

Inclusive Leadership and Intent to Stay in a Midwestern US Nonprofit Faith-Based Hospital – A Cross-Sectional Study of Nursing Staff

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Introduction: The healthcare industry is facing unprecedented challenges related to nursing shortages and staff retention. In response to escalating turnover rates, particularly after the COVID-19 pandemic, healthcare organizations are seeking evidence-based strategies to support long-term workforce stability.

This study explored the gap in evidence linking perceived inclusive leadership and nurses' intent to stay at a single Midwestern faith-based medical center. Inclusive leadership—defined by behaviors that promote fairness, value uniqueness, and foster belonging—has emerged as a potential driver of employee engagement and their intent to stay employed.

Methods: A cross-sectional survey using a validated Inclusive Leadership Questionnaire (ILQ) was administered to a convenience sampling of front-line nurses and nurse managers at a single hospital. Nurses rated leadership behaviors; managers assessed organizational support. Seventy-one responses (59 nurses, 12 managers) were analyzed. The ILQ scores were then summarized by ILQ dimension categories. Associations between leadership perceptions, inclusivity and intent to stay were analyzed using one-way analysis of variance of the ILQ scores and nurse self-reported intent to stay.

Discussion: Nurses perceived their managers as inclusive, especially in fostering belonging and support. However, weaker scores in team integration highlight ongoing challenges with collaboration. A disconnect between leadership behaviors and organizational support suggests systemic gaps. Inclusive leadership was positively linked to retention, particularly for long-tenured staff, emphasizing its long-term value.

Results: Results showed that nurses who perceived higher levels of inclusive leadership were significantly more likely to express an intent to stay ($p=0.01$), particularly among those with longer tenure. Belonging and individual support were the highest-rated dimensions, while integration and fairness across teams were noted as areas needing improvement. Nurse managers reported moderate organizational support for inclusive leadership.

Conclusion: The study concludes that inclusive leadership is associated with a meaningful, actionable strategy for improving nurse intent to stay. Embedding inclusive practices in leadership development and aligning systems to support them may help healthcare organizations foster long-term commitment and address persistent workforce challenges.

Keywords: workforce stability, organizational support, leadership behaviors, nurse retention, healthcare management

Introduction

The COVID-19 pandemic intensified existing pressures on the healthcare workforce, particularly among nurses, who faced increased workloads, moral distress, and unprecedented attrition rates. The turnover rate for nurses continues to rise, nationally it was 16.4% in 2024. Although the US Health Resources & Services Administration projects the number of registered nurses (RNs) to continue to grow nationwide, it will fall alarmingly short of their projected need in 2037.¹

The resulting nurse shortages have jeopardized patient care, disrupted team cohesion, and imposed significant financial costs on hospitals. Additionally, RN attrition weighs heavily on a hospital's bottom line, while retaining nurses represents savings.²

Although many hospitals have focused on recruitment incentives, retention has emerged as the more sustainable workforce strategy. Leadership behaviors are an important factor and play a particularly vital role in influencing nurses and their intent to stay. Studies show that nurse satisfaction and intent to stay are strongly linked to relational factors such as empowerment, inclusion, and perceived organizational support.^{3,4} Inclusive leadership, a leadership style that emphasizes fairness, equity, openness, and appreciation for employee uniqueness, has demonstrated promise in improving psychological safety, engagement, and retention.^{5,6}

Inclusive leadership is not merely interpersonal but structural. Leaders who intentionally foster belonging while validating individual differences are more likely to build cohesive, resilient teams. In nursing units, inclusive leaders reduce barriers to voice, empower diverse contributions, and create environments where employees feel valued and heard.⁷ This study applied the Inclusion Framework⁵ to examine whether inclusive leadership behaviors influence nurses' intent to stay at a Midwestern faith-based hospital, where turnover rates mirrored national trends. In addition, we investigated how nurse managers perceive the organization's support for inclusive practices.

Despite widespread diversity initiatives in healthcare, the operationalization of inclusion remains uneven, and few studies have quantitatively assessed its impact on nurse intent to stay. By identifying associations between perceived inclusive leadership and intent to stay, this study aimed to provide actionable insights for healthcare systems seeking to stabilize their nursing workforce and foster inclusive organizational cultures.

