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Redefining Nursing Leadership: A Multilevel Competency Framework for Future Healthcare Challenges

Aleix Fontanals-Jimenez[1,2,3] | Marta Trapero-Bertran[2,4] | Montserrat Gea-Sánchez[1,2,5] | Esther Insa-Calderón[3,6]

[1]Society, Health, Education and Culture Research Group (GESEC), Department of Nursing and Physiotherapy, University of Lleida, Lleida, Spain | [2]Healthcare Research Group (GRECS), Institute of Biomedical Research in Lleida (IRBLleida), Lleida, Spain | [3]Social Determinants and Health Education Research Group (SDHEd), Hospital del Mar Research Institute, Barcelona, Spain | [4]Health, Education and Culture Research Group (GESEC), Department of Economics and Business, Universitat de Lleida, Lleida, Spain | [5]CIBER Fragility and Healthy Aging (CIBERFES), Instituto de Salud Carlos III (ISCIII), Madrid, Spain | [6]Hospital del Mar Nursing School (ESIHMar), Universitat Pompeu Fabra-Affiliated, Barcelona, Spain

Correspondence: Marta Trapero-Bertran (marta.trapero@udl.cat)

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ABSTRACT

Aim: To examine the conceptual ambiguity of nursing leadership, particularly in relation to management roles, and to propose a multilevel competency framework that redefines leadership as a core dimension of nursing practice. The paper introduces an innovative hybrid Iceberg–Alles model that integrates observable competencies with deeper motivational, ethical and personality-based attributes.

Design: Integrative review.

Methods: Two-stage evidence identification process informed by theoretical reflection and existing evidence on nursing leadership and management.

Data Sources: A literature search was conducted in targeted databases such as PubMed, Scopus, Web of Science, CINAHL and extended to Google Scholar and grey literature.

Implications for Nursing: Current understandings of nursing leadership are fragmented and often limited to managerial skills, overlooking crucial aspects such as ethical commitment, personal values, interpersonal skills and relational capacities. The hybrid Iceberg–Alles model reconceptualizes leadership as a multidimensional construct that balances visible skills with underlying drivers such as motivation, self-awareness and value alignment, offering a more comprehensive basis for leadership development.

Conclusions: Nursing leadership should be understood as a relational and value-based process embedded across all levels of practice, not confined to formal administrative positions. The proposed model enhances conceptual clarity and provides a transferable framework that can be adapted across diverse health systems, roles and organisational structures.

Impact: Broadening the scope of nursing leadership can reduce role ambiguity, highlight the unique contribution of nurses to healthcare systems, and strengthen the profession's influence in policy and decision-making. The hybrid model provides concrete guidance for educational programmes, competency-based curricula and organisational strategies aimed at preparing future nurse leaders to manage complexity, promote collaboration and improve patient care.

Reporting Method: This manuscript followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews guidelines (PRISMA-ScR).

Patient or Public Contribution: This study did not include patient or public involvement in its design, conduct or reporting.

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1 | Introduction

Nurses represent the largest professional group within the healthcare sector, and their leadership role is fundamental to healthcare organisations. There is robust evidence that effective nursing leadership contributes to better patient health outcomes, which aligns with other studies on the management skills of healthcare organisation executives and their indirect impact on patient health (Heinen et al. 2019; Gottlieb et al. 2012).

Despite the importance of nursing leadership, it lacks a clear model or definition. As Cengiz et al. (2021) described in their review on role ambiguity experienced by bedside hospital nurses, lack of role clarity, training, poor practice environment conditions and organisational culture increase stress, job dissatisfaction, burnout, intent to leave and decrease organisational commitment. Evidence suggests that the nursing role in leadership positions, such as management roles, is also ambiguous, understudied, and often confined within the current biomedical model (Kalkman 2017; Dall'Agnol et al. 2013; Lankshear et al. 2016; Smith 2011). Preliminary results from a systematic review currently underway have identified a significant mismatch between the interpretation and separation of nursing leadership and managerial functions within the profession (Fontanals, Trapero-Bertran, and Insa-Calderón 2025; Fontanals, Insa-Calderón, and Trapero-Bertran 2025). This raises the following concerns: (1) the need to separate and define the concepts of 'nurse leadership' and 'nurse management'; and (2) the need to broaden nursing leadership and nurse-led intervention beyond managerial roles.

Nursing leaders emerge at all levels of the profession. As Ljungbeck et al. (2020) highlighted in their review of the nurse practitioner role, and as Hamric et al. (2014) propose through the four leadership dimensions of clinical nurse leaders, leadership is not limited to formal managerial roles. At the administrative level, Perez-Gonzalez et al. (2024) described the characteristics of the distinctive leadership competencies of nurse managers. Across these diverse contexts, we find professionals driven by intrinsic motivation and a deep commitment to improving care, fostering innovation, educating others and mentoring colleagues. While the Canadian Nurses Association views leadership as a key competency in care practice and mentorship, the National Organization of Nurse Practitioner Faculties (USA) defines it as focused on systems transformation and management (Fitzgerald et al. 2017; Ainslie et al. 2024). These are two distinct visions: one linked to influence and change, the other to management; one linked to competency, the other to capability. To enhance conceptual clarity from the outset, this manuscript considers that a nurse manager and a nurse leader play distinct but complementary roles: while the *nurse manager* is the professional who focuses on coordinating resources and overseeing planning, organisation, direction, and control in a department to achieve specific nursing objectives, the *nurse leader* is the professional responsible for shaping a vision and inspiring others (nurses and other health professionals) to bring that vision to life through motivation, influence and empowerment (Fitzgerald et al. 2017; Ainslie et al. 2024; ANA 2024). However, both profiles can fit into a single nurse and therefore health organisations should consider nursing managers who are also leaders at their respective levels.

