care setting – traumatology ward.

You are taking part in a multidisciplinary team meeting (MDT) in which a decision will be made about the discharge of a service user whose home situation may be unsafe. The service user is not present during this meeting.

Starting situation

You are on placement in the traumatology ward and, together with a fellow student, are involved in the care of a 60-year-old service user of Romanian origin who has been living in Belgium for 7 years. He was admitted with a hip fracture, which was initially attributed to an accidental fall. During a physiotherapy session, however, the service user indicated that his injury may have been caused by being pushed by his partner, causing him to fall down the stairs.

In the subsequent care contacts, you and your colleague notice that the service user is reluctant to talk about his home situation. He shows signs of shame, fear, and uncertainty, and appears to be uncertain about what he wants or is able to disclose. The available information is partly contradictory: the service user previously indicated that violence had occurred, but sometimes qualifies this in later conversations. At times he qualifies or minimises earlier statements. Communication is further hampered by a language barrier, as the service user only speaks English, which makes it difficult to fully and accurately assess the situation.

The service user has a limited social network in Belgium and appears to be heavily dependent on his partner. This may influence his willingness to communicate openly.

The service user's discharge is planned within 24 to 48 hours. In the meantime, the charge nurse and the social worker have had an in-depth conversation with the service user, during which additional indications of a possibly unsafe home situation came to light. This information will be discussed during the multidisciplinary team meeting (MDT).

The MDT is the central decision-making moment at which it is determined whether the planned discharge is medically and psychosocially safe. The service user is not present during this meeting, which means the team must rely on indirect information and observations from various care providers.

Not all team members have access to the same information; each discipline brings its own observations and insights. The available information is also incomplete and partly contradictory. This requires the team to actively share, analyse, and integrate information.

A tension arises between respecting the service user's autonomy and safeguarding his safety. The team must, despite these uncertainties and under time pressure, assess the risk of an unsafe situation and make a well-reasoned decision about the next steps.

As nurses, you are in a key position, as you have the most direct and frequent contact with the service user and insight into his behaviour, emotions, doubts, and vulnerabilities. During the MDT you are expected to:

- contribute observations and concerns.
- represent the service user's perspective.
- contribute to thinking about possible solutions.
- adopt a well-reasoned position.

Key question for the meeting: Is a discharge home (planned within 24–48 hours) justified and safe for this service user, given the signs of possible domestic violence?

2. Roles and role distribution

Provide a brief explanation for each role.

Role	**Description**	**To be played by**	**Key behaviours / points to note**
Nurse	(Re)cognising fear, shame, and behaviour of the service user Represent the service user Feels a strong sense of responsibility Clearly sees the risks Dares to speak up, but must remain persuasive Contribute your observations and concerns Participate actively and influence decision-making	2 student nurses	Has doubts Wants to "do the right thing" Needs to develop assertiveness You have spoken with the service user several times You sense that he does not feel safe, despite his uncertainty. You must decide: "Do I keep pushing for what is safe, even when the service user is uncertain or does not clearly agree?", even when the care recipient is unsure or does not give clear consent?

Charge nurse	**Overview of the team** Coordinating lead Focus on throughput and organisation Practical and organisation-oriented Mildly critical towards nurses Tests the argumentation of the other roles	Educator	Decision-making, safeguarding safety. Results-oriented. Safeguards safety & policy. Challenges the nurse to argue strongly.
Social worker	**Focus on the service user who sometimes minimises** Support and advice Understanding of the situation, but cautious Empathetic but nuanced Aware of the complexity of violence Introduces doubt and reality Says, for example: "If the service user does not want help, we are in a difficult position."	Extra	Exploring the home situation and support services Contributes: • Information about the home situation • Possible support channels
Doctor	**Focus on medical discharge readiness** Clinical, rational, time-oriented Knows the service user only from a medical perspective Tries to maintain structure, but also steers towards discharge		

3. Clinical leadership competencies

Primary competences – secondary competences addressed by this case

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

Domain – communication and collaboration

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

Specific behaviours practised: speaking up, ethical reasoning, managing cultural differences, multidisciplinary team meeting.

