

PREPRINT (in *peer-review)*

Clinical leadership competence in nursing:

An integrative literature review

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1. Background

Clinical leadership is increasingly recognised as a key component of contemporary nursing practice, particularly within complex healthcare systems. These systems require nurses to coordinate care, support team functioning and respond effectively to rapidly changing clinical situations (World Health Organization Regional Office for Europe, 2023; Xue et al., 2025). Unlike hierarchical leadership, clinical leadership is enacted by nurses within everyday practice and is independent of formal authority. It refers to the capacity of bedside nurses to influence care processes, guide team interactions and contribute to the achievement of shared clinical goals (Booher et al., 2021; Nachtergaele et al., 2024). Clinical leadership is therefore inherently practice-based and closely embedded in direct patient care.

Despite its growing prominence, clinical leadership remains a concept characterised by varying interpretations. Leadership can be approached from different perspectives, such as autocratic, situational and relational leadership; however, clinical leadership is better understood as a dynamic, context-bound process that emerges through interactions within teams rather than being confined to formal roles or hierarchical leadership positions (Booher et al., 2021; Guibert-Lacasa & Vázquez-Calatayud, 2022). The literature emphasises that clinical leaders are primarily recognised through their actions in practice, particularly through their ability to align values with care delivery and to influence others in real-time clinical situations (Mrayyan et al., 2023). Clinical leadership is thus less about formal roles and more about how leadership is enacted within the context of care.

The importance of clinical leadership in nursing is widely supported. Contemporary healthcare systems are characterised by increasing complexity, workforce pressures and the need for high-quality, patient-centred care, all of which require strong clinical leadership at the point of care (Joseph & Huber, 2015; World Health Organization Regional Office for Europe, 2023). In addition, evidence shows that clinical leadership is associated with improved quality of care, enhanced team functioning and increased work engagement among nurses (Wong et al., 2013; Xue et al., 2025). Furthermore, clinical leadership enacted by frontline nurses plays a critical role in facilitating interprofessional collaboration, supporting decision-making in complex situations and driving improvements in clinical practice (Cummings et al., 2018). Together, these findings underline that clinical leadership is not optional but an essential capability for ensuring safe, effective and responsive healthcare.

Given this importance, there is a growing expectation that clinical leadership should be explicitly addressed within nursing education. Future nurses are expected to take on leadership roles at the bedside, requiring them to guide care, collaborate within interprofessional teams and contribute to ongoing improvements in practice (Scammell et al., 2020). However, translating this expectation into educational practice remains challenging. Although components of clinical leadership are embedded in nursing curricula, they are often fragmented and not explicitly framed as clinical leadership competences expected of each nurse. This lack of explicit conceptualisation results in broad and insufficiently specified educational approaches, providing limited guidance on what should be taught and how learning should be structured when

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developing nursing students' clinical leadership competences (Brown et al., 2016; Scammell et al., 2020).

A key issue underlying this challenge is the lack of clarity regarding the competences associated with clinical leadership. Without a shared and explicit understanding of these competences, it becomes difficult to operationalise and teach clinical leadership in nursing education. In this study, competence is defined as a combination of knowledge, skills, capability and professionalism, while its outcomes are manifested in safe practice, high-quality nursing care and optimal patient outcomes (Swift et al., 2025). The lack of a specific definition for clinical leadership competences limits the development of targeted teaching strategies, the alignment of learning outcomes and the assessment of students' development (Brown et al., 2016). Previous research has emphasised that leadership development requires contextualised and experiential learning opportunities, including work-based, enquiry-based and practice-embedded learning, rather than decontextualised theoretical approaches (Duprez et al., 2024; Guibert-Lacasa & Vázquez-Calatayud, 2022). These findings further underscore the need for a clearer articulation of the competences that underpin clinical leadership in practice.

Consequently, a persistent gap remains between the recognised importance of clinical leadership in nursing practice and its systematic integration into nursing education. This results in a misalignment between the leadership capabilities required in clinical practice and those systematically developed within nursing education programmes. Addressing this gap requires a more explicit understanding of the competences that define clinical leadership and that can be translated into educational practice.

The aim of this review is to synthesise existing evidence on competences associated with clinical leadership in nursing and based on this synthesis, to develop a clinical leadership competence framework for nursing education. The resulting framework aims to articulate core domains of clinical leadership competence and to provide a structured basis for curriculum design, teaching strategies and assessment in nursing education. Such a framework has the potential to support educators, clinical mentors and curriculum developers in making clinical leadership more explicit, teachable and assessable.

2. Purpose and research question

The purpose of the study is to describe the competences for clinical leadership in nursing. The research question is as follows: What are the competences required in clinical leadership in nursing?

3. Methods

3.1 Review method

An integrative literature review was chosen as the study method because it is well suited to framework development. Integrative literature reviews allow the synthesis of evidence from studies using multiple research methods, enabling the development of a comprehensive understanding of the phenomenon. Whittemore and Knafl's (2005) method was followed in the review process. This method includes the following five steps: (1) problem identification, (2)

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literature search, (3) data evaluation, (4) data analysis and (5) presentation of the results. The PRISMA protocol was followed in the literature selection process and in reporting the article.

3.2 Search strategy

The literature search of the CINAHL, ProQuest Central and PubMed databases was conducted primarily in December 2024 and updated in September 2026. The following terms were used in the search, with the database-specific truncations: 'nursing', 'nurse', 'nurse student', 'registered nurse', 'general nurse', 'professional nurse', 'clinical leadership', 'clinical leader', 'clinical competence', 'competence', 'ability', 'skill', 'characteristic', 'capability', 'attitude', 'knowledge' and 'values'. The search phrases were developed in collaboration with a university information specialist. The literature search was limited to scientific peer-reviewed articles, including original research papers, reviews, conceptual analysis papers and expert opinions, written in English and with an available abstract. No time limit was set because of the need for an in-depth description of the phenomenon.

Articles were included in the review if they described clinical leadership competence in nursing or nursing education contexts. Articles were excluded if they focused on clinical leadership from the perspective of a formal leadership role or on methods for learning clinical leadership, or if they did not describe clinical leadership competence. Finally, a manual search of the reference lists of the selected articles was conducted.

3.3 Study selection

From the database search, 1166 articles (CINAHL: 382, ProQuest: 358, PubMed: 426) were identified. In addition, two articles were identified through a manual search of the reference lists. Following the database search, records were imported into Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia), which was used to manage the study selection process. After removing duplicates (n = 475), the titles and abstracts were screened (n = 693), and 614 articles were excluded from the review. Finally, the full texts of the articles were read (n = 79), and 36 articles were selected for review (Figure 1). Article screening was conducted independently in Covidence by two researchers (MA and NG) and verified by the research team.

3.4 Quality appraisal

The methodological quality of the included studies was assessed using the Mixed Methods Appraisal Tool (Hong et al., 2018) for original research articles, the JBI Checklist for Systematic Reviews (Aromataris et al., 2015) for review studies, and the JBI Checklist for Textual Evidence: Expert Opinion (McArthur et al., 2025) for expert opinion papers. No quality assessment was conducted for papers utilising conceptual analysis as a study method due to the lack of an appropriate appraisal tool (n = 2; Chávez & Yoder, 2015; Jack et al., 2022). Quality assessment was first conducted independently by two researchers (NG and MA), after which any discrepancies were discussed and resolved through consensus. No articles were excluded from the review based on the quality assessment. The results of the quality appraisal are presented in Table 1.

3.5 Data analysis

At the beginning of the analysis phase (Whittemore & Knafl, 2005), key characteristics of the included articles and findings relevant to the research question were compiled into a table (Table 2). The meaning units were condensed, coded and compared. Finally, subcategories were formulated and then synthesised into main categories. All authors contributed to the data

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extraction, and the main analysis phase was conducted by two researchers (NG and MA). The findings of the analysis were discussed during several meetings of the research team and validated.