This dichotomy is also reflected in studies related to nurse management competencies, which are used to establish competency lists grouped by domains, with specific activities for certification. However, these models typically focus solely on management skills, neglecting fundamental aspects such as educational background and moral dimensional traits like values and care, or the emotional and social dimension for humane and inspirational leadership. When we take a closer look at the idea that leadership exists at all levels, we find various competency assessment tools related to leadership in nursing and in healthcare systems, as well as in general management. These tools are useful for both professionals aspiring to take on management positions or health care organisations as self-assessment mechanisms for professionals occupying these positions or identifying characteristics they need in future leaders. Yet models like that of the American Organization for Nursing Leadership (AONL) outline four domains of competencies, which theoretically rely on an 'inner leader,' a concept that is poorly defined and directed towards personal development, without a distinct domain for leadership (Hughes et al. 2022). Similarly, the American College of Healthcare Executives model does not specify this aspect either, hindering the development of nurse leaders into executive positions (ACHE 2024). This is problematic, as it ignores the need for a synergy between management skills and leadership competencies in managerial roles, and also ignores the values and motivation to take on these roles, being key for current organisations that the values of their leaders align with those of the institution, as well as the professionals who constitute the unit with its referent. Otherwise, some European models have adopted a more integrated approach. For instance, the National Health Service Clinical Leadership Framework (2012) and the proposal by González García et al. (2022) for nursing directors include additional personal traits such as self-perception and personality. However, these more intrinsic elements are discussed in a limited way, tend not to be sufficiently applicable in practice between different contexts and systems, and are only focused on executive positions. Given the differences between health systems—structural, cultural and organisational—it is imperative to develop a model of leadership based on theory and adaptable through contexts and roles, promoting leadership from front-line nurses to board members.

As mentioned earlier regarding the lack of consensus on the concepts of 'nurse leader' and 'nurse manager,' due to the absence of a universally accepted classification there are significant differences in the definitions of roles and responsibilities of these positions in the literature and in the organisations.

The American Nurses Association (ANA) proposed a hierarchical model that outlines a path from 'charge nurses' to 'nurse executives,' the highest leadership position, placing 'nurse managers' and 'nurse administrators' in intermediate positions (ANA 2024). However, scientific literature does not always follow this framework: some studies group all of these roles under the term 'nurse manager,' while others distinguish only 'first-line nurse managers', a term that is often confused with 'charge nurse' or 'head nurse' (ANA 2024; Ferguson-Paré 2003).

To further add to the complexity, the terminology may not be applicable across contexts. For example, in the Spanish context, this classification from the ANA is hardly applicable.

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The distinction between an assistant director and a director of nursing is not always clear, as they often share functions and responsibilities. Additionally, the distinction between 'administrators' and 'executives' or 'managers' does not fully align with the structure of healthcare institutions in Spain. There are nurses who have reached Chief Executive Officer (CEO) positions as leaders; however, very few have taken a big step forward in nursing management and from the social perspective on the ceiling of this profession. Therefore, it is necessary to establish a universally accepted classification as an answer from the nurse leadership roles investigation following this theoretical proposal.

2 | Background and Theoretical Framework

Continuing the redefinition of leadership as a nursing competency, it is crucial to standardise according to a holistic perspective inherent to the profession to be more adjusted to current professional values and social changes. This is essential for the training of undergraduates, the development and engagement of clinical nurses, and the empowerment of current and future executives. In 2008, nursing competency was proposed as 'the ability to act by combining knowledge, skills, values, beliefs, and experience acquired as a nurse', and understood as an integrated performance that reflects emotions, thoughts and professional judgement (Fukada 2018). For this reason, we suggest integrating this holistic view of leadership competence rather than reducing it to resource management as is currently the case. Financial knowledge, interprofessional collaboration, and many other listed skills are important for these management roles and nursing leadership empowerment, but the intrinsic motivations and values to develop professionally in this field are also something that must be visible and attractive to change the current perspective on these positions.