4. Learning objectives for students

The student recognises and names signs of domestic violence.

The student applies the principles of patient safety and mandatory reporting to the case.

The student collaborates interprofessionally and formulates follow-up steps.

The student participates actively in a multidisciplinary team meeting:

- The student formulates at least one specific concern.
- The student raises at least one observation linked to risk.
- The student takes a clear position (e.g. for/against discharge).

The student represents the service user's perspective at the MDT, in the absence of the service user.
The student translates observations into clinical and ethical reasoning.
The student demonstrates the ability to manage uncertainty and hierarchy.
The student adopts a well-reasoned position.

5. Case progression

For this exercise, a multidisciplinary team meeting is organised.

Participants

- 2 student nurses (primary care providers for the service user)
- Doctor
- Charge Nurse
- Social Worker

Context

- Brief, structured meeting (15–20 min)
- Aim: to decide on safe discharge and next steps

Points for attention before the start

- Distribute the roles among the participants
    - Only give nurses (= students) their own role card in advance (not those of others)
    - Ask each additional role (= non-nurses) to select 2–3 sentences from their role card that they definitely want to use – encourage them to improvise around these formulations
- The information is incomplete and partly contradictory. Students must learn to manage uncertainty and still adopt a well-reasoned position.

Scenario Outline

The case can be run through in its entirety or step by step with guidance from the educator (depending on the students' stage of training).

Phase 0: Introduction (educator – 5')

- Brief explanation of the case context
- Outline the aims of the exercise

- At the end, formulate a concrete decision and rationale.
- Distribution of roles
    - Stay true to your role, even if this leads to discussion.
- **Role of the observers**
    - Observe, during the MDT, using the following questions and give concrete examples:
        - Do the nurses speak up?
        - Do the nurses advocate for the service user?
        - Do the nurses influence the group?
        - Do the nurses explicitly name signs?
        - Do the nurses dare to ask difficult questions?
        - Do the nurses keep the service user central?
        - Do the nurses argue their position?
        - Do the nurses take initiative in the meeting?

Phase 1: Preparation Phase per Role (10–15')

- **Aim: to prepare participants for their role and to structure information**

- **Method:**
    - Participants form pairs within the same role (or per role type)
    - Each role receives a brief role card with specific information
    - They prepare their contribution to the MDT together

- **Key question: Is a discharge home justified and safe for this service user, given the signs of possible domestic violence?**
- **Recap of key elements from the case:**
    - Incomplete and contradictory information
    - Time pressure (discharge within 48 hours)
    - Language barrier
    - Dependency on partner
    - Shame and male victimhood
    - Tension: autonomy vs. safety

    - **Tasks for participants:**
        - What information do you have about the service user?
        - What are your main observations or concerns?
        - What do you definitely want to raise during the meeting?
        - What is your preliminary position on the discharge?
        - What questions do you want to ask other team members?

- **Additional for student nurses:**
  - What concerns you most in this case?
  - What do you know for certain, and what do you not?
  - What could happen if the service user goes home?
  - Which signs point to possible unsafety?
  - How can you formulate this concretely during the meeting?

- **Educator's role:**
  - circulate and coach
  - help participants to be more specific
  - provide guidance where needed (do not steer towards the "correct answer")

Phase 2: Multidisciplinary Team Meeting (15–20')

- **Aim: share information, argue, and decide**

- Opening script – started by the educator:
  - Educator: "Right, let's begin. Today we are discussing the discharge of a 60-year-old service user with a hip fracture. Medically, discharge appears possible in the near future. However, there are signs of possible unsafety in the home situation. What do you all think?
- ALLOW A PAUSE HERE SO THAT STUDENTS CAN TAKE THE INITIATIVE

- Roles contribute their perspective
- Students participate actively and adopt a position. If students remain silent: "What have you, as nurses, noticed?