4. Results

4.1 Characteristics of the included studies

The 36 studies included in this review were conducted in 18 countries. The largest number of studies originated from Australia (n = 6), followed by Canada (n = 5), the United Kingdom (n = 4), Ireland (n = 3) and the United States (n = 3). The remaining studies were conducted in Turkey (n = 2), Spain (n = 2) and a range of other countries with single studies each. One study involved multiple countries.

The publication years ranged from 2004 to 2025. Most studies were published between 2011 and 2024, with 2018 representing the most frequent publication year (n = 5).

A variety of research designs were employed. Qualitative approaches were the most common, particularly grounded theory (n = 4) and qualitative exploratory designs (n = 3). In addition, cross-sectional surveys (n = 2), mixed-methods designs (n = 2), concept analyses (n = 2), expert opinion papers (n = 2) and systematic reviews (n = 2) were included. Other study designs were represented by single studies. Participants included registered nurses (n = 4110) representing various nursing specialties and healthcare settings, nursing leaders (n = 23), nursing students (n = 32) and mixed interprofessional groups (n = 180).

4.2 Clinical leadership competence in nursing

In this integrative literature review, clinical leadership competence in nursing consisted of the following domains: (1) ethics, (2) professional nursing, (3) innovation and change, (4) influencing and advocacy, (5) team leadership and (6) communication and collaboration (Figure 2).

4.2.1 Ethics

The ethics domain consisted of ethical competence, including ethical principles and values, professional integrity and accountability. Ethical principles and values were described as the ability to work and lead in accordance with ethical principles and values in nursing (Beiboer et al., 2023; Boutin et al., 2025; Budak & Özer, 2018; Carney, 2009; Grindel, 2016; Jack et al., 2022; Stanley, 2006, 2009; Stanley & Stanley, 2018). Professional integrity and accountability were described as the ability to act consistently with one's stated values, take responsibility for one's actions, acknowledge mistakes and maintain awareness of one's strengths and limitations (Budak & Özer, 2018; Grindel, 2016; Iraizoz-Iraizoz et al., 2023; Larsson & Sahlsten, 2016; Pepin et al., 2011; Rogers, 2017; Scott et al., 2025; Stanley, 2006; Supamanee et al., 2011).

4.2.2 Professional nursing

Professional nursing consisted of clinical competence, quality management competence, evidence-based practice competence, decision-making competence and self-development competence.

Clinical competence was described as clinical knowledge and skills in general nursing practice, as well as in a specific clinical area of nursing (Al-Dossary et al., 2016; Boamah, 2018; Budak & Özer, 2018; Burns, 2009; Chávez & Yoder, 2015; Davidson et al., 2006; Duprez et al., 2024; Enghiad et al., 2022; Fealy et al., 2015; Grindel, 2016; Husebø & Olsen, 2019; Iraizoz-Iraizoz et al.,

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2023; Jack et al., 2022; Larsson & Sahlsten, 2016; Mianda & Voce, 2018; Mrayyan et al., 2023; Nachtergaele et al., 2024; Rogers, 2017; Scott et al., 2025; Stanley, 2006, 2009; Stanley & Stanley, 2018; Supamanee et al., 2011). In addition, the ability to apply the nursing process was considered important. This included the ability to assess, plan, implement and evaluate nursing care (Boamah, 2018; Budak & Özer, 2018; Chávez & Yoder, 2015; Husebø & Olsen, 2019; Larsson & Sahlsten, 2016). Finally, health promotion was discussed as the ability to promote patients' health, provide patient education (share information) and offer support to patients (Davidson et al., 2006; Ennis et al., 2015).

Quality management competence included the ability to provide high-quality care and ensure patient safety. Competence in providing high-quality care was described as the ability to monitor care practices and promote and facilitate practices that support high-quality care (Boutin et al., 2025; Cook & Leathard, 2004; Fealy et al., 2015; Husebø & Olsen, 2019; Karatepe & Türkmen, 2023; Larsson & Sahlsten, 2016; Mianda & Voce, 2018; Stanley & Stanley, 2018). Moreover, ensuring patient safety was described as the ability to provide and promote safe nursing care (Carney, 2009; Fealy et al., 2015; Husebø & Olsen, 2019; Larsson & Sahlsten, 2016).

Evidence-based practice competence was described as the ability to provide evidence-based care (Beiboer et al., 2023; Carney, 2009; Larsson & Sahlsten, 2016). Moreover, decision-making competence included critical thinking, the ability to make decisions and problem-solving skills. Critical thinking was described as the ability to think, reflect and evaluate critically (Boutin et al., 2025; Guibert-Lacasa & Vázquez-Calatayud, 2022; Jack et al., 2022; Supamanee et al., 2011), while decision-making competence was described as the ability to make decisions about patient care (Carney, 2009; Enghiad et al., 2022; Fealy et al., 2015; Guibert-Lacasa & Vázquez-Calatayud, 2022; Mianda & Voce, 2018; Pepin et al., 2011; Scott et al., 2025; Stanley, 2006, 2009; Stanley & Stanley, 2018; Supamanee et al., 2011). Problem-solving was described as the ability to prevent and solve problems and address unpredictable situations that occur in clinical practice (Burns, 2009; Ennis et al., 2015; Larsson & Sahlsten, 2016; Pepin et al., 2011; Supamanee et al., 2011). Self-development competence was described as the ability to educate oneself and as a commitment to lifelong learning and professional development throughout one's career (Carney, 2009; Pepin et al., 2011).

4.2.3 Innovation and change

The innovation and change domain consisted of visioning competence and change management competence.

Visioning competence was described as the ability to engage in future-orientated thinking, assess situations comprehensively, innovate and question established practices. Future-orientated thinking was regarded as the ability to have a vision and set direction (Boutin et al., 2025; Burns, 2009; Carney, 2009; Connolly et al., 2018; Davidson et al., 2006; Duprez et al., 2024; Iraizoz-Iraizoz et al., 2023; Mianda & Voce, 2018; Patrick et al., 2011; Stanley, 2006). The ability to assess situations comprehensively was described as forming a comprehensive understanding of a situation by considering multiple perspectives and seeing the big picture (Cook & Leathard, 2004; Davidson et al., 2006; Patrick et al., 2011; Scott et al., 2025; Supamanee et al., 2011). Moreover, the ability to innovate was described as discovering new ways of working (Chávez & Yoder, 2015; Cook & Leathard, 2004; Davidson et al., 2006; Nachtergaele et al., 2024; Pepin et al., 2011; Scott et al., 2025). The ability to question was described as thinking critically and open-mindedly, challenging established practices and identifying inefficiencies (Boamah, 2018;

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Connolly et al., 2018; Cook & Leathard, 2004; Davidson et al., 2006; Pepin et al., 2011; Scott et al., 2025).

Change management competence was described as the ability to initiate change (Duprez et al., 2024), advocate change (Beiboer et al., 2023) and implement change in practice (Budak & Özer, 2018; Casey et al., 2011; Chávez & Yoder, 2015; Cook & Leathard, 2004; Guibert-Lacasa & Vázquez-Calatayud, 2022; Mianda & Voce, 2018; Mrayyan et al., 2023; Nachtergaele et al., 2024; Pepin et al., 2011; Stanley, 2006).

