Nursing Retention in the Post-Covid Era:

Can Inclusive Leadership Slow the Hemorrhaging?

David W. Brown, Mary Luallen, & R. Wesley Swen
Capstone Advisor: Dr. Jeanie M. Forray

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Vanderbilt University

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Executive Summary

The overarching goal of this study was to fulfill AdventHealth Shawnee Mission's quest to garner a deeper understanding of how to retain its nurses through the lens of inclusive leadership behaviors. This project is of particular interest to the institution considering recent and concerning nurse attrition rates, despite efforts to stem voluntary departures. The center of its operations pivots on both the passion of its nursing staff as well as leadership's ability to keep nurses motivated enough to remain on the job. AdventHealth Shawnee Mission generally wants to know (i) whether there is a relationship between front-line nurses' perceptions of their nurse managers' inclusive leadership practices and front-line nurses' intent to stay and (ii) the nurse managers' perceptions of the organization's support to become more inclusive managers. Having recently conducted a system-wide internal evaluation of its adherence to the core principle of inclusion, AdventHealth Shawnee Mission is keen on acknowledging and mitigating unfavorable perceptions of inclusive leadership and ultimately cauterizing its attrition numbers by advancing strategies that will foster greater collaboration between front-line nurses and their managers in the decision-making process.

To support this effort, we used a cross-sectional survey design to gauge the nurses' perceptions of inclusive leadership and analyzed the quantitative data to arrive at our recommendations. Prior to the dissemination of the survey, delving into our problem of practice, we conducted a literature review that focused on inclusive leadership and retention. While researching this space, we zoomed in on the dimensions of belongingness and uniqueness, which have been conceptualized in the Inclusion Framework (Shore et al., 2011). The problem of practice, literature review, and conceptual framework led us to develop three project questions.

Project Questions

1. What are the perceptions of Advent Health Shawnee Mission nurses with respect to their manager's inclusive leadership?

2. What are the perceptions of nurse managers with respect to how AdventHealth Shawnee Mission supports their efforts to become inclusive leaders?

3. Is there a relationship between the perceptions of inclusive leadership and retention among nursing staff at AdventHealth Shawnee Mission?

Key Findings

1. Front-line nurses reported that their supervisors encouraged integration of and synergy among work units less than they do for the other dimensions of inclusive leadership, as described in the Inclusive Leadership Questionnaire (Li, 2021). Ostensibly, this suggests that nurse managers could more effectively integrate front-line nurses' ideas, suggestions, and opinions into the decision-making process within the work units.

2. Nurse managers perceive that AdventHealth Shawnee Mission's leadership provides support in creating a sense of inclusiveness between nurse managers and front-line nurses; however, the same level of support was not being provided equally across work units.

3. Nurses intending to remain at AdventHealth Shawnee Mission for at least five years indicated that their nurse managers engaged in inclusive leadership behaviors more frequently, on average, than nurses who intended to stay at the hospital for less than five years.

Recommendations

1. **Promote more robust collaboration opportunities within and across work units.** The hospital's leadership should develop initiatives that foster more engagement among employees including, but not limited to: (i) establishing advisory committees to advise leadership on high-priority internal issues, (ii) streamlining job rotation and work collaboration processes to allow for new learning and knowledge exchange, and (iii) conducting regular cohort-wide meetings (based on nurse class years) where

nurses can provide their suggestions and feedback on matters under discussion, and pose their questions directly to hospital leaders.

2. **Assess the level of support the organization provides to individual nurse managers vis-à-vis teams with respect to inclusive leadership training.**
Creating team goals can be an effective moderating tool for improving interpersonal relationships. AdventHealth Shawnee Mission should evaluate whether current nurse manager trainings are sufficient in meeting the needs of all members of the various work units and determine whether implementation of such training has been equally applied across work teams. Poignantly, the organization should seek to "codify" and promote the inclusive leadership practices of its high-performing nurse managers which would redound to the benefit of all its nurses.

3. **Actively incentivize nurse managers' engagement in inclusive leadership practices.**
Importantly, the hospital's leadership should directly convey its inclusive leadership expectations to the nurse managers. However, this should be done in a manner that reinforces a positive view of inclusive leadership habits and makes such behaviors attractive goals for nurse managers to attain. To accomplish this, AdventHealth Shawnee Mission is encouraged to, among other things: (i) outline specific related behaviors and practices associated with inclusive leadership by incorporating them into performance evaluations, (ii) promote a sense of inclusion and empowerment by providing avenues for anonymous feedback, and responsively addressing such feedback, and (iii) implement a recognition and rewards system which highlights and celebrates inclusive leadership behaviors.

I. Organizational Context

Opening in 1962, AdventHealth Shawnee Mission (AHSM) is a non-profit medical center located in Merriam, Kansas. It is part of the multi-state Seventh-Day Adventist Church-affiliated AdventHealth Hospital System (AdventHealth) which is based in Altamont Springs, Florida. The AdventHealth medical care system boasts 50 hospitals in 9 states and over 1,400 ancillary doctor offices and clinics. In addition to the main hospital building in Kansas, AHSM has outpatient surgical facilities, a community health and education building, and a childcare center. Applying its "whole-person care" philosophy, the institution serves the Kansas City Metropolitan Area (KCMA) residents in general emergency medicine, oncology, cardiovascular health, OBGYN services, orthopedics, neurology, geriatrics, and surgical procedures. Importantly, the KCMA encompasses 14 counties straddling Kansas and Missouri's state border.

U.S. News & World Report ranks AHSM as the fourth-best hospital in the KCMA and the third-best in Kansas. AHSM employs more than 700 physicians working in over 50 different medical specialties. Approximately 3,300 associates support these healthcare providers, and together they work to provide quality healthcare to the residents of KCMA, whose population has exceeded 2.1 million people (about the population of the state of New Mexico). According to US census data, and zooming in closer to the hospital's home base, Kansas City (Kansas side) has a per capita income of $22,500, a poverty rate of 19.2% (double that of the metro area), and a medically uninsured rate of 20% which is 12 percent above the national average (U.S. Census Bureau, n.d). AHSM, therefore, serves a vital role in providing medical services to the communities that rely on it.

Figure 1: AdventHealth Shawnee Mission facts and figures (AdventHealth, n.d.).

Organizational Leadership

Our partnership with AHSM was strengthened by the robust engagement with key executives. These include the President of the AHSM, Michael Knecht, who has broad oversight for the implementation of the recommendations that will eventually address the nurse turnover challenges at AHSM. Daniel Fontoura, Chief Operating Officer, attends to the overall operations and programming at the facility. Another key stakeholder is Gina Creek, who has charge over personnel in AdventHealth's Mid-America Region. While having regional responsibilities, she is based at AHSM and is a 2021 Vanderbilt University's Leadership and Learning in Organizations (LLO) Program graduate. Creek's stake in our project stems from her interest in nurse welfare at AHSM and her commitment to the LLO program's continued success. Also of import is the hospital's Chief Nursing Officer, Raimonda Shelton, who we anticipate will use the data and the research findings to guide future decisions on team building and personal development efforts for her nurses.

II. Problem of Practice

At the height of the COVID-19 pandemic, the national spotlight shone on the grit and commitment of the country's healthcare workers as doctors and nurses were called upon to work extended hours while large segments of the population remained home under voluntary or mandatory stay-at-home protocols. Nurses have and continue to stand on the frontline in providing healthcare to patients. They are part of a cadre of healthcare professionals who put their own wellbeing at risk to tend to the needs of the sick, the distressed, and the destitute during a time when most others were isolated at home to limit the spread of COVID-19. For some nurses, that degree of sacrifice has become overwhelming, and many have opted to leave the profession (Nursing Solutions, Inc., 2022). While nurse attrition is not a new issue in the healthcare industry (Bugajski et al., 2017; Tang & Hudson, 2019), the trend has taken center stage recently. In fact, worldwide nursing shortages have plagued healthcare systems and communities for decades (International Council of Nurses, 2021).

The United States, despite being a more affluent country than many of its global neighbors and having access to a vast amount of healthcare resources, has not escaped the nurse staffing shortages that have been exacerbated by COVID-19 (Eriksson et al., 2022). Lee and Jang (2020) note that attrition worries have been further complicated by a pre-existing worldwide shortage of nurses. In a study conducted by the U.S. Department of Health and Human Services (2017), the demand for registered nurses is projected to hit more than 3.6 million by 2030. Therefore, one crucial and immediate step toward addressing nursing shortages is to stem the tide of nurses leaving their jobs in hospitals and healthcare centers.

Despite healthcare workers' heroism, we also witnessed hospital systems strain under pressure to deliver quality service to patients. Caving to the lures of the "Great Resignation" and buckling under the demands of their working environment, 25.9% of healthcare workers opted to leave their posts in 2022, representing a 6.4% increase over the previous year. Nursing Solutions Inc. (2022) has been conducting an annual survey of hospital workers since 2000 and reported that, for the first time since the survey's inception, the nation's average registered nurse (RN) turnover surpassed 27.1%. Notably, RNs employed in surgical services, women's health, and pediatrics accounted for the lowest attrition rate, while their counterparts working in step-down telemetry and emergency services recorded the highest turnover rate (Nursing Solutions, Inc., 2022).

A major concern for many hospital systems is the attrition rate of first-year nurses. Approximately 24% of nurses leave their jobs within their first 12 months of employment, while those with at least 5 years of service in their posts tend to leave at a lower rate (Plescia, 2021). Larger hospitals (500 or more beds) have less turnover, but those with between 200 and 349 beds have seen some 23% of their nurses leave (Plescia, 2021). With the rising numbers in nurse attrition, there is a substantial increase in RN vacancy rates across hospitals – 17%, signifying a 7.1% rise year over year (Nursing Solutions, Inc., 2022). So, what does this all mean for hospitals and their ability to thrive and attend to their patient’s healthcare needs? It comes down to the bottom line. Labor cost is a key budget item for any hospital. The average hospital is losing between $5.2M and $9M each year because of RN attrition, with each hired nurse saving the

hospital around $210,000. Additionally, for those hospitals that turn to travel nurses to supplement their staff, eliminating 20 travel nurses saves about $4.2M (Nursing Solutions, Inc., 2022).

Research Relevance to AHSM

The urgent need for nurses in the United States aligns with the global trend. Using predictive modeling, Juraschek et al. (2019) forecast a shortage of one million nursing jobs in the United States by the year 2020 and calculated the deficit to increase by 2030. Having reviewed the literature, Haddad et al. (2023) corroborated this need, stating that registered nurse vacancies would top the list of available openings with a projected growth rate of 9% from 2016 to 2026, which was faster than any other occupation. Of interest to AdventHealth's Mid-America region will be the impending need for approximately 76,000 nurses in the mid-west; 4,000 of those positions are in Kansas, where the AHSM is located (Bureau of Labor Statistics, 2022).

According to Nursing Solutions Inc. (2022), the North Central region of the country represents the area with the highest hospital turnover rates at 28.6%. This region includes Kansas, the location of AHSM, and neighboring Missouri. The numbers tell the story, and AHSM has its own chapter in this national narrative. In speaking with the hospital's Chief People Officer, we were the daunting challenge that the institution faces in retaining its nursing staff seized our research team's attention. Creek informed us that the organization had recently conducted a system-wide review and noted that many of its nurses were leaving between their first and third years of employment. Of note, AHSM had seen a steady rise in nurse turnover, with 15.94% (180 nurses) at the end of the 2017-18 fiscal year to 25.22% (243 nurses) at the close of the 2021-22 fiscal year. This is despite the year-over-year growth in the number of hires over the same four-year period. With a renewed focus on inclusion and collaboration, the hospital's management is keen on developing an appreciation for how inclusive leadership efforts can contribute towards its goal of reducing its nurse attrition rate by 5% over the next year or two. This goal is important to the organization as it seeks to (i) stem the bleeding of its financial resources and (ii) strengthen its organizational culture by reinvigorating the bonds among staff members.

