The Dual Competence in Clinical Leadership

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Content

The concept of dual competence refers to the combination of clinical and organisational competencies, regarded as equal and mutually dependent dimensions of nursing practice. As everyday work in the healthcare system has become increasingly complex, this chapter begins by explaining the underlying mechanisms behind this development and how they have made organisational tasks an ever more central and necessary part of clinical work.

The focus then shifts to organisational competencies, which include both a broad understanding of healthcare systems and practical organisational skills. Nurses must possess knowledge of the systems that surround clinical practice; that is, a broad understanding of the structures, cultures, and processes at the clinical, organisational, and health service levels. In addition, nurses need action-oriented organisational skills, which are outlined in this chapter under clinical leadership, patient pathway coordination, and quality improvement. These three organisational competency areas are elaborated in the following sections, and the chapter concludes with a discussion of the boundaries of nurses' organisational responsibilities and the associated challenges and dilemmas.

The dual competence

When the ambition is to become a skilled clinical nurse, is it also essential to be able to organise and coordinate patient pathways across organisations, professions, and sectors? According to a group of senior nursing leaders, the answer is yes.

"Good nursing is about creating connections. The truly competent nurse understands how to be part of the system – and how to hand over tasks within the system."

(Focus group with ward and chief nurses)

This requirement for nursing competence is captured by the term "dual competence." It refers to the idea that nurses must possess both clinical and organisational competencies to provide high-quality nursing care (see Figure 3.1). In other words, we define organisational tasks as legitimate

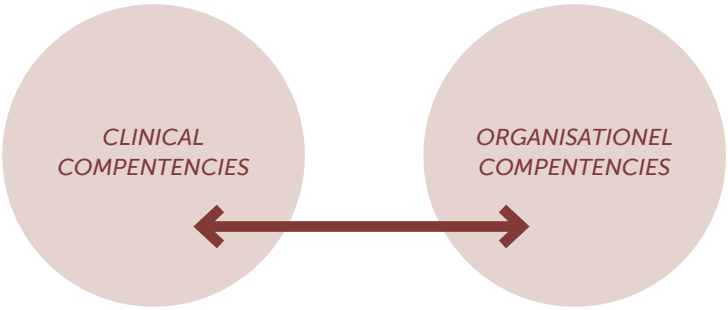

Figure 3.1. The dual competence

and integral to the nursing profession – traditionally described as *"leading nursing care."*

Clinical and organisational competencies are equal, interdependent, and mutually enabling (Orvik, 2022). Performing clinical tasks requires professional knowledge and technical skill, as well as organisational awareness – for instance, an understanding of task distribution within the healthcare system and of one's own role and responsibilities within the overall patient pathway. Conversely, undertaking organisational tasks such as planning admissions or discharges requires insight into the clinical work to be performed, so that planning can be adjusted accordingly. In short, clinical practice always takes place within and between organisations, and therefore presupposes organisation.

The need for this dual competence is reflected in the widely used definition of healthcare quality, which emphasises that high-quality care both increases the likelihood of desired health outcomes and is delivered in accordance with current professional knowledge. According to the World Health Organization, quality care is effective, safe and peoplecentred, and it is provided in ways that are timely, equitable, efficient and integrated (World Health Organization, 2026). These elements underline that healthcare quality is not only a matter of clinical expertise but also of how care is organised and coordinated. Consequently, nurses must be able to deliver high clinical standards while simultaneously managing and coordinating care in ways that meet these broader systemlevel expectations (WHO, 2026). Hence, the very concept of healthcare quality is founded on the integration of clinical and organisational aims, which nurses and other health professionals must be competent to support.

Furthermore, in today's healthcare system, there is a growing need for organisational competence due to the system's increasing complexity

and patients' overall circumstances. This can be described as a condition of high organisational complexity combined with high task complexity; a relationship that will be further explored below to provide a deeper understanding of why such organisational competencies have become indispensable for health professionals.

Organisational complexity

Organisational complexity in the healthcare system arises primarily from increasing differentiation, that is, the division of work into a growing number of specialised domains. The expanding professional specialisation within healthcare represents functional differentiation. As an example, in acute and community settings, tissue viability nurse specialists provide expert assessment and management of complex wounds, pressure injuries and leg ulcers, and lead education and quality improvement programmes across teams.

The advantage of both functional and structural differentiation is a high level of professional expertise (Døssing, 2018), i.e., the *know-how* and capacity to perform tasks more efficiently and effectively. However, the downside is that greater differentiation also means more actors are involved in each patient pathway, each responsible for an increasingly smaller part of the overall care process. The more actors involved, the more transitions occur, and the greater the need for organisation and coordination across professional and organisational boundaries to avoid fragmented and poorly coordinated care (Axelsson & Axelsson, 2006).