4.2.4 Influencing and advocacy

Influencing and advocacy included influencing competence and patient advocacy competence. Influencing competence was described as the ability to influence and inspire colleagues and other professionals (Beiboer et al., 2023; Boamah, 2018; Boutin et al., 2025; Budak & Özer, 2018; Burns, 2009; Chávez & Yoder, 2015; Connolly et al., 2018; Enghiad et al., 2022; Ennis et al., 2013; Ennis et al., 2015; Husebø & Olsen, 2019; Iraizoz-Iraizoz et al., 2023; Jack et al., 2022; Karatepe & Türkmen, 2023; Mianda & Voce, 2018; Mrayyan et al., 2023; Nachtergaele et al., 2024; Patrick et al., 2011; Pepin et al., 2011; Rogers, 2017; Scott et al., 2025; Stanley, 2006, 2009; Stanley & Stanley, 2018; Supamanee et al., 2011), as well as to motivate and empower others (Beiboer et al., 2023; Budak & Özer, 2018; Burns, 2009; Carney, 2009; Enghiad et al., 2022; Ennis et al., 2013; Husebø & Olsen, 2019; Iraizoz-Iraizoz et al., 2023; Mianda & Voce, 2018; Nachtergaele et al., 2024; Patrick et al., 2011; Rogers, 2017; Stanley, 2006, 2009; Supamanee et al., 2011). Advocacy competence referred to the ability to advocate for both patients and fellow nurses. Patient advocacy was described as safeguarding patients' rights, representing their interests and ensuring that their voices, preferences and needs are respected in care decisions (Boamah, 2018; Davidson et al., 2006; Fealy et al., 2015; Nachtergaele et al., 2024; Rogers, 2017). Advocating for nurses was seen as defending nurses and the nursing profession (Scott et al., 2025).

4.2.5 Team leadership

Team leadership included team leadership competence and guidance competence. Team leadership competence comprised team formation (Boamah, 2018; Carney, 2009; Davidson et al., 2006; Iraizoz-Iraizoz et al., 2023; Patrick et al., 2011; Stanley, 2006; Stanley & Stanley, 2018), coordination (Al-Dossary et al., 2016; Boutin et al., 2025; Carney, 2009; Fealy et al., 2015; Grindel, 2016; Guibert-Lacasa & Vázquez-Calatayud, 2022; Husebø & Olsen, 2019; Larsson & Sahlsten, 2016; Mrayyan et al., 2023; Patrick et al., 2011; Pepin et al., 2011; Supamanee et al., 2011) and the promotion of a positive working atmosphere (Boutin et al., 2025; Ennis et al., 2013; Ennis et al., 2015; Husebø & Olsen, 2019; Nachtergaele et al., 2024; Pepin et al., 2011). Previous studies emphasised the importance of leaders' ability to build functional teams, coordinate tasks and workflows and foster supportive and collaborative environments. In addition, guidance competence, including supervision (Jack et al., 2022; Larsson & Sahlsten, 2016) and mentoring (Carney, 2009; Ennis et al., 2013; Husebø & Olsen, 2019; Larsson & Sahlsten, 2016; Mianda & Voce, 2018; Mrayyan et al., 2023; Patrick et al., 2011; Pepin et al., 2011; Stanley & Stanley, 2018), was highlighted as essential for supporting professional development and promoting autonomy and responsibility in clinical practice.

4.2.6 Communication and collaboration

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Communication and collaboration consisted of communication competence and collaboration competence. Communication competence included effective communication (Al-Dossary et al., 2016; Boamah, 2018; Budak & Özer, 2018; Burns, 2009; Chávez & Yoder, 2015; Cook & Leathard, 2004; Duprez et al., 2024; Enghiad et al., 2022; Ennis et al., 2013; Fealy et al., 2015; Grindel, 2016; Husebø & Olsen, 2019; Jack et al., 2022; Mrayyan et al., 2023; Nachtergaele et al., 2024; Patrick et al., 2011; Stanley, 2006, 2009; Stanley & Stanley, 2018; Supamanee et al., 2011) and dialogical competence (Al-Dossary et al., 2016; Beiboer et al., 2023; Boamah, 2018; Casey et al., 2011; Chávez & Yoder, 2015; Davidson et al., 2006; Duprez et al., 2024; Ennis et al., 2013; Ennis et al., 2015; Guibert-Lacasa & Vázquez-Calatayud, 2022; Iraizoz-Iraizoz et al., 2023; Jack et al., 2022; Larsson & Sahlsten, 2016; Patrick et al., 2011; Pepin et al., 2011; Stanley, 2006; Supamanee et al., 2011), emphasising the ability to communicate clearly and engage in open, reflective interaction through active listening, questioning and sharing perspectives.

Collaboration competence encompasses interprofessional collaboration (Boamah, 2018; Carney, 2009; Davidson et al., 2006) and professional collaboration (Al-Dossary et al., 2016; Beiboer et al., 2023; Budak & Özer, 2018; Chávez & Yoder, 2015; Duprez et al., 2024; Grindel, 2016; Patrick et al., 2011; Pepin et al., 2011). Previous studies highlighted the importance of the ability to work across professional boundaries and establish meaningful professional relationships and networks that support coordinated and high-quality care.

5. Discussion

5.1 A multidimensional framework for clinical leadership competence

The findings of this review provide a structured and comprehensive framework for clinical leadership competence in nursing. The framework supports systematic competence development during nursing education and enables students and nursing professionals to develop the competence needed for clinical leadership. The competence framework identified in this review aligns closely with the definition adopted in this study from Swift et al. (2025), as it conceptualises competence as a multidimensional integration of knowledge, skills, capability and professionalism, while simultaneously linking these attributes to their practical outcomes, namely safe practice, high-quality nursing care and optimal patient outcomes. The framework comprises six domains encompassing 14 related competences.

Ethics serves as the foundational pillar for clinical leadership competence. The ethics domain was the only one represented by a single competence: ethical competence, which includes ethical principles and values, professional integrity and accountability. The strong emphasis on ethics is not surprising, as it is consistently highlighted across professional guidelines and documents. Guidelines such as the ICN Code of Ethics for Nurses, revised in 2021 (International Council of Nurses [ICN], 2021), highlight ethics as inherent to the foundation of the nursing profession. This code of nursing ethics is acknowledged across several studies addressing clinical leadership in nursing (Beiboer et al., 2023; Lima Gelbcke et al., 2009; Mahoney, 2001), further supporting the integration of an ethical domain within the proposed framework. Stanley (2006) argued that clinical leaders are followed not because of hierarchical power but because of their visible commitment to ethical practice and integrity. Carney (2009) similarly linked clinical leadership to adherence to professional codes and ethical conduct, while Beiboer et al. (2023) specifically emphasised nurses' accountability for prioritising patient needs and preventing missed care in resource-constrained environments.

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Another foundational domain, professional nursing, represents the technical and developmental foundation of clinical leadership, encompassing clinical competence, quality and safety management, evidence-based practice, decision-making and self-development. Although these competences largely overlap with those expected of nurses generally, their consistent prominence in the review indicates that well-established clinical competence is essential for clinical leaders to gain credibility, influence practice and make sound decisions in complex care situations (Beiboer et al., 2023; Boamah, 2018; Chávez & Yoder, 2015; Larsson & Sahlsten, 2016). This interpretation is consistent with the practice-based and context-bound understanding of clinical leadership, whereby leadership is enacted in everyday patient care rather than through formal authority (Booher et al., 2021; Guibert-Lacasa & Vázquez-Calatayud, 2022).

The innovation and change and influencing and advocacy domains are closely connected and particularly central to clinical leadership because they enable clinical leaders to identify and shape improvements, mobilise colleagues, advocate for patients and the profession and influence organisational practices without relying on formal authority (Al-Dossary et al., 2016; Beiboer et al., 2023; Boamah, 2018; Chávez & Yoder, 2015; Nachtergaele et al., 2024). A critical question is how far these competences can develop during education, since authentic influence, advocacy and change management depend partly on clinical experience, professional credibility and organisational opportunities. Nevertheless, nursing education should establish their foundations through explicit learning outcomes and contextualised, experiential opportunities to question established practices, advocate for patients, collaborate in change and reflect on the consequences of actions; these foundations can then be consolidated and extended in working life (Brown et al., 2016; Duprez et al., 2024; Scammell et al., 2020).