The management's assumption was that those nurses who felt more included in the decision-making processes instituted at the hospital were more likely to be loyal and, thereby, choose not to leave the hospital prematurely. While AHSM had raw data on voluntary separations, its leadership partnered with our research team to survey their nurses, potentially interview select managers and executives on the current state of inclusive leadership at the organization, and learn whether policy changes are warranted.

This capstone project aimed to work with AHSM in applying research to identify leadership strategy imperatives to reduce nurse attrition concerns and develop recommendations to address gaps in inclusive leadership practices. Hospital systems are complex organizations that require high coordination and cooperation across many components. Implementing changes in the wrong places or at inappropriate times may not facilitate the desired transformation. Through this capstone project, system leaders could leverage neutral third parties' additional expertise and knowledge. This support will help them look beyond internal biases toward departments, programs, or personnel as they chart a practical and dynamic path forward, maximizing both impact and outcomes.

Stakeholders

The primary beneficiaries of hospital services are patients who consistently rely on nurses to deliver above-standard healthcare. This project will also have significant implications for internal stakeholders at AHSM, particularly the nurses. Floor nurses and nurse managers are two key groups of nursing staff likely to be affected by the recommendations of this project. Floor nurses are the frontline healthcare staff who work closely with patients to provide direct care and are often the patients' first point of contact. The recommendations from this project focus mainly on leadership behaviors that impact nurse job satisfaction and retention rates. Nurse managers are responsible for managing frontline nurses, implementing policies, and being accountable for the overall delivery of high-quality patient care. The project's findings may influence how nurse managers manage their staff, create a positive work environment, and prioritize learning opportunities for themselves and their teams.

III. Literature Review

Nurse Retention

Considering the universal nurse shortage, staff retention is a high priority for healthcare systems (Halter et al., 2017). Retention, as defined by Tang and Hudson (2019), is the ability of an organization to maintain the employment of an individual once hired. Unfortunately, lucrative salary offers, sign-on bonuses, other enticing benefits, and travel contracts (which sometimes pay as much as three times the going rate for a full-time nurse) have some nurses shopping around for what they deem as better employment opportunities.

Turnover costs can be emotional and financial (Tang & Hudson, 2019; Gillet, 2013). Managers who create environments with positive social capital increase job satisfaction. In fact, job satisfaction is reported as the factor most impactful to a nurse's intent to remain at their current place of employment (Kida et al., 2021; Nicholson, 2021; Tang & Hudson, 2019). Given the bonds that are formed over time among co-workers, emotions play a great deal in the decision-making process, impacting both the nurses who leave and those who remain.

Tang and Hudson (2021) described factors that influence nurse workplace satisfaction. Many of these elements incorporate inclusive behaviors such as cohesion, support, autonomy, and involvement. Halter et al. (2017) widened the definition of inclusion to integrate empowerment, shared control, and social support, listing these traits as crucial factors in nurses' intention to stay. An inclusive environment created by leadership directly affects the performance and satisfaction of the work unit participants.

Inclusive Leadership Framework

The study of inclusivity and its relationship to nurse retention prompted our search for an appropriate framework from which to approach our study. Using ProQuest, we used the search terms "diversity, equity, and inclusion" and "nurse retention," which presented results for the Optimal Distinctiveness Theory ("ODT") and Belonging Theory. Narrowing the search to include

only "inclusion" and "nurse retention" netted the Inclusion Framework presented by Shore et al. (2011). This framework has deep roots stemming from ODT, which describes a tension and need for balance between the validation of individuation and similarity. Thus, Shore et al. (2011) defined inclusion as "the degree to which an employee perceives that he or she (they) are an esteemed member of the work group through experiencing treatment that satisfies his or her needs for belongingness and uniqueness" (p. 1265).

Reviewing all studies that cited Shore et al. (2011) resulted in the discovery of work by Randel et al. in 2018. Randel et al. (2018) noted the importance of leadership's recognition and acceptance of belongingness and uniqueness within groups, leading them to conceptualize the Inclusive Leadership Framework around those two concepts. The framework uses belongingness and uniqueness as managerial goals to nurture relationships within work groups for creating an inclusive environment. Shore and Chung (2022) refined this framework by classifying five leadership behaviors supporting belongingness and uniqueness. The five dimensions of belongingness and uniqueness are:

i. Belonging Behavior One: supporting group members
ii. Belonging Behavior Two: ensuring justice and equity
iii. Belonging Behavior Three: shared decision-making
iv. Uniqueness Behavior One: encourage diverse contributions
v. Uniqueness Behavior Two: helping group members fully contribute

Inclusivity Through Belongingness and Uniqueness

Research conducted by Shore et al. (2011) highlighted that several studies and resultant policies have focused on equitable workforce representation by diverse groups, and rightly so. Notwithstanding, an inclusive working group, which goes beyond mere diversity in numbers, is just as important for the hiring and retention process. This notion was supported by Vanderbilt lecturer Dr. Sherard Robbins (personal communication, June 16, 2022), who remarked that "recruitment without retention is diversity without inclusion." Shore and Chung (2022, p. 724)

have defined inclusion as "the degree to which an employee perceives that he or she is an esteemed member of the work group through experiencing treatment that satisfies his or her needs for belongingness and uniqueness."

Cockshaw et al. (2013) separated belongingness into two different categories. The first is the level of acceptance that an individual believes that he or she has within the community. This would be the degree to which a person sensed that they fit in and to what extent they felt welcomed by the other members of the group. The second category is the self-assessed level of the individual's intrinsic relational value. This is simply the perceived value that an individual has of themself within the team. Borrott et al. (2016) agrees and have spoken specifically to a nurse's need for other members of their work team to accept them and to feel that there are those in their work groups that they could trust and confide in.

Uniqueness, on the other hand, is the valued difference that an individual brings to the group (Shore et al., 2011). Expanding the definition, Simsek & Yalınçetin (2010) place a reflective value on being a unique individual, allowing for freedom of choice and a willingness to interact within the social environment. This supports the self-verification theory Shore et al. (2011) mentioned when they modeled their Inclusion Framework. Randel et al. (2018) focus on the individual's need to contribute their unique perspective and to feel safe in doing so.

Relationships built within an inclusive social environment enhance team relationships (Hofmeyer, 2013), and a healthy relational network creates positive workplace conditions. This has advantageous implications for workplace satisfaction and creates team building through bonding and bridging (Xu et al., 2020). In their work with nursing units, Kida et al. (2021) conclude that building social capital within nursing units intentionally improves an environment of inclusivity. Lastly, tying the concept of workplace inclusion to retention, Nishii and Mayer (2009) reiterated the importance of authentic, inclusive leadership at all organizational levels and found that the perception of a genuine, inclusive work environment directly affects an employee's intent to stay. This strongly supported our premise that nurse managers' inclusive management style at AHSM can influence nurse turnover by creating an environment where individuals feel included through the facilitation of belongingness and valuing uniqueness.

Examining Inclusive Leadership

Inclusivity in leadership practice is "a multi-dimensional construct" that requires leaders to treat all employees equitably and respectfully; encourage homogenization of and collaboration among employee groups; and promote organizational diversity, equity, and inclusion (DEI) related strategies that support inclusion and prevent exclusion within the work unit while encouraging individual uniqueness (Li, 2021). This encapsulated the description of inclusive leadership put forward by Randel et al. (2018), which posited facilitating belongingness while valuing uniqueness. Inclusive leadership traits include openness, equality, accessibility (Bass, 1985; Randel et al., 2018), cultural humility, and an authentic self (Nikpour et al., 2022). Inclusive leaders foster diverse contributions and assist group members in actively contributing to ensure that all voices are heard (Randel et al., 2018). Mitchell et al. (2015) concurred and added that leaders who possess these qualities remove the barriers to a cohesive work environment by reducing status, social, and economic differences. These actions strengthen team connectivity, community affiliation, and attachment.

Inclusive Leadership Impacts Nurse Retention

In relation to nursing practice, Stenhouse (2021) points to organizational culture and support as principal factors in creating organizational diversity, equity, and inclusion. As healthcare workers continue to work in silos, through professional diversity and inclusiveness, leaders act to create cohesive healthcare teams. Halter et al. (2017) carried out a literature review and found that a transformational (participative) management style was most indicative of a nurse's intent to stay. This management style has been linked to many of the inclusive leadership traits previously mentioned.

Inclusive Leadership Management Training

The modern-day workforce is as unique as it has ever been, and corporations need to embrace inclusive leadership when leveraging diverse human capital (Nishii & Mayer, 2009). Studies of inclusive leadership show positive correlations to psychological safety, creativity, productivity, and overall team performance (Shore & Chung, 2023). The development of nurse managers

who effectively create inclusive work environments can directly affect the work-life satisfaction of floor nurses, their retention, and the bottom line (Nishii & Mayer, 2009). Establishing an inclusive workplace environment does not happen organically but can be nurtured by well-trained, supported, and fully resourced nurse managers.

Simmons and Yawson (2022) put forward three goals for inclusive leadership training. The first goal is creating a common purpose (i.e., a happy workplace with successful patient outcomes) along with a sense of belonging. The second is treating all workers on the unit with dignity and respect regardless of position, education, or training. The last goal is to facilitate engagement by all unit members to ensure full participation with equal consideration. A similar inclusive leadership training was developed by LEAD Inc^{SM} (HC Vantage, 2022) through a series of workshops that also incorporate the goals outlined by Simmons and Yawson. The workshops are designed to "Set" the leaders with inclusive leadership skills, then "Shape" the new skills learned, and finally "Sustain" the inclusivity training through continuous improvement, accountability, and inspiring others.

IV. Conceptual Framework

The Inclusion Framework (Shore et al., 2011) is most applicable for our capstone project because it models, in a relatively intuitive manner, the human impulse to attain social identities through belongingness, recognition, and acceptance, even in the work setting. The framework explores how leaders within the workplace can shape the development of personnel under their supervision through the formation and maintenance of strong working relationships (Shore & Chung, 2023). Conversely, research shows that when workers feel ostracized by their colleagues or perceive a lack of support from their manager, their moods are negatively impacted and they change their behavior to guard against threatened needs for inclusion (Hales et al., 2016).

Using the dimensions of the theoretical framework, our project examines the interplay among the contextual factors that contribute to one's feelings/perceptions of inclusion based on the

actions of leaders: exclusion, assimilation, differentiation, and inclusion. These actions result in various outcomes: (i) low belongingness, (ii) high belongingness, (iii) low value in uniqueness, and (iv) high value in uniqueness. The selected theoretical model augurs well for our research goals as it sufficiently captures the juxtaposition between leaders valuing their workers' individuality and workers' desires to maintain a sense of group belonging (Shore et al., 2011). The Inclusion Framework was apt in molding and formalizing our project questions, survey design, and data analysis.

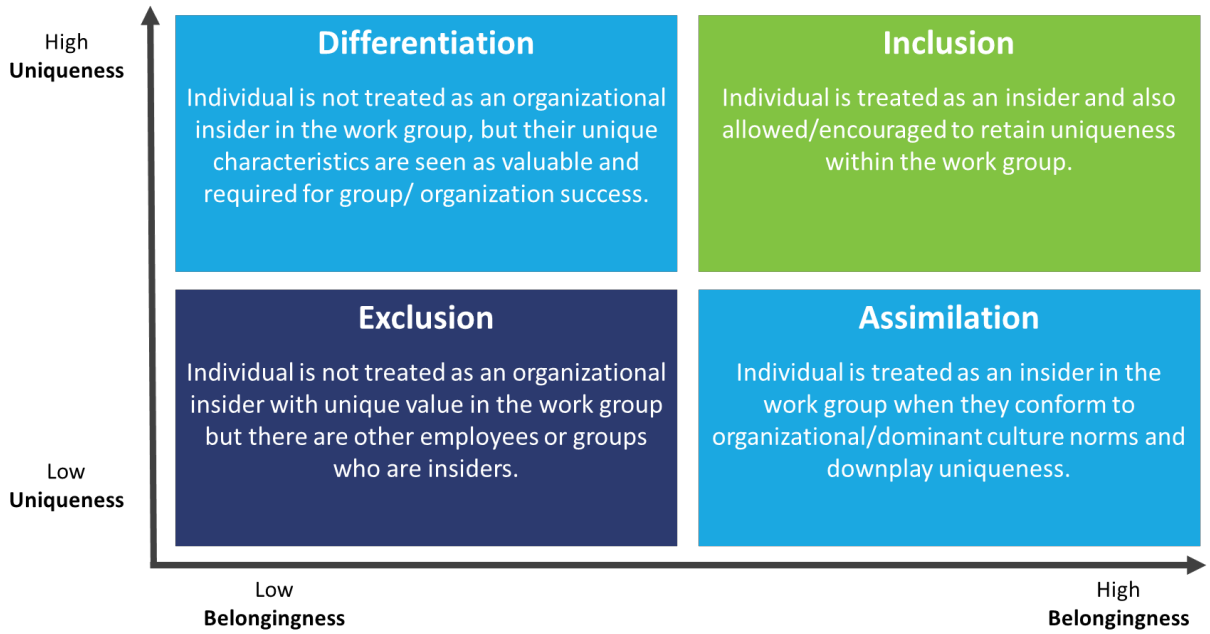


Figure 2: Inclusion Framework (Shore et al., 2011).