In sum, functional and structural differentiation create the potential for high-quality care and treatment, while also generating a growing need for organisation and coordination across multiple transitions in the patient pathway. While this ensures a high professional standard, it also requires nurses to spend more time organising and coordinating the total care provided – tasks that call for well-developed organisational competencies.

Complexity in healthcare is further intensified by changes such as the transfer of tasks from hospitals to communitybased services and general practice, as well as the increased pace and flow of hospital admissions and discharges (Allen, 2019; Rasmussen et al., 2021). Hospital stays have become steadily shorter, especially in highincome and OECD countries, where average length of stay has decreased significantly in the past decade (Golinelli et al., 2024), and a growing number of treatments and health services that were once hospital-based are now delivered in patients' homes or local communities (Baes-Jørgensen, 2019; Rasmussen et al., 2021). As a result, the organi-

sation and coordination of patient care must now occur within shorter timeframes, often disrupting established routines and necessitating a continual process of reorganisation, i.e., redefining who does what, when, and where throughout the patient pathway.

Task complexity

Patient-related complexity arises from the fact that a growing number of individuals live with multiple chronic conditions (multimorbidity or comorbidities) (Frølich et al., 2017), which significantly increases the overall complexity of their health status. For example, many patients with depression also have diabetes and hypertension (Barton et al., 2020), and these combinations must be taken into account in medical treatment, clinical observation, and support for the patient's self-care. The presence of multiple conditions also means that patients receive services from various healthcare units where professional tasks often overlap or interact. Consequently, health professionals must continuously adjust their actions to one another as a natural part of collaboration. In professional terms, this is described as mutual adjustment resulting from interdependence among tasks. In everyday language, this means that nurses must continuously align their own work with that of others involved in the patient's care, taking into account what others have done, what they are expected to do, and what they have not yet managed to do.

Multimorbidity also makes it challenging to plan professional interventions. Although chronic illness trajectories can be somewhat predictable, the intensity of disease activity often fluctuates, making it hard to foresee when a patient will require nursing or other health and social care services (Doessing & Bureau, 2015). Moreover, illness affects each patient differently, which calls for individualised planning and continuous adjustment of interventions (Døssing, 2018). Each patient therefore, brings with them a unique set of collaborative relationships, depending on their specific combination of conditions.

For instance, one patient's care may involve a mix of nursing services, home assistance, community-based rehabilitation, monitoring of one condition by a specialist physician and another by a hospital outpatient clinic, or annual check-ups with a general practitioner. As a result, nurses engage in both long-term, stable collaborations and short-term, shifting interactions with a wide range of actors across the health and social care sectors.

Taken together, these factors – organisational differentiation and patient-level complexity – illustrate the growing need for well-developed or-

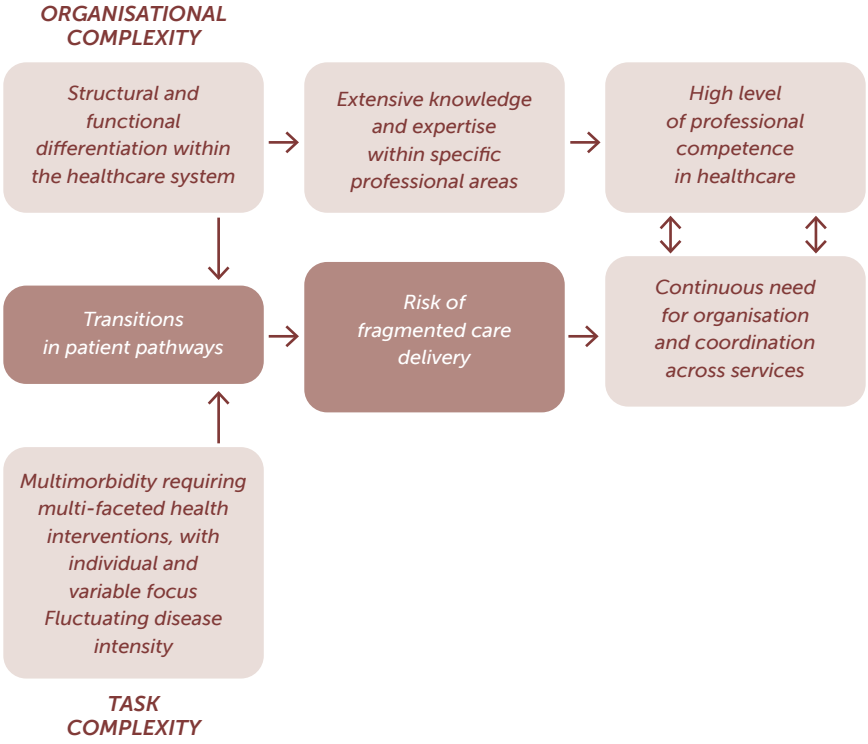

Figure 3.2. The relationship between complexity and the need for organisation and coordination of care efforts

ganisational competencies among healthcare professionals to prevent fragmented, poorly coordinated care delivery throughout the patient pathway (see Figure 3.2).

