

Clinical leadership in nursing education

"Shaping clinical leadership in nursing internships: Learning goals and insights from a workshop with nursing internship supervisors"

*These workshop results were **developed** within the Erasmus+ KA220-HED project "Clinical leadership in nursing education" and has been co-funded with support from the Erasmus+ Programme of the European Union.*

The European Commission's support for the production of this publication does not constitute an endorsement of the contents, which reflect the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

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Disclaimer – Contextual Scope of the Findings

The findings presented in this document primarily reflect the perspectives gathered during a workshop with internship supervisors in Belgium and should therefore be interpreted within this specific national and educational context. While these insights provide a valuable foundation for understanding the development and assessment of clinical leadership during internships, they represent only one part of a broader, collaborative process within the ERA+ project. Input and feedback from the international project partners are included in subsequent sections of this document, where they further complement, nuance, and broaden the perspectives presented here.

Introduction

Within the Erasmus+ KA220-HED project "Clinical leadership in nursing education" a workshop was organized with nursing internship supervisors focusing on clinical leadership within nursing internship. These internship supervisors, registered nurses who mentor, guide, and assess nursing students during their clinical placements, explored how competencies related to clinical leadership are currently observed, evaluated, and developed during nursing internships.

For this workshop, clinical leadership was approached using the clinical leadership in nursing education competency framework developed within this project (see figure), a more detailed version of this framework is available on the project website.



Source: ERA+ consortium within the Erasmus+ KA220-HED project "Clinical leadership in nursing education"

Additionally, the definition of clinical leadership as used in this project was used in this workshop: clinical leadership is defined as the ability of a healthcare professional to use personal influence to impact individuals or groups, with the aim of improving patient outcomes and strengthening the broader healthcare environment. Clinical leaders recognize their influence as well as their professional and ethical responsibilities. They are clinical experts who provide direct patient care and demonstrate emotional intelligence in their actions. They challenge ineffective work processes and inspire others to act. From this position, they actively participate in decision-making within interprofessional practice settings, based on clinical autonomy. This definition was adopted by the Erasmus+ consortium and is based on Grindel (2016).

Through interactive exercises, participants reflected on which competencies are visible in practice, which remain difficult to assess, and how observable behavior can be translated into concrete learning goals for nursing students.

The findings presented in this document are drawn from these workshops but are not limited to them. The findings are context-dependent and influenced by differences between settings and supervisory approaches. They are further informed by ongoing discussions, analytical reflections, and exchanges within the project consortium, exchanges between education and clinical practice, as well as using existing conceptual frameworks. As such, the outcomes represent an interpretative synthesis in which empirical input from practice is combined with project-based analysis and expertise.

Key findings

- Clinical leadership requires **a shared yet flexible framework** that can accommodate diverse clinical contexts.
- The **context** of practice strongly shapes how clinical leadership is developed and demonstrated.
- A persistent **gap** exists **between educational expectations and clinical reality**.
- **Psychological safety** is a **prerequisite** for learning, experimenting, and leadership development.
- Clinical leadership should be made **explicit, observable, and discussable** in practice.
- Leadership is not a separate activity but is **embedded in everyday nursing practice**.
- The **development** of clinical leadership is **progressive**, evolving over time.
- **Expectations** regarding clinical leadership should be **aligned** with the **student's level and role**.
- Not all clinical leadership competencies are **equally observable or assessable**.
- **Assessment** should be contextualized and focused on growth, rather than solely on performance.
- Effective **assessment requires more than checklists**, incorporating reflection, dialogue, and professional judgment.
- **Mentors play a crucial role** in supporting and assessing students' clinical leadership development.

Exploring clinical leadership in nursing internship

Emerging themes

This section presents findings on how clinical leadership emerges and develops within Belgian nursing internship contexts. In line with the project proposal, a workshop was conducted in Belgium to gather perspectives of internship supervisors on clinical leadership in nursing internships. The findings presented here are based on participants' reflections during this workshop and do not originate from a review of the literature. The workshop reflections provided insight into the contextual conditions, learning processes, and structural challenges that shape the development of clinical leadership within the Belgian nursing education and practice context. Subsequently, these findings were discussed with the international partners of the ERA consortium to explore their relevance beyond the Belgian context and to identify areas of international consensus and divergence regarding the development of clinical leadership in nursing internships.

Context and learning environment for nursing students

The development of clinical leadership during nursing internships is **strongly shaped by the context** in which students are placed, particularly ward culture and the learning conditions provided. A supportive ward culture determines whether students are encouraged to take initiative, engage in decision-making, and actively participate in team processes. In environments characterized by openness, collaboration, and mutual respect, clinical leadership is more likely to be experienced as a shared and embedded aspect of daily practice.

Rather than functioning merely as a background condition, the clinical environment acts as an **enabling or constraining factor** for the enactment of clinical leadership. In this sense, leadership development can be understood as emerging from the interaction between the nursing student and the practice context, rather than as an individual attribute alone.

Closely related to this is the **importance of a psychologically safe learning environment**, in which students feel psychologically secure to ask questions, reflect on their actions, and experiment with new responsibilities without fear of negative consequences. Psychological safety is particularly crucial because many behaviors associated with clinical leadership, such as questioning decisions, expressing uncertainty, or initiating discussions, require a willingness to take interpersonal risks. Without such safety, students may remain passive observers rather than active participants in clinical practice.

Fostering clinical leadership in internships requires not only clearly defined learning goals, but also intentional attention to the learning environment, supervision practices, and the **opportunities provided to students** to actively engage in leadership within clinical practice. This suggests that enhancing clinical leadership development is not solely a matter of curriculum design, but also of shaping clinical learning environments that actively enable participation, dialogue, and progressive autonomy.

