

Leadership Inclusivity and Workforce Retention in Nursing: Empirical Evidence from a Faith-Based Hospital

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Abstract

Healthcare organizations face critical challenges, including nurse shortages and staff turnover. Faced with rising turnover following the COVID-19 pandemic, many providers are seeking proven methods to build a more stable workforce. This research examined the missing evidence on how perceived inclusive leadership relates to nurses' desire to continue working at a single faith-based medical center in the Midwest. Inclusive leadership involves actions that support fairness, recognize individual differences, and help people feel they belong. It is increasingly seen as a factor that can boost employee engagement and encourage staff to stay. Researchers conducted a cross-sectional survey using the validated Inclusive Leadership Questionnaire (ILQ). The survey was distributed to a convenience sample of frontline nurses and nurse managers working in one hospital. Nurses rated their leaders' behaviors, while managers evaluated how well the organization supported these efforts. In total, seventy-one responses were collected and analyzed (59 from nurses and 12 from managers). Scores from the ILQ were grouped and summarized by their main dimension categories. Statistical relationships among how leadership was viewed, levels of inclusivity, and nurses' plans to stay were tested using one-way analysis of variance on ILQ scores and nurses' own reports of their intent to stay.

The analysis found that nurses who experienced higher levels of inclusive leadership were significantly more likely to report that they intended to stay with the organization ($P = 0.01$). This connection was particularly strong for those with longer years of service. The highest-scoring areas were belonging and individual support, while team integration and fairness across different groups were flagged as needing the most attention and improvement. Nurse managers described the organization's backing for inclusive leadership practices as only moderate. Overall, the findings suggest that inclusive leadership serves as a useful and practical way to strengthen nurses' intention to remain in their roles. By weaving inclusive habits into leadership training and ensuring organizational systems fully support them, healthcare institutions can foster deeper staff loyalty and better manage the ongoing challenges of maintaining an adequate workforce.

Keywords: Workforce stability, Organizational support, Leadership behaviors, Nurse retention, Healthcare management

Introduction

The COVID-19 pandemic exacerbated existing difficulties in healthcare staffing, especially for nurses who had to handle increased workloads, moral strain, and unusually high rates of job turnover. Nurse turnover has

continued to rise, with the national rate reaching 16.4% in 2024. Even though the US Health Resources and Services Administration expects the total number of registered nurses (RNs) to keep growing nationwide, the supply is still projected to fall far short of what will be needed by 2037 [1]. Shortages like these have put patient safety at risk, weakened teamwork, and created heavy financial pressure on hospitals. The cost of losing RNs is high, whereas retaining experienced nurses yields clear savings [2].

Many hospitals have focused primarily on offering recruitment bonuses, but retaining current staff has proven to be a more reliable long-term solution for

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workforce stability. The way leaders behave plays a major role in shaping whether nurses want to stay. Previous research has shown that nurse satisfaction and the desire to remain employed are closely tied to factors such as feeling empowered, being included, and sensing strong organizational support [3, 4]. Inclusive leadership emphasizes fairness, equal treatment, openness, and the value of each person's uniqueness. It has shown real potential to improve psychological safety and staff engagement, and to reduce turnover [5, 6].

This type of leadership goes beyond one-on-one interactions and includes structural changes. When leaders actively work to make everyone feel they belong while respecting personal differences, they are better able to build strong, adaptable teams. In nursing departments, inclusive leaders remove obstacles that prevent people from speaking up, encourage contributions from all backgrounds, and build workplaces where staff feel respected and listened to [7]. Using the Inclusion Framework [5] as a guide, this study explored whether inclusive leadership behaviors could affect nurses' willingness to remain at a faith-based hospital in the Midwest, where turnover levels were similar to those nationwide. The research also asked nurse managers how much support they felt the organization gave to inclusive practices.

Although healthcare systems have launched many diversity programs, turning inclusion into everyday practice is still inconsistent. Very few studies have quantified its impact on nurses' intent to stay using numerical data. By uncovering the links between how nurses perceive their leaders' inclusiveness and their plans to stay, this study aimed to offer healthcare leaders concrete ideas for strengthening their nursing teams and creating more welcoming workplace environments.

Background

The healthcare industry is still struggling to retain nurses. Long before the COVID-19 pandemic began, high nursing turnover created major operational and financial problems for healthcare facilities [8]. In the years following the pandemic, these challenges have worsened due to heavier workloads, emotional fatigue, and severe staff shortages. Registered nurse (RN) turnover rates hit a record peak of 27.1% in 2022. This pushed RN vacancy rates to 17%, a rise of more than 7% in a single year [2]. The effects of these staff departures are widespread, interrupting patient care and costing hospitals an estimated \$5.2 to \$9 million each year [2].