Background

The healthcare sector continues to grapple with persistent challenges related to nurse retention. Even before the COVID-19 pandemic, nursing turnover posed serious operational and financial burdens for healthcare institutions.⁸ In the post-pandemic environment, these issues have been exacerbated by increased workload, emotional exhaustion, and widespread staffing shortages. Registered nurse (RN) turnover rates reached an all-time high of 27.1% in 2022, leading to a corresponding rise in RN vacancy rates to 17%, an increase of over 7% in just one year.² The implications of these departures are far-reaching, not only disrupting patient care but costing hospitals an estimated \$5.2 to \$9 million annually.²

In response to rising attrition, the hospital implemented traditional bonus programs, educational reimbursement incentives, and professional development initiatives to help mitigate nurse turnover. Although current systematic reviews show that financial incentives alone rarely address the complex organizational factors contributing to nurse attrition, more recent observational work during the COVID-19 era suggests that targeted bonus schemes can temporarily increase full-time equivalent staffing.⁹ However, without sustained investment in the work environment and leadership support systems, such gains are unlikely to reduce long-term turnover.¹⁰ In this context, inclusive leadership has emerged as a potentially powerful cultural framework to improve nurse engagement and intent to stay.

Existing leadership theories often overlook how corporate leaders engage in collaborative problem-solving with marginalized populations. Traditional leadership styles, such as transactional and even transformational, fail to account for the individual traits that enable leaders to share power and promote inclusive decision-making with these communities in pursuit of societal well-being.¹¹ Inclusive leadership is characterized by behaviors that actively invite, appreciate, and leverage the diverse perspectives of team members while fostering a sense of belonging.⁵ In the context of nursing leadership, inclusive leadership builds on participative and servant leadership by combining shared decision-making and individualized support with a deliberate emphasis on belongingness and valuing diversity to enhance team cohesion and retention.^{5-7,11} Inclusion is best understood through the dual lenses of belongingness and uniqueness, where individuals feel simultaneously connected to their team and valued for what makes them different.⁶ In healthcare environments, where interdisciplinary collaboration and culturally competent care are essential, inclusive leadership practices can cultivate high-performing, psychologically safe teams.⁷

In nursing, specifically, inclusive leadership is not only a relational ideal but a practical necessity. Nurses working in inclusive environments report higher job satisfaction, increased psychological safety, and stronger organizational

commitment.^{3,4} These factors are positively associated with retention. Conversely, environments perceived as exclusionary or hierarchical tend to undermine nurse morale and increase turnover intention.^{8,12} When nurse managers intentionally engage in inclusive leadership behaviors—such as promoting fairness, ensuring equitable access to resources, encouraging input from all staff, and fostering team integration—they set the stage for both individual and collective success.¹³ Inclusive leadership directly influences nurse experiences by enhancing job satisfaction and reducing burnout, while promoting team cohesion and cooperation. This, in turn, has been shown to improve patient outcomes, as cohesive, well-supported teams are more effective in providing high-quality care and making timely decisions in critical situations.¹⁴

Several frameworks have been proposed to operationalize inclusive leadership, but the Inclusion Framework developed by Shore et al⁵ and extended by Randel et al⁷ is particularly well-suited for the healthcare context (Figure 1). Shore conceptualizes inclusion as the simultaneous experience of belongingness and uniqueness within an organizational context.⁵ In nursing leadership, this framework underscores the importance of fostering inclusive environments that enhance trust, engagement, and retention by ensuring nurses feel both supported and recognized for their professional distinctiveness. Randel further identifies five leadership behaviors that cultivate this environment: supporting group members, ensuring justice and equity, fostering shared decision-making, encouraging diverse contributions, and helping team members fully contribute.⁷ These behaviors align well with the expectations of nurse managers, who are charged with leading complex, high-stakes care teams under constantly shifting pressures.

Despite a growing body of literature supporting the efficacy of inclusive leadership in business and academic settings, there remains a dearth of research exploring its application in clinical nursing environments. Tang and Hudson found that many of the factors contributing to nursing job satisfaction—such as autonomy, support, cohesion, and involvement—are also central components of inclusive leadership.³ Likewise, Nishii and Mayer demonstrated that inclusive leadership is particularly beneficial in diverse teams, where perceptions of fairness and recognition strongly influence intent to stay.⁸ Recent empirical work builds on this: Du et al found that inclusive leadership negatively predicts turnover intention in ICU nurses, with organization-based self-esteem and interactional justice acting as chain mediators.¹⁵ Jiménez-Cáceres et al's integrative review similarly shows that inclusive leadership (alongside transformational, ethical, servant, and authentic leadership styles) is consistently associated with lower turnover intentions in hospital settings.¹⁶ In China, under the normalization of COVID-19 prevention, Zeng et al reported that inclusive leadership both directly and via psychological ownership increases intent to stay among large samples of nurses.¹⁷ Another recent study of nurses in China demonstrated that inclusive leadership improves psychological ownership and increases intent to stay, highlighting fairness, communication, and self-development as mechanisms.¹⁸ These findings suggest that inclusive leadership is more than a theoretical ideal—it has measurable, negative associations with turnover intention through psychological and