The extent to which students can demonstrate clinical leadership **depends on the level of responsibility and autonomy granted to them**. When students are entrusted with meaningful responsibilities, within appropriate supervision, they are better able to translate theoretical competencies into observable behaviors, such as coordinating care, communicating within the team, and contributing to decision-making processes. Without such opportunities, clinical leadership remains abstract and difficult to assess. This highlights a critical tension: while clinical leadership is often formulated as a set of competencies, its development depends on access to authentic participation in clinical nursing practices. Without meaningful opportunities to assume real responsibilities, leadership can be difficult to fully develop beyond a theoretical or conceptual level.

Gaps and transitions

The transitions within nursing education reveal several structural gaps that influence the development of clinical leadership. The first gap exists **between education and internship**, where theoretical learning objectives do not always seamlessly translate into the realities of clinical practice. Students often enter internships with predefined competencies yet encounter environments where these are interpreted differently or not explicitly foregrounded. This disconnect can make it difficult for both students and supervisors to align expectations and to make clinical leadership behaviors visible and assessable.

In addition, **unequal access to learning opportunities** further complicates this progression. Variations in ward culture, supervision style, patient population, and organizational context can lead to significant differences in what students are able to experience during their internships. Consequently, not all students are equally exposed to situations that allow them to develop or demonstrate clinical leadership. This variability highlights that the development of clinical leadership is partly dependent on contingent learning conditions, raising questions about equity and consistency in educational outcomes across internship settings.

A second gap emerges **between the internship phase and the professional field**. While internships aim to prepare students for autonomous practice, opportunities to fully exercise leadership roles often remain limited. As a result, newly graduated nurses may still need to further develop their clinical leadership capacities in the workplace, highlighting

the need for greater continuity between educational preparation and professional expectations. This suggests that clinical leadership development does not follow a linear trajectory but rather continues beyond graduation, requiring alignment across the continuum from education to practice.

These gaps can be understood as manifestations of a **broader misalignment between educational frameworks, clinical practice environments, and professional expectations**. Each of these domains operates with its own logic, priorities, and interpretations of competence, resulting in what can be described as boundary tensions. Addressing these gaps requires clearer alignment between education, internship, and practice, as well as deliberate efforts to ensure equitable and meaningful learning opportunities across clinical settings. In addition, it calls for a shared understanding of what constitutes clinical leadership in practice, to reduce ambiguity and support both learning and assessment.

Assessment challenges

Assessing clinical leadership in nursing internships presents several challenges. **Not all competencies** associated with clinical leadership **are easily observable or measurable in day-to-day practice**, particularly those related to attitudes, influence, or reflective thinking. As a result, supervisors may find it difficult to determine whether and to what extent nursing students have achieved these competencies. This challenge is further compounded by the lack of clear criteria and standardized assessment tools, which can lead to variability in how clinical leadership is interpreted and evaluated across different settings. A key difficulty lies in the distinction between observable behaviors and underlying competencies. While certain actions, such as communication or coordination, can be directly seen or heard, other dimensions of clinical leadership, such as influence, ethical reasoning, or critical reflection, remain inferential and require interpretation.

In practice, assessment often depends heavily on the individual mentor or supervisor, whose expectations, experience, and interpretation of clinical leadership may differ. As a result, assessment should not be understood as a purely objective measurement, but rather as a situated and interpretative judgement, shaped by the supervisor's frame of reference and the specific clinical context. This dependence can result in inconsistencies in evaluation and may affect the transparency and fairness of the assessment process. This raises **concerns regarding reliability and equity**, as different students may be evaluated against implicit and variable standards. Consequently, there is a need for more explicit frameworks and shared understandings that make clinical leadership competencies more concrete, while still acknowledging the complexity and context-specific nature of clinical practice. In addition, this suggests the value of combining multiple sources of information, such as direct observation, reflective dialogue, and feedback processes, to capture the

multifaceted nature of clinical leadership more accurately.

Internship structure

The development of clinical leadership during internships is often constrained by structural limitations within the educational trajectory. One of the main challenges is the limited time available for nursing students to develop leadership-related competencies. Internships are typically short and focused on multiple learning objectives, making it difficult for nursing students to gain sufficient experience in more complex roles such as coordinating care, influencing others, or contributing to team processes. As a result, clinical leadership development may remain superficial or fragmented. This challenge is not unique to a specific educational context, but reflects a broader issue across nursing programmes internationally, where internship structures are often characterized by **time constraints, fragmented placements, and competing learning priorities**.

This limitation highlights the **need for longer or more continuous internship experiences**, allowing students to engage more deeply in clinical practice and to take on increasing levels of responsibility over time. From a developmental perspective, this points to the importance of continuity and sustained participation in practice, as leadership capabilities require repeated exposure to complex situations rather than isolated learning experiences. Closely related to this is the importance of a gradual and phased development of competencies. Clinical leadership cannot be expected to emerge fully within a single placement; rather, it requires a **progressive build-up** across various stages of the curriculum, with opportunities to revisit and deepen learning in increasingly complex contexts. Such a phased approach aligns with competency-based education models that emphasize progression from guided participation toward increasing autonomy and responsibility in practice.

In addition, the current practice of evaluating a wide range of competencies simultaneously further complicates this process. When too many competencies are assessed at once, it becomes difficult for both students and supervisors to focus on meaningful development and clear observation of behaviors. This reflects a broader tension between breadth and depth in competency-based assessment, where the ambition to cover multiple domains may inadvertently reduce learning to fragmented and less meaningful experiences. A **more selective approach**, in which fewer competencies are prioritized and assessed in depth, may support more focused learning and provide better opportunities to make clinical leadership behaviors visible and assessable within the limited timeframe of internships. This also suggests the need for careful curriculum design, in which clinical leadership is not treated as an isolated competency, but is intentionally embedded and revisited across multiple learning experiences throughout the programme.