The term *"dual competence"* was introduced initially by Sveiby and Riesling (1987) in their studies of knowledge-based organisations. Their key argument was that the quality of a service improves when professionals, in addition to their disciplinary expertise, also possess an understanding of the systems surrounding their work and the ability to organise and coordinate that work. A related idea is found in Irgens and Wennes' (2011) concept of *"two-eyed competence"*, referring to professionals' need to develop multiple frames of understanding to perceive and act upon situations with a broader and deeper perspective.

However, such dual awareness cannot be taken for granted. Organisational aspects and professional practice are often separated in professionals' consciousness. Health professionals tend to focus primarily on

their own discipline and immediate tasks, paying less attention to the broader system of which they are a part (Abbot, 1988). This remains a challenge in modern healthcare, where organisational researchers stress the importance of professionals taking a greater interest in current organisational problems and participating in the search for solutions – so that systems, workflows, and task performance can be adjusted to meet patients' changing needs and the evolving context of healthcare delivery (Noordegraaf, 2011; Plochg et al., 2011).

Traditionally, understandings of nursing competence have emphasised clinical skills, although organisational work has always been an integral part of nursing practice (Allen, 2014; Postma et al., 2015). The risk of such a *"one-eyed"* focus on clinical competence is the emergence of a *"reality gap"* between what nursing students learn during their education and what is actually required and expected of them in clinical practice. A lack of coherence between education and realworld practice can trigger 'reality shock' (Kramer, 1974), which has been associated with attrition and frequent job changes (Aagesen & Højbjerg, 2015; Ministry of Higher Education and Science, 2020). It is therefore essential that nursing education supports the development and integration of clinical and organisational competencies, ensuring that educational outcomes align with the realities of professional practice.

Above, we have summarised the argument for why well-executed clinical nursing tasks alone are insufficient in a complex healthcare system characterised by high task complexity. Clinical competencies form the foundation for high-quality nursing, yet they must be combined with organisational competencies to safeguard the quality of the overall patient care trajectory.

The remainder of this chapter will focus on describing and elaborating the organisational competencies. These are not confined to nursing alone, and we therefore alternate between the terms *health professional* and *nurse*, while our primary concern remains how organisational competence manifests itself in nursing practice.

Organisational competencies

Organisational competence comprises two interconnected dimensions: a reflective and an action-oriented one. The reflective dimension is closely linked to system understanding, which forms the basis for developing the skills that constitute the action-oriented dimension. Accordingly, this section first explains the concept of system understanding and then outlines the organisational skills that build on it.

Before doing so, however, it is essential to clarify what is meant by *organisation*. An organisation should not be understood merely as a physical entity, but rather as a social system deliberately constructed to perform specific tasks and achieve specific goals. Organisations are made up of people who interact and collectively represent the organisation. Every organisation depends on the fact that someone benefits from its services and is willing to pay for them – otherwise, it cannot sustain its operations.

At the core of any organisation lies task performance, which should ideally be carried out in the best possible way and with the most efficient use of resources – that is, with high quality and organisational efficiency. Tasks are distributed among different departments, each with defined patterns of responsibility – who does what and who has the authority to make which decisions (Jacobsen & Thorsvik, 2014).

Task performance within the same organisation is referred to as *intra-organisational*, whereas collaboration across different organisations is called *inter-organisational*. For example, cooperation between an emergency department and a radiology unit within the same hospital represents intra-organisational collaboration. In contrast, cooperation between a general practitioner and a nursing home is inter-organisational. This distinction is crucial because organisational affiliation shapes how staff can act and prioritise. This is particularly important in inter-organisational collaboration, where professionals must recognise that partner organisations may pursue different objectives and operate according to different internal logics.

Consequently, health professionals need a system understanding that extends beyond their own department or organisation and includes the key contextual factors of their partner organisations. Such understanding is a basic prerequisite for interpreting others' actions within a patient pathway and for achieving mutual adjustment of professional efforts to ensure continuity of care.

System understanding

Health professionals must understand how organisations function and evolve, and be able to assess the healthcare system within a critical societal perspective. System understanding is therefore based on both knowledge of and reflection on the contextual factors that influence the provision of health services to patients, as well as the working conditions of health professionals.

These contextual, or framework factors, may have either positive or negative effects and can be divided into three main categories: structure, culture, and process (Orvik, 2022):

- Structure: Concerns how clinical practice, organisations, and the healthcare system are organised and structured.
- Culture: Refers to the prevailing norms and values – the shared set of assumptions and meanings that characterise a particular professional or social context.
- Process: Denotes a sequence of actions or activities through which resources are transformed into concrete outcomes.

System understanding spans three levels: the **clinical level** (where direct care is delivered), the **organisational level** (the specific organisation employing the nurse), and the **health system level** (macro level, encompassing national governance and regulatory frameworks) (Orvik, 2022).