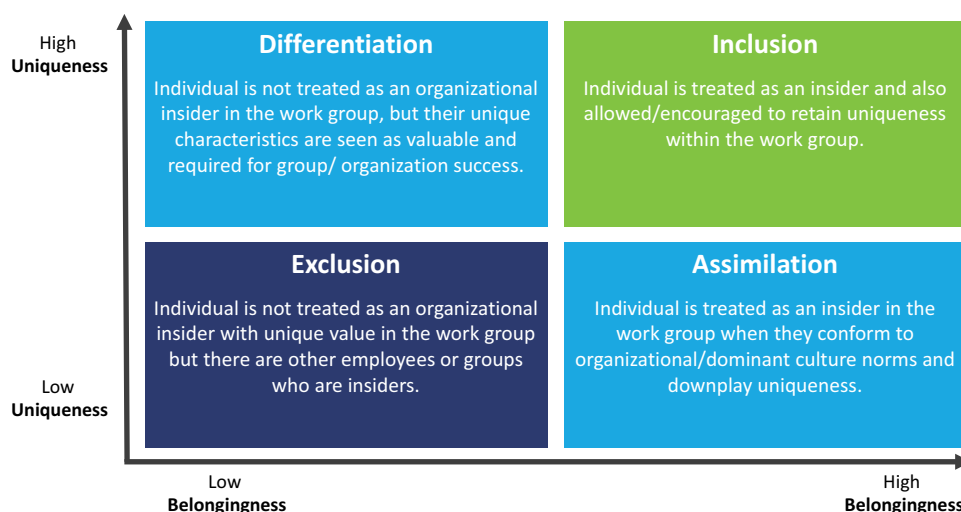


Figure 1 Inclusion Framework (Shore et al, 2011).

organizational pathways in clinical nursing settings. Yet these findings have not been broadly translated into healthcare policy or management training, representing a missed opportunity for leadership development and system-wide improvement. There is also emerging evidence that inclusive leadership can directly influence team performance by enhancing what Hofmeyer describes as “social capital”—the relational networks and norms that enable teams to function cohesively.¹⁹ In their study of hospital nursing units, Kida et al found that intentional investments in inclusion led to stronger team bonds and better collaboration.⁴ Other scholars have linked inclusive leadership to greater psychological safety, which in healthcare can translate into increased willingness to report errors, offer suggestions, and advocate for patient-centered improvements.²⁰ These outcomes are particularly important in high-risk environments like hospitals, where poor communication and disengagement can have life-threatening consequences.

The importance of inclusive leadership is further underscored in training and development contexts. Building on the Future of Nursing 2020–2030 calls for expanded nursing leadership to address social determinants of health, improve care for marginalized populations, and confront systemic healthcare inequities beyond traditional clinical settings.²¹ While there is a plethora of evidence in business and academic contexts, healthcare leadership programs often face key limitations, including a lack of diversity in recruitment, an overemphasis on individual skills over systemic issues, and a short-term focus that hinders the study of sustainable leadership development.²² Simmons and Yawson outline three critical goals for inclusive leadership development in healthcare: creating a shared sense of purpose, treating all team members with dignity and respect, and encouraging full participation from all individuals regardless of role or background.²³ These goals resonate with recent programmatic efforts—such as those by HC Vantage—to instill inclusive competencies in nurse leaders. However, without robust institutional support and alignment, such efforts may fall short of systemic change.²⁴ Nurse managers need more than just personal conviction to lead inclusively; they require organizational resources, authority, and reinforcement from hospital leadership to model and sustain inclusive behaviors.

The current study builds upon this foundational research to explore the state of inclusive leadership at a Midwestern nonprofit hospital. Located in a region with one of the highest nurse turnover rates in the country—28.6% in the North Central U.S.²—the hospital was seeking to reduce its attrition rate by at least 5% through culture-based strategies. Leadership believes that fostering inclusion at the nurse-manager level may be a key lever in this effort and wanted to study the current state of inclusive leadership in their institution. To that end, this research sought to answer the following three questions:

What are the perceptions of the hospital’s nurses regarding their manager’s inclusive leadership? (Floor nurse ILQ)

What are the perceptions of nurse managers regarding how the hospital administration supports their efforts to become inclusive leaders? (Nurse manager ILQ)

Is there a relationship between the perceptions of inclusive leadership and intent to stay among nursing staff at the hospital? (Comparison of demographic and intent to stay questions, and ILQs)

Hypothesis

Hypothesis 1: The researchers believed that floor nurses at the hospital would perceive their nurse managers as displaying inclusive behaviors.