Clinical leadership in nursing education framework domain-specific remarks

Within the Belgian context, in which this workshop was conducted, several clinical leadership competencies are present but not always clearly articulated or fully operationalized, as reflected in the perspectives of internship supervisors. This suggests that clinical leadership is often embedded in practice in an implicit manner, rather than being explicitly recognized, named, or framed as leadership. This implicit nature of clinical leadership partly explains why students and supervisors may struggle to recognize leadership behaviors, as these are often embedded in routine care activities rather than explicitly labelled as leadership. This aligns with broader findings from our literature summary (ERA+ Clinical Leadership Literature Summary, 2026), which conceptualize clinical leadership in nursing not as a set of abstract competencies, but as a practice-embedded form of influence enacted in direct patient care and interprofessional interactions.

The analysis is structured around the domains of the "clinical leadership in nursing education framework" developed within the ERA+ project. These domains include, among others, ethical competence, clinical decision-making (professional reasoning), communication and interdisciplinary collaboration, reflective practice, and professional behavior. They provide a structure to interpret how clinical leadership becomes visible—or remains implicit—in internship practice.

Ethical practice, for example, is consistently part of daily care, yet it often remains implicit rather than being explicitly linked to clinical leadership or translated into concrete learning goals. Importantly, clinical leadership in nursing is closely intertwined with clinical expertise and judgement. Influence at the bedside depends on the ability to assess, prioritize, and act on patient needs, meaning that leadership development cannot be separated from the development of clinical competence. As a result, opportunities to recognize and develop ethical leadership may remain underutilized, as they are not systematically identified or discussed as part of leadership development.

Similarly, **communication** is recognized as essential, but its role within clinical leadership lacks clear definition, making it difficult to distinguish between general communication skills and leadership-oriented communication behaviors. This blurring of boundaries makes it challenging to differentiate between participating in communication and actively shaping communication processes as a form of leadership.

In addition, certain competencies — such as **motivating** others — are not always feasible for students to demonstrate, given their limited position and authority within the team. This highlights the need to carefully align expectations of clinical leadership with the student's role and level of responsibility, rather than directly transferring models derived from fully qualified professionals.

A broader challenge emerges when clinical leadership is conceptualized as **influence**: while influencing others is a core element of leadership, it is difficult to operationalize and assess in an internship setting where students are still developing confidence and are not always able to lead peers or shape team dynamics. From this perspective, clinical leadership in internships is often enacted at a micro-level, through small but meaningful actions in everyday practice, such as raising concerns, structuring communication, or coordinating care activities. In this context, influence may need to be reconceptualized as small-scale, situational actions, such as asking questions, sharing observations, or initiating dialogue, rather than overt leadership over others. Overall, these observations illustrate that although key elements of clinical leadership are present in internships, there remains a need to make them more explicit, contextually adapted, and realistically attainable for students within their current roles. This requires translating broad leadership concepts into concrete, observable, and level-appropriate behaviors that align with everyday clinical practice. At the same time, the literature highlights a limited evidence base regarding how these competencies develop in undergraduate nursing students, particularly in terms of observable behavioral change, reinforcing the need for further research in this area.

International perspectives on clinical leadership: Findings from the ERA+-consortium discussions

The Belgian workshop provided context-specific insights into the development of clinical leadership in nursing internships. To explore the broader relevance of these findings, they were subsequently discussed within the international ERA+ consortium. Across participating countries, consortium members recognized similar opportunities and challenges in supporting the development of clinical leadership during nursing internships, suggesting that many of the issues identified in the Belgian context are not unique to a single educational or healthcare system. This international exchange enabled a comparison of experiences across diverse educational and healthcare contexts, helping to distinguish context-specific observations from more widely shared challenges and enabling factors. The following section presents the key insights that emerged from these international discussions.

Confirming the importance of context

A key outcome of the international discussions was the **strong confirmation of the themes** identified during the Belgian workshop. Across participating countries, consortium partners similarly highlighted the decisive role of the clinical learning environment in shaping leadership development. Students' opportunities to demonstrate clinical leadership were reported to be strongly influenced by organizational culture, supervisory practices, levels of autonomy, and team dynamics. Clinical leadership was therefore consistently understood not as an individual attribute alone, but as a competence that develops through participation in authentic clinical practice.

The consortium discussions further reinforced the **importance of psychologically safe learning environments**. Students require opportunities to ask questions, express concerns, take initiative, and learn from mistakes without fear of negative consequences. At the same time, partners emphasized the need to gradually prepare students to exercise leadership in a variety of clinical environments, including those that may be less supportive.

Towards a shared understanding of clinical leadership

Although educational systems and internship structures differed across countries, a mutual understanding of clinical leadership emerged. Consortium partners agreed that clinical leadership is primarily enacted **within everyday nursing practice** rather than through formal leadership roles. Clinical leadership was associated with clinical expertise, professional judgement, effective communication, advocacy, teamwork, and the ability to positively influence patient care and collaborative processes.

At the same time, discussions highlighted that clinical leadership **often remains implicit** within nursing education and practice. Like the Belgian findings, partners reported challenges in recognizing, articulating, and assessing leadership behaviors when they are embedded within routine clinical activities. This underscores the need to translate broad leadership concepts into concrete and observable behaviors that are appropriate to students' developmental level and scope of practice.

Implications for learning and assessment

A recurring theme concerned the assessment of clinical leadership during internships. Consortium partners acknowledged that **some components of clinical leadership are more readily observable than others**. While behaviors such as communication, coordination, and participation in decision-making can often be observed directly, competencies related to ethical reasoning, influence, innovation, and vision are more difficult to assess within routine clinical practice.

As a result, participants agreed that **assessment** should extend **beyond checklist-based observation** and incorporate reflective dialogue, feedback, and exploration of students' reasoning processes. The discussions emphasized that clinical leadership development should be viewed as a longitudinal process, with expectations and assessment strategies evolving throughout the educational programme. Rather than attempting to assess all leadership competencies during every placement, assessment should be aligned with the learning opportunities available within specific clinical contexts and with students' progressive levels of responsibility.