To address the rising number of nurses quitting, the hospital introduced standard bonus programs, tuition reimbursement incentives, and opportunities for professional growth to reduce turnover. Although recent systematic reviews indicate that money-based rewards alone seldom address the deeper organizational issues driving nurse departures, newer observational studies from the COVID-19 period show that carefully designed bonus plans can temporarily boost full-time equivalent staffing levels [9]. Still, without ongoing efforts to improve the work setting and strengthen leadership support, these short-term improvements are unlikely to reduce turnover in the long run [10]. Against this backdrop, inclusive leadership has emerged as a strong cultural approach that could boost nurse engagement and their desire to remain in their positions.

Many established leadership models do not fully account for how organizational leaders collaborate with underrepresented groups in problem-solving. Conventional leadership approaches, including transactional and even transformational styles, do not adequately address the personal qualities that enable leaders to distribute power and encourage inclusive decision-making within these groups, benefiting society as a whole [11]. Inclusive leadership is defined by actions that actively welcome, value, and leverage team members' varied viewpoints while fostering a sense of belonging [5]. Within nursing leadership, inclusive leadership expands on participative and servant leadership models. It merges joint decision-making and personalized assistance with a clear focus on fostering belonging and appreciating diversity, all aimed at strengthening team unity and improving retention [5–7, 11]. Inclusion is most effectively viewed through the combined perspectives of belongingness and uniqueness. In this view, people feel both connected to their team and recognized for the qualities that set them apart [6]. In healthcare settings, where teamwork across disciplines and culturally sensitive care are vital, inclusive leadership methods can help develop high-performing teams that feel psychologically safe [7].

For nurses in particular, inclusive leadership goes beyond being a theoretical goal and becomes an essential practical requirement. Nurses who work in inclusive surroundings tend to experience greater job satisfaction, improved psychological safety, and deeper loyalty to their organization [3, 4]. These elements are closely linked to better retention. On the other hand, workplaces that feel exclusionary or overly hierarchical often

damage nurse morale and raise the likelihood of turnover [8, 12]. When nurse managers deliberately practice inclusive leadership behaviors—such as advancing fairness, guaranteeing equal access to resources, inviting contributions from every staff member, and building stronger team connections—they create conditions for both personal and group achievements [13]. Inclusive leadership shapes nurses' daily experiences by increasing job satisfaction and decreasing burnout, while also encouraging greater teamwork and collaboration. These improvements have been shown to lead to better patient outcomes, as unified, well-supported teams deliver higher-quality care and respond more effectively in urgent situations [14].

Several frameworks have been suggested for putting inclusive leadership into practice. However, the Inclusion Framework, created by Shore *et al.* [5] and later expanded by Randel *et al.* [7], is particularly appropriate

for healthcare settings (**Figure 1**). According to Shore, inclusion involves experiencing both a strong sense of belonging and a feeling of being valued for one's unique qualities inside the organization [5]. Within nursing leadership, this approach highlights the need to build environments where nurses feel genuinely supported and appreciated for their individual professional strengths. This, in turn, helps strengthen trust, boost engagement, and improve staff retention. Randel *et al.* [7] describe five key leadership behaviors that help create such an environment: offering support to team members, promoting justice and fairness, enabling shared decision-making, inviting varied perspectives and inputs, and assisting everyone to make their fullest contribution [7]. These actions closely align with the responsibilities of nurse managers, who must guide intricate, high-pressure care teams amid ongoing, unpredictable demands.



Figure 1. Inclusion framework [5].

Although substantial research has confirmed the benefits of inclusive leadership in corporate and university environments, far fewer studies have examined how it operates in actual clinical nursing settings. Tang and Hudson found that many elements associated with higher nursing job satisfaction—including autonomy, support, team cohesion, and active involvement—overlap significantly with the core elements of inclusive leadership [3]. Similarly, Nishii and Mayer showed that inclusive leadership is especially effective in diverse teams, as feelings of fairness and recognition play a major role in whether staff choose to remain [8]. More recent studies add to this picture: Du *et al.* [15] reported that inclusive leadership reduces turnover intention

among ICU nurses, with organization-based self-esteem and interactional justice serving as sequential mediators. In their integrative review, Jimenez-Caceres *et al.* [16] found that inclusive leadership, along with transformational, ethical, servant, and authentic leadership styles, is consistently associated with lower intentions to leave among hospital nurses. During the period of normalized COVID-19 prevention measures in China, Zeng *et al.* [17] observed that inclusive leadership increased nurses' intent to stay, both directly and through increased psychological ownership, across large nurse samples. A separate recent investigation among Chinese nurses similarly concluded that inclusive leadership strengthens psychological ownership and boosts

retention, with fairness, open communication, and opportunities for self-development acting as important pathways [18]. Taken together, these results indicate that inclusive leadership goes beyond being a mere concept; it shows clear, measurable links to lower turnover intention via psychological and organizational processes in real-world clinical nursing.