Hypothesis 2: The researchers believed that the nurse managers would feel supported by the hospital to be/become inclusive leaders.

Hypothesis 3: The researchers believed that perceptions of inclusive leadership would add to the nursing staff’s intent to stay.

Methods

Study Design

This study employed a cross-sectional survey design to examine the relationship between perceived inclusive leadership and nurses’ intent to stay at a large (> 500-bed) Midwest nonprofit faith-based hospital. Cross-sectional studies are particularly useful for identifying associations among variables at a single point in time^{25,26} allowing this research to

assess perceptions of leadership behaviors and nurse intent to stay concurrently. It also enabled researchers to compare the perceived leadership behaviors and perceived levels of support received by the hospital administration. Perceptions of floor nurses and perceptions of support by nurse leaders were not compared.

Setting and Participants

The hospital studied is part of the larger health system operating across nine US states. The hospital employs approximately 700 physicians and over 3300 staff, including a nursing workforce composed of both front-line nurses and nurse managers. All front-line nurses and nurse managers formally reporting to the Chief Nursing Officer were invited to participate. This included 694 front-line nurses and 38 nurse managers. A total of 71 surveys were completed: 59 from front-line nurses (8.5% response rate) and 12 from nurse managers (31.6% response rate).

IRB Approval and Informed Consent

The proposed study, focused on identifying and implementing leadership strategies to improve nurse retention, was submitted for review to the Vanderbilt University Institutional Review Board (IRB). The Vanderbilt IRB determined that the project's primary aim was quality improvement within the institution, rather than the generation of generalizable knowledge, and therefore did not meet the criteria for human subject research requiring formal IRB approval under federal regulations. As such, this initiative was classified as a quality improvement project. Informed consent for using the deidentified data was obtained from each participant at the beginning of the voluntary survey.

Data Collection

The research team distributed two tailored surveys (floor nurses and nurse managers) via Qualtrics between April and May 2023. Recruitment involved a multi-step strategy: first, awareness emails were disseminated to department leaders, followed by direct individualized email invitations to eligible participants. Survey participants were sent email reminders every two weeks while the survey was conducted. Survey participants were assured that responses were 100% anonymous and participation was voluntary. Hospital administration noted that the hospital had recently converted its electronic medical records to a new system and had recently surveyed the nurses. Because of this, we offered the participants the opportunity to enter a drawing for a \$50 gift card as an incentive. Both of our surveys closed on May 14, 2023.

Measures

Inclusive Leadership

Inclusive leadership behaviors were measured using the Inclusive Leadership Questionnaire (ILQ) (Figure 2) developed by Li.¹³ The ILQ is a 40-item validated instrument assessing four dimensions of inclusive leadership:

- Dimension 1 - Equal treatment and fairness
- Dimension 2 - Integration and synergy among team members
- Dimension 3 - Support for belongingness and uniqueness
- Dimension 4 - Implementation of diversity and inclusion policies

Front-line nurses rated the frequency with which their nurse manager demonstrated inclusive behaviors. Nurse managers assessed the extent to which they felt organizationally supported to engage in those behaviors. All items were rated on a 5-point Likert scale (1 = Almost Never to 5 = Almost Always). The ILQ measures 4 dimensions of inclusive leadership, an overall mean, and has demonstrated a high internal consistency score of $\alpha = 0.97$.¹³ Because of this, investigators felt that this single tool was sufficient to measure the perceptions of the nurses and nurse managers.

All items from the ILQ for nurse managers begin with "As a nurse manager, my organization has provided me with resources and/or support to...", and for "frontline nurses," "My nurse manager...". Examples of items for Dimension 1 include: share(s) important information with all work unit members, treat(s) all work unit members fairly, manage(s) biases toward marginalized group members in the work unit. Items for Dimension 2 include: listen(s) to all work unit members with respect, encourages diverse inputs from all members to achieve work unit goals, integrates perspectives from all work unit members, encourages everyone in the work unit to participate in decision making. Dimension 3 items

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 (Li, 2021).

include: respect(s) individual differences in the work unit, encourages work unit members to share their true selves, tries to make all members feel like they belong to the work unit. And for Dimension 4: Complies with organizational diversity and inclusion policies in the work unit, implements organizational diversity and inclusion initiatives in the work unit.¹³

Intent to Stay

Nurses' intent to remain at the hospital was measured using a single-item categorical question: "I intend to continue working" for "the hospital" with response options of:

- Less than 6 months
- 6 months to 1 year
- 1–3 years
- 3–5 years
- More than 5 years

Demographics

Participants provided demographic information, including gender, age (categorized by decade), years of nursing experience, and years of employment at the institution. These demographic variables were collected for use as covariates in analyses examining the relationship between inclusive leadership and intent to stay.