Strengthening the connection between education and practice

Across participating countries, consortium members identified a continuing gap between educational preparation and the realities of clinical practice. While nursing programmes increasingly recognize the importance of clinical leadership, **opportunities** to practice and further develop leadership capabilities often **depend on workplace conditions** that lie beyond the direct control of educational institutions.

This observation reinforced the importance of **collaboration between educational programmes and clinical practice settings**. The successful development of clinical leadership requires not only clearly articulated learning goals, but also supportive workplace cultures, skilled mentorship, meaningful opportunities for participation, and a shared understanding of leadership expectations across the transition from student to registered nurse.

Implications for the ERA+ clinical leadership framework

Taken together, the international discussions validated many of the themes that emerged from the Belgian workshop while providing a broader cross-national perspective. They highlighted the need for a shared framework for clinical leadership development that offers sufficient consistency across educational contexts while remaining adaptable to local realities. Further, the findings suggest that clinical leadership should be conceptualized as a context-dependent, developmental process that emerges through active participation in clinical practice and is influenced by both educational and workplace environments.

Toward learning goals for clinical leadership in nursing curriculum

The learning goals presented in this section have been developed within the Erasmus+ KA220-HED project "Clinical Leadership in Nursing Education" and build upon the combined insights from workshop findings, project-level analysis, and international collaboration.

These learning goals are **not intended as a fixed or exhaustive set of competencies**, but rather as a proposed and context-sensitive framework to support the integration of clinical leadership within nursing curricula. They reflect an effort to translate the concept of clinical leadership into concrete, observable, and developmentally appropriate learning outcomes that can be applied across educational trajectories as well as within internship settings.

The proposed learning goals include **both goals** that can be addressed **throughout the nursing curriculum and** goals that are more specifically linked to the development and enactment of clinical leadership **during internships**. Together, they illustrate how the competencies within the framework may be translated into educational practice across various stages of learning and professional development.

Given the diversity of educational systems, clinical environments, and curriculum structures, these learning goals are designed to be adaptable. They may therefore **serve as a source of inspiration for institutions** seeking to strengthen clinical leadership development, while allowing for alignment with local contexts, programme structures, and pedagogical approaches.

Furthermore, the list of learning goals **should not be regarded as complete or definitive**. Rather, it represents a collection of learning goals associated with the competencies identified in the framework. As such, it provides a starting point for discussion and implementation, while leaving ample room for adaptation, expansion, and refinement according to specific educational needs and contexts.
In this sense, the proposed learning goals should be understood as a guiding framework that invites further contextualization, development, and integration, rather than as a prescriptive model to be applied uniformly across settings. Their value lies not only in the specific formulations, but also in the underlying approach: making clinical leadership explicit, observable, and progressively developable within nursing education.

Example of (progressive) learning goals per competence in nursing internship and curriculum

The learning goals presented below were developed through a multi-step process. First, participants in the ERA+ workshop *Clinical Leadership in Nursing Internship* (WP4), consisting of internship supervisors, collaboratively identified and discussed learning goals related to four key dimensions of clinical leadership: influencing competence, team leadership competence, ethical competence, and decision-making competence. These **workshop-generated learning goals served as a starting point for further development** by the ERA+ consortium, which explored how the identified themes could be translated into broader learning goals applicable across nursing curricula. Finally, the learning goals were reviewed and enriched using principles from Kouzes and Posner's leadership model (2017). The resulting overview reflects the integration of stakeholder expertise, educational practice, and leadership theory.

The resulting overview provides a collection of potential learning goals that can support students, clinical mentors, educators, and institutions in fostering clinical leadership competencies throughout internship experiences. **The learning goals are intended as practical guidance and inspiration rather than as a prescriptive or definitive framework**. As clinical leadership develops within diverse educational and healthcare contexts, the applicability, relevance, and feasibility of individual learning goals may vary considerably.

Therefore**, the list should be considered a starting point for discussion, reflection, and further adaptation**. Stakeholders are encouraged to critically assess the proposed learning goals in relation to their specific context and to modify, expand, or prioritize them where necessary and feasible. The overview is not exhaustive and recognizes that additional learning goals may emerge depending on local educational requirements, practice settings, student learning needs, and evolving understandings of clinical leadership.

By offering a flexible and context-sensitive set of learning goals, this project aims to support the meaningful integration of clinical leadership development within nursing internship programmes and to stimulate further dialogue on how leadership can be cultivated throughout nursing education and practice.

Relevant **domain** (ERA+ clinical leadership framework)	Relevant **competency** (ERA+ clinical leadership framework)	Possible learning goals (curriculum and internship)	Related remarks or core insights from the workshop
Ethics	**Ethical competence**	**Year 1: Ethical awareness and self-reflection** • The student recognizes ethical aspects and tensions in clinical situations, including everyday care situations. • The student reflects on personal values, beliefs, assumptions, and responses in care situations. **Year 2: Ethical analysis and dialogue** • The student demonstrates willingness to address ethical dilemmas, even when they are unclear or complex. • The student discusses ethical questions and dilemmas related to patient care with mentors, patients, and/or family members. • The student uses appropriate reflection or ethical frameworks to analyze care situations and explore different perspectives. **Year 3: Professional and accountable ethical practice** • The student takes responsibility for ethical and professional conduct within the nursing team. • The student justifies nursing decisions based on ethical principles, professional values, and clinical guidelines.	Ethics is present in both **major and small everyday situations.** Focus must be on **recognizing, naming, and discussing** ethical issues. Need to make ethics **more explicit and discussable in internship assignments and/or evaluation**