V. Research Questions

For our capstone project, we had three main research questions. They were:

1. What are the perceptions of Advent Health Shawnee Mission nurses with respect to their manager's inclusive leadership?
2. What are the perceptions of nurse managers with respect to how AdventHealth Shawnee Mission supports their efforts to become inclusive leaders?
3. Is there a relationship between the perceptions of inclusive leadership and retention among nursing staff at AdventHealth Shawnee Mission?

VI. Project Design

For this project, we used a cross-sectional survey approach (Babbie, 2015) to explore the relationship between perceptions of inclusive leadership and nurses' intent to stay at AHSM. The cross-sectional survey design allowed us to collect data on multiple variables simultaneously at a single point in time. This design enabled us to examine the perceived frequency nurses felt their managers engaged in inclusive leadership practices, the proportion of nurses who intend to stay or leave their job, and nurse managers' perception of the support received from AHSM to become inclusive leaders. In addition, we explored the relationship between perceptions of inclusive leadership and intent to stay among nurses. We acknowledge that a cross-sectional study does not establish causality (Babbie, 2015), and further research using other study designs may be necessary to determine the causal relationship between perceptions of a manager's inclusive leadership and intent to stay.

Study Population

The population for this cross-sectional survey study consisted of front-line nurses and nurse managers employed at AHSM. A convenience sampling method was utilized to recruit participants from various departments within AHSM. The project aimed to include nurses and nurse leaders across different specialties and experience levels who were within the formal reporting line of the Chief Nursing Office. There were no other exclusion criteria for participation in the project.

A total of 694 front-line nurses and 38 nurse managers who met the inclusion criteria were invited to participate in the survey. The nurses had an average of 6.98 years of experience specifically at AHSM and an average of 11.61 years of overall registered nurse (RN) experience. Among the 694 front-line nurses, 20.23% had less than one year of tenure at AHSM, 22.09% had two years of tenure, 5.74% had three years of tenure, 6.17% had four years of tenure, and 45.77% had five or more years of tenure at AHSM. Furthermore, within the sample of nurses, those with five or more years of tenure at AHSM had an average of 17.86 years of nursing

experience, while the other groups (based on tenure) employed at AHSM for four years or less had an average nursing experience ranging from 5.1 to 8.60 years. In the nurse manager subgroup, the average tenure at AHSM and years of nursing experience were 16.33 and 21.95, respectively. Out of the 38 nurse managers, 10.26% had less than one year of tenure at AHSM, 5.13% had two years of tenure, 2.56% had three years of tenure, 2.56% had four years of tenure, and 79.49% had five or more years of tenure at AHSM.

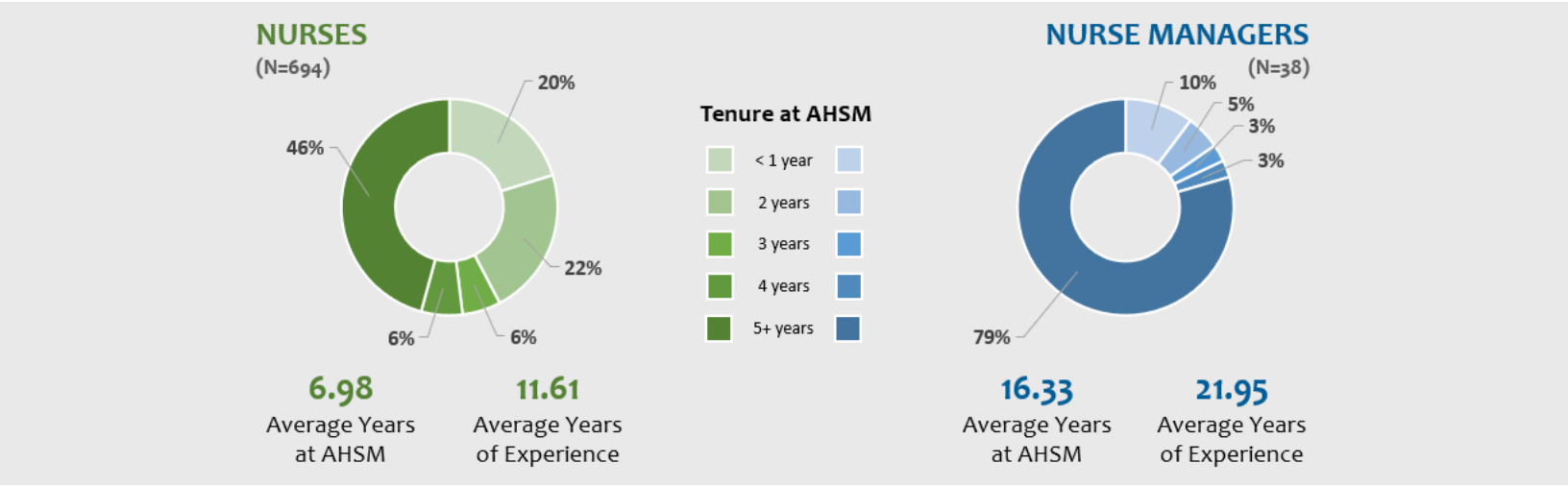


Figure 3: AHSM nurse and nurse manager tenure and years of experience.

Survey Instrument

The Inclusive Leadership Questionnaire (ILQ) developed by Li (2021) measures inclusive leadership within organizations. The instrument was developed to address the lack of consensus and limited measures available for understanding and measuring inclusive leadership. The ILQ developed by Li (2021) demonstrated "content, construct, convergent, discriminant, and criterion validity," establishing it as a reliable measure of inclusive leadership. Based on research, the 40-question instrument measures inclusive leadership as a multi-dimensional construct as shown in Figure 3.

The questionnaire aims to capture each of these dimensions and assess leaders' behaviors related to fairness, equality, respect, integration, synergy, and translating diversity and inclusion policies within their work units. Li (2021) envisioned that organizations would use the ILQ to assess leaders, pinpoint areas for improvement, cultivate inclusive leadership skills, incorporate

inclusive leadership criteria in human capital management, and promote the establishment of inclusive work environments, leading to sustained organizational health and growth.

Figure 4: Inclusive Leadership Questionnaire dimensions (Li, 2021).

MEASURES

Perception of Inclusive Leadership

Nurses' perception of their manager's inclusive leadership style was measured with the 40-item ILQ. Nurses were asked to rate the frequency their nurse manager engaged in inclusive leadership behaviors. The first survey question asked participants to identify their role to determine if they would receive the nurse or nurse manager survey questions. Nurses responded using a 5-point Likert scale (1 = Almost never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5= = Almost always). Sample items include: "…make resources equally accessible to all work unit members" and "…value the uniqueness of all work unit members." The reliability for this construct measured by Cronbach's alpha was .97 (Li, 2021).

Organizational Support to Develop Inclusive Leadership Behaviors

Nurse managers' perceptions of organizational support to develop inclusive leadership practices were also measured using the same 40-item ILQ provided to nurses. However, nurse managers

were asked to rate the frequency with which their organization provides them with the resources and/or support to develop inclusive leadership behaviors. The first survey question asked participants to identify their role to determine if they would receive the nurse or nurse manager survey questions. Nurse managers responded using a 5-point Likert scale (1 = Almost never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5= = Almost always). Sample items include: "…make resources equally accessible to all work unit members" and "…value the uniqueness of all work unit members." The reliability for this construct measured by Cronbach's alpha was .97 (Li, 2021).

Intent to Stay

One item was incorporated for front-line nurses to measure their intention to remain at AHSM. The question read, "I intend to continue working for AdventHealth Shawnee Mission." Participants provided responses using a 5-item rating scale (0-1 year, 2 years, 3 years, 4 years, 5+ years).

Demographic Variables

Participants were asked about their gender and age. Age ranges were grouped into six answer choices: 18-20, 21-29, 30-39, 40-49, 50-59, and 60 or older. In addition, participants were asked to indicate their years of nursing experience and the number of years they have been employed at AHSM. The answer choices for both questions were: 0-1 year, 2 years, 3 years, 4 years, and 5+ years.

VII. Data Collection and Analysis Sequence

The AHSM nursing staff were invited to participate in the project through a convenience sampling approach. We received a file from the AHSM HR department containing the contact information for all nurses and nurse managers who met the participation criteria. We used a multi-step approach to recruit participants, including nurse managers and front-line nurses, to collect data for this cross-sectional survey. The data collection process involved two main components: an overview email shared with the Chief Nursing Officer and Chief People Officer

for dissemination during department meetings and direct email communication with all nurses and nurse managers. The overview email aimed to promote widespread awareness before the survey was released, while the individualized emails ensured that all eligible nurses and nurse managers were directly informed about the project and given the opportunity to participate.

In this project, the Inclusive Leadership Questionnaire (ILQ) developed by Li (2021) was adapted to create two distinct survey instruments tailored for different groups of nurse staff. The front-line nurses were presented with questions that sought their perceptions of their nurse managers' inclusive management styles. The questionnaire for nurse managers aimed to gain insights into the adequacy of organizational support and opportunities provided to foster an inclusive working environment for front-line nurses under their charge. Both surveys also included demographic inquiries to assist leaders in designing targeted professional development strategies for various demographic subgroups. This information could, for example, help determine if male front-line nurses felt less included compared to their colleagues.

Both surveys were disseminated using Qualtrics on an account linked to Vanderbilt University. Upon the circulation of the surveys, nurse managers and nurses were advised that participation was voluntary and that their responses would remain anonymous. Once they completed the survey, participants were directed to a separate online link to enter a drawing for a $50 gift certificate.

Changes to the Original Data Collection Plan

Our capstone team anticipated that data collection would have been completed before the end of the Capstone I Seminar in late April 2023. We planned to release the surveys in March to allow for a two-week data collection period. However, several factors delayed the dissemination of the surveys, extending our data collection timeline beyond the end of the spring 2023 semester. First, our partner organization initiated a system-wide shift to Epic, a health information system, around the time we received IRB approval for the project. Epic is an integrative software that streamlines communication and improves efficiency throughout the entire hospital system. The changeover required four to eight weeks of cross-testing with the

legacy system before going live. AHSM representatives were of the view that asking staff to complete our survey shortly thereafter would have been burdensome to their nurses.

Second, to compound the timing issue, nurses at AHSM recently completed an unrelated evaluation survey and the Chief Nursing Officer, concerned about survey fatigued, requested we delay the release of our survey so that the nurses could have some cognitive recovery time. AHSM's leadership also felt that gap time would decrease any conflation with survey identity or employment evaluation implications. AHSM approved the dissemination of the survey on April 7, 2023. Since it was the beginning of the Easter holiday weekend and two weeks before the end of the semester, our capstone team decided to leave the survey open until the start of the summer semester, which began in early May 2023. Following the launch of the surveys, our capstone team sent the nurses intermittent email reminders every two weeks. We concluded our data collection on May 14, 2023.