Data Preparation and Analysis

Completed surveys were filtered based on respondents' job role, and all responses were numerically coded for analysis. Descriptive statistics were computed to examine central tendencies and distributions across leadership dimensions for nurses (**Table 1**), and for nurse managers (**Table 2**). A one-way analysis of variance (ANOVA) was conducted to examine the effect of nurses' perceptions of their managers' inclusive leadership on their intent to stay. The analysis indicated a statistically significant difference in intent to stay among the groups ($F(4, 54) = 3.51, p = 0.01$). Post hoc pairwise comparisons using the Tukey-Kramer test showed that nurses who intended to remain "over 3 years, up to 5

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

years” differed significantly in their perceptions of managerial inclusive leadership from those who intended to stay “over 5 years” ($t(54) = 4.05$, $p < 0.05$). No other pairwise comparisons demonstrated statistically significant differences.

All statistical analyses were performed using IBM SPSS Statistics, Version 28 and Microsoft Excel. A significance level of $p < 0.05$, statistical power of 0.80, and an anticipated large effect size (Cohen’s $d = 1.0$) were used to determine the required sample size, yielding a target of 30 participants per group, consistent with prior research examining leadership and nurse retention outcomes.¹⁵

Ethical Considerations

The study was approved by Vanderbilt University’s Institutional Review Board and received administrative support from the hospital leadership. Participation was voluntary and anonymous, data were de-identified, and all information was stored securely in accordance with university data protection policies.

Results

Participant Demographics

A total of 71 completed responses were analyzed: 59 responses were received from the front-line nurses, and 12 nurse managers responded to the survey (Figure 3). Among front-line nurse respondents, 86.4% reported more than five years of nursing experience, and 69.5% had worked at the hospital for at least five years. Most respondents identified as female and were between the ages of 30 and 59. The sample skewed toward longer-tenured employees, which is consistent with organizational records indicating that nurses with greater tenure are more likely to participate in institutional surveys.²⁷ The low response rate among nurses limits the generalizability of the findings, as younger nurses and those with shorter tenure were underrepresented in the sample. This limitation may reflect self-selection bias, wherein nurses with stronger opinions or longer institutional tenure were more motivated to participate than those newer to the organization.

Nurse managers also represented an experienced cohort, with an average of 21.95 years of total nursing experience and 16.3 years at the hospital. This demographic distribution reflects a stable leadership population but limits generalizability to newer staff.

Perceptions of Inclusive Leadership (Front-Line Nurses)

Overall, nurses rated their managers’ inclusive leadership practices positively (Figure 4). The mean score across all 40 ILQ items was 4.24 (SD = 0.97), suggesting that behaviors associated with inclusion occurred between “often” and “almost always.” Among the four ILQ dimensions, “supporting belongingness and uniqueness” received the highest mean score ($M = 4.31$), followed closely by “equal treatment and fairness” ($M = 4.27$) and “encouraging diverse

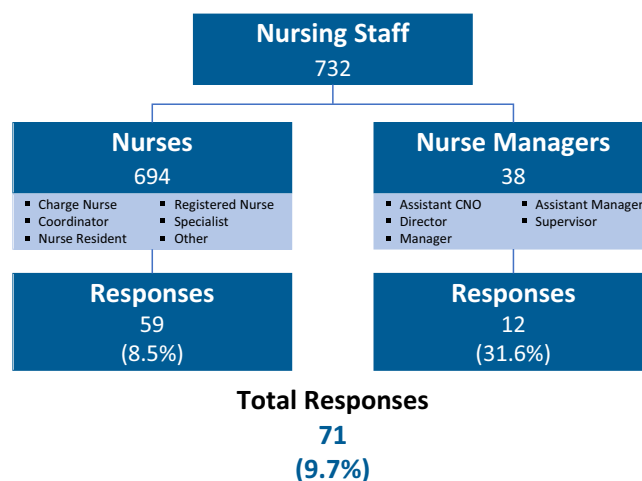


Figure 3 Response Rate 71 (9.7%).