Regarding team leadership, the literature emphasises a move towards collective and distributed leadership, where leadership is a shared process rather than a static role. Competences in coordination and team building are essential for integrating care across multidisciplinary teams and fostering unit synergy. Clinical leaders facilitate environments where others are enabled to act through shared decision-making and the recognition of individual contributions (Al-Dossary et al., 2016; Boamah, 2018; Boutin et al., 2025; Connolly et al., 2018; Patrick et al., 2011).

Advanced communication skills are crucial for managing interdependent relationships within the clinical environment. Therefore, the communication and collaboration domain holds great importance. This domain involves active listening, choosing appropriate language and being able to remain calm and confident during crises. Effective communication ensures the vital flow of information between different professions, particularly in high-pressure settings such as emergency departments or intensive care units. Collaboration is maintained through an attitude of openness and accessibility, which builds the trust necessary for high-performing teams (Al-Dossary et al., 2016; Boamah, 2018; Boutin et al., 2025; Ennis et al., 2013; Ennis et al., 2015; Larsson & Sahlsten, 2016). Communication and collaboration are also key competence areas in nursing more generally. However, the studies included in this review clearly demonstrated that clinical leadership requires nurses to possess particularly strong competence in both areas.

In summary, the clinical leadership competence framework consists of the following domains: ethics, professional nursing, innovation and change, influencing and advocacy, team leadership and communication and collaboration. Clinical leadership competence can be seen as an integration of high-level clinical expertise, values-congruent actions and advanced relational abilities. Furthermore, it involves the ability to innovate and influence others, as well as to collaborate and work in teams. Developing these competences requires a transition from simply ‘doing’ to a reflective, evidence-based praxis that empowers the entire healthcare team at the

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point of care, while also supporting the development of healthcare services and contributing to better health outcomes for patients and society.

5.2 Educational implications for developing clinical leadership competence

The framework developed in this study helps clarify the concept of clinical leadership by highlighting its key domains and the areas in which it is demonstrated. In this way, nursing education stakeholders can undertake assessments of curricula or learning programmes and verify the extent to which the domains and competences presented are reflected in their respective curricula. Such assessment requires depth, as the analysis must focus not only on whether a given domains or competence is addressed within the framework but also on how it is approached. As a contribution to the discussion, it is proposed that certain domain and competences will be more readily developed through teaching typologies suited to their nature and characteristics. For example, while the ethical domain may initially be developed through more theoretical foundations, the communication domain will require an approach that is, from the outset, more firmly grounded in practical situations or even simulation.

Some of the domains presented, such as professional nursing or communication and collaboration, may be developed more effectively in simulation and clinical placement contexts, which provide valuable settings for the learning and consolidation of clinical leadership competences (Melo et al., 2020; Paim et al., 2021; Hashish & Bajbeir, 2022; Spigelmyer & Loughran, 2022). On the other hand, domains such as innovation and change or influencing and advocacy may be more difficult to develop in practical settings and will therefore require approaches more closely associated with reflective learning in the classroom, such as flipped-classroom methodologies or student-led conferences, identified as appropriate for developing competences found within the framework (Öz & Abaan, 2021; De Juan Pardo et al., 2021). The ability to influence others, which features prominently in the framework, may be fostered through methodologies such as student-run teams the ideal context for fostering its development among students (Reime et al., 2022). Still, methodologies such as simulation may also be indicated for the development of the skills related to this domain, as suggested by Ha and Pepin (2018).

5.3 Conceptual considerations and directions for future research

During the analytical process, it was observed that many studies described clinical leadership through the personal characteristics of nurses rather than through their competences. The distinction between characteristics and competences was not straightforward in the review, nor was it always necessary or reasonable. Consequently, some expressions that could be interpreted as characteristics were described as competences, given that the review is strongly grounded in nursing education and, as competence descriptions, they can be more readily integrated into teaching.

Finally, it is also worth highlighting, particularly from an educational perspective, that the competences aimed at fostering clinical leadership in nursing students overlap substantially with the characteristics expected of all nurses, not exclusively of clinical leaders. This discussion was initiated by Stanley (2006), who proposed the concept of congruent leadership, representing the alignment between practical competences, the work performed in practice and values and beliefs about care. Rather than focusing solely on specific competences, exploring how to

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optimise this congruence in nursing students may make a valuable contribution to reflection on curricula design and development, with a view to nurturing clinical leadership.

Further research is needed to strengthen the evidence base regarding methods that support the development of clinical leadership competence. In particular, there is a need to examine how the development of clinical leadership can be supported during the early stages of a nurse's career. If undergraduate nursing education can establish a foundation for becoming a clinical leader, working life should also be able to support this developmental process effectively. Future research should also evaluate the framework across diverse educational and healthcare contexts.

5.4 Limitations and strengths

This study has limitations that should be considered when interpreting the findings of this review. First, both original research and reviews were included in this study, and this may have resulted in some overlap in the evidence base. Second, the included studies were mainly conducted in high-income Western countries, which may limit the transferability of the findings to different kinds of healthcare and educational systems or cultural contexts. Third, while the studies included in the literature review represented a range of nursing specialties and healthcare settings, not all the nursing specialities or contexts were covered; therefore, some specific characteristics of clinical leadership may not have been recognised in the review.

Regarding the strengths of the study, first, the analysis was conducted by two researchers and discussed repeatedly within the wider research group, thereby strengthening the credibility of the interpretive process. The research group included members from three countries, providing multiple contextual perspectives and potentially reducing the influence of assumptions arising from a single national nursing or educational context. Second, the article selection process was conducted systematically, with the research team discussing the different stages and resolving any uncertainties collaboratively. Third, the review included a relatively large number of articles (n = 36), providing a broad range of perspectives, with clear saturation reached during the analysis. Therefore, in the research team's view, the review enabled the development of a comprehensive framework describing clinical leadership in nursing.

Conclusions

This integrative review provided a structured framework for clinical leadership competence in nursing comprising six interrelated domains: ethics, professional nursing, innovation and change, influencing and advocacy, team leadership and communication and collaboration. The findings reinforce clinical leadership as a multidimensional, practice-based competence that is enacted in everyday patient care rather than being dependent on formal authority. Although many of the identified competences overlap with those expected of nurses more broadly, clinical leadership requires their particularly strong, integrated and context-sensitive application to influence practice, support others, advocate for patients and improve the quality and safety of care. The framework provides a basis for making clinical leadership more explicit, teachable and assessable in nursing education. Its foundations should be established through contextualised and experiential learning during nursing education and further strengthened through clinical experience and supportive practice environments.