Data Cleaning and Preparation

The data cleaning and preparation process involved several key activities. First, only completed surveys could be submitted, ensuring all participants who submitted responses were included in the dataset. Second, the dataset was split into two groups based on whether the participant was directed to answer the nurse or nurse manager questions, allowing for separate analysis of the two groups' data (Figure 5). The survey included a branching logic for the first question: "Which of the following best describes your current role or job at AdventHealth Shawnee Mission?" Respondents who selected charge nurse, coordinator, nurse resident, registered nurse, specialist, or other were directed to answer the front-line nurse questions. Respondents who selected Assistant CNO, director, manager, assistant manager, or supervisor were directed to answer the nurse manager questions. Next, the Likert scale questions in the Inclusive Leadership Questionnaire were recoded to numeric values for consistency and ease of analysis. For the Inclusive Leadership Questionnaire, the Likert scale values were recoded as follows: 1 = Almost never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5 = Almost always. This recoding step standardized the responses and facilitated quantitative analysis of the data.

VIII. Data Analysis

Survey Responses

We received a total of 71 responses from the 732 AHSM nursing staff included in the survey distribution emails, resulting in an overall response rate of 9.7%. Of the 71 respondents, 59 were front-line nurses and 12 were nurse managers, culminating in 8.5% and 31.6% response rates, respectively.

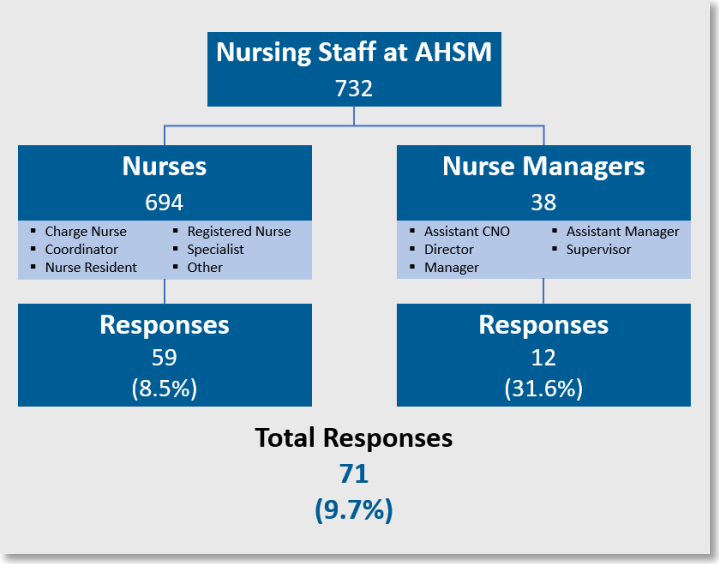


Figure 5: Survey groups and response rates.

Descriptive Analysis

Nurse Survey Responses

We conducted a descriptive analysis to provide an overview of the participant survey responses. For the analysis, we calculated descriptive statistics for all questions, including measures of central tendency (such as mean or median) and measures of dispersion (such as standard deviation or range). The statistics below summarize the nurse participants' perceptions of their manager's inclusive leadership practices (Table 1).

	Count (N)	Mean	Standard Deviation	Median	Min.	Max.	Range	Skewness	Kurtosis	Standard Error	Sample Variance	Confidence Level (95.0%)
Inclusive Leadership (IL)	59	4.24	0.89	4.73	2.15	5.00	2.85	-1.00	-0.32	0.12	0.79	0.23
IL Dimension 1	59	4.27	0.83	4.70	2.10	5.00	2.90	-1.00	-0.03	0.11	0.69	0.22
IL Dimension 2	59	4.19	0.98	4.78	1.83	5.00	3.17	-1.01	-0.19	0.13	0.97	0.26
IL Dimension 3	59	4.29	0.98	5.00	1.33	5.00	3.67	-1.31	0.90	0.13	0.96	0.26
IL Dimension 4	59	4.31	0.97	5.00	1.00	5.00	4.00	-1.60	2.26	0.13	0.95	0.25

Table 1: Descriptive statistics of nurse survey responses.

The overall mean score for nurses' ratings of their manager's inclusive leadership practices was 4.24, suggesting a generally positive perception of inclusive leadership among the nurses, with the response "Often" (4) being selected as the most frequent rating. The standard deviation of

0.97 indicated moderate variability in responses, signifying some diversity in perceptions. Examining each dimension individually, Dimension 1 (see Figure 6) had a mean score of 4.27, indicating a slightly higher perception rating than the mean rating for all dimensions. The standard deviation of 0.83 suggested relatively less variability in responses for Dimension 1 compared to the overall survey. In Dimension 2, the mean score was 4.19, which was slightly lower than the overall mean. The standard deviation of 0.98 indicated moderate variability in front-line nurses' perceptions of their manager's inclusive leadership practices for this dimension. Dimension 3 and Dimension 4 had mean scores of 4.29 and 4.31, respectively. These scores suggested a similar perception of inclusive leadership behavior in both dimensions, which was slightly higher than the mean for all dimensions. The standard deviations for both dimensions were 0.98, indicating moderate variability in responses. Notably, the median values for all dimensions were consistently higher than the mean scores, intimating some degree of skewness towards higher ratings. This indicated that most nurses rated their manager's inclusive leadership practices on the higher end of the Likert scale, with fewer respondents providing lower ratings.

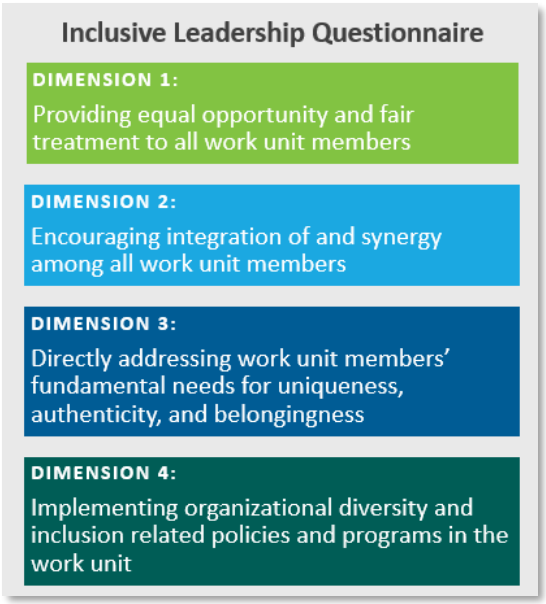
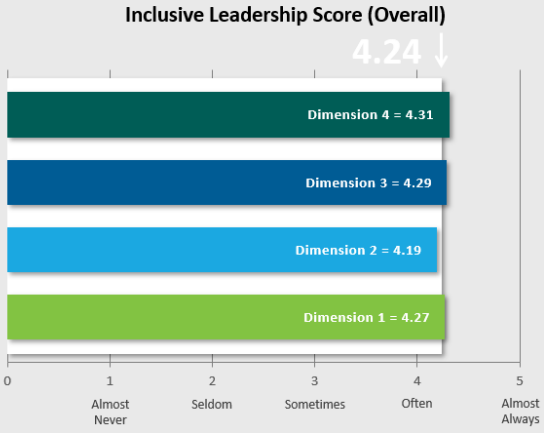
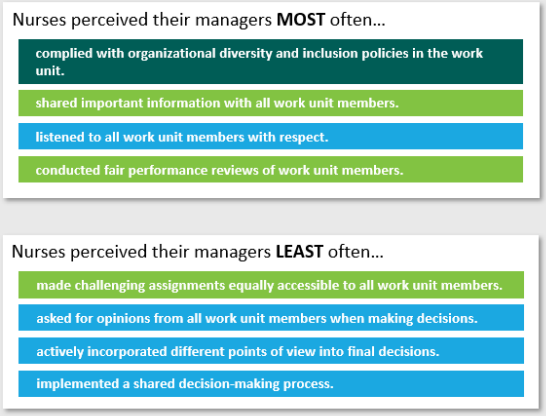


Figure 6: Inclusive Leadership Questionnaire dimensions (Li, 2021).

Nurses indicated that their manager **often** demonstrates inclusive leadership.





Nurse Manager Survey Responses

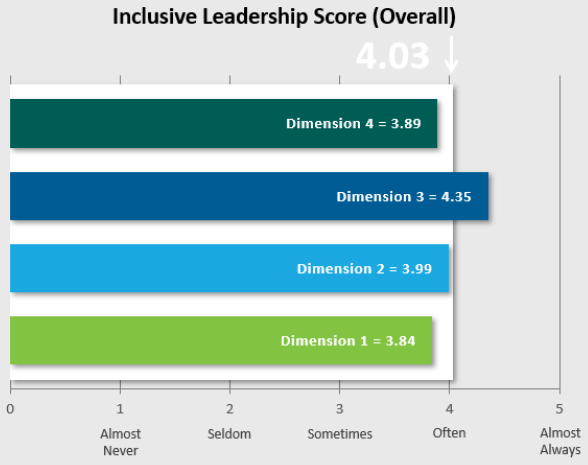
For nurse managers, the statistics below summarize their perception of the organizational support to be inclusive leaders (Table 2).

	Count (N)	Mean	Standard Deviation	Median	Min.	Max.	Range	Skewness	Kurtosis	Standard Error	Sample Variance	Confidence Level (95.0%)
Inclusive Leadership (IL)	12	4.03	0.69	4.16	3.00	4.95	1.95	-0.36	-1.08	0.20	0.48	0.44
IL Dimension 1	12	3.84	0.83	3.95	2.50	5.00	2.50	-0.17	-1.17	0.24	0.69	0.53
IL Dimension 2	12	3.99	0.75	4.00	2.72	5.00	2.28	-0.27	-0.86	0.22	0.56	0.47
IL Dimension 3	12	4.35	0.63	4.39	3.00	5.00	2.00	-0.90	0.36	0.18	0.40	0.40
IL Dimension 4	12	3.89	0.87	3.83	2.33	5.00	2.67	-0.12	-0.87	0.25	0.75	0.55

Table 2: Descriptive statistics for nurse manager survey responses.

The survey had a sample size of 12 nurse managers. Overall, the mean score for organizational support towards inclusive leadership was 4.03 (SD = .69), indicating a relatively positive perception among the respondents as the value was above the midpoint of the Likert scale. Analyzing the individual dimensions of the nurse managers' data, Dimension 1 received a mean score of 3.84 (SD = .83), suggesting a slightly lower perception of organizational support when compared to the mean for all the dimensions. Dimension 2 had a mean score of 3.99 (SD = .75), which was close to the overall mean. Dimension 3 received the highest mean score of 4.35 (SD = .63), which indicated a relatively stronger perception of organizational support for inclusive leadership in this dimension. Dimension 4 had a mean score of 3.89, which was slightly below the overall mean, and had a higher standard deviation of 0.87, intimating a wider range of responses within this dimension.

Nurse managers indicated that AHSM often supports them in becoming inclusive leaders.



Nurse managers felt AHSM supported them the **MOST** to...

- value the uniqueness of all work unit members.
- value the differences that members of diverse backgrounds bring to the work unit.
- respect individual differences in the work unit.
- comply with organizational diversity and inclusion policies in the work unit.

Nurse managers felt AHSM supported them **LEAST** to...

- implement organizational diversity and inclusion programs in the work unit.
- make challenging assignments equally accessible to all work unit members.
- encourage work unit members to challenge each other's perspectives in a constructive way.
- share important information with all work unit members.

Participant Demographics

Additionally, frequencies were examined for categorical variables, including the nurse manager's intent to stay and demographic information such as gender, age, years of nursing experience, and years at AHSM (Table 3). Most of the nurse survey respondents had 5+ years of experience in nursing (86.4%), worked at AHSM for 5 years or more (69.5%), and intend to stay at AHSM for 3 years or more (59.3%). The high percentage of nurses with 5 or more years of experience suggested that the survey responses were captured from a relatively experienced group of individuals at AHSM.