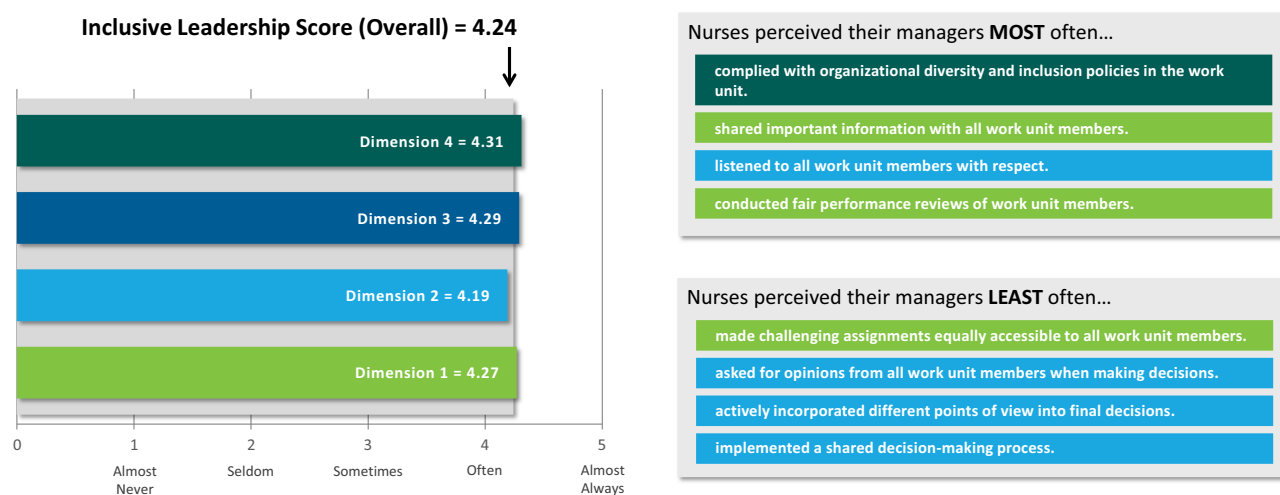


Figure 4 Nurses indicated that their manager often demonstrates inclusive leadership. Arrow represents overall ILQ mean.

contributions” ($M = 4.29$). The lowest-rated dimension was “integration and synergy across work units” ($M = 4.19$), indicating relatively weaker perceptions regarding shared decision-making and collaborative cohesion. This trend aligned with existing literature suggesting that even when individual support is strong, collective inclusivity may lag in hierarchical or siloed healthcare environments.^{5,19}

Perceptions of Organizational Support (Nurse Managers)

Nurse managers reported a moderate to high degree of organizational support for inclusive leadership (Figure 5). The mean overall ILQ score was 4.03 ($SD = 0.69$). Support for fostering individual inclusion ($M = 4.35$) was perceived more strongly than support for unit-wide integration ($M = 3.99$) or equity-related policy implementation ($M = 3.89$). The lowest scoring domain was “equal opportunity and fairness” ($M = 3.84$), suggesting that managers perceived inconsistencies in support and how organizational resources were allocated across departments. This disparity reinforces prior findings that inclusion is often enacted at the interpersonal level but not consistently reinforced through systemic processes.^{7,23}