- Focus is on
  - Argumentation
  - Interprofessional interaction
  - Managing uncertainty

- **Possible escalations (optional)**
  - The educator can make it more challenging:
    - Doctor increases pressure: "We cannot simply keep service users here without reason."
    - Social Worker expresses doubt: "We have no hard evidence…"
    - Time pressure: "Discharge is planned for tomorrow."
  - This triggers:

        - ethical thinking
        - speaking up against hierarchy

Phase 3: Decision-Making (5–10')

- **Aim: have students adopt a position – the group reaches a joint decision**

- Doctor says:
    - "I hear concerns, but what do you concretely propose? Delaying discharge?"

- Decision options – possible outcomes for this service user:
    - Discharge proceeds (with conditions)
    - Discharge is delayed
    - Additional screening/observation
    - Referral to external support

- Students must clarify their position.
    - formulate a position
    - argue
    - respond to others

Phase 4: Debriefing (20–25')

6. Materials needed

- Room set up as a meeting room (MDT)
- Chairs around a table
- Scenario description (student version)
- Role cards per discipline (nurse, doctor, social worker, ...)
- Task/instructions for students (what is expected in the MDT)
- Learning objectives/observation form/debriefing questions (for educator)
- Optional: simplified patient record

7. Debriefing guidelines

Relevance for clinical leadership – the case focuses on

- Leadership in complex care situations
- Interprofessional collaboration on a sensitive topic.
- Ethical decision-making
- Patient safety
- Cultural sensitivity, managing language and cultural barriers

Optional clinical leadership observation points

Assess (✓/✗ or scale 1–5):

Criteria	Observation
Speaks up spontaneously in the MDT	☐
Names specifically what he/she has seen or heard	☐
Explicitly articulates the needs, vulnerabilities, or situation of the service user	☐
Supports position with observation + risk	☐
Dares to express own opinion and responds respectfully to other (e.g. dominant) team members	☐
Proposes at least one concrete follow-up step or solution	☐

Possible pitfalls

- Students remain descriptive without taking a position
- Following the dominant role (doctor) too quickly
- Insufficient link between observation and risk
- Avoiding ethical discussion

Step 1: General debriefing

- Reflection questions
    - “What was it like to represent the service user without him being present?”
    - “When did you feel you had enough information to adopt a position?”
    - “What made it difficult to speak up?”
    - “How did you manage doubt and uncertainty?”
    - “What would you do differently next time?”
    - “When did you feel you needed to intervene but hesitated?”

- Additional possible questions
    - Multidisciplinary team meeting – what will you discuss? How will you raise this?
    - What do you feed back to the service user from this?
    - How will you support the service user afterwards?

- Ethical aspects + culture + shame
- When did you feel doubt? What did you do?
- Did you speak up? Why/why not?
- How did you experience power/hierarchy?
- What does “leadership” mean to you in this case?
- How do you combine empathy with action?
- What was it like to represent the service user without him being present?
- When did you have enough information to adopt a position?
- What, if anything, held you back from speaking?
- How do you deal with hierarchy in a team?

Step 2: Debriefing for/by individual students (nurse role):

- Nurse role:
  - first let students respond themselves
  - then show the desired examples (see above)
  - and reflect:
    - *“Which responses are similar to what I did?”*
    - *“What would I do differently next time?”*
- **Debriefing by observers using the questions above.**
- **Possible observations by the educator:**
  - Does the student take initiative to speak?
  - Are observations formulated concretely?
  - Are ethical considerations made?
  - Is the service user’s perspective defended?
  - How do they respond to different opinions? – Are other opinions integrated or ignored?
  - Do they speak in terms of facts vs. interpretations?
  - Do they dare to speak up against authority (doctor/charge nurse)?
  - Do they actively raise the service user’s perspective?
  - Who takes the initiative?
  - Are other opinions integrated or ignored?
  - Is patient safety explicitly named?

Take-home messages

- Information is incomplete and contradictory
- Decisions must still be made
- Nurses play a crucial role
- Patient safety is central

8. Additional remarks

Points for attention when using this case

- Ensure psychological safety during the simulation and the debriefing.
- Avoid accusatory language; focus on learning and growth.
- Maintain a respectful approach to the topic of domestic violence.

"Life Saver" – lifeline

- Always offer students the following option:
  - "If you get stuck, that is part of the learning process. You may receive or ask for support. Accepting help is not a failure — knowing when you need support is clinical leadership."
  - "If you get stuck: name your doubt. That is professional behaviour."