Nevertheless, these insights have rarely been incorporated into healthcare policies or leadership training programs, representing a significant missed opportunity to advance leadership capabilities and achieve broader system improvements. Additional evidence is also emerging that inclusive leadership can improve overall team performance by strengthening what Hofmeyer calls “social capital”—the networks of relationships and shared norms that allow teams to work together effectively [19]. Kida *et al.* [4] in their examination of hospital nursing units, found that deliberate efforts to promote inclusion led to stronger team connections and enhanced collaboration. Further research has connected inclusive leadership to higher levels of psychological safety. In healthcare, this can lead to greater staff readiness to report mistakes, share ideas, and push for improvements that are patient-centered [20]. Such results carry special weight in high-risk hospital environments, where breakdowns in communication or low staff engagement can lead to serious, even fatal, outcomes.

The value of inclusive leadership becomes even clearer when considering education and professional development. This aligns with the recommendations in the Future of Nursing 2020–2030 report, which urges broader nursing leadership roles to tackle social determinants of health, deliver better care to underserved groups, and address deep-rooted inequities across the healthcare system [21]. Despite abundant evidence from business and academic fields, healthcare leadership training initiatives commonly face significant shortcomings, including insufficient diversity in participant recruitment, an excessive focus on personal competencies rather than broader systemic challenges, and a preference for short-term outcomes that limit understanding of long-lasting leadership development [22]. Simmons and Yawson [23] identify three essential objectives for developing inclusive leadership in healthcare: establishing a shared sense of purpose, showing dignity and respect toward every team member, and promoting full involvement of all individuals, regardless of position or background. These objectives

closely align with current initiatives, including HC Vantage’s programs to build inclusive skills among nurse leaders. Still, without strong institutional backing and coordination, these initiatives risk failing to produce meaningful, widespread change [24]. Nurse managers cannot rely solely on their own commitment to inclusive leadership; they also need adequate organizational support, decision-making authority, and consistent encouragement from senior hospital leaders to demonstrate and maintain these behaviors over time.

This investigation extends previous foundational studies by assessing the current level of inclusive leadership practices inside a Midwestern nonprofit hospital. The facility is located in an area that experiences one of the highest nurse turnover rates nationwide—28.6% across the North Central US [2]. Hospital administrators aimed to reduce staff attrition by at least 5% by implementing strategies centered on organizational culture. They considered the development of inclusion at the nurse-manager level a potentially powerful mechanism for achieving this target. They therefore decided to evaluate the current state of inclusive leadership across the institution. With this in mind, the research was structured to address the following three questions:

What are the views of the hospital’s nurses concerning the inclusive leadership demonstrated by their managers? (Floor nurse ILQ).

What are the views of nurse managers concerning the degree to which hospital administration backs their attempts to practice inclusive leadership? (Nurse manager ILQ).

Does a connection exist between how inclusive leadership is perceived and nursing staff members’ intention to remain employed at the hospital? (Comparison of demographic and intent to stay questions, and ILQs).

Hypothesis:

Hypothesis 1: The researchers expected that floor nurses would see their nurse managers as exhibiting inclusive behaviors.

Hypothesis 2: The researchers expected that nurse managers would sense adequate support from the hospital in their efforts to develop or strengthen inclusive leadership skills.

Hypothesis 3: The researchers expected that favorable perceptions of inclusive leadership would increase nursing staff members’ desire to continue working at the hospital.

Materials and Methods

Study design

The study used a cross-sectional survey to examine the relationship between perceived inclusive leadership and nurses' intention to remain at a large (>500-bed) nonprofit faith-based hospital in the Midwest. Cross-sectional designs are well-suited for uncovering relationships among variables captured at a single point in time [25, 26]. This format enabled the simultaneous measurement of how nurses viewed their leaders' behaviors and how strongly they wished to remain in their positions. It further allowed for a comparison between the leadership behaviors perceived by front-line staff and the administrative support perceived by those in managerial roles. However, no direct comparisons were made between floor nurses' and nurse leaders' perceptions of support.

Setting and participants

This hospital is part of an extensive health system that provides services across nine states in the United States. It currently employs about 700 physicians and more than 3,300 total personnel, including both bedside nurses and supervisory nurse managers. Every frontline nurse and every nurse manager reporting directly to the Chief Nursing Officer received an invitation to join the project. The eligible group included 694 front-line nurses and 38 nurse managers. Ultimately, 71 completed surveys were received: 59 from front-line nurses, representing an 8.5% response rate, and 12 from nurse managers, representing a 31.6% response rate.

IRB approval and informed consent

The planned project, which concentrated on discovering and applying leadership approaches to strengthen nurse retention, was presented to the Vanderbilt University Institutional Review Board (IRB) for evaluation. After review, the Vanderbilt IRB concluded that the effort was primarily intended to drive internal quality improvement rather than to produce broadly applicable scientific knowledge. As a result, the work did not fulfill the federal definition of human subjects research and did not require formal IRB oversight. The project was therefore categorized as a quality improvement activity. At the outset of the voluntary survey, each participant provided informed consent for the later use of their deidentified responses.