		Year 4: Ethical influence and leadership • The student demonstrates professional responsibility and accountability within (inter-)professional collaboration and increasingly complex care situations, by consistently acting in accordance with ethical standards, clinical guidelines, and agreed responsibilities. • The student contributes ethical perspectives constructively to interprofessional discussions and decision-making processes. • The student takes responsibility for ethically sound care in complex situations and supports others through role modelling and constructive feedback.	
Professional nursing	**Clinical competence**	**Year 1: Observation and linking observations** *"What do I see and what does this possibly mean?"* • The student collects and reports relevant patient information in a systematic manner. • The student recognizes basic relationships between patient observations and care needs. • The student reflects on own clinical observations and identifies learning needs. **Year 2: Interpreting data** *"Why does this happen with this patient?"* • The student uses patient assessment findings to identify actual and potential care needs. • The student formulates clinical judgments using a structured clinical reasoning approach.	Need for **active questioning ("why?")** Making reasoning **visible and explicit**

		• The student considers the patient's context, preferences and environment when interpreting clinical information. **Year 3: justify decision-making** *"Which course of action is most appropriate, and why?"* • The student prioritizes nursing problems based on patient assessment and clinical urgency. • The student explains and justifies nursing decisions using patient data, professional knowledge, and evidence. • The student evaluates patient outcomes and adapts nursing interventions accordingly. **Year 4: Complexity, anticipation, coordinate** *"How can I support shared decision-making and care coordination?"* • The student contributes clinical reasoning to interprofessional decision-making processes and complex care situations. • The student anticipates risks, weighs alternatives, and coordinates nursing actions to support safe and effective patient care.	
Professional nursing	**Quality management competence**	***Quality of Care*** **Year 1: Awareness of quality** • The student reflects on errors, uncertainties, and unexpected situations, identifying personal learning needs related to safe and high-quality care.	

		• The student recognizes and names aspects of quality of care based on provided examples from practice. • The student recognizes and names unsafe situations in care contexts in the framework of patient safety, based on provided examples. **Year 2: Acting correctly and safely** • The student follows quality standards and clinical guidelines in the delivery of patient care. • The student analyses the quality of care in their own care situations and provides concrete examples from clinical placement, linking them to relevant principles or models. **Year 3: Looking beyond one's own actions** • The student evaluates care practices and identifies opportunities to enhance quality of care. • The student analyses the quality of care in their own care situations and provides concrete examples from clinical placement, linking them to relevant principles or models. **Year 4: Actively contribute to improving quality** • The student contributes to quality improvement initiatives within the healthcare team. • The student formulates substantiated proposals for improving the quality of care in a concrete care context, based on analysis of practice.	

		Patient Safety **Year 1: Awareness of safety.** • The student recognizes situations that may compromise patient safety and reflect on own actions. **Year 2-3: Actively contribute to improving quality** • The student consistently applies safety procedures and learns from errors and near misses. • The student analyses patient safety in their own care situations and provides examples from clinical placement, linking them to relevant principles. **Year 4: Actively contribute to improving safety** • The student promotes patient safety by raising concerns and contributing to discussions on safe care practices. • The student formulates substantiated proposals to improve patient safety in a concrete care context.	
Professional nursing	**Evidence based practice competence**	**Year 1: An introduction to evidence-based thinking** • The student demonstrates curiosity towards the evidence underlying nursing care and recognizes that clinical practice should be informed by evidence. • The student formulates simple clinical questions arising from practice and learning experiences.	

		Year 2: Learning how to find evidence and apply it to patient care. • The student searches for relevant evidence to answer clinical questions encountered during patient care. • The student recognizes how evidence can support nursing decisions in individual patient situations. **Year 3: Analyzing information critically and justifying choices.** • The student critically appraises and discusses evidence relevant to nursing practice with supervisors and team members. • The student integrates evidence, clinical expertise and patient preferences when justifying nursing actions. **Year 4: Using evidence to improve care and collaboration.** • The student contributes to discussions on evidence-informed improvements in patient care and clinical practice. • The student advocates for the use of evidence-based practices within interprofessional collaboration and quality improvement initiatives.	
Professional nursing	**Decision making competence**	**Year 1: Observation and reasoning** • The student identifies relevant patient information and recognizes basic relationships between observations and care needs. • The student reflects on own thinking processes and learning needs when making clinical judgments.	Importance of **gradual development (starting early in training)**

		Year 2: Clinical reasoning in patient care • The student uses patient assessment data to formulate and explain clinical judgments. • The student applies a structured clinical reasoning approach to explore possible explanations and care priorities. **Year 3: Justify decision-making** • The student justifies nursing decisions using patient assessment findings, professional knowledge, and available evidence. • The student evaluates the outcomes of decisions and adapts actions based on feedback and changing patient needs. **Year 4: Shared decision-making and coordination** • The student contributes clinical reasoning to interprofessional decision-making processes in complex care situations. • The student anticipates risks, weighs alternatives, and coordinates nursing actions to support safe and effective patient care.	Reflection is key but often implicit
Professional nursing	**Self-development competence**	**Year 1: Self-awareness and openness to learning** *"Who am I as a learner and future nurse?"* • The student explores and reflects on themselves as a learner, identifies personal values, strengths, areas for development	Learning goals must be: • Gradually • Context-dependent

		and learning needs, and recognizes how the learning context influences their own learning process. • The student demonstrates a learning-oriented attitude by actively seeking opportunities to learn from everyday experiences. **Year 2: Self-directed learning** *"How can I improve my practice with patients?"* • The student reflects on personal values, strengths, limitations, and learning needs in clinical practice. • The student formulates personal learning goals and follows them up during clinical placements. • The student reflects on own actions and patient encounters to identify learning points and areas for improvement. **Year 3: Professional growth through reflection and feedback** *"How do I learn within a professional team?"* • The student purposefully steers their own learning process based on experiences and feedback, develops a personal learning or development plan, and connects their own development to their professional identity. • The student integrates feedback from mentors, patients, and team members into professional practice. • The student uses complex, uncertain, or challenging situations as opportunities for learning and professional development. • The student articulates personal learning goals and connects them to broader care objectives, demonstrating awareness of their role within the team.	• Realistic per training year

		Year 4: Lifelong learning and professional maturity *"How do I actively direct my own professional development?"* • The student takes autonomous responsibility for their own professional development, integrates feedback, experience, and knowledge into their practice, develops a consistent professional identity, and supports others in their learning process. • The student aligns personal learning goals with patient care priorities and team objectives. • The student demonstrates increasing autonomy in identifying, pursuing, and evaluating professional development needs.	
Innovation and change	**Visioning competence**	**Year 1: Recognizing curiosity and potential for improvement** *"How could care be improved?"* • The student recognizes opportunities for improvement in care situations and daily clinical practice. • The student demonstrates curiosity and openness towards new ideas and different approaches to care. • The student describes and reflects on their own vision of good care and the nursing profession, naming personal values and norms and acknowledging that different perspectives (patient, team, and organization) influence this vision.	Students may not fully lead a vision, but **can participate in shaping it**. **Central question:** What could be improved? By: • Identifying opportunities for improvement.