- Clinical level: Also referred to as the *operative* level. This is where the actual delivery of nursing care takes place, and where nurse and patient interact and build a direct relationship. In other words, this level encompasses all aspects directly related to the nurse's clinical practice.
- Organisational level: Refers to the specific organisation in which the nurse is employed - for example, a hospital, a community-based organisation or a general practice. In large organisations, it can be difficult to define meaningful boundaries. One must therefore decide whether it makes most sense to view the organisation as, for instance, the entire hospital or as the specific departments within it.
- Health system level: Covers the national healthcare system as a whole and is also referred to as the *macro level*. It includes the central authorities – ministries and health agencies – that have the mandate to issue guidance and regulations for actors within the healthcare sector, as well as all organisational units within the system.

Examples of this are presented in Fact Box 3.1.

Competencies

Clinical practice presupposes a certain degree of organisation, and the associated organisational competences are *action-oriented*. In this chapter, they are described as comprising three main areas:

- Clinical leadership
- Coordination of patient care pathways (care coordination)
- Quality management in clinical practice

This, however, is not an exhaustive list. The literature contains a wide range of partially overlapping terms and varying definitions of the same concepts. Such theoretical diversity

Fact Box 3.1.

Examples of relevant system understanding

At the clinical level, during cross-sectoral meetings, it is important to recognise cultural and organisational differences between acute care settings and community or primary care services. In hospitals, the emphasis is often on evidence-based treatment of specific conditions, whereas community-based care typically adopts a broader, person-centred approach that includes rehabilitation, self-management support and social participation (Lehn, 2023).

At the organisational level, it is essential to understand the structural distinction between those who **commission** services and those who **deliver** them. In many health systems, commissioning bodies fund and define service standards, while providers are responsible for delivering and documenting care. This separation means that:
(1) the **commissioning function** assesses needs and authorises services based on eligibility criteria and patient condition, and
(2) the **provider function** delivers the agreed services and maintains records.
For example, if a hospital nurse needs to arrange **home health nursing** after discharge, they must liaise with the **care assessor** or case manager responsible for authorising community support. Conversely, if the nurse requires information about the patient's preadmission situation (and cannot find it in the discharge summary), they would contact the **community nursing team** or **long-term care provider** delivering the service.

At the health system level, it is important to understand the **interagency agreements** or **regional care coordination protocols** that govern transitions between sectors. These agreements define responsibilities for admission, discharge planning and followup across hospitals, primary care and community services, ensuring continuity and integration of care (Døssing, 2018).

is common, yet it can be confusing for students seeking to gain a clear understanding of a new field. Therefore, we have chosen to present our own coherent and practical division of organisational skills, rather than reproducing the many competing conceptualisations. It should be noted, though, that this approach inevitably comes at the expense of some theoretical nuance.

Overall, every health professio-

nal must be capable of leading their own work while also coordinating interventions and tasks with other actors in the healthcare system. This patient-centred organisation of work is often referred to as *"the small-scale organisation"*, yet from the perspective of patients and their relatives, it is crucial for the experience of continuity of care – that is, the extent to which patients and families perceive a series of healthcare events as coherent, connected, and aligned with the patient's treatment needs and personal context (Haggerty et al., 2003).

Beyond *clinical leadership*, which is the *everyday leadership* exercised by all nurses, many nurses also serve as organisational resource persons with particular responsibilities, such as *specialist nurses*. Furthermore, nurses are often placed in integrator positions – roles in which the main responsibility is to coordinate across departments or organisations, but *without formal decision-making authority* in those settings (Jacobsen & Thorsvik, 2013). Examples include positions such as *patient flow coordinator*.

The organisation of clinical practice also involves responsibility for the service as a whole, including resource management and quality assurance. While managers and leaders hold the formal responsibility for these aspects, all health professionals must be able to align their practice with the organisation's strategies and goals, act with awareness of resource use, and balance the needs of patients, efficiency requirements, and their own working conditions (Tewes, 2015). Moreover, professionals are frequently involved in the (re)organisation of clinical practice and contribute actively to organisational change, often serving as team leaders within their units.

The skill of coordinating patient care pathways is, according to a WHO Europe report, relevant to all healthcare personnel. Patient-centred coordination and integration of health services require that professionals are able to:

- Create the conditions for and deliver *coordinated and integrated care* that is centred on the patient's and relatives' needs, values, and preferences.
- Support patients in *navigating their own care pathway*.
- Function effectively as members of *inter-professional teams*, demonstrating understanding of group dynamics and processes to build productive working relationships (Langins & Borgermans, 2015).

In continuation of this, it is essential to recognise that coordination of patient care involves not only the ability to collaborate but also the ability to plan, deliver, and activate healthcare services along a continuum that spans both intra- and inter-organisational settings.