Data collection

The investigative team delivered two specially designed surveys—one for floor nurses and another for nurse managers—through Qualtrics during April and May 2023. Recruitment followed a stepwise approach: awareness messages were first sent to department heads, then followed by personalized email invitations sent straight to every qualified staff member. Reminder emails were sent to all potential respondents every 2 weeks throughout the survey window. Everyone who took part was told that their answers would stay fully anonymous and that joining the study was completely optional. Hospital officials pointed out that the organization had only recently switched over to a new electronic medical record platform and had also run another nurse survey not long before. To offset any survey fatigue caused by these recent activities, those who completed the questionnaire were entered into a random draw for a \$50 gift card. Both surveys officially ended on May 14, 2023.

Measures

Inclusive leadership

Inclusive leadership actions were evaluated using the Inclusive Leadership Questionnaire (ILQ) (**Figure 2**) designed by Li [13]. This tool is a 40-item, validated scale that examines four separate aspects of inclusive leadership:

Inclusive Leadership Questionnaire

DIMENSION 1:

Providing equal opportunity and fair treatment to all work unit members

DIMENSION 2:

Encouraging integration of and synergy among all work unit members

DIMENSION 3:

Directly addressing work unit members' fundamental needs for uniqueness, authenticity, and belongingness

DIMENSION 4:

Implementing organizational diversity and inclusion related policies and programs in the work unit

Figure 2. Inclusive leadership questionnaire: four dimensions [13]; dimension 1: Equal treatment and

fairness, dimension 2: Integration and synergy among team members, dimension 3: Support for belongingness and uniqueness, and dimension 4: Implementation of diversity and inclusion policies.

Front-line nurses reported how frequently their direct nurse manager engaged in inclusive actions. Nurse managers rated the level of backing they received from the organization to carry out those actions. Responses for every statement used a 5-point Likert scale, where 1 meant almost never, and 5 meant almost always. The ILQ produces subscale scores for each of the 4 dimensions and an overall average score. It has displayed very strong reliability, with a Cronbach's alpha coefficient of 0.97 [13]. Based on this solid performance, the study team concluded that a single instrument was sufficient to gauge the views of both the nursing staff and the managerial group.

All ILQ statements directed at nurse managers started with the stem "As a nurse manager, my organization has provided me with resources and/or support to...." In contrast, items for front-line nurses began with "My nurse manager...". Sample items for dimension 1 included sharing important information with all members of the work unit, treating all work unit members equitably, and addressing personal biases against members of marginalized groups within the unit. Dimension 2 examples covered listening respectfully to every work unit member, inviting varied viewpoints from all staff to reach unit objectives, combining different perspectives from across the unit, and inviting full participation from everyone when making decisions. Dimension 3 items addressed personal differences among unit members, urged staff to express their authentic selves, and worked to help every person feel they truly belong in the unit. Dimension 4 focused on following the organization's diversity and inclusion rules within the work unit and implementing the organization's diversity and inclusion programs within the unit [13].

Intent to stay

The desire of nurses to keep working at the hospital was assessed with one straightforward categorical item: "I intend to continue working" at "the hospital," offering these answer choices: Less than 6 months, 6 months to 1 year, 1–3 years, 3–5 years, and more than 5 years.

Demographics

Respondents supplied background information on gender, age bracket (organized by decade), total years spent in nursing practice, and how long they had worked at this particular hospital. These details were gathered to serve as control variables in exploring links between perceptions of inclusive leadership and the intention to remain employed.

Data preparation and analysis

Returned surveys were first separated according to the participant's job category, after which all answers were converted into numerical values for statistical processing. Descriptive statistics were calculated to summarize average scores and score distributions for the various leadership dimensions among floor nurses (**Table 1**) and among nurse managers (**Table 2**). A one-way analysis of variance (ANOVA) was performed to test whether nurses' views of their managers' inclusive leadership influenced their intention to remain at the hospital. The test revealed a statistically significant difference in intent to stay across the groups ($F(4, 54) = 3.51, P = 0.01$). Follow-up pairwise comparisons with the Tukey-Kramer method indicated that nurses planning to stay "over 3 years, up to 5 years" held markedly different perceptions of their managers' inclusive leadership compared with those intending to stay "over 5 years" ($t(54) = 4.05, P < 0.05$). No additional pairwise differences reached statistical significance.