		Year 2: Analyzing opportunities for improvement from the patient's perspective *"What improvements would benefit this patient?"* • The student analyses clinical situations from different perspectives to identify potential improvements in patient care. • The student connects patient needs and contextual factors when considering possible improvements. **Year 3: Formulating and sharing ideas** *"How can our team work better?"* • The student adopts a critical and inquisitive attitude towards clinical situations, questioning and reflecting on practice in a respectful way. • The student contributes constructive suggestions for improving nursing care or team processes based on observations in practice. • The student critically examines existing practices and discusses improvement opportunities with team members. • The student uses a personal vision of quality care to underpin and adjust their own actions within a concrete clinical placement context, critically confronting this vision with practice and on that basis identifying and motivating relevant opportunities for improvement.	• developing a broad perspective. • thinking with a view to the future. • devising new possibilities.

		Year 4: Forward-thinking and innovation *"How can care evolve to meet future needs?"* • The student considers the broader impact of care decisions by integrating patient, organizational and interprofessional perspectives. • The student contributes to innovation and improvement initiatives by proposing and supporting future-oriented solutions. • The student uses a substantiated vision of quality care to develop concrete innovation and improvement initiatives and to describe proposals for change in practice.	
Innovation and change	**Change management competence**	**Year 1: Openness to change** *"Why do we do things this way?"* • The student demonstrates openness towards new ideas, feedback, and opportunities for improvement in clinical practice. • The student shows curiosity about how care processes could be improved. • The student recognizes and identifies situations where change or improvement is needed, based on examples provided from healthcare practice. **Year 2: Recognizing and discussing improvement opportunities** *"How could care for this patient be improved?"* • The student identifies opportunities for improving patient care and discusses them constructively with supervisors.	**Central question:** How can improvement happen? How do I help improvements become reality? By: • Encouraging discussion of improvements. • Getting others on board. • Contributing to implementation. • Supporting change.

		• The student explores alternative approaches to care under supervision and reflects on their potential value. **Year 3: Advocating change** *"How can I contribute to positive change in the team?"* • The student expresses improvement-oriented ideas respectfully and appropriately within the nursing team. • The student contributes to discussions about practice improvement by providing observations and reasoned suggestions. • The student recognizes and identifies situations where change or improvement is needed, based on examples provided from healthcare practice. **Year 4: Contributing to change initiatives.** *"How can change be supported and translated into practice?"* • The student formulates and justifies founded proposals for change within a specific healthcare context. • The student participates in improvement or changes initiatives by taking responsibility for agreed actions appropriate to their role. • The student encourages constructive dialogue about change by considering different professional perspectives and potential barriers to implementation.	
Influencing and advocacy	**Influencing competence (empower)**	**Year 1: Becoming aware of one's own influence.** *"How do my actions affect others?"* • The student adapts communication to the pace, needs, and understanding of patients and colleagues.	**Central question:** How do I positively influence, inspire, and motivate others?

		• The student demonstrates empathy, kindness, and compassion in interactions with patients, families, and team members. • The student contributes to a positive and respectful care environment through professional behavior and communication. **Year 2: Influence through day-to-day interactions** *"How can I contribute positively to those around me?"* • The student uses communication strategies that foster trust, engagement, and collaboration. • The student provides constructive feedback and respectfully discusses opportunities for improvement in care delivery. • The student encourages patients to participate actively in decisions regarding their care. **Year 3: Contribute constructively to the team** *"How can I positively influence my nursing team?"* • The student contributes to a positive and collaborative team climate through respectful communication and professional behavior. • The student provides constructive feedback and addresses concerns in a solution-focused manner. • The student identifies opportunities for improvement in care delivery and proposes evidence-informed solutions. • The student uses relational leadership skills to motivate, support, and positively influence colleagues and interprofessional team members.	Progressive curriculum line can be awareness of influence → positive interpersonal influence → constructive influence within the nursing team → influencing and motivating within interprofessional collaboration

		• The student encourages shared responsibility and active participation within the healthcare team to achieve high-quality patient care. **Year 4: To inspire and influence** *"How can I inspire others and contribute to shared goals?"* • The student uses communication and professional credibility to influence discussions and promote high-quality patient care. • The student motivates and empowers others by demonstrating initiative, professionalism, and a constructive attitude. • The student practices influencing and supporting other care providers within the interdisciplinary team in a care context.	
Influencing and advocacy	**Patient advocacy competence**	**Year 1: Respect for the patient** *"What matters to this patient?"* • The student demonstrates respect for the dignity, values, and preferences of patients. • The student recognizes the importance of the patient's perspective in care. • The student recognizes and names the meaning of patient advocacy, describes why this is a responsibility of the nurse, and identifies vulnerable target groups based on concrete examples from nursing practice.	**Central question:** How can I champion the patient's interests, preferences, and voice?