We propose nursing leadership to be understood as a comprehensive competency present at all levels of the profession and key to care and team management, self-management, and influence on clinical practice such as evidence-based nursing care implementation, innovation in care and decision-making. Based on Marta Alles's Contemporary Competency Model and the Iceberg Model by Spencer & Spencer, this approach balances the visible elements of leadership (knowledge and technical skills) with deeper and more intangible factors (values, motivations and self-perception) (Villalobos-Pérez et al. 2011; Alles 2005; Spencer and Spencer 1993; Chopra 2014). On the one hand, Alles M. (Villalobos-Pérez et al. 2011; Alles 2005) defines competencies as personal attributes that enable satisfactory job performance and classifies them into different categories: basic and general competencies, which are common to all workers, and specific competencies, adjusted to different organisational levels and roles or tasks. On the other hand, Spencer and Spencer (Villalobos-Pérez et al. 2011; Spencer and Spencer 1993; Chopra 2014) describe competencies as 'a characteristic underlying an individual which is causally related to effective or superior performance in a job or situation'. While both authors agree that competencies are measurable constructs, Spencer and Spencer (1993) conceptualise them through the iceberg model, where visible elements such as knowledge and skills sit above the surface, while deeper behavioural components—motives, personal traits and self-image—remain hidden. By integrating both models, this hybrid approach fosters a more dynamic and holistic vision of leadership as a competency, better aligned with the evolving needs of today's healthcare systems.

As the healthcare system gradually evolves towards a model focused on health promotion, primary care, and community-based home care, the role of individuals and communities has changed, assuming greater control over health decisions (Hancock 1999; Committee on Public Health Strategies to Improve Health 2012). Simultaneously, new generations of professionals and nursing students have emerged, with distinct life expectations, values and knowledge. Lately, educational institutions have made significant efforts to support newly graduated nurses throughout their transition into clinical practice. However, nurses' personal values and individual personality traits are equally crucial factors in facilitating their successful adaptation and integration into professional roles (Baharum et al. 2023), but it doesn't seem to be considered by the host and recruitment models of the healthcare institutions at the moment. As Feng and Tsai (2012) described, 'the transition from new graduate nurse to practicing nurse was stressful for these participants, particularly due to the clash between the professional value of patient-oriented nursing care and the organizational value of task-oriented nursing'.

3 | Aim

This review aimed to examine the conceptual ambiguity of nursing leadership, particularly in relation to management roles, and to propose a multilevel competency framework that redefines leadership as a core dimension of nursing practice: introducing an innovative hybrid Iceberg–Alles model that integrates observable competencies with deeper motivational, ethical and personality-based attributes.

4 | Methods

4.1 | Design

This paper draws on preliminary findings from a systematic review during 2025 registered in PROSPERO (CRD420251037951) on nurses' roles, competencies, and leadership during the pilot of the results phase where the need to redefine nursing leadership as a competency was identified. For this reason, the present study adopts an integrative review design, which enables the inclusion of both qualitative and quantitative evidence and supports a comprehensive and theoretically informed synthesis of nursing leadership and managerial roles. This approach aligns with a holistic understanding of leadership consistent with the holistic nature of nursing practice.

In order to improve the quality and transparency of research, we adhere to the EQUATOR Research Reporting Guidelines using The Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews Checklist (PRISMAScR) to guide the reporting of this review because the purpose of the review is conceptual rather than exhaustive

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(Tricco et al. 2018; Stewart et al. 2018). Although this study follows an integrative review design, PRISMA-ScR is appropriate because both integrative reviews and scoping reviews share similar characteristics: they synthesise diverse evidence types, include heterogeneous sources without mandatory quality appraisal of all materials, and employ narrative rather than quantitative analysis. The PRISMA-ScR framework provides structured reporting for our two-stage search strategy, while the conceptual and analytical approach remains grounded in integrative review methodology (Grønstad 2026). For this reason, principles for integrative reviews proposed by Whittemore and Knafl (2005) were incorporated to strengthen methodological transparency. The conceptualisation process was reinforced by Heinonen and Gruen (2024) research, presenting in this manuscript a freeform conceptualising approach that supports creativity and innovation to synthesising evidence.

4.2 | Search Strategies

All references were first identified using PubMed, Scopus, Web of Science, CINAHL as data sources without time and language restrictions. This prior review identified conceptual and practical gaps that motivated the development of a renewed framework. The second approach consisted of expanding the searches to Google Scholar, snowballing, targeted retrieval of influential organisational frameworks (e.g., NHS, AONL) and grey literature, as well as key theoretical models on leadership and nursing skills. This flexibility aligns with accepted practices in integrative reviews, which permit heterogeneous evidence and diverse retrieval strategies.

Search terms like 'Nursing Leadership', 'Nurse Manager' and 'Quality' were combined using Boolean operators such as AND and OR. As an example from PubMed: ('Nurs* manag*' OR 'Nurs* executiv*' OR 'Nurs* administrat*' OR 'Chief Nurs* Offic*' OR 'Head Nurs*') AND ('Nurs* competenc*' OR 'Nurs* leadership*' OR 'Nurs* role*' OR 'Nurs* intervent*' OR 'Nurs* decision-mak*' OR 'Nurs* influence*' OR 'Leadership competenc*') AND ('Health Care Organization*' OR 'Resourc* manag*' OR 'Nurs* Staff' OR 'Patient Outcome*' OR 'Nurs* Outcome*' OR 'Performanc*' OR 'Quality' OR 'Organizational outcome*').

4.3 | Inclusion and/or Exclusion Criteria

The population included for this review are all types of nurses' profiles and positions. From those who work in formal leadership positions (e.g., Nurse Managers, Nurse Executives) to clinical nurses whose interventions or roles lead interventions or manage teams, resources, or others.