- Life saver 1 – when students become stuck > restore structure
  - "May I briefly summarise what we know so far?"
  - "I would like to come back to the safety of this service user..."
  - "What does this mean concretely for the discharge?"

- Life saver 2 – thinking questions > return to clinical reasoning
  - What do we know for certain?
  - What do we not know?
  - What concerns me most?
  - What happens if we do nothing?

- Life saver 3 – ethical anchors > activating higher-level thinking
  - "Is this safe for the service user?"
  - "What if the service user is in danger?"
  - "What weighs more heavily here: autonomy or safety?"

- Facilitator (after inserting a pause in the scenario):
  - Coaching (guiding without giving the answer):
    - "What do you notice about this service user?"
    - "What have you yourself observed?"
  - Seeking depth – raising tension – activating discussion:
    - "The service user now says that everything is fine at home."
    - "His partner is coming to collect him tomorrow."
    - "We have 5 minutes left to decide."

    - Forcing a position:
        - “What is your position as nurses?”
        - “Would you let him leave: yes or no?”
    - Reflection
        - “I hear a lot of description — what do you conclude from this?”
        - “What risks do you see concretely?”

- Hidden hint cards (students may ask for one card during the simulation) – for example:
    - Structure: “Summarise what we know and do not know”
    - Safety: “What risks does the service user face if he goes home?”
    - Position: “Adopt a clear position (for/against discharge)”
    - Speak up: “dare to name your concern explicitly”
    - Follow-up questions: “What information are we still missing?”
    - Counterweight: “What could be a reason to delay the discharge?”
    - Patient perspective: “what would the service user need in order to feel safe?”

- Debriefing on the use of the lifeline
    - “Why did you get stuck?”
    - “What helped you to move forward?”
    - “What does this tell you about leadership in practice?”

Annex 1 – Role Cards per Role

	Nurses	**Doctor**	**Charge Nurse**	**Social Worker**

Your information	• The service user is reticent and finds it difficult to talk about his home situation
	• You have observed signs of fear and shame
	• He previously indicated that violence may have occurred
	• Language barrier → communication / information is not fully reliable
	• See also case
		• The service user is medically stable
		• Discharge is planned
		• Beds must remain available
			• You know the team and have gathered signals
			• You notice that nurses are concerned
			• You want a balanced decision
			• You feel somewhat caught between concern for the service user/team versus the practical organisation of the ward, which is always at the back of your mind (bed pressure, staff shortages, …)
				• The service user gave contradictory information
				• He appears dependent on his partner
				• He has no network in Belgium
				• You will introduce the following new information in the MDT:
				  ○ The service user confirms violence by the partner
				  ○ This is not the first time
				  ○ The partner has an alcohol problem
				  ○ The service user does not want “problems” to arise
				  ○ The service user is uncertain about

				returning home, but also says: "I have no one else" ○ The service user fears social isolation and shame
Your focus in the MDT	• Represent the service user's perspective • Contribute observations • Name risks • Adopt a position	• You stick firmly to your role – you push through and steer (hierarchical role) • Medical argumentation • Efficiency and throughput	• Structure the meeting • Name concerns • Give the team a chance to contribute	• Clarify context and vulnerability • Name uncertainty
		Aim of this role: Maintain structure, give direction, but also create pressure towards decision-making • Focus: medical recovery → discharge possible • Attitude: rational, mild time pressure • Key phrase:	**Aim of this role:** To challenge students to speak concretely, realistically, and with sound reasoning	