Table 1. Nurse perceptions of nurse manager inclusive leadership

	Count (N)	Mean	Standard deviation
Inclusive leadership (IL)	59	4.24	0.89
IL dimension 1	59	4.27	0.83
IL dimension 2	59	4.19	0.98
IL dimension 3	59	4.29	0.98
IL dimension 4	59	4.31	0.97

Table 2. Nurse managers perceptions of support

	Count (N)	Mean	Standard deviation
Inclusive leadership (IL)	12	4.03	0.69
IL dimension 1	12	3.84	0.83
IL dimension 2	12	3.99	0.75
IL dimension 3	12	4.35	0.63
IL dimension 4	12	3.89	0.87

All statistical procedures were carried out with IBM SPSS Statistics, Version 28, and Microsoft Excel. A

significance threshold of $P < 0.05$, statistical power of 0.80, and an expected large effect size (Cohen's $d = 1.0$) guided the sample size calculation, resulting in a goal of 30 participants per group. This target aligned with earlier studies that investigated leadership practices and nurse retention [15].

Ethical considerations

The project received approval from Vanderbilt University's Institutional Review Board and gained full backing from the hospital's administrative team. Involvement remained entirely voluntary and anonymous; all collected data were stripped of identifying details, and every record was kept in a secure environment in accordance with university data protection guidelines.

Results and Discussion

Participant demographics

In total, 71 completed questionnaires were included in the analysis: 59 from frontline nurses and 12 from nurse managers (**Figure 3**). Within the frontline nurse group, 86.4% reported more than 5 years of nursing experience, while 69.5% had been employed at the hospital for 5 years or longer. The majority identified as female and were between 30 and 59 years old. The sample leaned heavily toward long-serving staff members, mirroring internal hospital data showing that nurses with extended tenure are more likely to respond to organizational surveys [27]. The modest response rate among nurses limits the extent to which the results can be applied, as younger nurses and those with shorter employment histories were notably underrepresented. This pattern may point to self-selection bias, in which individuals holding stronger views or deeper ties to the organization were more inclined to participate than those who had joined more recently.

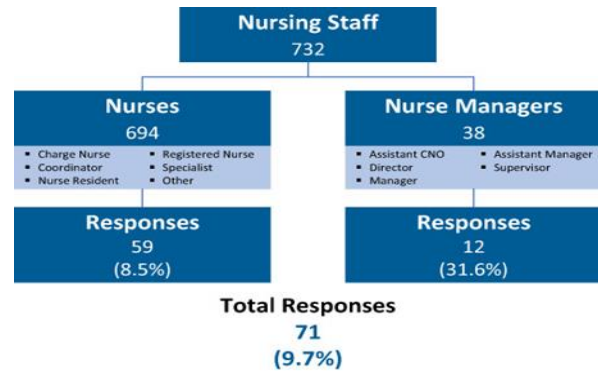


Figure 3. Response rate 71 (9.7%).

Nurse managers formed an equally seasoned group, reporting an average of 21.95 years of overall nursing experience and 16.3 years working at this hospital. Such a profile points to a stable managerial team, yet it also limits the ability to extend those conclusions to leaders earlier in their careers.

Perceptions of inclusive leadership (Front-Line Nurses)

On the whole, nurses gave favorable ratings to their managers' inclusive leadership practices (**Figure 4**). The average score across the full set of 40 ILQ items was 4.24 ($SD = 0.97$), indicating that inclusive behaviors were observed at levels between "often" and "almost always." Of the four ILQ dimensions, "support for belongingness and uniqueness" earned the highest average ($M = 4.31$). It was followed closely by "equal treatment and fairness" ($M = 4.27$) and "encouraging diverse contributions" ($M = 4.29$). The dimension receiving the lowest rating was "integration and synergy across work units" ($M = 4.19$). This lower score points to comparatively weaker views around shared decision-making and team-wide collaboration. The pattern matches earlier research showing that strong individual-level support can coexist with weaker collective inclusivity in traditional, hierarchical, or compartmentalized healthcare settings [5, 19].

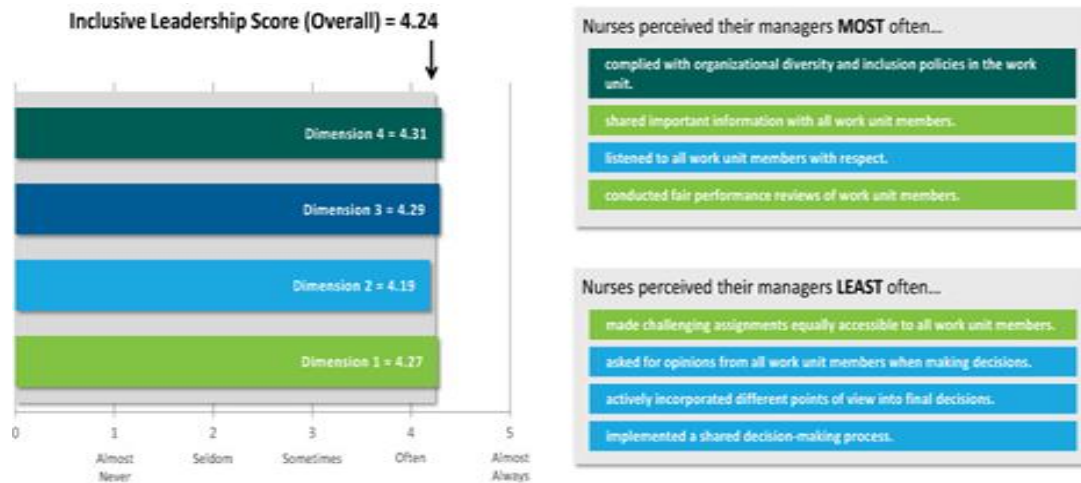


Figure 4. Nurses indicated that their manager often demonstrates inclusive leadership. The arrow represents the overall ILQ mean.