	Nurses (#)	Nurses (%)	Nurse Managers (#)	Nurse Managers (%)
Responses (N)	59	-	12	-
Gender				
Female	54	91.5%	12	100.0%
Male	2	3.4%	-	-
Prefer not to say	2	3.4%	-	-
Prefer to self-describe	1	1.7%	-	-
Race/Ethnicity				
Black or African American	4	6.8%	1	8.3%
Multiracial	1	1.7%	1	8.3%
White or Caucasian	49	83.1%	10	83.3%
Other	2	3.4%	-	-
Prefer not to say	3	5.1%	-	-
Age				
18-24 years old	4	6.8%	-	-
25-34 years old	11	18.6%	1	8.3%
35-44 years old	15	25.4%	4	33.3%
45-54 years old	16	27.1%	3	25.0%
55-64 years old	9	15.3%	4	33.3%
65+ years old	4	6.8%	-	-
Years at AHSM				
Less than 1 year	5	8.5%	1	8.3%
2 years	9	15.3%	1	8.3%
3 years	2	3.4%	1	8.3%
4 years	2	3.4%	-	-
5+ years	41	69.5%	9	75.0%
Years of Nursing Experience				
Less than 1 year	3	5.1%	-	-
2 years	4	6.8%	-	-
3 years	-	-	-	-
4 years	1	1.7%	1	8.3%
5+ years	51	86.4%	11	91.7%

Table 3: Frequencies for demographic variables.

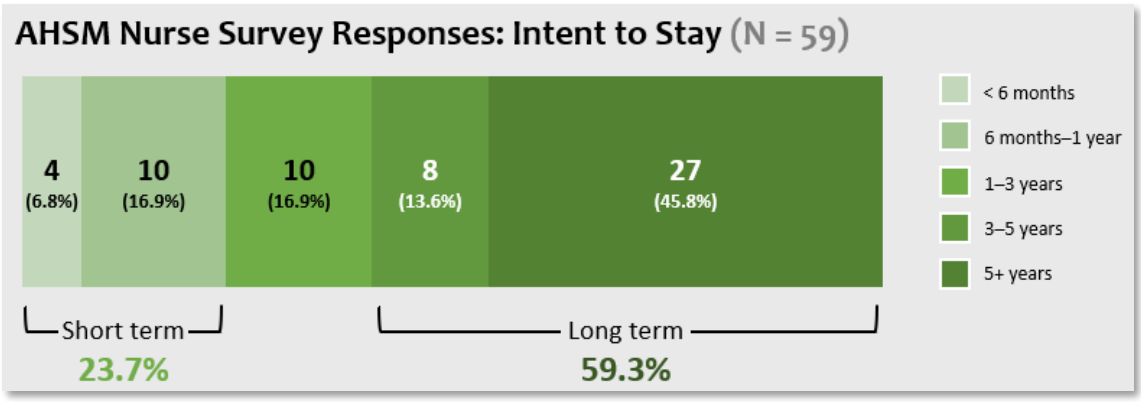


Figure 7: Nurse intent to stay survey responses.

The descriptive analysis provides a basic understanding of the participants' characteristics and their perceptions, laying the foundation for further analysis and interpretation of the data. The

overall analysis suggested that respondents had a positive perception of the actions highlighted in the survey question items and considered the behaviors identified to occur frequently or consistently based on their experience. For nurse managers, there was a positive perception of organizational support for inclusive leadership, although there was a greater degree of variations across the surveyed dimensions.

Inclusive Leadership and Intent to Stay

The analysis of nurses' perceptions of their manager's inclusive leadership scores grouped by intent to stay revealed interesting findings.

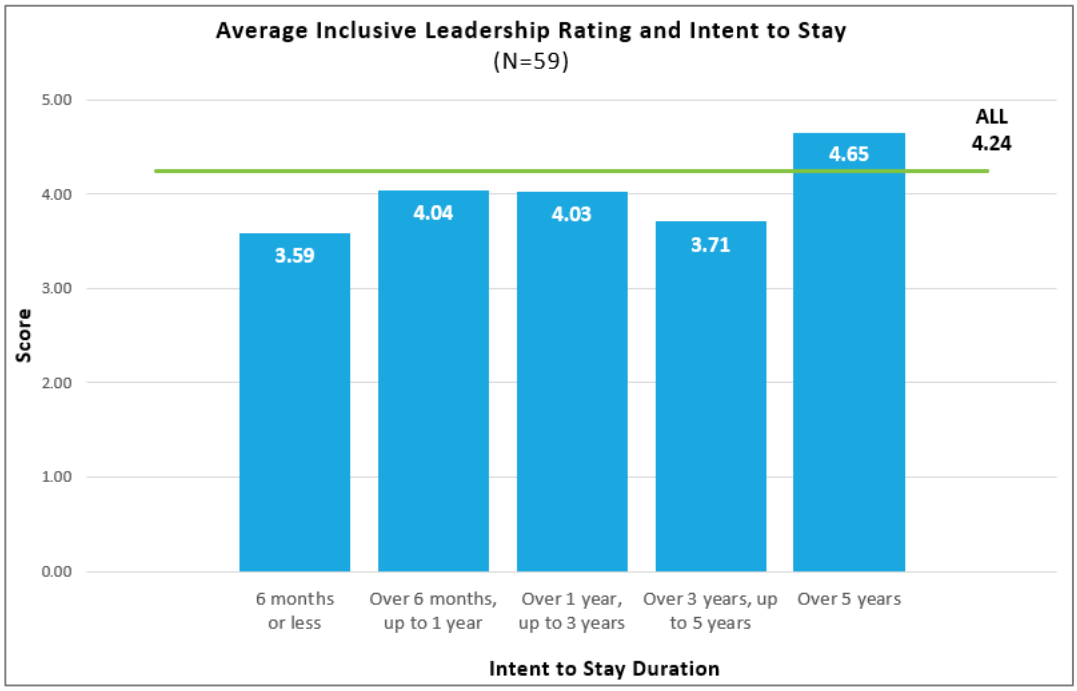


Figure 8: Nurse intent to stay and inclusive leadership rating.

Nurses who reported an intent to stay for less than 6 months had an average inclusive leadership rating of 3.59. This suggested a relatively lower perception of inclusive leadership among this group, potentially indicating concerns or dissatisfaction that might contribute to their intention to leave. Nurses who expressed an intent to stay for over 6 months but less than a year had a higher average inclusive leadership rating of 4.04. This indicated a more positive perception of inclusive leadership among this group, suggesting they feel more supported and included in the workplace. Similarly, for nurses intending to stay for 1 to 3 years, the average

inclusive leadership rating was 4.03. This indicated a relatively consistent perception of inclusive leadership with the previous group, implying that nurses in this category felt their managers demonstrated a similar level of inclusive leadership practices. However, nurses intending to stay for 3 to 5 years had a lower average inclusive leadership rating of 3.71 for their managers. This suggested a minor decrease in perception compared to the previous groups, potentially indicating a need for further investigation into factors that might specifically affect this group of nurses. In line with research, nurses who expressed an intent to stay for over 5 years had the highest average inclusive leadership rating of 4.65. This pointed to a significantly positive perception of inclusive leadership practices among this group, reflecting a strong sense of support and inclusivity that might contribute to their long-term commitment to AHSM.

A one-way ANOVA was performed to compare the effect of nurses' perceptions of their manager's inclusive leadership on their intent to stay at AHSM. A one-way ANOVA revealed that there was a statistically significant difference in intent to stay between at least two groups ($F(4, 54) = 3.51$, $p = .01$). Post hoc pairwise comparisons, using the Tukey-Kramer test, revealed perception of the managers' inclusive leadership practices were significantly different between the nurses that intended to stay "over 3 years, up to 5 years" and those that intended to stay "over 5 years" ($t(54) = 4.05$, $p<0.05$). There was no statistically significant difference between any other group pairs.

SUMMARY

Groups	*Count*	*Average*	*Variance*
6 months or less	4	3.59	1.96
Over 6 months, up to 1 year	10	4.04	0.91
Over 1 year, up to 3 years	10	4.03	0.87
Over 3 years, up to 5 years	8	3.71	1.00
Over 5 years	27	4.65	0.28

ANOVA

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	9.42	4	2.35	3.51	0.01	2.54
Within Groups	36.23	54	0.67			
Total	45.65	58				

Table 4: One-way ANOVA

Broadly speaking, the analysis highlighted the important relationship between nurses' perception of their manager's inclusive leadership practices and their intent to stay. The data conveyed that nurses who perceived higher levels of their manager's inclusive leadership practices were likelier to stay, while those with lower perceptions may be more prone to consider other employment opportunities. These findings underscored the significance of promoting and enhancing inclusive leadership practices as a means to increase nurse retention and foster a positive work environment.

Tenure at AHSM and Intent to Stay

The survey data revealed several notable points regarding the tenure of nurses at AHSM and their intentions to stay with the organization. First, most front-line nurse respondents (41 out of 59) worked at the hospital for 5 or more years, demonstrating, as previously noted, that the data was skewed toward long-term employees. This group also had the highest percentage of responses indicating their intent to stay at the hospital for a substantial period of time (3 years or more). Second, the smallest number of nurses responding to the survey fell into the mid-term tenure category—2 to 4 years working at AHSM. However, it is noteworthy that all these nurses expressed an intention to remain at the hospital for at least a year or more, suggesting a commitment to their current positions despite the relatively lower representation in the survey sample.

Finally, the nursing staff with the least tenure at AHSM, 2 years or less, also had low participation rates in the survey. These nurses, who historically experience higher turnover rates based on data shared by AHSM, could potentially provide valuable insights; however, their engagement with the survey was limited. Among those who did respond, their intentions to stay varied. Approximately 50% expressed an intent to remain at AHSM for the long term (3 years or more), while 14% intended to stay for the medium term (3 years), and 36% intended to stay only for the short term (less than 1 year).

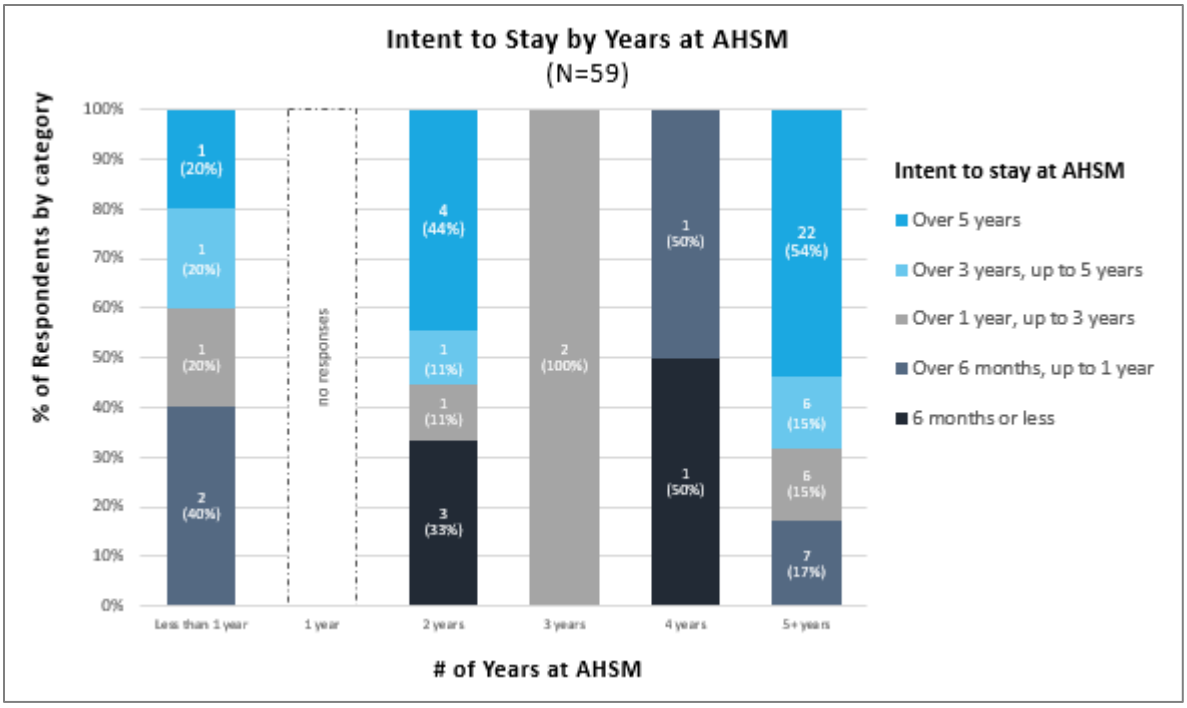


Figure 9: Nurse intent to stay and tenure at AHSM.