Eligible publications included studies examining nursing competencies, leadership skills, leadership development, and the effects of leadership on organisational performance, staff well-being, and patient outcomes, as well as conceptual papers addressing managerial roles in nursing. Consistent with integrative review methodology, no restrictions were applied regarding publication date, language, or study design in order to ensure conceptual breadth.

The appraisal strategy sought to ensure conceptual rigour without excluding theoretically influential non-empirical sources, as recommended by the integrative review framework.

4.4 | Data Extraction and Data Synthesis

Data extraction from the first stage proceeded after removing duplicates. Screening was conducted at the Title/Abstract level, followed by full-text review by two independent reviewers, with disagreements resolved through discussion or, when necessary, by a third reviewer. Given the conceptual aim of this integrative review, extracted information was synthesised narratively rather than tabulated in a formal data extraction matrix. The information retrieved included broad study characteristics (e.g., citation, year, country), descriptions of leadership or managerial roles, and key conceptual contributions related to competencies, values and leadership behaviours.

Data from the second stage of the search—comprising conceptual literature, organisational frameworks and theoretical papers—were incorporated to enrich the conceptual analysis and inform model development. In line with Whittemore and Knafl (2005), these sources were not subjected to formal quality appraisal, as no gold standard exists for evaluating theoretical or organisational documents in integrative reviews. To ensure methodological rigour, two authors independently screened all sources for relevance and consistency with the review purpose using the Rayyan software. No expert consultations were carried out during the synthesis phase. However, informal consultations were conducted after model development to confirm face validity and conceptual clarity.

5 | Results

5.1 | Search Outcome

A total of 8021 records were identified in the first-stage database search (PubMed, Scopus, Web of Science, CINAHL). After removing duplicates, 5114 titles and abstracts were screened, of which 4966 were excluded. Full-text assessment resulted in 148 articles meeting the eligibility criteria: the 122 articles included in the systematic review, and the other 26 literature reviews excluded initially because of the exclusion criteria in the other review process. The second-stage search (Google Scholar, snowballing, grey literature and organisational frameworks such as the NHS Clinical Leadership Framework (2012) and AONL competencies) identified an additional 20 sources. Combined with 11 articles from the first-stage search selected for their conceptual contribution to leadership framework development, the final sample for thematic synthesis comprised 31 sources. These sources were also screened for conceptual relevance by two independent reviewers (see Figure 1).

5.2 | Study Characteristics

The final sample consisted of 31 sources, including empirical studies related to skill development or leadership competencies;

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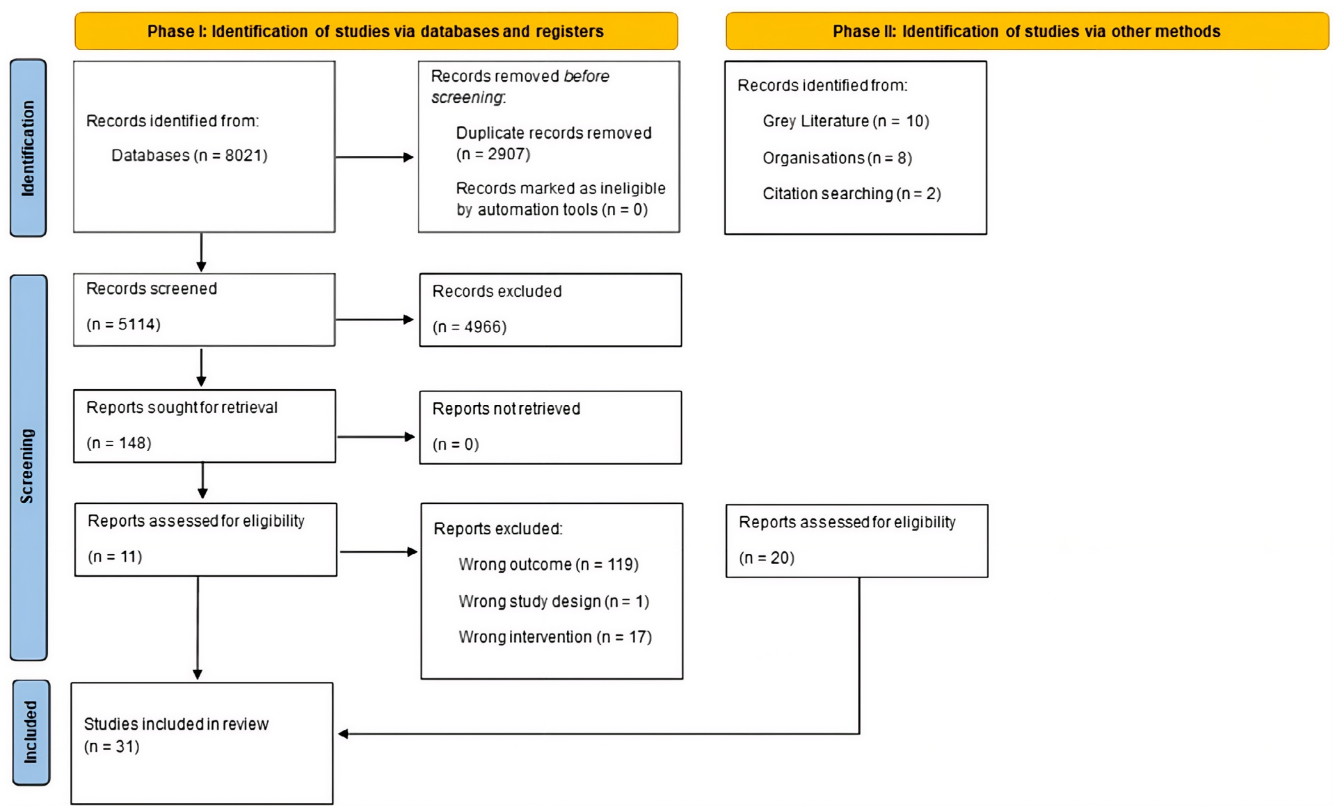