		Year 2: Supporting patient participation. *"How can I help patients make their voice heard?"* • The student encourages patients to express their preferences, concerns, and questions. • The student supports patient participation in care and decision-making appropriate to the clinical context. **Year 3: Standing up for the patient.** *"How do I represent the patient's perspective within the team?"* • The student communicates patient needs, preferences, and concerns to members of the nursing team. • The student advocates for patient-centered care by respectfully raising issues that may affect patient well-being or quality of care. • The student analyses a self-chosen situation from their own clinical placement around patient advocacy, identifies the vulnerability factors of the patient concerned, and substantiates which nursing actions contribute to defending that patient's interests. **Year 4: Patient representation in complex care** *"How do I safeguard the patient's interests within interprofessional decision-making?"* • The student integrates patient preferences and values into interprofessional discussions and care planning. • The student promotes shared decision-making by ensuring that the patient's voice is considered in complex care situations.	

		• The student demonstrates in a safe practice context how they defend the interests of a vulnerable patient within an interdisciplinary consultation and substantiates the nursing position in relation to the other care providers.	

Team leadership	**Team leadership competence**	**Year 1: My role within a team** *"How do I function within a team?"* • The student demonstrates respect, empathy, and professionalism in interactions with patients, peers, and staff. • The student recognizes how personal behavior contributes to a positive and safe learning environment. • The student describes and reflects on their own role within a team and recognizes factors that contribute to a positive and psychologically safe working atmosphere. **Year 2: Constructive collaboration** *"How can I contribute positively to teamwork?"* • The student collaborates constructively with team members while respecting separate roles and responsibilities. • The student contributes to a supportive team climate through respectful communication and appreciation of others' contributions. **Year 3: Understanding and influencing team dynamics.** *"How do I strengthen team functioning?"* • The student demonstrates awareness of team dynamics and adapts behavior to support effective collaboration. • The student promotes a positive working atmosphere by encouraging, supporting, and recognizing the contributions of others. • The student participates actively and constructively in teamwork, contributes to a safe and positive working	**Central question:** How do I coordinate or guide others? **Progressive curriculum** line can be team member → constructive colleague → someone who boosts team dynamics → informal team leader. **Three key building blocks:** • Working together in a positive and respectful manner. • Recognizing team dynamics. • Actively contributing to a positive

		atmosphere, and deals appropriately with feedback and tensions within the team. **Year 4: Informal leadership within teams** *"How do I help teams function effectively?"* • The student facilitates collaboration by helping to coordinate communication and shared goals within the interprofessional team. • The student contributes to a psychologically safe and inclusive team environment in which different perspectives are valued. • The student takes initiative to strengthen teamwork by promoting a safe and positive team culture, supporting collaboration, and constructively dealing with tensions and changes within the team in the educational setting (not in care practice).	working environment.
Team leadership	**Guidance competence**	**Year 1: Develop a supportive attitude.** *"How do I contribute positively to a learning environment?"* • The student demonstrates a supportive and respectful attitude towards peers, colleagues, and fellow students. • The student recognizes the importance of sharing knowledge and helping others learn. **Year 2: Learning to share.** *"How can I support the learning of my peers?"* • The student shares relevant knowledge, experiences, and resources with peers when appropriate.	**Central question:** How do I support the learning and development of others?

		• The student supports fellow students in achieving learning objectives within the clinical learning environment. **Year 3: Feedback en coaching.** *"How can I facilitate learning in others?"* • The student provides constructive and supportive feedback to peers, appropriate to their role and level of competence. • The student encourages peers to reflect on their practice and identify learning opportunities. **Year 4: Informal mentorship** *"How can I contribute to the development of future colleagues?"* • The student supports the learning and integration of peers or junior students through role modelling, guidance, and constructive feedback. • The student promotes autonomy, confidence, and responsibility in others within the limits of the student role.	
Communication and collaboration	**Communication competence**	**Year 1: Basic communication and active listening** *"How do I communicate effectively and respectfully with others?"* • The student communicates respectfully and professionally with patients, families, peers, and supervisors. • The student seeks clarification and asks questions to better understand patients, situations, and expectations.	Focus on **network and interdisciplinary context** Need to make behavior **visible (what can we hear/see)**

		Year 2: Patient-centered communication *"How do I build meaningful communication with patients and families?"* • The student demonstrates empathy, active listening, and openness in interactions with patients, families, and informal carers. • The student adapts communication to the needs, preferences and understanding of patients and families. • The student describes what conflicts are in a care setting, recognizes speak-up behavior and names the importance of speaking up in concrete examples from nursing practice (towards patient and network). • The student demonstrates insight into the method of emotion regulation and insight into the difference between overt and passive-aggressive forms of conflict (towards patient and network). **Year 3: Professional dialogue** *"How do I engage in constructive professional dialogue?"* • The student communicates clinical information, decisions, and reasoning clearly with peers and supervisors. • The student actively seeks, receives, and uses feedback to improve professional practice. • The student practices speaking up and constructive conflict management in a safe practice situation and consciously applies emotion regulation as part of professional communication within the care setting (towards patient and network).	**Central question:** How do I communicate effectively? **Progressive curriculum** line can be basic communication → patient-centered communication → professional dialogue → interprofessional communication.

		Year 4: Feedback and joint decision-making *"How do I use communication to support collaboration and shared decision-making?"* • The student contributes constructively to interprofessional discussions through clear, respectful, and transparent communication. • The student provides constructive feedback and facilitates open dialogue that supports collaboration and high-quality patient care.	
Communication and collaboration	**Collaboration competence**	**Year 1: Understanding my role in collaboration.** *"What is my role within a healthcare team?"* • The student recognizes the importance of collaboration in providing safe and effective patient care. • The student participates respectfully in interactions with team members and contributes to shared activities when appropriate. **Year 2: Collaborative patient care** *"How do I work together with others to support patient care?"* • The student collaborates with team members while respecting professional roles and responsibilities. • The student shares relevant patient-related information with supervisors and nursing team members.	**Central question:** How can I work effectively with others to deliver high-quality care?'