This data highlighted the importance of considering the tenure of nursing staff when examining their intentions to stay at the hospital. While the majority of long-term employees expressed a desire to remain at AHSM, the mid-term group also demonstrated a consistent intent to remain. However, further attention and targeted efforts to engage and understand the intentions of newer nursing staff are needed given their historically higher turnover rates at AHSM and limited survey participation. It is also 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 AHSM based solely on these survey responses.

Limitations

Survey Response Rate

Determining a "good" survey response rate for research on working nurses can be challenging, as it depends on various factors such as the study objectives, target population, survey method, and research context. Response rates to surveys and interviews in healthcare and nursing

research is a moving benchmark with complicated calculations (American Association for Public Opinion Research [AAPOR], 2023). In an attempt to focus our project, we accepted only fully completed surveys and our goal was to receive an overall response rate of 30%.

Response rate percentages are important indicators of the representativeness and potential bias of the study sample. A higher response rate increases the likelihood that the sample accurately reflects the perspectives and experiences of the nursing population at AHSM and enhances the validity of the findings. Lower response rates raise concerns about non-response bias and the generalizability of the results. For our research, we employed several literature-supported strategies to maximize response rates to the survey. These included using personalized invitations, providing clear instructions, offering incentives, utilizing multiple reminders, and ensuring the confidentiality of responses (O'Connor, 2022).

Nurses may have chosen not to respond to surveys regarding their intent to stay in their current positions for several reasons. One significant factor is survey fatigue, where nurses may feel overwhelmed by the number of surveys they receive and opt not to participate in additional ones (Polit & Beck, 2021). The AHSM nurses recently completed an in-house survey, so we delayed the release of our survey by an additional week to mitigate fatigue. Additionally, workload and time constraints can influence an individual's willingness to engage in surveys, especially when they perceive the surveys as time-consuming or burdensome (Keusch et al., 2019). Moreover, concerns related to confidentiality and anonymity may discourage nurses from participating, particularly if they fear that their responses may not be anonymous (Polit & Beck, 2021).

The final reason our response rate from the front-line nurses may have been lower than desired was the unfortunate timing of our survey that coincided with a hospital-wide transition to Epic, their new electronic health record (EHR) system. Research has highlighted the stress experienced by nurses during EHR implementation. For example, a study by Granja et al. (2018) explored the stressors associated with the introduction of an EHR system in a hospital setting. The findings revealed that nurses experienced heightened stress due to factors such as increased workload, challenges in adapting to the new system, and concerns about patient

safety. Another study by Babbott et al. (2014) investigated the impact of EHR implementation on nurses' professional quality of life. The results indicated that nurses reported higher levels of stress and burnout following the implementation, with a negative effect on their well-being and job satisfaction. This added stress may have resulted in a decreased response rate by the AHSM nursing staff.

Of note was the limited response from the front-line nurses with less than two years of work experience at AHSM. AHSM leadership was particularly interested in this group; however, insufficient data inhibited our ability to develop meaningful insights related to their perceptions and behaviors. Furthermore, it is crucial to recognize that a considerable number of nurses who responded to the survey have been employed at AHSM for a substantial period, averaging nearly 7 years. Nurses with more years of experience may better understand their roles and organizational dynamics, which could influence their perceptions of inclusive leadership. Also, their extended tenure likely impacts their level of familiarity with the organizational culture, policies, and leadership practices. Similarly, managers had relatively long tenures at AHSM, which may have also positively influenced their perceptions of organizational support. However, the perspectives of the nurses and nurse managers with longer tenure at AHSM may not be representative of the general sentiment held by the broader cross-section of nurses who did not respond to the survey.

Bias

Bias was an important consideration in this project, and several potential sources of bias could have influenced the results and their interpretation. First, the overall response rate of 9.7% raises concerns about selection bias. The nurses who chose to participate differ from non-respondents in terms of their employment characteristics and may differ in their perspectives and experiences as well. As previously noted, this could limit the generalizability of the findings to the broader nursing population at AHSM. Additionally, self-selection bias may be present due to the survey being conducted via email. Nurses with stronger opinions or experiences related to inclusive leadership and intent to stay may have been more likely to participate, potentially skewing the results by overrepresenting extreme viewpoints. Similarly, nurses with no intention

of remaining at AHSM long term or have no interest in inclusive leadership may have lacked the motivation to complete the survey. Social desirability bias is another potential concern, as participants may have felt compelled to provide socially desirable responses or align their answers with organizational expectations at AHSM, leading to biased perception ratings. Furthermore, recall bias could have influenced participants' ability to accurately recall the frequency of their manager's inclusive leadership behaviors. Additionally, confirmation bias may have influenced responses, as nurses with preconceived notions or expectations about inclusive leadership may have selectively sought out answer choices in the survey that confirmed their beliefs.

Survey Design and Administration

Two significant limitations of this project pertain to the survey administration and the utilization of a single-time, cross-sectional survey design. First, the study design adopted restricts the ability to establish causal relationships and examine changes in perceptions of inclusive leadership and intent to stay over time. Both these constructs are dynamic and subject to fluctuations. Without longitudinal data, it is challenging to capture the temporal nature of these relationships and account for potential changes in perceptions or intentions that may occur in the future or due to interventions implemented by AHSM’s leadership. Consequently, the findings can only provide a snapshot of the relationship between nurses' perceptions of their manager's inclusive leadership and their intent to stay at AHSM at a particular period in time.

Second, the survey was administered via email by doctoral students who were not associated with AHSM. While efforts were made to ensure anonymity and minimize bias, the involvement of external parties may have influenced the response rate and participants' willingness to provide accurate and comprehensive responses. The limited direct involvement from AHSM staff and potential unfamiliarity between the survey participants and the project team could have impacted the overall response rate and potentially introduced response biases.

IX. Findings

Finding #1

Project Question #1:

What are the perceptions of Advent Health Shawnee Mission nurses with respect to their manager's inclusive leadership?

When asked about their views of their nurse managers' inclusive leadership traits, the frontline nurses had relatively positive feedback. However, while the survey findings showed comparable responses to the questions categorized in Dimensions 1, 3, and 4, ranging from a mean dimension score of 4.27 to 4.31, there was a slight decrease in the overall average for questions captured in Dimension 2, which had a mean score of 4.19. Dimension 2 in the survey addresses workplace integration. We found that frontline nurses believed that their supervisors encouraged integration of and synergy among work units less than other dimensions of inclusive leadership (see Table 1 above, which highlights the mean score responses among the four dimensions of inclusive leadership).

This finding is of particular interest to the project because the sub-dimensions and the related survey questions are a more balanced mix of questions related to the concepts of uniqueness and belongingness. This is unlike Dimension 1, which only captured the concept of uniqueness, or Dimension 3, which overwhelmingly focused on the concept of belongingness. The nurses' view that there may be a "synergy gap" among their teams aligns with Hofmeyer's (2013) notion that nurses thrive better within more inclusive work settings. Importantly, nurses will be more inclined to remain in their posts if they perceive that their leaders authentically create such inclusive work environments (Nishii & Mayer, 2009). Dimension 2 tells us several factors that nurses consider when evaluating their manager's inclusive leadership practices. In the area of uniqueness, nurses desire their supervisors to (i) seek out their ideas when setting goals for their work unit, (ii) be more open to various perspectives whenever the group is working on shared challenges, and (iii) push to integrate viewpoints from team members. With respect to belongingness, nurses are tasking their managers with (i) communicating openly with all nurses

within the working team, (ii) establishing an inclusive problem-solving mechanism, (iii) reinforcing work collaboration efforts, and (iv) inviting constructive debates.

Our finding here suggests a perception that while nurse managers treat those under their charge fairly and they directly address frontline nurses' need for belongingness and uniqueness, there are opportunities for leaders to integrate the views of the nursing staff more affirmatively in decision-making.

Finding #2

Nurse managers gave the organization considerably high ratings (average 4.35) for Dimension 3: support in directly addressing work unit members' fundamental needs for uniqueness, authenticity, and belongingness (see Table 2). Responses for all nine questions in Dimension 3 fell within the top 15 highest-rated responses in the questionnaire.

Project Question #2:

What are the perceptions of nurse managers with respect to how AdventHealth Shawnee Mission supports their efforts to become inclusive leaders?

Dimension 1, the support for providing equal opportunity and fair treatment to all work unit members (average 3.84), had the lowest ratings. The first ten questions of the survey pointed to the first dimension, and interestingly, seven of those ten questions were amongst the lowest 12 responses. Dimension 4, implementing organizational diversity and inclusion-related policies and programs in the work unit, also scored lower (3.89). The last three questions of the survey supported Dimension 4, and two of those three questions were among the ten lowest-scoring questions. Support for implementing diversity and inclusion programs and initiatives in the work unit scored on the low end, but support for complying with diversity and inclusive policies scored fourth highest amongst all questions. Dimension 2, support in encouraging integration of and synergy among all work unit members, came in right below the mean (3.99).

The results of the analysis suggested that nurse managers felt the greatest organizational support for creating inclusion for the front-line nurses individually. Organizational support for belongingness and uniqueness towards individuals scored equally high amongst respondents.

Lower scores came in supporting managers when implementing inclusive behaviors and creating equity across the entire work unit. These findings could suggest that nurse managers perceived more support in creating a sense of inclusivity for each floor nurse on the team and less support in creating an inclusive environment among the members within the team. This leadership support is important to team cohesion.

This finding is of interest because, as previously stated, Tang and Hudson (2019) noted that nurse belongingness improved retention and Nishii & Mayer (2009) concluded that the development of nurse managers who effectively create inclusive work environments could directly affect the work-life satisfaction of floor nurses.

Finding #3

Project Question #3:

Is there a relationship between the perceptions of inclusive leadership and retention among nursing staff at AdventHealth Shawnee Mission?

The results of the analysis aligned with previous research on the relationship between inclusive leadership and employee retention. Studies have consistently shown that inclusive leadership, characterized by supportive and inclusive behaviors from managers, plays a crucial role in employee engagement and commitment to an organization (Chami-Maleb, 2022; Lee & Jang, 2020; Wang et al., 2019). The finding that nurses intending to stay for over 5 years had the highest average inclusive leadership rating aligns with research suggesting that employees who perceive a higher level of inclusive leadership are more likely to exhibit a long-term commitment to their organization (see Figure 9). This positive perception indicated that these nurses felt valued, a sense of belonging, and included in decision-making processes, thereby fostering a sense of loyalty and dedication (Tang & Hudson, 2019).

On the other hand, the lower average inclusive leadership rating among nurses intending to stay for less than six months and 3-5 years highlighted a potential area of opportunity for improvement by AHSM leadership. Research has demonstrated that the lack of inclusivity, among other factors, can negatively affect employee retention (Wang et al., 2019). These

findings emphasized the importance of addressing any gaps in inclusive leadership practices, particularly for nurses with lower perceptions of their manager's inclusive leadership, to enhance their job satisfaction and intention to stay.

Overall, the alignment between the survey results and existing research strengthened the validity and reliability of this finding, despite low survey response rates. It reinforced the understanding that inclusive leadership is a critical factor in creating a positive work environment and retaining valuable nursing staff. AHSM can utilize this finding to inform targeted interventions and initiatives aimed at strengthening inclusive leadership behaviors, ultimately improving nurse retention rates and maintaining a supportive workplace culture.

X. Recommendations

Recommendation #1

Provide more robust collaboration opportunities within and across the work units.

Front-line nurse survey responses indicated there is an opportunity for greater integration of ideas, perspectives, and opinions in the decision-making process. As such, in addressing Finding #1, we recommend that AHSM creates and/or promotes stronger collaboration opportunities that embrace group dynamics both within and across work units at the hospital. Employees who find that they are being engaged are more committed to their jobs and are less likely to transition to a new, external position, thus reducing turnover rates (Kuligowski, 2023). Furthermore, the more engaged employees are, the more productive and innovative they tend to be. (Kuligowski, 2023). Examples of integration efforts include: (i) establishing advisory committees to advise the leadership team on various topical matters, (ii) conducting regular cohort-wide meetings where nurses can provide suggestions and ask questions of leadership, (iii) streamlining job rotation and work collaboration processes to allow for new learning and knowledge exchange, and (iv) providing several options for nurses to give their feedback on proposed policy and programmatic changes.