FIGURE 1 | Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram.

conceptual papers addressing role ambiguity or leadership definitions; and organisational models such as the NHS Clinical Leadership Framework or AONL Nurse Leader Competencies. Publications ranged from 2003 to 2024 and represented diverse perspectives and health systems such as the United Kingdom, United States, Canada, Spain or Australia, enabling examination of both cross-system similarities and contextual variations. Across sources, nurses in a wide range of roles were represented, including clinical nurses, charge nurses, nurse managers, directors of nursing and executive leaders. Sources variably conceptualised leadership as competency, capability, role behaviour or organisational function.

5.3 | Thematic Synthesis

Three overarching themes emerged:

1. Conceptual ambiguity between leadership and management. Most sources described overlapping definitions or used the terms interchangeably, contributing to role confusion and inconsistent expectations across clinical and managerial levels.
2. Frameworks such as AONL and ACHE emphasised managerial skills while underrepresenting motivational, ethical and relational dimensions. European models included personal traits but lacked operational guidance and cross-context applicability.
3. Leadership is a multilevel phenomenon requiring integration across roles. Evidence consistently showed that leadership occurs at clinical, supervisory, managerial and executive levels, but few models linked competencies across these tiers. Hidden or inner competencies (values, motivation, moral responsibility, self-awareness) emerged as essential but insufficiently incorporated in existing frameworks.

Once the topics were identified, categories were created and labels were assigned to data fragments. Concepts, theories and other findings from the different studies were compared, and differences, similarities, and relationships were identified.

5.4 | Narrative Synthesis and Conceptualisation of the Framework

5.4.1 | Narrative Synthesis

A narrative approach was used to articulate the main results and present them within a clear and coherent line of reasoning. Based on the narrative synthesis, a framework combining two existing leadership models was conceptualised. After that, informal feedback from clinical nurse leaders was sought to confirm face validity and practical applicability.

6 | Discussion

6.1 | Proposal for Interpretation

Nursing leadership is not solely dependent on knowledge and technical skills, but also on invisible factors such as motivation, vocation for service, and the ability to inspire others. In today's

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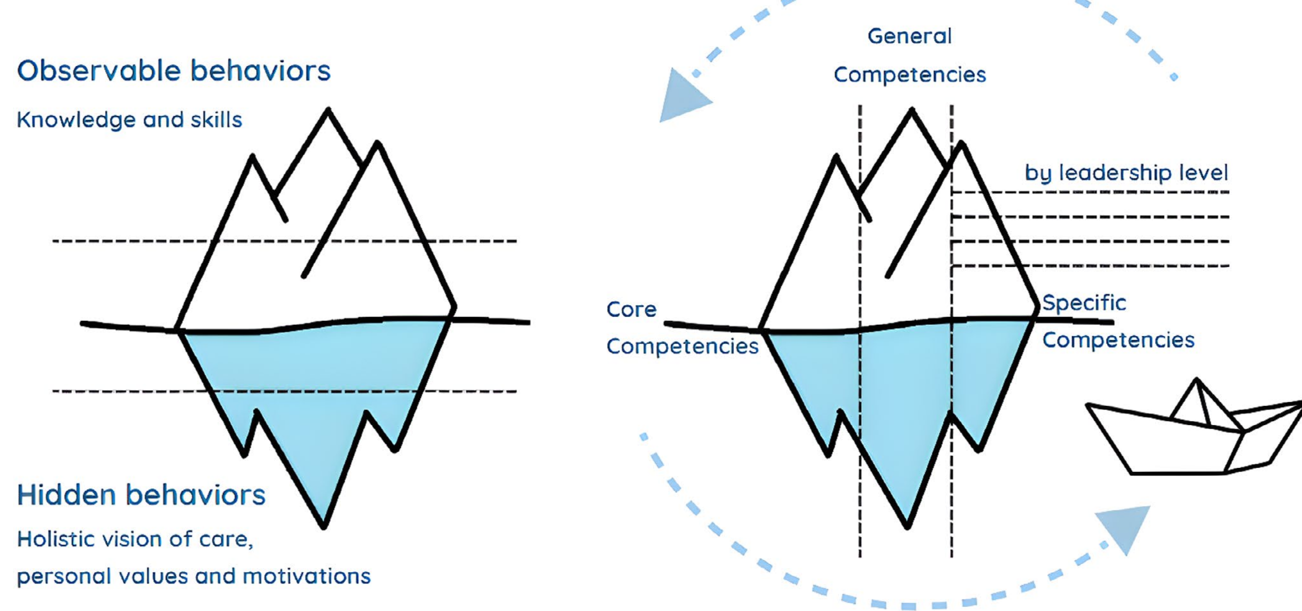