A key condition in intra and inter-organisational collaboration is that professionals generally cannot make commitments or decisions on behalf of other organisations or teams. Put plainly, employees in one organisation (or suborganisation) do not direct what employees in another organisation should do, except where formal delegation or sharedcare agreements explicitly apply (e.g., clearly defined protocols for task delegation, supervision, and accountability).

Example:
A hospital nurse should not promise that a community nursing team will conduct a home health visit unless the commissioning/authorising function (e.g., the care assessor or case manager) has approved the service and the local provider policies support home visits (rather than attendance at a nurseled clinic). In practice, the hospital nurse can initiate the request and coordinate information to enable the decision, but cannot guarantee delivery by another provider.

In this chapter, we adopt WHO's quality framework. Quality improvement (QI) denotes systematic and continuous actions to enhance the quality of services and patient outcomes, while quality assurance (QA) refers to ongoing processes that ensure actual performance meets explicit standards (World Health Organisation, 2026). In all cases, this

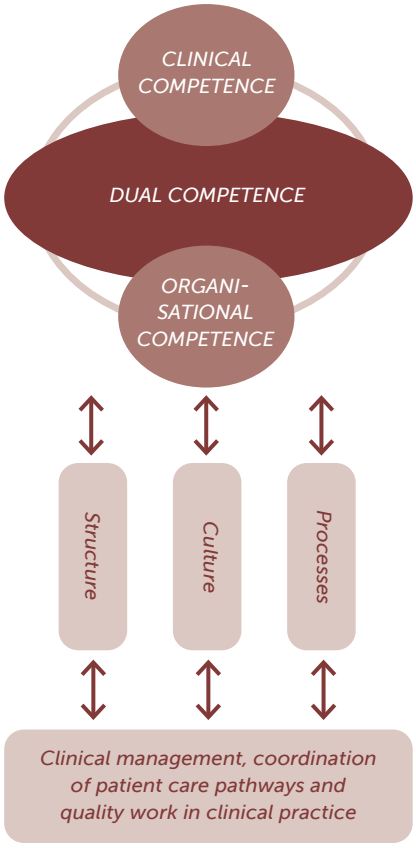

Figure 3.3. Organisational Competence

work demands an understanding of quality processes, organisational change, and behavioural adaptation within staff groups. Moreover, quality work integrates multiple perspectives – patient, professional, and organisational – and involves a variety of methods such as *patient satisfaction surveys*, *indicator monitoring in clinical databases*, and *unannounced inspections* in nursing homes.

In summary, organisational competence is both reflective and action-oriented. It is expressed through *system understanding* – with attention to structure, culture, and processes at the clinical, organisational, and health service levels – and through *skills* in clinical leadership, patient pathway coordination, and quality work within clinical practice. This interrelation is illustrated in Figure 3.3, which links these dimensions to the broader concept of *dual competence*.

Clinical leadership and coordination of patient pathways

Competence refers to the ability to apply knowledge and skills in a work situation, where skills express what a person is capable of doing or performing (Ministry of Higher Education and Science, 2020). In line with this definition, this section elaborates on the skills involved in clinical leadership and coordination of patient pathways.

Clinical leadership

A range of partially overlapping concepts is used to describe the management of work. Among the most common are *control*, *administration*, and *management*. For the sake of clarity, however, we use the term clinical leadership to denote the integrative activities of organising and prioritising tasks.

Clinical leadership can be divided into two dimensions: a general leadership responsibility embedded in everyday clinical work and involving all healthcare professionals, and a specific leadership responsibility that applies to formal managerial positions and roles (Kirkevold, 2012; Orvik, 2022). For example, nursing staff in a hospital ward may exercise general clinical leadership by organising the daily clinical work, whereas a head nurse carries a specific leadership responsibility by setting the direction and framework for the ward's operations and for staff development. The advantage of distinguishing between these two forms of clinical leadership is that it makes clear that leadership is not reserved for those in managerial positions. On the contrary, every nurse who makes decisions, organises, and prioritises takes on a general leadership responsibility for their own and others' work.

The general leadership responsibility can further be divided into a basic and an advanced level (see Figure 3.4). All registered nurses are expected to provide basic-level general clinical leadership. This includes, among other things, the ability to use resources and competencies effectively within a team, to manage one's own work, and to guide and support others. More explicitly, this means that the nurse, drawing on a clear un-