Disclosure of the use of AI

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During the preparation of this work, the authors used Microsoft Copilot to assist with table formatting and language editing. The substantive content of all tables was created by the authors. Following the use of this tool, the authors reviewed and edited all outputs as needed and take full responsibility for the content of the published article**References**

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Figure 1. Study selection process

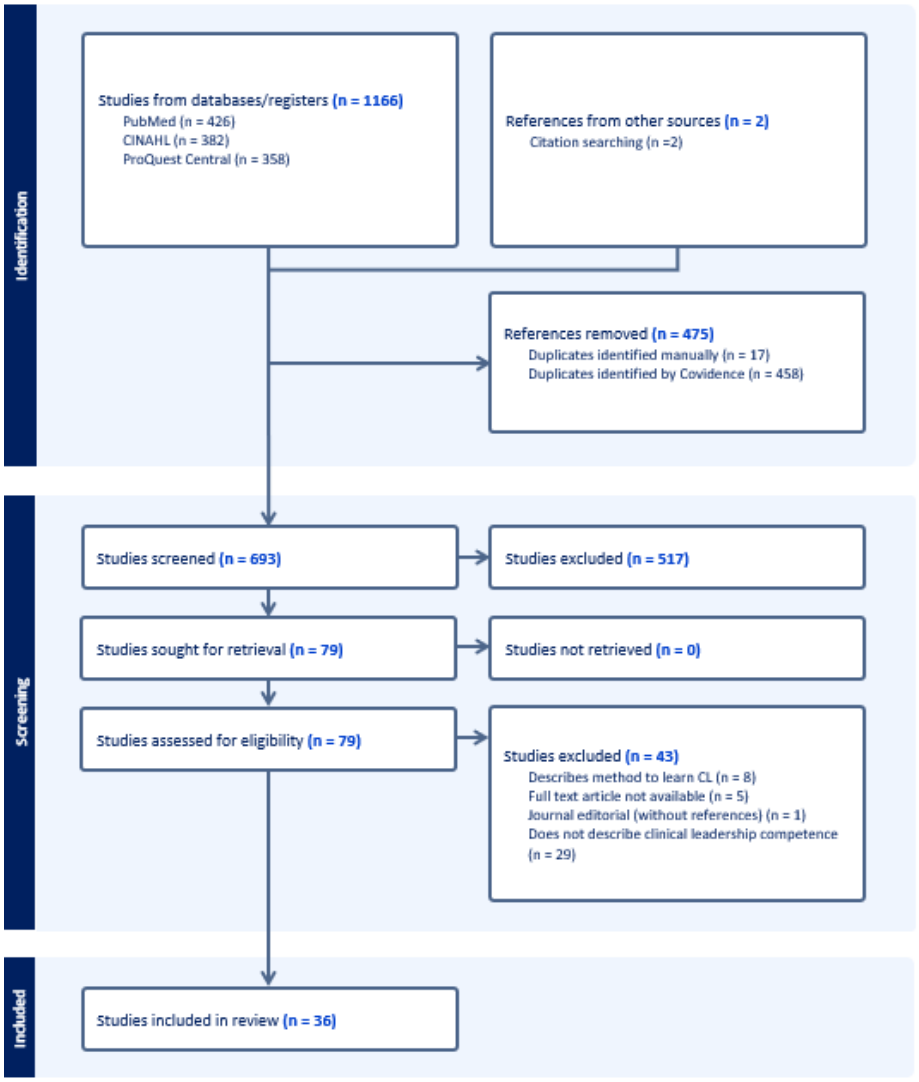


Figure 2. Results of the review



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Table 1. Quality appraisal of the selected studies

Mixed Methods Appraisal Tool (MMAT), qualitative studies

Study	Is the qualitative approach appropriate to answer the research question?	Are the qualitative data collection methods adequate to address the research question?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Total
Beiboer et al. 2023	Yes	Yes	Yes	Yes	Yes	100%
Boutin et al. 2024	Yes	Yes	Yes	Yes	Yes	100%
Burns 2009	Yes	Yes	No	No	Yes	60%
Carney 2009	Yes	Yes	Yes	Yes	Yes	100%
Cook & Leathard. 2004	Yes	Yes	No	Yes	Yes	80%
Ennis et al. 2013	Yes	Yes	No	Yes	Yes	80%
Ennis et al. 2014	Yes	Yes	No	Yes	Yes	80%
Fealy et al. 2015	Yes	Yes	No	Yes	Yes	80%
Husebø & Olsen 2019	Yes	Yes	Yes	Yes	Yes	100%
Larsson & Sahlsten 2016	Yes	Yes	Yes	Yes	Yes	100%
Nachtergaele et al. 2024	Yes	Yes	Yes	Yes	Yes	100%
Pepin et al. 2011	Yes	Yes	No	Yes	Yes	80%
Scott et al. 2025	Yes	Yes	Yes	Yes	Yes	100%
Stanley 2006 (BJN)	Yes	No	No	No	Yes	40%
Stanley 2006 (JRN)	Yes	No	No	No	Yes	40%
Stanley 2009	Yes	No	No	Yes	Yes	60%

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Supamanee et al. 2011	Yes	Yes	Yes	Yes	Yes	100%

Mixed Methods Appraisal Tool (MMAT), quantitative descriptive

Study	Is the sampling strategy relevant to address the research question?	Is the sample representative of the target population?	Are the measurements appropriate?	Is the risk of nonresponse bias low?	Is the statistical analysis appropriate to answer the research question?	Total
Patrick et al. 2011	Yes	Yes	Yes	Yes	Yes	100%
Al-Dossary et al. 2016	Yes	No	Yes	Yes	Yes	80%
Boamah 2018	Yes	Yes	Yes	No	Yes	80%
Budak & Özer 2018	Yes	No	Yes	No	No	40%
Karatepe & Türkmen 2023	Yes	No	Yes	Yes	Yes	80%
Mrayyan et al. 2023	Yes	No	Yes	No	Yes	60%

Mixed Methods Appraisal Tool (MMAT), mixed methods

Study	Is there an adequate rationale for using a mixed methods design to address the research question?	Are the different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Total
Casey ym. 2011	Yes	Yes	Yes	Yes	Yes	100%
Connolly et al. 2018	No	No	Yes	No	No	20%
Rogers 2017	Yes	No	Yes	No	No	40%

JBI Quality appraisal for Expert Opinions

Study Yes=Y No=N Unclear=U	Is the source of the opinion clearly identified?	Does the source of opinion have standing in the field of expertise?	Are the interests of the relevant population the central focus of the opinion?	Does the opinion demonstrate a logically defended argument to support the conclusions drawn?	Is there reference to the extant literature?	Is any incongruence with the literature/sources logically defended?

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Not applicable=NA											
Davidson et al. 2006	Yes		Yes		Yes		Yes			Yes	Yes
Grindel 2016	Yes		Yes		Yes		Yes			Yes	Yes

JBI checklist for systematic reviews

Study Yes=Y No=N Unclear=U Not applicable=NA	Is the review question clearly and explicitly stated?	Were the inclusion criteria appropriate for the review question?	Was the search strategy appropriate?	Were the sources and resources used to search for studies adequate?	Were the criteria for appraising studies appropriate?	Was critical appraisal conducted by two or more reviewers independently?	Were there methods to minimize errors in data extraction?	Were the methods used to combine studies appropriate?	Was the likelihood of publication bias assessed?	Were recommendations for policy and/or practice supported by the reported data?	Were the specific directives for new research appropriate?
Duprez et al. 2024	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes
Enghiad et al. 2022	Yes	Yes	Yes	Yes	Yes	U	U	Yes	NA	Yes	Yes
Guibert-Lacasa & Vázquez-Calatayud 2022	Yes	Yes	Yes	Yes	Yes	Yes	U	U	NA	Yes	Yes
Iraizoz-Iraizoz 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	Yes
Mianda & Voce 2017	Yes	Yes	Yes	Yes	Yes	U	U	No	NA	Yes	Yes
Stanley & Stanley 2018	Yes	U	Yes	Yes	Yes	U	U	U	NA	Yes	Yes

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Table 2. Summary of the selected studies (n=36)