		Year 3: Effective teamwork *"How can I strengthen collaboration within the nursing team?"* • The student actively participates in team discussions and contributes constructively to shared decision-making. • The student demonstrates awareness of team dynamics and adapts behavior to support effective collaboration. **Year 4: Interprofessional collaboration** *"How do I contribute to effective interprofessional collaboration?"* • The student collaborates effectively with professionals from different disciplines to support coordinated and patient-centered care. • The student integrates diverse professional perspectives when contributing to care planning and decision-making.	

Concluding note

This document reflects the first step toward aligning educational goals with clinical practice regarding clinical leadership. Rather than presenting a fixed or exhaustive framework, it offers an interpretative synthesis of practice-based insights, workshop findings, and project-level analysis, aimed at making clinical leadership more explicit, visible, and applicable within internship contexts.

It highlights the need for better alignment, clearer assessment frameworks, attention to attitudes, and structured opportunities for gradual development.

Importantly, the findings suggest that the main challenge does not lie in the absence of clinical leadership in internships, but in its limited articulation, observability, and systematic integration into learning and assessment processes.

Across the different sections, clinical leadership emerges as a situated, relational, and developmental practice, shaped by context, learning opportunities, and levels of responsibility, rather than as a static set of competencies.

This implies that fostering clinical leadership in nursing education requires not only clearly defined learning goals, but also intentional design of clinical learning environments, supervision practices, and curriculum structures that enable students to actively engage in leadership within everyday care.

Finally, this work contributes to an ongoing international dialogue on how clinical leadership can be meaningfully integrated into undergraduate nursing education, while remaining responsive to the diversity of clinical settings and educational systems in which students are trained.

Further research and collaboration are needed to refine these insights, develop robust assessment approaches, and support the longitudinal development of observable clinical leadership behaviors in practice.

Further reading

Article: The exercise of nurses' clinical leadership in hospital care units: A qualitative multiple case study (Boutin et al., 2025)

The workshop findings can be further interpreted using the model proposed by Boutin et al. (2025), which conceptualizes clinical leadership in practice as a set of five active forms: reflective thinking and intervention, coaching and influencing, contributing to quality improvement, promoting team cohesion, and mobilizing personal and collaborative capacities. This model offers a useful framework for understanding the workshop results, as it emphasizes that clinical leadership is not limited to formal authority but is expressed through observable actions, collaboration, and context-sensitive practice.

Summary of the article

Boutin et al. (2025) conducted a qualitative multiple case study in hospital care units to explore how nurses exercise clinical leadership in daily practice. The study identified five key forms through which clinical leadership becomes visible in practice:

1. Taking initiative through reflective thinking and intervention (e.g., assessing needs, making decisions, coordinating care)
2. Influencing others through coaching, both towards patients and colleagues
3. Contributing to quality-of-care improvement, such as participating in projects or developing tools
4. Promoting team cohesion and collaboration, including teamwork and supervising students
5. Mobilizing personal and collaborative capacities, such as self-confidence, communication, and openness

Importantly, the study highlights that clinical leadership is collective rather than individual, emerging in interactions, collaboration, and shared problem-solving within teams.

In addition, the authors show that clinical leadership is strongly influenced by contextual factors, including:

- availability of time and resources.
- organizational structure and autonomy.
- team climate and support.

- opportunities for participation and collaboration.

The study also demonstrates that clinical leadership has a positive “ripple effect”, meaning that individual leadership behaviors can trigger a chain of positive influences that extend to colleagues, team functioning, patient care, and organizational outcomes. Impacting patients, nurses, teams, and organizational performance.

Relevance to the workshop findings
The study reinforces several reflections emerging from the workshop. It
confirms that the assessability of clinical leadership remains challenging, as it depends strongly on:

- a supportive learning environment
- sufficient time and opportunity
- professional autonomy
- team climate and mentorship

Therefore, the challenge is not only to define competencies, but also to create conditions in which students can demonstrate these competencies in observable and assessable ways during internships.

The leadership practices model of Kouzes en Posner (2017)

The ERA+ Clinical Leadership Framework (2026) and the Leadership Practices Model of Kouzes and Posner (2017) offer complementary perspectives on clinical leadership. While the ERA+ framework identifies the competencies required for clinical leadership in nursing practice, the Kouzes and Posner model provides a theoretical lens for understanding how these competencies are enacted in practice. Together, they highlight that clinical leadership extends beyond formal leadership positions and is demonstrated through influence, collaboration, professional expertise, and a commitment to improving patient car

While no single model for clinical leadership is explicitly prioritized, the model of Kouzes and Posner provides concrete and practice-oriented guidance to translate clinical leadership into educational settings and internship contexts. In particular, the model offers a structured yet flexible framework to conceptualize leadership as a set of observable behaviors embedded in everyday practice, rather than as an abstract or purely dispositional construct.

Its use strengthens the current framework as it connects attitudes, behaviors, and competencies into a coherent leadership model and emphasizes that leadership can be

observed in everyday actions. This behavioral orientation aligns closely with one of the central challenges identified in this project, namely the need to make clinical leadership more explicit, visible, and assessable within internship settings.

Moreover, it closely aligns with the findings of this workshop—particularly regarding communication, reflection, and responsibility—and resonates with the perspective of Boutin et al., who conceptualize clinical leadership as embedded in daily practice. In addition, the five practices described by Kouzes and Posner (e.g., modelling the way, enabling others to act, challenging the process) provide a useful lens to reinterpret clinical leadership as enacted through relational, context-sensitive interactions within nursing teams. Importantly, these practices can be meaningfully adapted to the level of undergraduate nursing students by focusing on micro-level leadership behaviors, such as articulating clinical concerns, contributing to team dialogue, or initiating small improvements in care processes.

In addition, the model contributes to making clinical leadership more tangible and assessable, thereby addressing one of the key challenges identified during the workshop. By linking broader leadership concepts to concrete and observable actions, the model supports the translation of clinical leadership into educationally relevant learning goals and assessment approaches, while remaining adaptable to the specificities of bedside nursing practice.

References

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