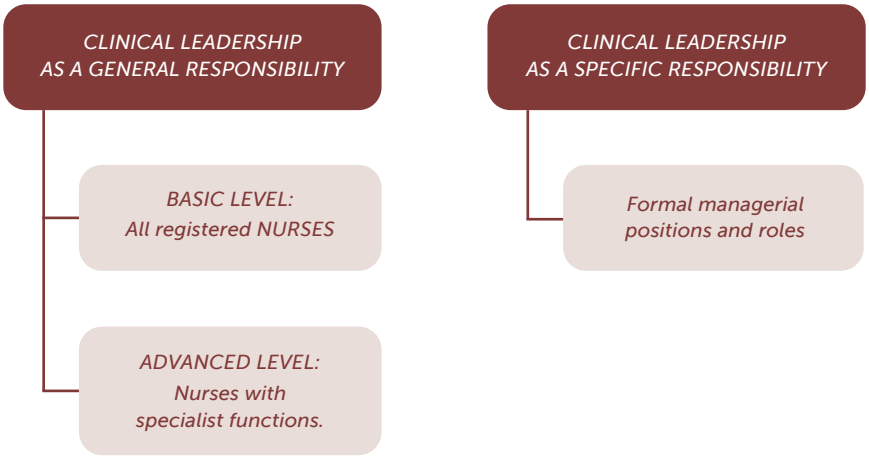

Figure 3.4. Clinical leadership as a general and a specific responsibility
(inspired by Kirkevold, 2012; Orvik, 2022)

derstanding of the healthcare system, must be able to:

- Gain an overview of a situation.
- Make decisions and prioritise nursing interventions while maintaining patient safety.
- Organise work tasks in an appropriate sequence and manner.
- Coordinate one's own actions with those of others.
- Delegate tasks to colleagues, including those with shorter educational backgrounds, which require instruction, follow-up, supervision, and support.
- Manage dilemmas, such as balancing the requirement to follow standardised clinical guidelines with the need to individualise nursing care to the patient. (Orvik, 2022)

General clinical leadership at the advanced level refers to nurses who hold a special function or have clearly defined, clinical leadership responsibilities (as previously mentioned for nurses in special positions such as nurse specialists or flow coordinators). Søndergård and Pjedsted (2021) describe this as an "*in-betweener*" position, referring to staff members who take on coordinating functions and leadership tasks without having formal managerial authority. Consequently, they must be able to handle a position that lies *between staff and management* (Søndergård & Pjedsted, 2021). The specific skills required depend on the content and area of responsibility of the special function, as well as the competencies it demands, typically requiring additional post-graduate education.

Regardless of level, clinical leadership must always be situational. Classical leadership theory distinguishes between a *supportive and relationship-oriented* leadership style and a *task-oriented* style that focuses more directly on the work itself. In practice, these styles must be combined, so that the choice of leadership approach is adapted to the situation and to the staff members' qualifications, motivation, and experience (Orvik, 2022).

Clinical leadership is closely linked to clinical decision-making yet represents two distinct areas of competence. New clinical assessments and decisions typically create a need for further coordination and (re)organisation of work tasks – not only concerning the individual patient in question, but also other patients whose examinations may need to be postponed or whose care must be delegated to other staff groups. Thus, clinical decision-making forms the basis of clinical leadership, while clinical leadership is the means by which clinical decisions are translated into action. A nurse's assessments and decisions are primarily clinical, but these clinical decisions affect the overall workflow and therefore require the nurse to assume a leadership role, making organisational decisions about the prioritisation, coordination, and organisation of nursing tasks.

Prioritisation is an implicit part of clinical leadership. It involves deciding which patients are in greatest need of nursing expertise and therefore should receive help first. For newly qualified nurses, prioritisation can be especially challenging, and the "prioritisation triangle" (Figure 3.5) can serve as a useful guide.

The figure distinguishes between:

1. Tasks that are nonurgent and can be postponed without compromising patient safety.
2. Tasks that must be completed but are of lower urgency.
3. Tasks that require immediate attention and cannot be delayed or omitted.

In other words, there are "must-do" tasks that, by their very nature, cannot be postponed, and "can-do" tasks, which are the ones between which nurses must prioritise at the two upper levels of the triangle (Hansen, 2019). For example, vital signs must be monitored in an unstable patient; pain relief must be given immediately to a patient in severe pain; and the same applies to insulin administration for a patient at home who has already eaten breakfast. By contrast, a multidisciplinary meeting with the patient and relatives about a rehabilitation plan, although essential, can be postponed, and routine observations such as weekly weight control at a nursing home can also wait.