Recommendation #2

Evaluate whether there is a difference in support for individuals vis-a-vis teams in AHSM nurse manager training. Further, assess inclusive leadership practices being employed by successful nurse managers, codify and disseminate to AHSM managers system-wide.

To reduce the perception of decreased support by nurse managers and nurses in the area of equal opportunity and support to all work unit members, leadership at AHSM should evaluate current nurse manager training and assess if there is an imbalance between interpersonal leadership training and team training. A study conducted by Abu Bakar and Sheer (2013) highlighted the contrast between leader-member relationships and feelings of envy and unfairness by others, which negatively impacted team solidarity, and the significance of interpersonal team relationships, which enhanced group cohesion. Therefore, in addition to managing individual team members, we encourage AHSM to prioritize efforts in supporting nurse managers in building team unity and equitable access to work opportunities. For example, one strategy AHSM can use for building team unity is providing training to managers on team goal setting. Lam et al. (2016) found that creating team goals was a moderating tool used for improving team interpersonal relationships.

The vast majority of the nurse manager responses averaged a score of 4 or higher. Considering the high ratings, the AHSM administration should run a cost-benefit analysis before moving forward with the creation of any new training programs, bearing in mind that research and development of managerial programs can be costly and time-consuming. In addition, management should dedicate time to explore and evaluate inclusive leadership practices currently being employed by successful nurse managers. The most effective strategies should be captured and codified so that they can be shared across the organization. An intentional process of codifying best practices can enhance inclusive leadership practices hospital-wide.

Recommendation #3

Actively incentivize nurse managers' development of inclusive leadership practices.

AHSM leadership should actively promote and foster an inclusive culture to ensure the nursing staff continues to feel positive about their managers' inclusive leadership practices. This can be achieved through several key strategies. First, AHSM leadership can establish clear expectations and accountability by communicating the specific behaviors and practices associated with inclusive leadership to all nurse managers. These expectations should be incorporated into performance evaluations and promotions, with measurable goals and indicators to track progress. By linking inclusive leadership to career advancement, AHSM can incentivize nurse managers to engage actively in inclusive practices. Accountability should be integrated into the organizations' performance management system, where goals are incorporated into performance assessments, executive evaluations, and even tied to compensation, ensuring that inclusiveness remains a priority across all levels of the organization (Offermann & Basford, 2013).

Second, fostering open communication channels is crucial in creating a culture where nurses feel comfortable expressing their ideas, concerns, and feedback. Particularly important in a high-risk setting such as a hospital, nurse managers who exhibit inclusive behaviors can encourage their staff to speak up and report errors, ultimately improving patient safety in environments where speaking up is culturally discouraged or unacceptable (Lee & Dahinten, 2021). AHSM leadership should establish avenues for anonymous feedback, such as suggestion boxes or online platforms, to encourage honest input. Regularly reviewing and addressing the feedback received will demonstrate that nurses' voices are heard and valued, promoting a sense of inclusion and empowerment.

Third, implementing a recognition and rewards system can significantly reinforce and celebrate inclusive leadership behaviors (Wang et al., 2021). AHSM should recognize and acknowledge nurse managers who consistently demonstrate inclusive practices and actively contribute to creating an inclusive work environment. This can take the form of public recognition, awards, or even financial incentives tied to the outcomes of inclusive leadership.

Last, conducting regular assessments and progress monitoring is essential in evaluating AHSM's progress and success in promoting and fostering inclusive leadership. Collecting feedback from nurses regarding their perceptions of inclusive leadership within the organization can provide valuable insights. Effective leaders recognize that understanding personal and team gaps, developing action plans, and implementing monitoring processes are crucial for driving inclusive practices and fostering a diverse and inclusive organization (Henderson, 2013). By identifying areas of improvement through assessments, AHSM can implement targeted interventions and training programs to address gaps and ensure continuous, consistent growth in promoting inclusive leadership.

XI. Conclusion

Our capstone project aimed to inform the leadership at AHSM as to whether a particular leadership strategy has been impacting nurse retention. Given the institution's renewed focus on its core principle of inclusion, we sought to ascertain (i) the degree to which front-line nurses viewed their superiors' leadership styles to be inclusive and (ii) the level of support the nurse managers felt the organization provides in inclusive leadership training. To complement these interests, AHSM ultimately expressed interest in exploring if there was a connection between engaging in inclusive leadership practices in the work environment and nurses' intent to remain at AHSM. Utilizing a cross-sectional survey method, we extrapolated three overarching findings and identified at least one main recommendation for each finding. A comprehensive dive into the literature led us to formulate three project questions:

1. What are the perceptions of Advent Health Shawnee Mission nurses with respect to their manager's inclusive leadership?

2. What are the perceptions of nurse managers with respect to how AdventHealth Shawnee Mission supports their efforts to become inclusive leaders?

3. Is there a relationship between the perceptions of inclusive leadership and retention among nursing staff at AdventHealth Shawnee Mission?

Having disseminated a survey to the nursing staff and analyzed the data, we drew three findings, with each being associated with the project questions and designed to address the problem of practice. Our first finding intimated that front-line nurses believe that their managers could more frequently integrate their ideas, opinions, and viewpoints into the decision-making process with the work units. Our second finding pointed to the need for AHSM's leadership to provide equal opportunities and fair treatment for nurse managers. The third finding revealed that nurses intending to stay at AHSM for at least five years or more indicated their managers engaged in inclusive leadership behaviors more frequently, on average, than nurses that intended to stay at AHSM for less time.

From the three findings, we were able to develop our recommendations for AHSM. These recommendations aligned with our literature review, which covered inclusive work environments, job satisfaction, and retention. While not all-encompassing, these recommendations provide a starting point for AHSM in curating and bolstering best practices in the inclusive leadership area, which will, in turn, positively impact the turnover rate. Our first recommendation was for AHSM to create and/or promote stronger collaboration opportunities that embrace group dynamics both within and across the various work units at the hospital. The second recommendation encouraged management to dedicate time to explore and evaluate inclusive leadership practices currently being employed by successful nurse managers. Importantly, the most effective strategies should be captured and codified so that they can be shared across the organization. Third, we recommended that the organization actively promote inclusive leadership by establishing clear expectations and accountability, fostering open communication channels, implementing recognition and rewards systems, and conducting regular assessments to track progress. By incorporating these strategies, AHSM can create a culture where nurses feel valued, respected, and included, ultimately improving nurses' sense of belongingness and their retention.

With the results from the survey being largely positive, nurses at AHSM are seemingly generally satisfied with the work environment despite the need for greater inclusive leadership habits to be practiced. As the organization looks to keep its nurses happy and reduce its turnover rates,

implementing these recommendations may likely serve to strengthen the relationship between front-line nurses and their managers. Further, their implementation would be an opportunity for leadership at large to be transparent, communicative, and responsive to the staff's integration needs. This approach would be a worthwhile organizational catalyst to reduce revenue loss, build on its core value of inclusion, and retain its talented cadre of frontline nurses and managers. Leveraging these strategies would favorably augment nurses' perceptions of their leaders, resulting in their desire to remain long-term at AHSM.

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APPENDIX A

INCLUSIVE NURSING LEADERSHIP QUESTIONNAIRE – Nurses (adapted from Li, 2021)

Instructions:

- Please read each statement carefully and think about how often your manager engaged in the described behaviors in your work unit or department. Your **manager** is the person to whom you report most directly to and with whom you have the most direct communication.
- Please rate each question on a five-point scale: 1 = Almost never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5= Almost always.

Internal Structure	Specific Sub-Dimensions	Items
		My nurse manager...
Dimension 1: Providing equal opportunity and fair treatment to all work unit members	providing equal opportunity to all work unit members	1. makes training opportunities equally accessible to all work unit members.
		2. makes challenging assignments equally accessible to all work unit members.
		3. makes her/him self equally accessible to all work unit members.
		4. makes resources equally accessible to all work unit members.
		5. shares important information with all work unit members.
	providing fair treatment to all work unit members	6. conducts fair performance reviews of work unit members.
		7. makes recommendations for promotion fairly in the work unit.
		8. treats everyone in the work unit fairly.
	managing micro inequalities and subtle discrimination	9. manages biases toward marginalized group members in the work unit.
		10. confronts both direct and subtle forms of discrimination in the work unit.
Dimension 2: Encouraging integration of and synergy among all work unit members	facilitating open communication among all work unit members	11. listens to all work unit members with respect.
		12. tries to understand different viewpoints in the work unit.
		13. communicates openly with all work unit members.
	seeking all work unit members' contributions	14. seeks member input when pursuing work unit goals.
		15. encourages diverse inputs from all members to achieve work unit goals.
		16. encourages work unit members to contribute in their own ways.
	integrating perspectives from all work unit members	17. is open to alternative perspectives when working on shared problems in the work unit.
		18. integrates perspectives from all work unit members.
	encouraging inclusive decision making and problem-solving processes among all work unit members	19. encourages everyone in the work unit to participate in decision making.
		20. asks for opinions from all work unit members when making decisions.
		21. actively incorporates different points of view into final decisions.
		22. implements a shared decision-making process.
		23. implements an inclusive problem-solving process.
		24. welcomes constructive debate among work unit members.

Internal Structure	Specific Sub-Dimensions	Items
		My nurse manager...
	welcoming constructive collaboration among all work unit members	25. encourages work unit members to challenge each other's perspectives in a constructive way.
		26. encourages all work unit members to collaborate with each other.
	Encouraging mutual learning among all work unit members.	27. encourages work unit members of diverse backgrounds to exchange ideas.
		28. encourages all work unit members to learn from one another.
Dimension 3: Directly addressing work unit members' fundamental needs for uniqueness, authenticity, and belongingness	directly addressing work unit members' fundamental need for uniqueness	29. respects individual differences in the work unit.
		30. values the uniqueness of all work unit members.
		31. values the differences that members of diverse backgrounds bring to the work unit.
	directly addressing work unit members' fundamental need for authenticity	32. encourages work unit members to share their true selves.
		33. encourages work unit members to be their authentic selves.
		34. makes it safe for work unit members to authentically express themselves.
	directly addressing work unit members' fundamental need for belongingness	35. tries to create an atmosphere in which all work unit members feel a sense of belongingness.
		36. tries to make all members feel like they belong to the work unit
		37. tries to create a cohesive work unit where members feel like they belong.
Dimension 4: Implementing organizational diversity and inclusion related policies and programs in the work unit	enacting organizational diversity and inclusion related policies and programs in the work unit	38. complies with organizational diversity and inclusion policies in the work unit.
		39. implements organizational diversity and inclusion programs in the work unit.
		40. implements organizational diversity and inclusion initiatives in the work unit.

APPENDIX B

INCLUSIVE NURSING LEADERSHIP QUESTIONNAIRE – Nurse Managers (adapted from Li, 2021)

Instructions:

- Please read each statement carefully and think about how often your organization has provided you with resources and/or support to engage in the described behaviors in your work unit or department.
- Please rate each question on a five-point scale: 1 = Almost never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5= Almost always.