		○ "From a medical standpoint, there is no reason to delay the discharge."		
	Example phrases: • "We notice that the service user reacts with tension when asked about home…" • "I am concerned about his safety upon discharge."	**Suggested phrases** • "Let's keep the aim of this meeting in mind: what constitutes a safe and feasible discharge?" • "Can someone make this concrete in terms of a decision?" • "I hear concerns, but what does this mean practically?" • "From a medical standpoint, there is no reason for admission — do you see it differently?" • "What makes you assess this as unsafe?" • "We must also take the service user's wishes into account — how do you view that?" • "Can you support that with observations?"	**Suggested phrases** • "We must also remain practical in our decision – we cannot keep them here without a clear reason." • "What do you concretely propose?" • "How do you see that organised in practice?" • "We cannot simply keep a service user longer — how do you substantiate that?" • "Is this a feeling, or can you support it clinically?" • "What makes you see this as a priority?" • "What risks do you see if we do nothing?"	**Suggested phrases** • "If the service user does not want help, we are in a difficult situation." • "He does not want to cause problems, but there are signs of violence." • "We must take his fear of social isolation into account." • "There is dependency within the relationship." • "He minimises what is happening — we see this more often in such situations." • "We can offer support, but without his cooperation that is limited."

		• "I would like to formulate a clear recommendation by the end of this meeting."		• "What makes you feel this is the right moment to intervene?"
		Tension phrases (important!) • "If we decide nothing, he will simply be discharged. Is that what you want?" • "What do you think the risk is if we let him leave?"	**Tension phrases** • "And suppose he says again tomorrow that he wants to go home?" • "Where do you draw the line on patient safety?" • "Why do you think this is different from other situations?"	**Tension phrases** • "We have signals, but no hard confirmation." • "What does 'safe' mean to you in this situation?" • "What role do we as care providers take when a service user is uncertain?"

Annex 2: Desired and undesired responses of the nurse at key moments in the case

Key moments in the MDT	DESIRED response of nurse	UNDESIRED response of nurse
PRESENTATION OF INITIAL ASSESSMENT BY THE NURSES (after other roles)	"We are concerned about safety upon discharge, because the gentleman reacts with anxiety when his partner is mentioned and his account is inconsistent." "We notice that the service user reacts with anxiety when the home situation is raised." "He previously indicated that there was violence — we cannot ignore that." Strength: • concrete • based on observations • clear position	"We think it might not be so safe." Problem: • vague • no substantiation • little persuasive power

Response to “he wants to go home” > WHEN AUTONOMY IS EMPHASISED BY THE OTHER ROLES	“I understand that autonomy is important, but we also see signs of unsafety. I think we need to take both into account in our decision.” Strength: • acknowledges another view • but introduces nuance • preserves patient safety	“Yes, that’s true… if that’s what he wants, we have to respect that.” Problem: • immediately backs down • no weighing up • no advocacy
Response to “we cannot keep him here” > WHEN STUDENTS ARE PUT UNDER PRESSURE	“I understand the practical reality, but from a patient safety perspective, we find it difficult to support this discharge now without additional measures.” Strength: • acknowledges context • but maintains position • demonstrates leadership	“Yes… that is also true.” Problem: • passive • no contribution • avoids responsibility
WHEN ASKED FOR A CONCRETE PROPOSAL	“We would propose delaying discharge until a clear safety plan is in place, or at the very least ensuring intensive follow-up via social services.”	“Yes, perhaps we should think about that again…” Problem:

	Strength: • concrete • solution-oriented • takes responsibility Alternatives: “We propose delaying discharge and investigating further.” “We recommend delaying discharge until a safety plan is in place.” “Can we look at a temporary alternative care option?” “We would like this to be followed up before discharge.”	• evasive • no initiative • no leadership
WHEN THE NURSES MUST DEFEND THE PATIENT’S PERSPECTIVE	“He says it’s fine, but his body language and reticence give us a different signal. That is why we feel it is important to be cautious about discharge.” Strength: • names discrepancy • clinical reasoning	“He seemed fine, I think.” Problem: • minimising • lacks depth • not service-user-centred

	• strong observation	
SPEAK-UP MOMENT (tension moment!)	"May I respond to that? I feel it is important to emphasise that we do not yet have a guarantee of a safe home situation." Strength: • takes initiative • breaks hierarchy • clear and respectful	(remains silent) Problem: no leadership the service user has no voice
CLOSING POSITION	"In summary, we believe that an immediate discharge carries risks. We advocate for a more thorough assessment of safety first, and for support to be organised." Strength: • clear • summarising • direction-giving	"I'm not sure… it's difficult." Problem: • no position • no impact