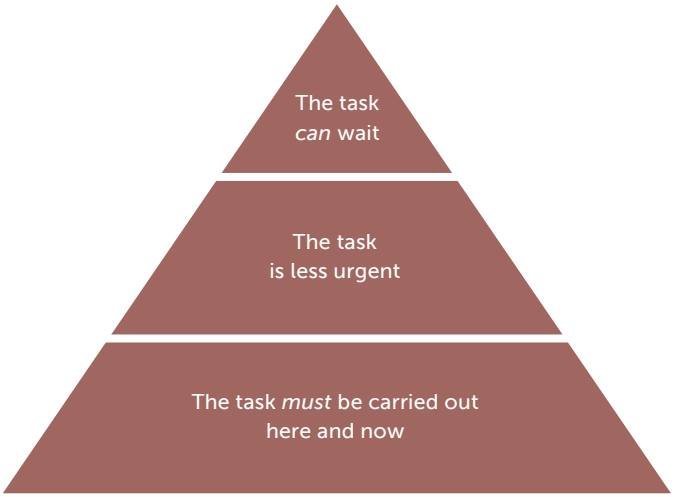

Figure 3.5. The Prioritisation Triangle

While some nursing tasks are always "must-do" tasks, the distinction between "must" and "can" will generally depend on the concrete situation and context, as well as on considerations of time and importance – that is, the potential consequences for the patient, colleagues, or the workplace if a task is postponed or prioritised. Conversely, some tasks may advantageously be deprioritised if they do not benefit the patient. For instance, the study "*When More Is Not Better*" found that around one quarter of participating patients had experienced unnecessary or redundant consultations, treatments, or examinations (Raft et al., 2021).

In relation to prioritisation, it is also important to recognise that it can be negatively affected by prolonged stress at the workplace – commonly referred to as burnout. Studies have shown that nurses experiencing burnout are significantly more likely to report missed care than those without burnout symptoms (White et al., 2019). Missed care refers to essential activities that are not performed due to a lack of time or resources. Its occurrence is a key indicator of declining care quality, adverse events, and lower patient satisfaction (White et al., 2019), and is also described in the patient safety literature as "work-arounds" (Berlinger, 2016). Thus, burnout increases the risk of inadequate prioritisation, with a negative impact on patient safety.

Finally, clinical leadership can be particularly demanding in acute situations. Acute scenarios are characterised by rapid changes in a patient's condition, making time a critical factor. In such cases, clear and direc-

tive leadership is essential and must occur in parallel with rapid clinical assessment and decision-making. In line with the principle of situational leadership, the nurse must therefore apply and master a more directive and instructive leadership style in acute situations.

Coordination of the patient pathway

"You have to know what needs to be coordinated, when, by whom, and how."

Community care nurse.

"We have to coordinate everything that needs to happen after discharge: arranging home care services and community-based nursing, scheduling visits to three different outpatient clinics at varying intervals, planning a home visit by the geriatric care team, and perhaps ensuring that the patient receives pastoral support if requested."

Hospital nurse

The quotes above illustrate that coordination of care pathways is a crucial part of nursing work, regardless of whether nurses work in community-based services or in hospital care.

At the clinical level, coordination across professions, organisations, and sectors has primarily been explored through the concepts of *case management* and *care coordination* (Karam et al., 2021; Lukersmith et al., 2016). However, the distinction between these concepts remains debated, likely because coordination is carried out by professionals from different disciplines, serving patients with varying problems in diverse contexts. Coordination can thus be either a specialised function (a full-time role) or an implicit part of a nurse's daily work.

The overall goal of coordination is to achieve integration of the healthcare services provided by multiple actors working with the same patient. In other words, it is the *intentional work* of ensuring that interventions from different professionals are harmoniously aligned, appropriately sequenced, and tailored to the individual patient's needs (Alter & Hage, 1993; McDonald et al., 2007). In practice, this involves the continuous activation of relevant services and the management of practical and informational aspects linked to moving and guiding patients through the healthcare system – including the use of digital systems for booking, information sharing, and communication.

It is essential to recognise, respond to, and manage the challenges arising from the high degree of differentiation in modern healthcare (as described earlier in the chapter). These challenges include:

- Overlapping responsibilities, leading to *duplication of work* (Lægreid et al., 2015) – for example, repeating tests or interventions already performed by others.

- Gaps in service delivery, where tasks fall through the cracks and no one assumes responsibility (Lægreid et al., 2015).
- Tunnel vision or silo mentality, where professionals or departments are so focused on their specialised tasks that they lose sight of the overall effort (Jacobsen & Thorsvik, 2014).
- Delays between sequential tasks, caused by dependencies in the workflow – e.g. when Unit A must complete its task before Unit B can proceed, and lack of capacity in Unit B creates a bottleneck (Jacobsen & Thorsvik, 2013). For instance, an emergency department must first complete its function and then transfer the patient to a ward. If the ward does not have the capacity to admit the patient, a bottleneck arises in the emergency department. Therefore, it is essential to maintain balance in the flow of patients into and out of departments

As mentioned earlier, "coordination competence" also involves the ability to collaborate, which is central to the theory of relational coordination (Gittell, 2012). This theory builds on the coordination mechanism of *mutual adjustment*, highlighting that shared goals, shared knowledge, and mutual respect are essential for frequent, timely, accurate, and problem-solving communication – ultimately improving both quality and efficiency. Nevertheless, studies show that collaboration across organisations remains challenging due to differing institutional goals, rules, and legal frameworks (Auschra, 2018).