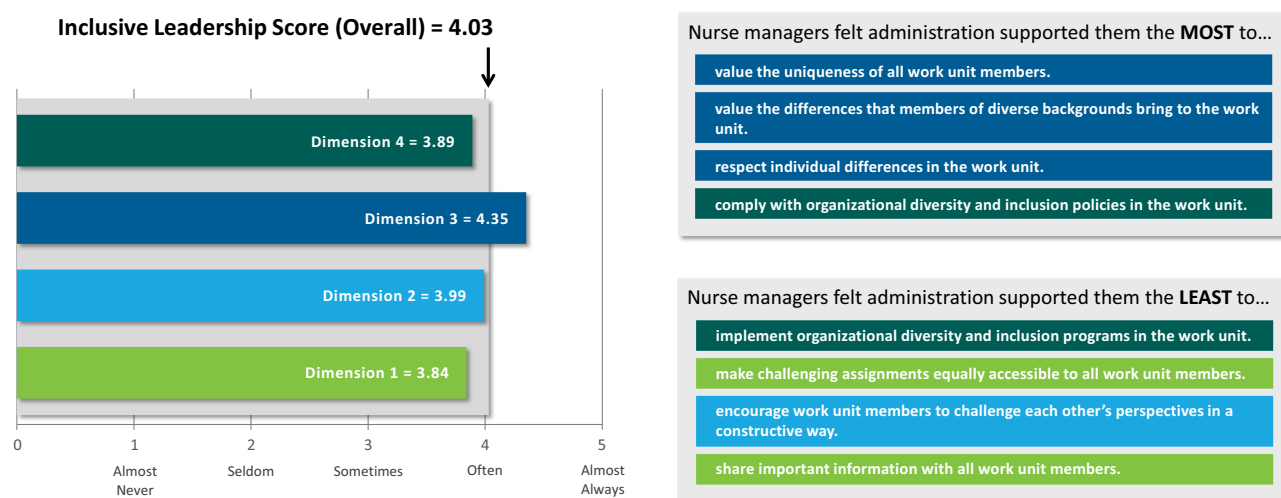


Figure 5 Nurse managers indicated that administration often supports them in becoming inclusive leaders. Arrow represents overall ILQ mean.

Inclusive Leadership and Intent to Stay

Overall ILQ means were compared to front-line nurses' intent to stay. Front-line nurses' perceptions of inclusive leadership were analyzed in relation to their self-reported intent to remain at the institution. Mean inclusive leadership scores varied significantly by intended tenure:

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: $M = 3.71$ ($n=8$)

More than 5 years: $M = 4.65$ ($n=27$)

A one-way ANOVA revealed a statistically significant effect of inclusive leadership perception on intent to stay, $F(4, 54) = 3.51$, $p = 0.01$. Post hoc Tukey-Kramer tests indicated a significant difference between those intending to stay more than 5 years and those intending to stay 3–5 years ($p < 0.05$). This finding suggests that stronger perceptions of inclusive leadership are associated with long-term organizational commitment, particularly among highly experienced nurses (Figure 6).

These results are consistent with prior studies demonstrating a positive correlation between inclusive leadership and intent to stay.^{3,8} They also echo the assertion by Lee and Dahinten that inclusive environments promote psychological safety and stability, which are critical for retaining healthcare professionals in high-stress settings.²⁰

Discussion

The results confirm hypothesis 1, that nurses felt their managers led inclusively and that aspects of inclusion, particularly those related to a sense of belonging and individual support, are viewed positively. However, lower scores in integration and synergy indicate that while nurses may feel individually supported, their sense of team cohesion and shared decision-making is weaker. This suggests that inclusive leadership at the individual level may not yet be translating into broader team-level collaboration.^{28–30} These lower scores may reflect persistent structural issues common in healthcare, such as hierarchical team structures, role-based silos, and limited opportunities for interprofessional dialogue, which are barriers to effective collaboration; addressing this may require intentional practices such as cross-disciplinary team huddles, shared decision-making protocols, or redesigning workflows to promote collaboration across roles.^{19,31}

Interestingly, hypothesis 2 was not confirmed as nurse managers rated organizational support for inclusivity lower than the inclusivity scores received at the managerial level, particularly regarding fairness and resource equity. This discrepancy highlights a potential gap between the inclusive intentions of management and the systemic structures that either reinforce or undermine these efforts. Simmons and Yawson emphasize that for inclusive leadership to be

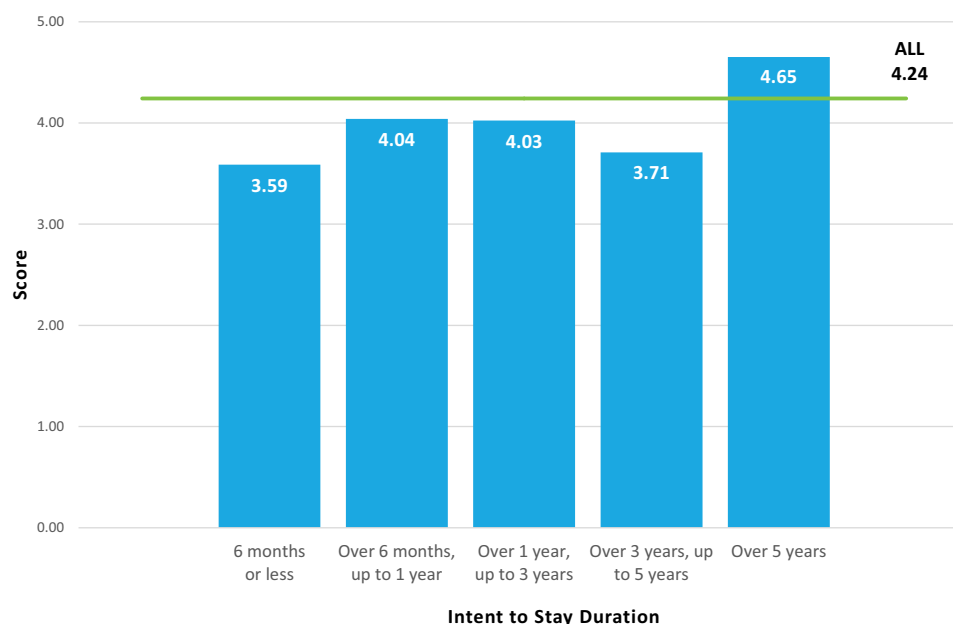


Figure 6 Average Inclusive Leadership Rating and Intent to Stay (n=59).