Perceptions of organizational support (Nurse managers)
Nurse managers reported moderate to strong organizational backing for practicing inclusive leadership (**Figure 5**). Their overall mean ILQ score reached 4.03 (SD = 0.69). They felt greater support for promoting individual inclusion (M = 4.35) than for fostering integration across the unit (M = 3.99) or for carrying out equity-focused policies (M = 3.89). The

lowest-rated area was “equal opportunity and fairness” (M = 3.84), suggesting perceived unevenness in how the organization provided support and distributed resources across departments. This gap echoes previous observations that inclusion tends to be practiced more effectively at the personal level than through consistent organization-wide systems [7, 23].

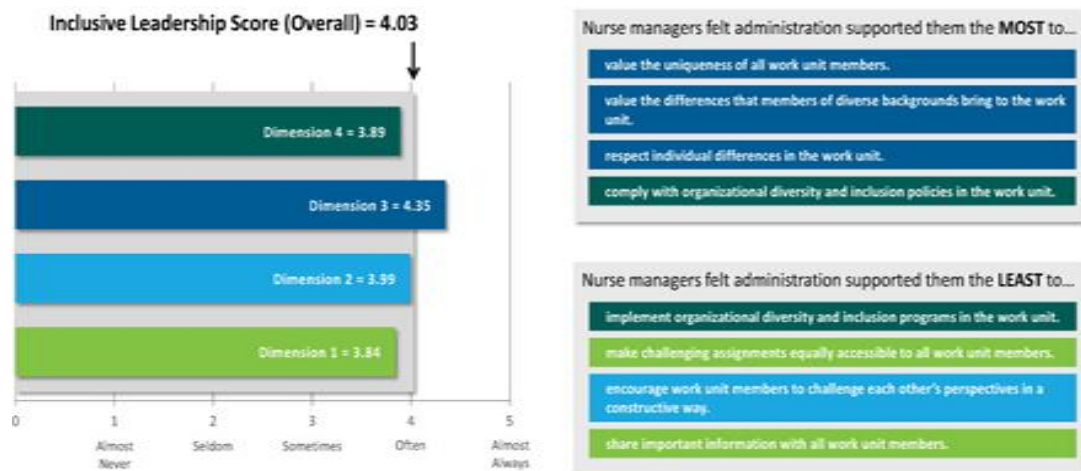


Figure 5. Nurse managers indicated that administration often supports them in becoming inclusive leaders. The arrow represents the overall ILQ mean.

Inclusive leadership and intent to stay

Overall ILQ means were examined alongside front-line nurses' reported plans to stay with the hospital. Nurses' views of inclusive leadership were compared with their stated intention to remain employed. Average inclusive leadership scores differed noticeably depending on the planned length of stay: Less than 6 months: M = 3.59 (n

= 4), 6 months to 1 year: M = 4.04 (n = 10), 1–3 years: M = 4.03 (n = 10), 3–5 years: M = 3.71 (n = 8), and more than 5 years: M = 4.65 (n = 27).

A one-way ANOVA showed a statistically significant relationship between perceptions of inclusive leadership and intent to stay, $F(4, 54) = 3.51$, $P = 0.01$. Follow-up Tukey-Kramer tests found a meaningful difference

between nurses planning to stay more than 5 years and those planning to stay 3–5 years ($P < 0.05$). The pattern suggests that clearer perceptions of inclusive leadership are associated with longer-term commitment to the organization, especially among the most seasoned nurses (Figure 6).

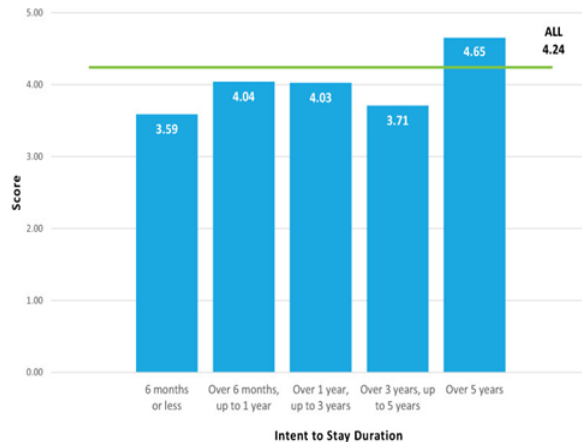


Figure 6. Average inclusive leadership rating and intent to stay ($n = 59$).