Other studies identify trust between collaborating actors as a fundamental precondition for effective cooperation (Williams, 2012). The following have been described as key skills for professionals managing cross-boundary collaboration at the clinical level:

- Diplomatic skills and the ability to negotiate
- Strategic and tactical understanding, including knowledge of *who holds decision-making authority*
- Willingness and openness to be influenced by others' perspectives
- Problem-solving abilities, including creativity and the ability to seize opportunities as they arise (Williams, 2012)

The organisation of staff interactions across different institutions can be understood through Brown's classical theory of organisational interfaces (Brown, 1983). According to Brown, an interface may be under-organised – with loose, open interaction where actors operate largely independently – or over-organised – with rigid, tightly controlled interaction that leaves little room for tailored solutions.

Under-organised interface:
An under-organised interface is characterised by loose and open interaction, allowing the parties to act independently according to their own discretion.

Example: Collaboration between home-based care providers and primary care teams supporting patients with chronic conditions may be so loosely structured that it relies entirely on individual judgment about what information to share, how to coordinate, and when to make contact. This can lead to gaps in continuity of care.

Over-organised interface:
An over-organised interface is characterised by rigid and tightly controlled interaction, leaving little flexibility for action.

Example: Patient transport services may be organised according to narrowly defined procedures that fail to accommodate socially vulnerable patients who require adjustments – for instance, flexible pickup times or assistance beyond the standard protocol. As a result, the rigid interface can obstruct rather than support access to treatment.

When recurring collaboration problems occur in practice, this theory suggests assessing whether the issues stem from under-organisation, in which actors work separately without coordination, or from over-organisation, where rigid rules and procedu-res prevent flexible solutions. The answer indicates whether more structure or greater autonomy is needed to achieve a well-aligned interface. The next step is to determine who has the mandate to make changes and how nurses can contribute to developing better collaboration, leading to the following section on the organisational responsibilities of nurses.

Limits to nurses' organisational responsibility

Patient-centred organisational work is also referred to as everyday leadership, and researchers emphasise that this is an undervalued competence in many parts of the healthcare system and among health professionals in general (Hellesø et al., 2016). This undervaluation is also evident within the nursing profession itself, despite nurses providing a 24-hour service and bearing responsibility for organising and coordinating patient care across nearly all areas of healthcare. According to Allen (2014), many of today's nurses show considerable ambivalence toward the value of the organisational work they perform. She links this to a dominant focus on the nurse-patient relationship and direct clinical care. However, this has not always been the case. For example, a historical study showed that nurses in Denmark once took pride in their organisational skills (Larsen, 2006).

Nurses' responsibility for the day-to-day functioning of the healthcare system has repeatedly been described as an implicit and invisible function that falls outside formal structures of organisation and accountability (Davies, 1995). A Danish study involving nurses from community-based services, hospitals, and general practice found that nurses continue to perform informal coordination tasks that supplement the formal system. This includes coordination work that sometimes involves bending the rules when these are not perceived to serve the patient's best interest. In this light, the nursing profession has been described as a flexible back-up function within the healthcare system – activated whenever nurses encounter gaps in task performance or lack of continuity in patients' care pathways (Døssing, 2018). This buffer work comes at a cost: it increases workload due to unforeseen extra tasks and requires nurses to make individual judgments about *"for whom the rules should be bent."* As organisational work occupies more and more of the nurse's time, it inevitably reduces the time available for direct patient care. This creates a profound dilemma: who, then, will care for the patients (Allen, 2019)? Several nurses have pointed out that there is a shift from care-related tasks to organisational tasks, leading to down-prioritisation or delegation of care to other staff groups. Elstad (2019) cautions that just because nursing work is organised this way does not mean it should remain so, calling on nurses to critically reflect on developments in healthcare. However, such critical reflection is an integral part of system understanding.

For the individual nurse, the dual responsibility for both patient care and organisational coordination can create a sense of powerlessness and role overload – that is, a misalignment between responsibility and the authority or resources needed to meet organisational expectations. Such experiences highlight that nurses cannot, and should not, be expected to carry systemlevel responsibilities without adequate organisational support. Therefore, it remains crucial to underline that ultimate system responsibility lies with management. Management is accountable for establishing governance structures and resources that ensure safe, highquality care, including strategic policy frameworks, effective oversight, appropriate regulation, attention to system design, and clear accountability mechanisms (World Health Organization, 2025b). This encompasses evidencebased policies and procedures (World Health Organization, 2025a) and a competent workforce supported through appropriate recruitment, regulation, supervision and continuing professional development (World Health Organization, 2024).

Study questions

1. Explain the concept of "dual competence" and discuss why it is essential for nursing practice in a complex healthcare system.
2. How can structure, culture and process factors at different levels influence nursing practice and care coordination?
3. Why is prioritisation an essential part of clinical leadership, and what principles can guide nurses when organising and sequencing tasks in practice?
4. Based on the chapter, what tasks belong to *general clinical leadership* at the *basic* level versus the *advanced* level, and how do these tasks support safe, coordinated care?

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