Author, year, country	Purpose	Design	Participants, sample size, data collection, analysis method	Findings of interest in this review
1. Al-Dossary et al. (2016), Saudi Arabia	To assess differences in leadership skills between newly graduated nurses who completed a residency programme and newly graduated nurses who did not participate in a residency programme.	A cross-sectional survey	Newly graduated Saudi nurses (n=98; residents n=43, non-residents n=55), the Clinical Leadership Survey in paper-and-pencil format, and descriptive and inferential statistics.	Clinical leadership includes the following practices: clinical expertise, effective communication, collaboration, coordination and interpersonal understanding.
2. Beiboer et al. (2023), Netherlands	To explore how nursing teams on inpatient hospital wards use teamwork to prevent or reduce missed nursing care and how teamwork is influenced by clinical leadership skills and environmental factors.	A qualitative exploratory study	Registered nurses (n=16), Focus group interviews, Thematic analysis	Clinical leadership skills encompass the ability to act as a professional role model and to provide expert, evidence-based nursing care grounded in theory and research. They also involve demonstrating an understanding of organisational theory to support and influence policy development, as well as collaborating effectively with colleagues and interprofessional teams to ensure optimal healthcare delivery. Clinical leaders assume responsibility for offering patients accurate information and appropriate

				support, and they engage in advocacy to promote changes that benefit both patients and the healthcare organisation. Furthermore, they adhere to nursing codes of ethics and standards of practice, maintain visibility and approachability within the clinical environment, and motivate team members to work toward shared goals.
3. Boamah (2018), Canada	To analyse the critical attributes of clinical leadership and test a model linking clinical leadership behaviours of staff nurses to patient care quality and job satisfaction.	A predictive cross-sectional design	Registered nurses (n=378), a survey consisting of three scales (the Clinical Leadership Survey, the global measure of job satisfaction, and nurses' perceptions of patient care quality), and descriptive statistics and structural equation modelling.	Clinical leadership involves the ability to empower team members to participate in clinical decision-making that supports safe, patient-centred outcomes. It includes the capacity to inspire a more comprehensive approach to patient care through effective communication, collaboration with other healthcare professionals, patient advocacy, and a willingness to question established practices. Additionally, clinical leaders demonstrate the ability to build strong social networks and foster constructive professional relationships with colleagues.

4. Boutin et al. (2025), Canada	To describe the exercise of clinical leadership by nurses within hospital care units, identify the factors influencing it and explore how nurses perceive its impact.	Qualitative multiple case study	Registered nurses (n=131), 36 interviews, 120 hours of observation and 66 documents, Thematic and cross-case analyses	Clinical leadership entails the ability to initiate and promote reflective thinking within the team, as well as the capacity to influence others in ways that support high-quality care. Effective clinical leaders can coach colleagues and facilitate their professional growth, thereby enabling improvements in care quality. They also contribute directly to enhancing the overall quality of care by fostering team cohesion and strengthening collaborative capabilities within the team. In addition, clinical leaders promote autonomy in daily practice and help cultivate a positive and supportive work climate.
5. Budak & Özer (2018), Turkey	To investigate the clinical leadership qualities of physicians and nurses and to examine the effects of different variables on the subdimensions of clinical leadership.	A cross-sectional survey	Registered nurses (n=196) and physicians (n=65), the Clinical Leadership Scale, and descriptive and inferential statistics.	The concept of clinical leadership is understood as a combination of leadership behaviours—such as organising systems, influencing others, promoting shared values, and applying clinical expertise—to meet the needs of patients as the central focus of healthcare delivery. Clinical leadership is grounded in the principle of

				shared leadership rather than a hierarchical leader–follower model, and it is distinguished from other leadership theories by its emphasis not only on specific leadership competencies but also on the collective responsibility for the success of service units and healthcare organisations.
6. Burns (2009), UK	To describe the concept of clinical leadership from a general practice nurse's perspective and determine nurses' clinical leadership needs.	A qualitative study adopting a phenomenological approach	General practice nurses (n=12), in-depth interviews, and Colaizzi's analysis method.	Clinical leadership involves providing support to colleagues by offering clear guidance and encouragement, as well as delivering professional assistance that strengthens their confidence and capacity to perform effectively.
7. Carney (2009), Ireland	To identify how clinical leadership skills are perceived by public health nurses in the course of their everyday work and to examine the effectiveness and consequences of such skills in primary care delivery.	A narrative qualitative study	Public Health Nurses (n=20), narrative interviews and analysis	Clinical leadership encompasses the capacity to promote effective interprofessional collaboration and to facilitate high-quality practice by applying evidence-based care. It requires adherence to professional codes of conduct and a commitment to mentoring both students and colleagues. Clinical leaders make clear and informed decisions, build and guide

				teams, and cultivate strong therapeutic relationships with clients while encouraging active team involvement. They also support ongoing professional development, motivate staff, ensure safe practice, and articulate a forward-looking vision for the future of care delivery.
8. Casey et al. (2011), Ireland	To describe nurses' and midwives' clinical leadership development needs.	A concurrent triangulation mixed methods design	Nurses and midwives participated in focus group interviews (n=184) and responded to the Clinical Leadership Analysis of Need Questionnaire (n=911), Thematic analysis and descriptive and inferential statistics.	Clinical leadership draws on key emotional and social competencies. These include self-awareness; such as recognising one's own emotions and maintaining self-confidence, and social awareness, characterised by empathy, a strong service orientation, and the ability to enable others. Effective leaders demonstrate self-regulation through self-control, trustworthiness, and the capacity to cope with change, while also exercising well-developed social skills in their interactions with colleagues and patients. In addition, they show self-motivation, which supports sustained commitment to high-quality

				practice and continuous improvement.
9. Chávez & Yoder (2015), USA	To provide a concept analysis of staff nurse clinical leadership	Concept analysis	14 articles, Walker and Avant concept analysis method	Nurses' clinical leadership competence is characterized by informal, emergent leadership, where staff nurses influence others and guide care delivery without holding formal managerial authority. This competence rests on high clinical expertise, effective communication, and strong relational coordination with other professionals in the healthcare team. To maintain their leadership role, clinically competent nurses must be able to initiate and manage change and innovation in their everyday clinical practice.
10. Connolly et al. (2018), New Zealand	To examine clinical leadership of registered nurses in an emergency department, based on evidence that it is important for nurses to feel psychologically and structurally empowered in order to act as clinical leaders.	Mixed-method, non-experimental descriptive design	Registered nurses (n=37), Online questionnaire with three validated surveys: Clinical Leadership Inventory (CLI), Psychological Empowerment Scale (PES), Conditions of Work Effectiveness Questionnaire-II (CWEQ-II) Four open-ended questions analysed thematically.	Clinical leadership competence among ED nurses is supported by effective teamwork, collaboration, and communication, which enable nurses to influence practice in everyday clinical work. Nurses most commonly demonstrate leadership through clear communication, providing support to colleagues, mentoring others, and leading by example, with "modelling

				the way" and "enabling others to act" rated as their strongest leadership behaviours.
11. Cook & Leathard (2004), UK	Research questions: What could be learnt about the attributes of effective clinical nurse leaders from observing their professional practice and talking with them? Is it possible to describe the attributes of effective clinical nurse leaders? Is it possible to identify developmental opportunities and activities that might enhance the appreciation and application of these attributes?	Ethnographic and interpretative, using a grounded theory and a grounded theory approach	Registered nurses (n=4), observations and interviews; data were analysed using the Strauss and Corbin method.	Five core attributes were identified as defining effective clinical nurse leadership: creativity, the ability to make practice visible, influence over others, respect for colleagues, and a strong commitment to providing support.
12. Davidson et al. (2006), Australia	To define and describe clinical leadership and identify the facilitators and barriers to clinical leadership. To describe strategies to develop clinical leaders in Australia	Expert opinion		Nurses' clinical leadership competence is grounded in expert clinical practice, the ability to influence care delivery, and a sustained focus on patient outcomes, rather than formal authority. Effective clinical leaders demonstrate vision, collaboration, communication, mentorship, and innovation, enabling practice change within interdisciplinary teams. However, their leadership is often constrained by organisational structures,