These outcomes line up with earlier investigations that have found a positive link between inclusive leadership and the desire to remain in a position [3, 8]. They also support the view expressed by Lee and Dahinten that inclusive workplaces help create psychological safety and a greater sense of stability—factors that play a key role in keeping healthcare workers in demanding environments [20].

The findings support hypothesis 1. Nurses generally perceived their managers as practicing inclusive leadership, with particularly strong approval for elements connected to belonging and personal support. Nevertheless, lower ratings in integration and synergy indicate that although nurses may feel individually valued, their experience of team unity and joint decision-making remains limited. This pattern implies that inclusive leadership applied at the personal level has not yet fully extended into wider team collaboration [28–30]. The reduced scores in this dimension could stem from longstanding organizational features typical in healthcare, including rigid hierarchical structures, professional silos, and limited opportunities for cross-disciplinary collaboration. Such factors often hinder effective teamwork. Overcoming them may require deliberate strategies such as regular interprofessional huddles, formal shared decision-making processes, or

revised workflow designs that encourage cooperation across roles [19, 31].

Interestingly, hypothesis 2 was not supported. Nurse managers gave lower ratings to the organizational support they received for inclusive leadership compared with the inclusivity scores they themselves received from staff, especially in matters of fairness and equitable resource distribution. This mismatch points to a possible divide between leadership's stated commitment to inclusion and the actual systems that either bolster or weaken those efforts. Simmons and Yawson [23] stress that sustainable inclusive leadership depends on organizations aligning policies, accountability mechanisms, and resources to enable inclusive actions throughout every department. Extending this view, more recent research by Sallam *et al.* [22] highlights that an evidence-based management approach—one that combines organizational culture, stakeholder involvement, knowledge management, implementation intentions, and implementation science—can establish the necessary systemic base for successfully developing and maintaining inclusive leadership in healthcare organizations.

This study confirmed hypothesis 3 and offers direct evidence of a positive link between inclusive leadership and nurses' intention to remain employed within a faith-based healthcare environment. Nurses who viewed their managers as demonstrating inclusive leadership were markedly more likely to plan to stay in the long term. The result is consistent with prior literature indicating that inclusive workplaces foster psychological safety, greater job satisfaction, and stronger organizational loyalty [5, 7]. In a similar healthcare setting, a recent systematic review of the global pharmacy workforce found that leadership support is a key driver of job satisfaction and staff retention. These outcomes highlight the broad importance of supportive leadership for maintaining workforce stability across various healthcare roles [32]. The particularly strong connection between inclusive leadership and intent to stay among nurses with extended service (over 5 years) suggests that inclusive practices may yield increasing benefits over time. It is also possible that seasoned nurses are more attuned to leadership actions that affect their professional satisfaction. Additional longitudinal studies would help establish the causal direction of this association.

Limitations

Key limitations of this study include its low response rate and the overrepresentation of nurses with long tenure. It should be recognized that the collected data may not accurately reflect the full group of 694 frontline nurses due to potential sampling bias. The responses largely captured the views and retention intentions of those individuals who decided to take part in the survey. Consequently, any broad statements about the entire nursing population at this hospital should be made with considerable caution. In addition, the cross-sectional design prevents firm conclusions about cause-and-effect relationships. Despite these constraints, the results still offer useful guidance for healthcare organizations aiming to strengthen their nursing workforce through leadership practices rooted in organizational culture. The fact that the research was conducted at only one Midwestern faith-based hospital further limits the applicability of the findings to other healthcare environments or geographic areas. Other limitations involve the use of a single-item question to measure nurses' intent to stay. The ILQ was deliberately chosen to help reduce common method bias and limit the time required from participants. While multi-item scales are typically considered more reliable, a single-item approach was adopted here because intent to stay was treated as a unidimensional concept. The study's reliance on self-reported data may also reduce its reliability, as responses may be influenced by response bias or a tendency to give socially desirable answers. Lastly, the study design did not control for other potential confounding factors, such as overall job satisfaction, nursing unit type, or flexibility in work schedules.

Future research

Future investigations should test the rollout of inclusive leadership training initiatives and track their sustained effects on nurses' intent to stay and on overall team effectiveness. Mixed-methods approaches could uncover richer details about how inclusion is both perceived and practiced at different layers of the organization. It is recommended that later studies evaluate well-structured leadership development programs. Moreover, research at the policy level is needed to assess broader organizational and system-wide strategies—such as uniform leadership competency models, staffing guidelines, and retention incentives—to increase the real-world usefulness and applicability of results across varied healthcare contexts. Such directions would enable future work to connect targeted leadership development efforts with concrete improvements in nurse retention and workforce stability.