FIGURE 2 | Iceberg reinterpretation for nursing leadership.

society, these factors must emerge and become visible. For example, there are organisations with directors of nursing who possess strong hospital management knowledge (visible part) but lack interpersonal skills and motivation (submerged part), resulting in ineffective leadership and high staff turnover (Pattali et al. 2024). Conversely, a clinical nurse in a managerial role—despite lacking formal education or training in leadership—can still demonstrate effective leadership by being self-aware of their strengths and weaknesses. By encouraging team members to contribute their own voices and work from their individual virtues, leaders can foster a collaborative and skill-enhancing environment. Through empathy, commitment and distinctive qualities such as strong environmental awareness and efforts to reduce healthcare expenditure, this renewed vision of nursing leadership can inspire professionals to become agents of change. It may even motivate them to develop further management competencies aligned with professional values, social and environmental responsibility (Luque-Alcaraz et al. 2024; Schenk and Johnson 2022).

Unfortunately, in reality several limitations persist. On the one hand, many of the most experienced professionals are unattracted to managerial roles because they are unable to see these personal and hidden traits in their leaders. They feel that their own leaders are not health promoting and don't promote skills development, nor cater for nurses' meaningfulness. On the other hand, younger professionals with leadership abilities are unable to grow professionally on this path because they find themselves locked in the eyes of others due to their lack of experience and the less than positive view of their senior colleagues about their nurse leaders. Therefore, it is essential to find a balance between the new generation of nurses and those with more experience, integrating their different motivations and perspectives into leadership. Doing so will aid in avoiding the collapse of current models of health care due to nurses' shortage. It is crucial that healthcare organisations think of nursing leadership in a holistic way as they do in health care (Heinen et al. 2019; Perez-Gonzalez et al. 2024; Gunawan et al. 2017; Eriksson et al. 2022).

Our proposal integrates the observable behaviours defined by Spencer (see Figure 2) with the competencies outlined in Alles' model (see Table 1 and Table S1), producing a hybrid model adapted to a nursing leadership perspective. The model is composed of three domains according to Alles' model, where each contains a set of visible and hidden competencies adapted to nursing roles and specific areas of management. We present the Core Competencies, which represent essential organisational values and are fundamental to nursing leadership. Next, the General Competencies are outlined as those common to all nurse leaders and applicable regardless of their leadership level. Finally, the Specific Competencies by Leadership Level refer to the key knowledge and abilities required in both management and clinical care.

Furthermore, certain hidden behaviours must emerge to ensure successful long-term leadership. Character traits such as fostering shared governance and building interprofessional relationships are essential for transformational leadership and improving care quality and professional well-being (Ghanem Atalla et al. 2023). In relation to these emerging behaviours and competencies, it is also essential to reflect on the responsibilities, skills and remuneration of nurse leaders. Currently, there is often no clear alignment between salary and job role for nurse administrators, with significant variation depending on the care setting (e.g., primary vs. hospital care) and geographic location (urban vs. rural areas) (AONL 2019). This raises the question of whether such disparities stem from the lack of standardised evaluation and classification tools for these roles, or from a broader undervaluation by healthcare organisations of the impact and strategic importance of nursing leadership within institutional governance structures.

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TABLE 1 | Proposed visible and hidden competence for each domain.

Competency level	Examples of proposed competencies
Core	– Ethics and commitment to patients and the team – Holistic vision of care – Empowerment of the team and the community – Adaptability and innovation in the healthcare system
General	– Effective and assertive communication – Conflict resolution and negotiation – Decision-making under pressure – Teamwork and interprofessional collaboration
Specific by leadership tier	– Nurse Executives needs strategic and politic vision – Nurse Managers should facilitate the professional and personal development of nurses – Charge Nurses must lead interprofessional collaboration – Clinical Leaders are able to implement and monitor new processes – E-Competencies are present in different conditions at all levels

While some personal values and motivations may remain at the base of the iceberg, some indicate that extrinsic motivations like social recognition are not highly influential (Van Dyk et al. 2016; Veenstra et al. 2020). However, Veenstra et al. (2020) found that introjected regulation—such as a desire to satisfy others—and alignment between personal values and the role were significant motivating factors for respondents. While we propose an iceberg model that highlights the visibility gap in leadership traits, it still cannot fully represent all competencies acquired or required in practice. Nurse leaders must constantly adjust which aspects of their competencies they reveal, depending on work environment, strategic objectives, and their own context such as burnout or resource scarcity, while organisations should take a reflective approach and analyse both current and emerging leaders across all dimensions of competence. Both leaders and organisations should take a step back in their interpretation of leadership and broaden their field of vision to be able to observe all sides of this competency. Nevertheless, this model offers a useful framework for interpreting the leaders that organisations aim to develop, and for fostering self-awareness among professionals about whether their knowledge, values and motivations align with those of the healthcare system.