Internal Structure	Specific Sub-Dimensions	Items
		As a nurse manager, my organization has provided me with resources and/or support to:
Dimension 1: Providing equal opportunity and fair treatment to all work unit members	providing equal opportunity to all work unit members	1. make training opportunities equally accessible to all work unit members.
		2. make challenging assignments equally accessible to all work unit members.
		3. make myself equally accessible to all work unit members.
		4. make resources equally accessible to all work unit members.
		5. share important information with all work unit members.
	providing fair treatment to all work unit members	6. conduct fair performance reviews of work unit members.
		7. make recommendations for promotion fairly in the work unit.
		8. treat everyone in the work unit fairly.
	managing micro inequalities and subtle discrimination	9. manage biases toward marginalized group members in the work unit.
		10. confront both direct and subtle forms of discrimination in the work unit.
Dimension 2: Encouraging integration of and synergy among all work unit members	facilitating open communication among all work unit members	11. listen to all work unit members with respect.
		12. try to understand different viewpoints in the work unit.
		13. communicate openly with all work unit members.
	seeking all work unit members' contributions	14. seek member input when pursuing work unit goals.
		15. encourage diverse inputs from all members to achieve work unit goals.
		16. encourage work unit members to contribute in their own ways.
	integrating perspectives from all work unit members	17. be open to alternative perspectives when working on shared problems in the work unit.
		18. integrate perspectives from all work unit members.
	encouraging inclusive decision making and problem-solving processes among all work unit members	19. encourage everyone in the work unit to participate in decision making.
		20. ask for opinions from all work unit members when making decisions.
		21. actively incorporate different points of view into final decisions.
		22. implement a shared decision-making process.
		23. implement an inclusive problem-solving process.
		24. welcome constructive debate among work unit members.

	welcoming constructive collaboration among all work unit members	25. encourage work unit members to challenge each other's perspectives in a constructive way.
		26. encourage all work unit members to collaborate with each other.
	Encouraging mutual learning among all work unit members.	27. encourage work unit members of diverse backgrounds to exchange ideas.
		28. encourage all work unit members to learn from one another.
Dimension 3: Directly addressing work unit members' fundamental needs for uniqueness, authenticity, and belongingness	directly addressing work unit members' fundamental need for uniqueness	29. respect individual differences in the work unit.
		30. value the uniqueness of all work unit members.
		31. value the differences that members of diverse backgrounds bring to the work unit.
	directly addressing work unit members' fundamental need for authenticity	32. encourage work unit members to share their true selves.
		33. encourage work unit members to be their authentic selves.
		34. make it safe for work unit members to authentically express themselves.
	directly addressing work unit members' fundamental need for belongingness	35. try to create an atmosphere in which all work unit members feel a sense of belongingness.
		36. try to make all members feel like they belong to the work unit
		37. try to create a cohesive work unit where members feel like they belong.
Dimension 4: Implementing organizational diversity and inclusion related policies and programs in the work unit	enacting organizational diversity and inclusion related policies and programs in the work unit	38. comply with organizational diversity and inclusion policies in the work unit.
		39. implement organizational diversity and inclusion programs in the work unit.
		40. implement organizational diversity and inclusion initiatives in the work unit.

Appendix C

Demographic Questions

1) Please indicate your gender
   - ☐ Male
   - ☐ Female
   - ☐ Other

2) Please indicate your race
   - ☐ African American or Black
   - ☐ Asian or Asian American
   - ☐ Hispanic or Latino
   - ☐ White
   - ☐ American Indian or Alaska Native
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ Other

3) Which category below includes your age?
   - ☐ 18-20
   - ☐ 21-29
   - ☐ 30-39
   - ☐ 40-49
   - ☐ 50-59
   - ☐ 60 or older

4) What is the highest level of education you have completed or the highest degree you have earned?
   - ☐ Licensed Practical or Vocational Nurse (LPN/LVN)
   - ☐ RN
   - ☐ BSN
   - ☐ Other Bachelor degree
   - ☐ Other Graduate degree

5) Which of the following categories best describes your employment status?
   - ☐ Part-time, working 1-39 hours per week
   - ☐ Full-time, working 40 or more hours per week
   - ☐ Per-Diem, working as much as I want

6) How many years of nursing experience do you have?
   - ☐ 0-1 year
   - ☐ 2 years
   - ☐ 3 years
   - ☐ 4 years
   - ☐ 5+ years

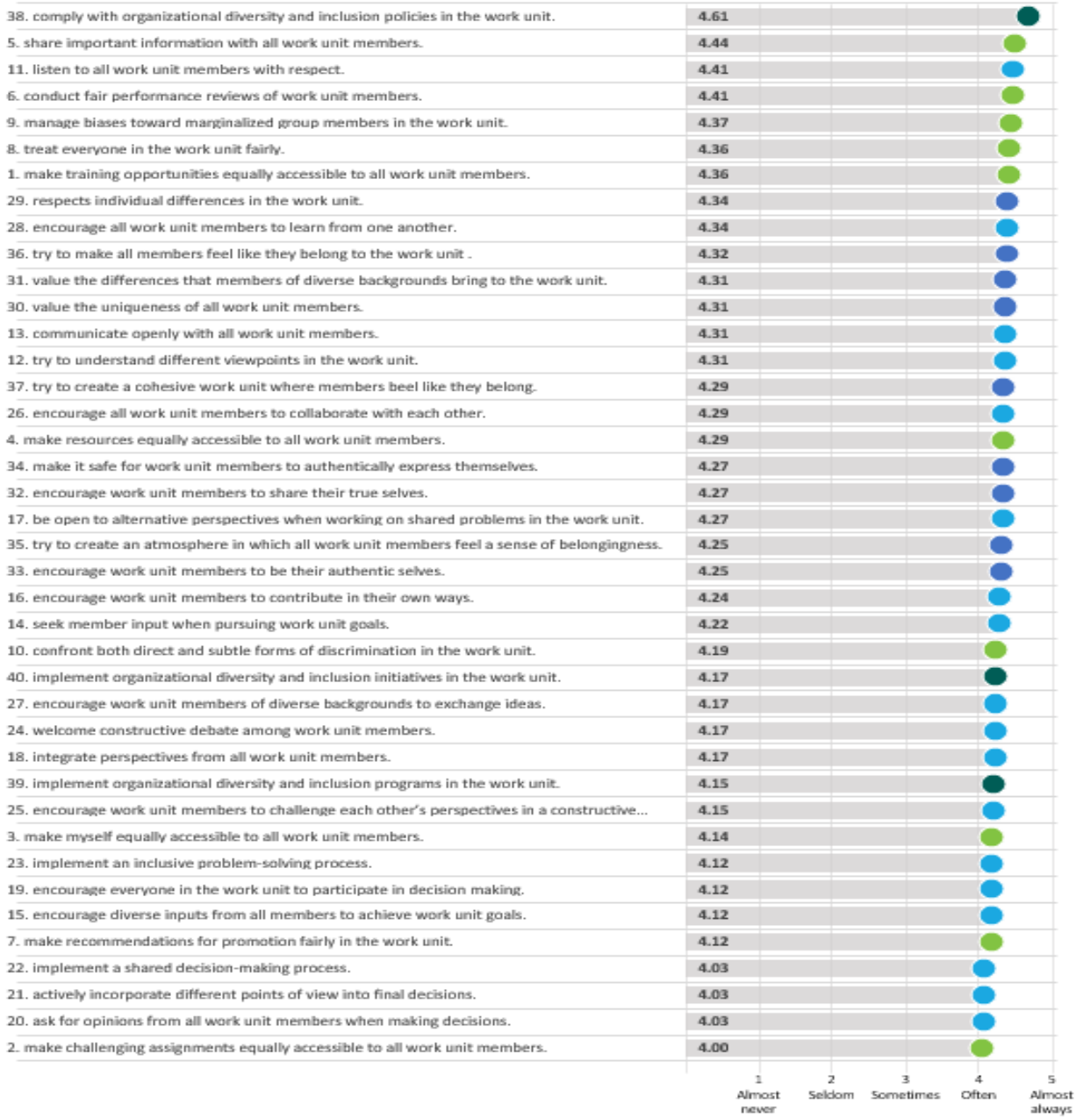
7) How many years have you worked at AHSM?
   - ☐ 0-1 year
   - ☐ 2 years
   - ☐ 3 years
   - ☐ 4 years
   - ☐ 5+ years

8) I intend to continue working for AHSM for:
   - ☐ 0-1 year
   - ☐ 2 years
   - ☐ 3 years
   - ☐ 4 years
   - ☐ 5+ years

Appendix D

Inclusive Leadership Questionnaire – Survey Responses

Nurse's perception of manager's inclusive leadership (mean rating)



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.

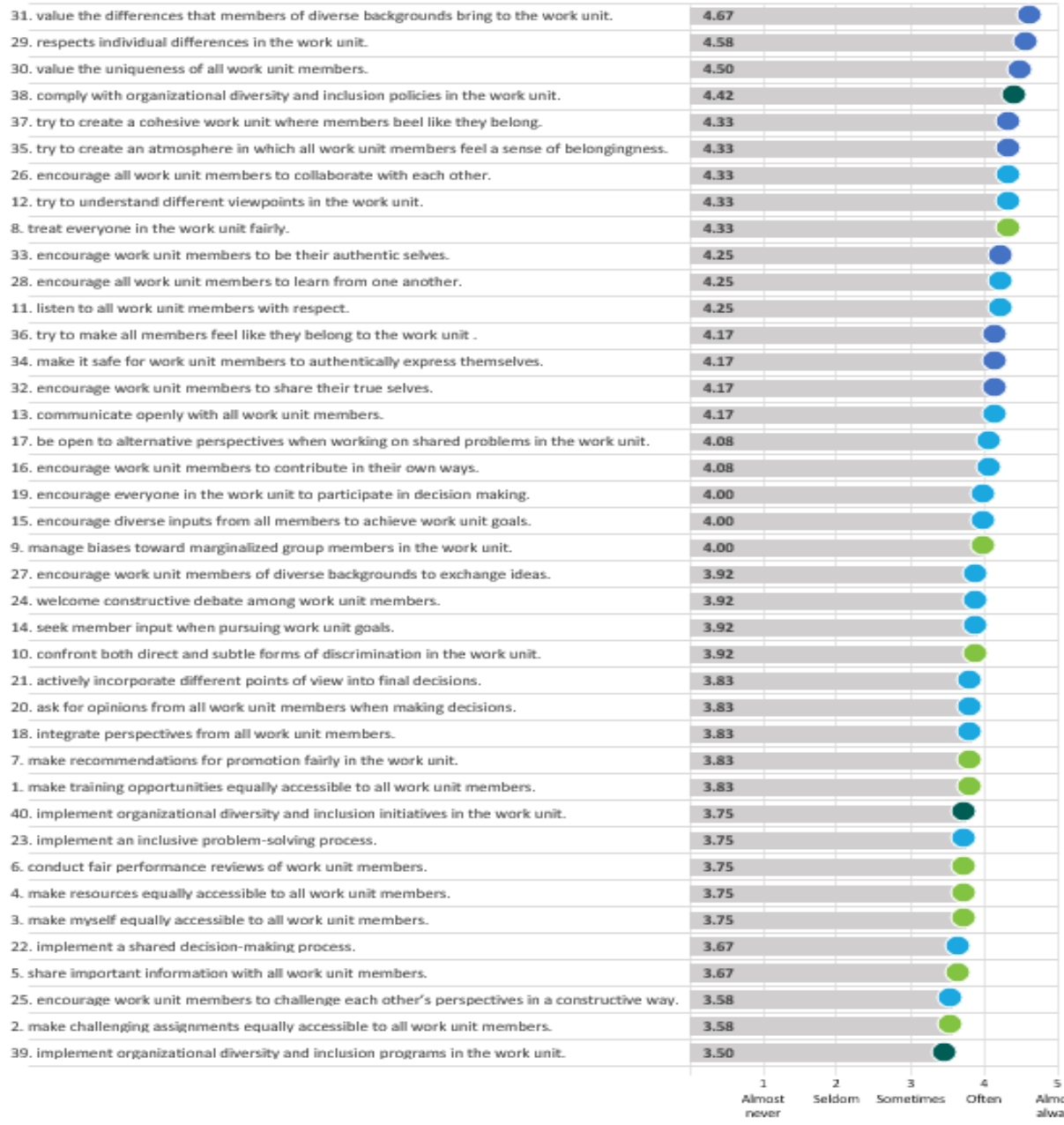
DIMENSION 3: Directly addressing work unit members' fundamental needs for uniqueness, authenticity, and belongingness.

DIMENSION 4: Implementing organizational diversity and inclusion related policies and programs in the work unit.

Appendix E

Inclusive Leadership Questionnaire – Survey Responses

Nurse manager's perception of organizational support to be an inclusive leader (mean rating)



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