				staffing shortages, limited participation in decision-making, and inadequate empowerment, highlighting the need for systemic support to develop and sustain clinical leadership.
13. Duprez et al. (2024), Belgium, Netherlands	To identify strategies that develop clinical nursing leadership competencies among staff nurses, and to explain the contextual elements and mechanisms that underpin the development of clinical nursing leadership competencies.	Realist review	10 articles, three iterative phases: development of initial programme theory, structured searches for relevant published and grey literature and data synthesis and interpretation by researchers and theory triangulation, and discussions within the research group.	Clinical leadership competence can be described as the capacity of nurses to lead care through strong clinical expertise, effective communication, collaboration, and interpersonal skills, while aligning vision, values, and action in daily practice. It involves the ability to initiate and sustain innovation and change, influence others, and support shared goals within the healthcare team.
14. Enghiad et al. (2022), Canada	To understand the concept of clinical leadership and clinical leadership development for nurses working with older adults.	Integrative literature review	16 articles, thematic analysis	Clinical leadership competence is best understood as a form of practice-based, values-driven, and predominantly informal leadership exercised by nurses at the point of care. It is characterised by strong clinical competence, effective communication, teamwork, decision-making, and the ability to influence and

				empower others without formal authority. Clinical leadership competence is grounded in nurses' personal and professional values, which align with their actions and motivate high-quality, person-centred care.
15. Ennis et al. (2013), Australia	To develop an understanding of what nurses working in mental health settings describe as the characteristics or attributes of effective clinical leaders.	Grounded Theory	Registered nurses (n=12), Individual semi-structured interviews, the data were analysed in a manner consistent with grounded theory	Clinical leadership competence is reflected in the ability to communicate effectively and build trusting relationships, using appropriate language, active listening, awareness of nonverbal cues, and assertiveness. It involves being approachable and relationship-oriented, enabling strong connections with patients, families, and team members. Through skilled communication, a clinical leader can influence others, provide support, empower colleagues, and inspire motivation, thereby strengthening teamwork and quality of care.
16. Ennis et al. (2014), Australia	Explore the perceptions of nurses working in mental health of effective clinical leadership	Grounded theory	Registered nurses (n=12), Individual in-depth interviews, the data were analysed in a manner	Clinical leadership competence is demonstrated through the ability to remain calm, confident, and

			consistent with grounded theory	composed during crisis and uncertainty, while effectively managing unpredictable and complex clinical situations. It includes acting as a positive role model in practice, fostering a supportive and constructive environment that promotes learning and resilience, particularly in challenging clinical contexts. Through strong interpersonal, problem-solving, and therapeutic communication skills, clinical leaders influence improved outcomes for consumers and contribute to the development of confident, compassionate practitioners.
17. Fealy et al. (2015), Ireland	To evaluate the service impact of a national clinical leadership development programme.	A case study design	Registered nurses and midwives and line managers (n=70), focus groups and Individual interview, document analysis, non-participant observation, data analysis involved a modified multi-stage approach	Clinical leadership competence is reflected in a set of contextually grounded intrapersonal and interpersonal capabilities that guide nurses' practice and development. It encompasses self-awareness, advocacy and empowerment, sound decision-making, and effective communication, alongside a strong commitment to quality and safety, teamwork, and

				clinical excellence. Together, these competencies shape how clinical leaders understand themselves, interact with others, and enact leadership within specific practice settings.
18. Grindel (2016), USA	To emphasize the need for clinical leadership among bedside nurses to ensure quality patient care, patient safety, and efficient work processes.	Expert opinion		Clinical leadership competence is the ability to apply strong clinical expertise, knowledge of quality and safety, and evidence-based practice within the care environment, while understanding healthcare systems and resource use. It is underpinned by emotional intelligence, ethical accountability, and professional integrity, and enacted through communication, coordination, and collaboration. Effective clinical leaders adapt these skills to the context, proactively improve care processes, and motivate others to enhance patient outcomes and the practice environment.
19. Guibert-Lacasa & Vázquez-	To identify the most effective interventions to facilitate	Systematic review	6 articles, data extraction, quality appraisal and narrative synthesis were	Clinical leadership competence is strengthened through multicomponent

Calatayud (2022), Spain	nurses' clinical leadership in the hospital setting		conducted in line with Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines.	development that integrates cognitive, interpersonal, and intrinsic competencies. It involves strong problem-solving and decision-making abilities, effective relationship-building and teamwork, and intrinsic capacities such as psychological empowerment, emotional intelligence, and critical self-reflection.
20. Husebø & Olsen (2019), Norway	To explore the activities performed by clinical leaders (charge nurses and doctors on-call) in the ED and to identify similarities and differences between their activities after completing a Clinical Leadership course.	Qualitative exploratory design	Five charge nurses and four on-call physicians in the emergency department were shadowed. Thematic analysis	Clinical leadership competence in the emergency department is the ability to combine strong clinical expertise and direct involvement in care with advanced interpersonal skills, role modelling, and empowerment of others. It is expressed through anticipatory, proactive coordination of care, effective communication and delegation, management of patient flow and priorities, and continuous quality assurance. In this fast-paced context, clinical leaders guide teams, secure resources, multitask effectively, and ensure safe, high-quality, patient-centred

				care while supporting and coaching colleagues.
21. Iraizoz-Iraizoz (2023), Spain	To explore the existing knowledge in the literature about nurses' clinical leadership in the intensive care unit	Scoping review	11 articles, thematic synthesis	Clinical leadership competence in intensive care units is characterised by transformational and situational leadership abilities, including idealised influence (professional expertise, autonomy, and communication), inspirational motivation (role modelling, vision, and integrity), intellectual stimulation (encouraging learning and team empowerment), and individual consideration grounded in emotional intelligence. Effective communication skills and extensive professional experience are key enablers of clinical leadership in this high-acuity setting.
22. Jack et al. (2022), Ireland, Israel, Netherlands, Portugal, Sweden, Switzerland, UK	To undertake a concept analysis of clinical leadership in nursing students.	Concept analysis	16 articles, Walker and Avant concept analysis method	Clinical leadership competence is demonstrated through effective interpersonal communication, up-to-date clinical expertise, and visible role modelling grounded in personal and professional values. It involves supporting and developing others through

				supervision, feedback, mentoring, and delegation, while prioritizing safe, high-quality care. When fostered through education and practice-based leadership support, this competence leads to strong team engagement, learner development, and improved quality and safety of care.
23. Karatepe & Türkmen (2023), Turkey	To investigate the serial multiple mediation of transformational and clinical leadership in the relationship between work overload and quality of life among clinical nurses and to test a model designed to examine the fit and relations between these variables.	Model-testing design with cross-sectional data	Registered nurses (n=415), a survey consisting of the following scales: the Work Overload Scale, Transformational Leadership Scale, Clinical Leadership Scale, and Quality of Work Life Scale; descriptive and inferential statistics.	Clinical leadership competence is the ability to provide expert, visible, and values-based leadership embedded in clinical care, characterized by role modelling, facilitation of safe and high-quality care, and working across professional boundaries. It includes motivating others to lead change, identifying and improving inefficient processes, and exercising autonomous, communicative, and supportive leadership to enhance patient outcomes and team performance.
24. Larsson & Sahlsten (2016), Sweden	To describe RN perceptions of what it entails to be the leader at the bedside of inpatient physical care.	Descriptive, qualitative, phenomenographic approach	Registered nurses (n=15), open interviews, phenomenographic analysis	Clinical leadership competence is the ability to combine strong clinical knowledge and

				evidence-based practice with collaborative, reflective, and structured coordination of care. It involves creating a respectful team culture, being visible and approachable in patient care, organizing work around patient needs, and monitoring and supporting colleagues' practice to ensure safe, high-quality care.
25. Mianda & Voce (2018), South Africa	To understand the ways in which clinical leadership is conceptualized from the perspective of frontline health care providers	Systematic review	8 articles, qualitative synthesis	Clinical leadership competence is defined by strong clinical expertise, moral and professional values, and continuous clinical engagement, combined with approachability, visibility, and effective communication. It includes the ability to role model best practice, influence and motivate others, remain calm in crisis, support and guide colleagues, and promote change that improves standards of care, with leadership exercised through informed clinical decision-making and a clear focus on patient outcomes.
26. Mrrayan et al. (2023), Jordan	To assess clinical nursing leadership in Jordan	Cross-sectional study	Registered nurses (n=296), Survey (Clinical Leadership Scale),	Clinical leadership competence is defined as a values-driven, practice-based