sustainable, organizations must align policies, accountability, and resources to support inclusive behavior across all units.²³ Building on this perspective, recent work by Sallam et al emphasizes that an evidence-based management framework—integrating organizational culture, stakeholder engagement, knowledge management, implementation intentions, and implementation science—can provide the systemic foundation necessary to effectively support and sustain inclusive leadership practices within healthcare settings.²²

This study confirmed hypothesis 3 and provides empirical support for the positive relationship between inclusive leadership and nurse intent to stay in a faith-based healthcare setting. Nurses who perceived their managers as practicing inclusive leadership were significantly more likely to express an intent to stay long-term. This finding aligns with existing literature, which suggests that inclusive environments promote psychological safety, job satisfaction, and organizational loyalty.^{5,7} In a comparable healthcare context, a recent systematic review of the global pharmacy workforce identified leadership support as a key determinant of job satisfaction and retention. These findings underscore the universal significance of supportive leadership in promoting workforce stability across healthcare professions.³²

The strong correlation between inclusive leadership and intent to stay among nurses with longer tenures (over 5 years) suggests that inclusive practices may have cumulative effects over time. Alternatively, it may indicate that experienced nurses are more perceptive of leadership behaviors that influence their professional well-being. Further longitudinal research could clarify the directionality of this relationship.

Limitations

Limitations include the study's low response rate and the overrepresentation of long-tenured nurses. It is important to note that the dataset may not represent the entire population of 694 frontline nurses due to potential sampling bias. The responses primarily reflected the opinions and intentions of the nurses who chose to participate in the survey. Therefore, caution should be exercised when generalizing about the overall population at this hospital based solely on these survey responses. Additionally, the cross-sectional design limits the ability to draw causal inferences. Nevertheless, the findings provide actionable insights for healthcare organizations seeking to stabilize their nursing workforce through culture-driven leadership development. The fact that the study focused on a single Midwestern faith-based institution may limit the generalizability of findings to other healthcare settings or regions. Additional limitations include the reliance on a single-item measure to assess nurses' intent to stay. The ILQ was selected to reduce common method bias and minimize

participant burden. Although a multi-item scale is generally considered a more robust approach, it was not employed due to the conceptualization of intent to stay as a unidimensional construct. The study's reliance on self-reported data may affect its reliability, as responses are susceptible to inaccuracies stemming from response bias and social desirability bias. Finally, due to study design, there was a lack of adjustment for other potential confounding variables such as job satisfaction, unit type, or schedule flexibility.

Future Research

Future research should explore the implementation of inclusive leadership training programs and assess their long-term impact on nurse intent to stay and team performance. Mixed-methods designs may also reveal deeper insights into how inclusion is experienced and enacted at various organizational levels. We recommend that subsequent studies examine structured leadership development programs. Additionally, policy-level research is warranted to evaluate organizational and system-wide interventions—such as standardized leadership competency frameworks, staffing policies, and retention incentives—to broaden the practical relevance and generalizability of findings across diverse healthcare settings. These approaches will allow future research to link specific leadership development initiatives with measurable outcomes in nurse retention and workforce stability.

Conclusion

This study demonstrates a practically meaningful association between perceived inclusive leadership and nurses' intent to stay at a Midwestern faith-based hospital. Nurses who viewed their managers as inclusive were more likely to report a desire to remain long-term. These findings affirm that inclusive leadership is a valuable and potentially transformative approach to addressing workforce instability in healthcare settings.

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 these expectations are embedded within performance evaluations and promotion criteria. Establishing measurable goals and indicators allows progress to be monitored, while linking inclusive leadership to career advancement provides motivation for 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, whereas strong interpersonal team relationships 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 providing 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 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.³⁷ At the team level, Li et al 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.³⁸ 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, compared to slight declines in retention among non-participants.⁴⁰ Additionally, a prospective cohort study of early-career Australian nurses found that positive work environments coupled with support from leadership 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, while 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 for improving staff engagement and reducing costly turnover in nursing.

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Disclosure

The authors report no conflicts of interest in this work.

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