Therefore, social awareness and self-image in nursing leadership must be made visible to prevent the current healthcare structure from collapsing. The unappealing perception of managerial roles, difficulty in access for non-medical professionals, and workload affecting work-life balance contribute to nurse leader burnout and reluctance to assume such roles. It is thus essential to recognise the social rationale for nursing leadership's impact on organisational culture, as well as fostering an environment grounded in equity, well-being and care ethics. Furthermore, leadership should be seen as a change agent that promotes care safety and defends the profession in strategic decision-making from first-line decisions to the board, consolidating a more humane, effective leadership, which is aligned with the real needs of the healthcare system and society (Robertson et al. 2023; Bayot and Varacallo 2023). Without all consideration for the elements discussed above, there may progressively be fewer nurses in the near future who are willing to lead and manage teams, with less skill and knowledge, and lower professional and social recognition.

In order to implement this leadership model and strengthen the role of nursing within healthcare and policy-making structures, three key elements emerge as both reflections and strategic needs: educational integration, standardisation of roles and competencies and future research directions. In terms of educational integration, leadership must be incorporated from the outset in nursing education, not merely as a future managerial skill, but as a fundamental professional competency present throughout all stages of a nursing career. For standardisation of roles and competencies, it is essential to develop shared frameworks that clearly differentiate leadership levels, define responsibilities, and link them to systems of evaluation, recognition and remuneration. Finally, empirical validation of this hybrid competency model is needed, particularly through longitudinal studies assessing its influence on patient outcomes, team performance and the long-term sustainability of nursing leadership. These priorities are crucial for turning this proposal into an actionable change and for reinforcing the strategic presence of nursing in healthcare organisations and political decision-making bodies.

6.2 | Application of the Model

To enhance clarity on the operationalisation of the proposed model, a direct mapping example is added between the three competency domains and the corresponding leadership tiers (see Table 2). Core competencies apply across all leadership tiers, functioning as the ethical and motivational foundation for clinical leaders, charge nurses, nurse managers and nurse executives. General competencies represent transversal abilities required at all levels but increase in complexity from clinical to executive leadership. Finally, specific competencies are differentiated according to leadership tier: clinical leaders focus on practice-level implementation, charge nurses on coordination and interprofessional interface, nurse managers on staff and unit development, and executives on organisational, strategic and political leadership.

For instance, a clinical nurse leading an evidence-based change (e.g., implementing early-mobilisation protocols) would rely primarily on core competencies such as ethical commitment and

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TABLE 2 | Mapping of competency levels to leadership tiers.

Competency level	Clinical: Clinical nurse leader	1st managerial: Charge nurse	2nd managerial: Middle manager	Executive: Director of nursing
CORE	Demonstrates motivation and integrity in everyday clinical decision-making	Uses ethical judgement to coordinate shifts	Ensures alignment between team values and organisational mission	Influences organisational ethics and vision
GENERAL	Take an active role in team coordination	Coordinates workflows and anticipates operational needs	Manages teams and resources	Manages complexity and system-wide change
SPECIFIC	Leads unit initiatives	Allocates resources during shifts to ensure continuity of care	Conducts staffing planning and manages budgets and organisational processes	Leads large-scale strategic projects that influence political and regulatory environments

team empowerment, combined with general competencies such as communication and conflict resolution. In contrast, a nurse manager implementing the same initiative at unit level would mobilise specific competencies including resource allocation, staff development and inter-unit negotiation.

A preliminary implementation roadmap can be outlined from the evidence reviewed and the proposed model: (1) integration of the Core competency domain into undergraduate and postgraduate curricula; (2) development of organisational assessment tools aligned with General competencies; (3) mapping of role descriptions to Specific competencies by leadership tier; (4) creation of evaluation tools that link hidden competencies (motivation, self-awareness, ethical orientation) to leadership progression or incorporate mentoring and career-progression pathways; and (5) monitoring implementation through indicators such as team climate, retention and care quality. This roadmap outlines five sequential actions to support integration of the Core, General and Specific competency domains into educational programmes, organisational structures and leadership development pathways and are represented in Figure 3.

Nonetheless, the adaptability and applicability of the model between health systems can be made easier by its layered structure which allows a readjustment of the skills needed at each level of leadership in each system or hospital network: Core Competences are maintained in all cultural and organisational contexts, while General and Specific Competences can be calibrated to reflect different regulatory structures, levels of decentralisation and organisational cultures. For example, in centralised systems such as the NHS, leadership expectations are more standardised, while in decentralised systems (like Spain or Canada), nursing managers may require stronger skills in negotiation and inter-institutional coordination. This flexibility favours transferability while maintaining the conceptual coherence of the model.

6.3 | Limitations

This study has several limitations. First, the review is conceptual in nature and does not aim to provide an exhaustive systematic account of all available literature. Although the search strategy incorporated structured database searches, it also relied on informal retrieval methods such as citation tracking, reflecting the flexible nature of integrative reviews. Secondly, the appraisal of conceptual and organisational sources is inherently subjective, although consistent criteria were applied to ensure conceptual rigour. Finally, future research should examine the relationship between the model's three competency layers and measurable outcomes such as patient safety indicators, interprofessional team functioning, staff retention, career satisfaction and organisational resilience. For this reason, we propose three complementary research strategies:

a. Longitudinal cohort studies tracking nurses from clinical roles through executive positions, examining how competency development (particularly hidden competencies such as values alignment and self-awareness) predicts leadership effectiveness, career progression, job satisfaction and retention in leadership roles over time.