			Descriptive and inferential statistics	capacity enacted by nurses in everyday clinical work rather than in formal managerial roles. It is characterised by clinical competence, effective communication, approachability, visibility in practice, role modelling, and supportive behaviours, underpinned by strong moral character and integrity. Clinical leadership competence is expressed through actions such as leading change and service improvement, empowering and supporting colleagues, participating in staff development, and influencing the quality and safety of care, thereby enabling innovation, teamwork, and improved patient and organisational outcomes.
27. Nachtergaele et al. (2024a), Belgium	To conceptualise and identify characteristics of clinical leadership in the nursing home setting.	A qualitative study	Healthcare professionals from nursing and other healthcare disciplines working in nursing homes (n=41), Focus group interviews, Qualitative thematic content analysis	Clinical leadership competence in nursing homes is defined by a strongly person-centred and team-oriented approach, combining clinical expertise, effective communication, and relational leadership. It involves being empathetic, accessible, resilient, and

				responsive, while serving as a trusted role model who motivates others, anticipates challenges, and delivers high-quality, person-centred care in a complex and changing care environment.
28. Patrick et al. (2011), Canada	To test the psychometric properties of the clinical leadership survey.	A non-experimental survey design	Registered nurses (n=480), Clinical Leadership Survey, Statistical methods, Psychometric evaluation	Clinical leadership competence is defined by the integrated use of clinical expertise, effective communication, collaboration, coordination, and interpersonal understanding. It involves applying clinical knowledge to influence and challenge practice, clearly articulating information to empower others, coordinating care and information flow across teams, and building trusting, supportive relationships that enable teamwork, reflective practice, recognition of others' contributions, and high-quality patient-centred care.
29. Pepin et al. (2011), Canada	To develop a cognitive learning model of the clinical nursing leadership competency, from the beginning of a nursing program to expertise	Interpretative phenomenological study	Nursing student (n=32) and registered nurses (n=21), in-depth interviews, Inductive analysis	Clinical leadership competence is the progressive ability to use clinical expertise, effective communication, collaboration, and interpersonal understanding to

				influence care, support others, and challenge the status quo. It develops from self-awareness and confidence in one's capacity to lead, through active role modelling and team mobilisation, to initiating change, adapting leadership to context, and contributing to organisational decision-making in order to improve patient- and family-centred care.
30. Rogers (2017), USA	To explore influences on the emergence of informal clinical leadership among bedside nurses in the acute care hospital setting	Mixed methods design	Registered nurses (n=134), survey including the following scales: Clinical Leadership Behaviors Questionnaire and Psychological Capital Questionnaire, Open-ended questions	Clinical leadership competence is reflected in being an experienced, clinically skilled, and up-to-date practitioner who demonstrates strong professional integrity, a positive and empowering attitude, and patient-centred practice. It includes the ability to inspire and support others, act as a resource within formal or informal leadership roles and apply expertise flexibly—even in new or evolving situations—to improve care.
31. Scott et al. (2025), Australia	To understand and describe how clinical leadership practices in nursing are enacted	Descriptive qualitative design	Registered nurses (n=10), semi-structured thematic interviews.	The analysis resulted in four themes: leadership as coaching, leadership as

	within the emergency department from the perspectives of experienced emergency nurses.			supporting others, leadership as being where the department needs the leader to be, and leadership as sustaining and using hospital systems.
32. Stanley (2006a), UK	To identify who the clinical leaders are and critically analyse the experience of being a clinical leader.	Grounded theory	Phase 1: (questionnaire) Registered nurses (n=188) Phase 2 (focused interviews): Registered nurses (n=42) Phase 3 (clinical leader interviews): nurses identified by colleagues as clinical leaders (n=8), Constant comparison techniques	Clinical leadership competence is the ability to deliver credible, expert care while influencing others through visible, values-based practice. It includes clinical expertise and knowledge, effective and adaptable communication, sound decision-making, and the capacity to empower and motivate colleagues. This competence is further defined by being approachable, open, and non-controlling, acting as a role model, and remaining present and engaged in the clinical environment rather than distant from practice.
33. Stanley (2006b), UK	To identify who the clinical leaders are in a large NHS Trust in the English Midlands and to explore and critically analyse the experience of being a clinical nurse leader.	A qualitative study with a sequential mixed approach	Phase 1 (questionnaire): registered nurses (n=188) Phase 2 (focused interviews): registered nurses (n=42); Phase 3 (clinical leader interviews): nurses identified by colleagues as clinical leaders (n=8);	Clinical leadership competence can be understood as the ability to provide expert, visible, values-driven nursing care that positively influences colleagues through example rather than authority. It is grounded in clinical credibility,

			constant comparison techniques.	effective communication, approachability, and empowerment, with leadership enacted at the point of care through consistent alignment between professional values and clinical actions.
34. Stanley (2009), Australia	To discuss the significance of congruent leadership theory for the development of clinical leadership in operating theatres.	Grounded theory	Phase 1: (questionnaire) Registered nurses (n=188) Phase 2 (focused interviews): Registered nurses (n=42) Phase 3 (clinical leader interviews): nurses identified by colleagues as clinical leaders (n=2), A computer-assisted qualitative data analysis	Clinical leadership competence is best understood as a values-driven, practice-based form of leadership enacted at the bedside rather than through formal authority. It is characterized by being clinically competent, visible, approachable, and effective in communication, with leaders influencing others through hands-on care, empowered decision-making, and positive role modelling. Unlike transformational leadership, clinical leadership is not driven by vision or creativity, but by congruence between personal values, beliefs, and everyday clinical actions—a form of leadership explained by congruent leadership, where nurses are followed because of how they act and care, not

				because of their title or future goals.
35. Stanley & Stanley (2018), Australia	To explore the concept of clinical leadership, including its definition, attributes of effective and less effective clinical leaders, leadership models, and the barriers to clinical leadership development	A literature review	27 articles, Data synthesis	Clinical leadership competence is the ability to deliver expert, high-quality clinical care while empowering, supporting, and influencing others through values-based practice rather than formal authority. It is characterized by clinical competence and knowledge, effective communication, approachability, visibility, teamsmanship, and role modelling, with leadership enacted through day-to-day decision-making, mentoring, and participation in staff development. Clinical leaders are followed because their beliefs and actions are aligned, not because they hold positions of control or promote visionary goals.
36. Supamanee et al. (2011), Thailand	To explore the clinical nursing leadership competency perspectives of Thai nurses working in a university hospital.	A qualitative exploratory study	Registered nurses (n=31) and nurse administrators (n=23), Focus groups with registered nurses and Individual semi-structured face-to-face interviews with nurse administrators,	Clinical leadership competence is the integration of deep personal drivers and professional skills that enable nurses to lead effectively in complex care situations. It combines hidden characteristics—such as

			a qualitative content analysis, guided by Spencer and Spencer's Iceberg Model of Competency.	strong professional values, self-confidence, emotional maturity, motivation for self-development, and commitment to patient-centred care—with surface characteristics, including advanced clinical knowledge, rapid and sound clinical decision-making, effective communication, coordination, negotiation, and clinical management skills. Together, these competencies allow nurses to adapt, lead teams, and ensure high-quality, safe care as clinical complexity increases.

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