Conclusion

This study reveals a meaningful practical connection between how nurses perceive inclusive leadership and their intention to remain employed at a Midwestern faith-based hospital. Nurses who saw their managers as inclusive were more likely to express a desire to stay long term. These results reinforce the idea that inclusive leadership is a valuable and potentially powerful strategy for addressing workforce instability in healthcare organizations.

Recommendations

Based on these findings, we recommend the following:

Leadership development

Hospitals should integrate inclusive leadership competencies into structured leadership development programs for nurse managers, with a focus on those that explicitly target inclusive leadership behaviors, such as workshops on fairness, equity, cultural competency, bias reduction, communication skills, and team engagement strategies. Leadership can define and communicate clear expectations for inclusive behaviors among nurse managers, ensuring they are embedded in performance evaluations and promotion criteria. Establishing measurable goals and indicators enables progress to be monitored, while linking inclusive leadership to career advancement motivates managers to adopt and maintain inclusive practices. Integrating accountability into the organization's performance management system—including performance assessments, executive evaluations, and potentially compensation—helps ensure that inclusiveness remains a sustained priority at all organizational levels [33].

Organizational support

Institutions must ensure consistent, system-wide reinforcement of inclusive practices through policies, resource allocation, and accountability mechanisms. They should proactively cultivate an inclusive organizational culture to reinforce nurses' positive perceptions of managerial inclusive practices. Leadership should evaluate current nurse manager training to determine whether sufficient emphasis is placed on team-level skills in addition to interpersonal leadership. Research by Abu Bakar and Sheer demonstrated that disparities in leader-member relationships can foster feelings of envy and unfairness,

undermining team cohesion. In contrast, strong interpersonal relationships within the team enhance group solidarity [34]. Accordingly, hospitals should prioritize supporting nurse managers in fostering team unity and equitable access to work opportunities. One practical approach is to provide training on team goal setting, which Lam *et al.* identified as an effective strategy for strengthening interpersonal relationships and collaboration within teams [35].

Assessment tools

To enhance the rigor of assessing inclusive leadership, researchers should consider triangulating the ILQ with complementary assessment tools and approaches. Triangulation allows for a more robust evaluation by capturing multiple dimensions of leadership behavior and its impact on staff and team outcomes. Rosenman *et al.* emphasize the importance of systematically evaluating team leadership in healthcare, noting that the use of multiple, validated instruments strengthens the reliability and applicability of findings [36]. Similarly, Ling *et al.* [37] demonstrated that combining structured observation rubrics, standardized feedback, and knowledge assessments provides a multidimensional view of leadership performance, reducing the limitations inherent in self-reported data. At the team level, Li *et al.* [38] highlighted how inclusive leadership interacts with psychological safety and team cohesion, suggesting that integrating measures of team dynamics alongside leader-focused assessments can provide valuable context. By triangulating these complementary tools—ranging from observational assessments to measures of team climate and psychological safety—researchers can obtain a more comprehensive understanding of how inclusive leadership influences nurse retention, engagement, and overall organizational effectiveness.

Retention strategy alignment

Retention strategies must not only align with organizational goals for inclusion but also feature proactive onboarding and early-career support to improve retention of new healthcare staff. Evidence shows that structured interventions such as preceptorship and mentoring programs lasting 3 to 6 months are particularly effective in increasing retention of new graduate nurses [39]. For example, a quasi-experimental study of early-career pediatric nurses (1–2 years of experience) demonstrated that career coaching improved engagement and maintained 100% retention over the

study period. In contrast, non-participants experienced slight declines in retention [40]. Additionally, a prospective cohort study of early-career Australian nurses found that positive work environments, leadership support, and opportunities for career development are strongly associated with intent to remain in the profession, even when new nurses desire position changes [41]. Integrating these findings, healthcare organizations should ensure onboarding programs include mentorship, managerial coaching, and structured check-ins during the first one to two years of practice, thereby embedding inclusion and support from day one.

Further research

Longitudinal and mixed-methods studies are needed to elucidate how inclusive leadership shapes nurses' intent to stay over time and across diverse clinical settings, and to determine whether changes in inclusive practices translate into measurable patient-level effects. Prospective cohort designs combined with repeated quantitative measurement (eg, the Inclusive Leadership Questionnaire, psychological-safety, and job-satisfaction scales) and embedded qualitative interviews would capture temporal dynamics and mechanisms. At the same time, multilevel modeling can link individual and unit-level leadership perceptions to outcomes. Importantly, future work should extend beyond staff outcomes to include patient-centered metrics—such as patient satisfaction, adverse events, care quality indicators, and safety culture scores—to assess the broader healthcare impact of inclusive leadership. Prior reviews and empirical studies suggest leadership styles influence both staff outcomes and patient care, underscoring the value of integrated designs that evaluate organizational, staff, and patient endpoints concurrently [42–44]. Adopting and institutionalizing inclusive leadership practices is not only a moral imperative but also a practical strategy to improve staff engagement and reduce costly turnover in nursing.

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