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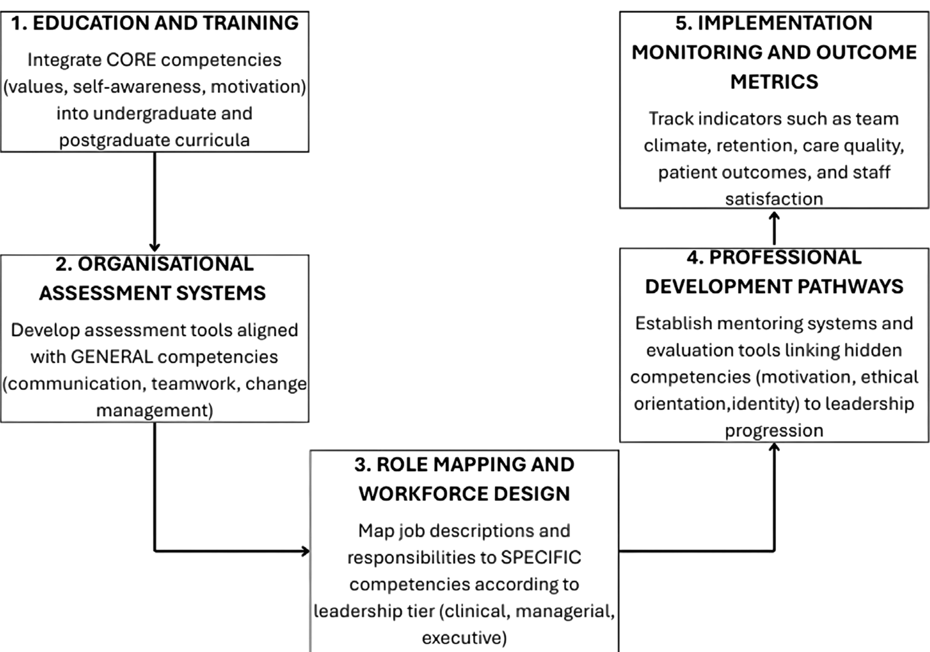

FIGURE 3 | Stepwise implementation roadmap for the nursing leadership competency model.

b. Multi-site comparative studies applying the framework across diverse health systems to test transferability and identify context-specific adaptations. These could include consensus-building approaches such as national or international Delphi panels with nursing leaders from different care settings (primary care, hospital, executive levels) to validate competency priorities and adapt the framework to local organisational structures and professional cultures. Comparative designs examining variations by system centralisation (e.g., NHS vs. decentralised systems), care setting complexity, and regional differences would establish which core competencies remain universal and which general or specific competencies require contextual adaptation.

c. Mixed-methods validation studies combining quantitative assessment of competency-outcome relationships with qualitative exploration of contextual factors influencing leadership development and effectiveness across different healthcare settings and cultural contexts.

d. Intervention studies using pre-post or quasi-experimental designs to test specific competency development strategies—such as participatory governance models, peer mentorship programmes, or autonomy-enhancing workplace practices (e.g., nurse-led self-scheduling systems, AI-shared decision-making tools)—to assess changes in team performance metrics (staff retention, psychological safety, role clarity), leadership self-efficacy and patient outcomes.

7 | Conclusions

This integrative review synthesises current evidence and conceptual perspectives on nursing leadership to propose an innovative theoretical reframing of nursing leadership as a comprehensive and dynamic professional competency, extending beyond traditional managerial functions. Grounded in established competency models and adapted to the complex and evolving realities of healthcare systems, our approach integrates technical expertise with intrinsic values, interpersonal capabilities and motivational drivers. This holistic perspective challenges the prevailing biomedical and hierarchical paradigms, which tend to narrow leadership to administrative control and resource management.

By conceptualising leadership as a transversal and stratified competency—manifesting at all levels of nursing practice—we aim to redefine the foundational attributes expected of nurse leaders. The proposed model provides a structured yet flexible framework that recognises leadership as both a personal and professional construct, influenced by individual self-awareness, ethical commitment and social accountability.

Importantly, this model responds to urgent system-level needs: improving care quality, supporting workforce sustainability and preparing nurses to act as agents of change in settings marked by increasing complexity, demographic shifts and resource constraints. It also addresses the current misalignment between leadership roles, institutional expectations and professional recognition, reducing today's ambiguity.

Ultimately, reconceptualising nursing leadership as a multidimensional, relational and value-based competency has the potential to transform the profession, empower emerging leaders, and foster more equitable and resilient healthcare systems. Achieving this vision requires dismantling structural barriers, redefining success in leadership and cultivating organisational cultures that recognise and support diverse leadership trajectories.

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Author Contributions

Aleix Fontanals-Jimenez: conceptualisation; methodology; writing – original draft; visualisation. **Marta Trapero-Bertran:** conceptualisation; methodology; writing – review and editing; supervision. **Montserrat Gea-Sánchez:** funding acquisition; validation; project administration; review and editing. **Esther Insa-Calderón:** writing – review and editing; supervision; resources.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table S1:** Competencies and supporting sources.

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