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Title page:

Leadership and Managerial Factors Influencing Nurse Retention: A Qualitative Study of Clinical Nurses in Iran

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Abstract

Background The global nursing shortage and the tendency to leave the profession, especially in middle-income countries, are recognized as critical challenges in the healthcare system. Without effective strategies to increase nurse retention, the global nursing shortage will not only persist but is likely to worsen over time. This qualitative study aimed to explain leadership and managerial factors affecting nurse retention as perceived by clinical nurses.

Methods A qualitative study using conventional content analysis was conducted. Fifteen clinical nurses were purposively recruited from public and private hospitals in Iran, and sampling continued until theoretical data saturation was achieved. Data were collected through semi-structured interviews and analyzed using Graneheim and Lundman's conventional content analysis.

Results Data analysis revealed three categories representing leadership and managerial factors that reinforced nurse retention: "Human-Centered Leadership," "Structuring for Resilience," and "Value Reflection." Five categories represented leadership and managerial factors that weakened nurse retention: "Systemic Invisibility," "Hierarchical Disconnect," "Context-Blind Policy Imposition," "Relationship-Based Discrimination," and "Blaming Culture."

Conclusion Nurse retention depends not only on adequate staffing but also on leadership practices that foster fairness, professional dignity, and organizational support. For the Iranian healthcare system, strengthening empathetic leadership and eliminating discriminatory and blame-oriented management practices should be a priority for improving nurse retention. These findings provide context-specific evidence to inform leadership development and retention policies in Iran and other resource-constrained healthcare systems.

Keywords Nurses, Retention, Leadership, Management, Qualitative Research

Introduction

The World Health Organization (WHO) Regional Office for Europe defines staff retention as an organized effort to create an environment that encourages employees to stay in their jobs [1]. Specifically, nursing staff retention is defined as "keeping nurses in their jobs" or "the extent to which nurses stay in their present job". This concept has four defined characteristics: individual motivation, intent, and decision; strategy and intervention; geographical context; and job attachment [1].

Nurses form the vital cornerstone of the healthcare system, playing an essential role in patient care delivery and constituting over half of the total healthcare workforce [2]. Global efforts to increase the number of nurses have included various strategies for recruiting and retaining domestic staff

and expanding nursing schools [3]. Despite these efforts, the WHO reported a shortage of 5.9 million nurses in 2018, projecting this deficit to reach 10.6 million by 2030 [4]. The increasing shortage of nurses and high attrition from the profession is a global dilemma present in both developed and developing countries [5]. The nursing shortage can seriously impact patient safety and quality of care [6, 7]. Without effective strategies to increase nurse retention, the global nursing shortage will not only persist but is likely to worsen over time [8].

Nurse retention is influenced by multi-level factors (individual, organizational, societal) [9]. Furthermore, Cowden and Cummings' theoretical model categorizes concepts affecting nurses' intent to stay into six domains: managerial factors, organizational attributes, job characteristics, nurse traits, and cognitive/affective responses to work. Their findings confirm that leadership practices influence retention intent, though precise mechanisms remain unclear [10].

Although theoretical models and quantitative studies have identified leadership and managerial factors as important predictors of nurse retention, they provide limited insight into how and why these factors influence nurses' decisions to remain in the profession within specific organizational and cultural contexts.

According to the WHO, workforce retention, particularly nursing workforce retention, is a global necessity and priority to meet the needs of the health sector [1]. Efforts to promote retention are also prioritized due to the significant financial costs of staff replacement, training new personnel, and impacts on care quality [11]. Therefore, understanding the predictors of nurse retention is crucial for enhancing care quality and reducing costs [12].

In Iran, the nursing shortage is recognized as the most significant challenge in the nursing field. Key factors for this shortage include low social status, work-related injuries, early retirement,

migration, intent to leave the job, employment in other professions, low employment rates, and increased hospital beds. Specifically, "lack of passion for staying in the profession" has been cited as a primary reason for this shortage [13]. A recent study in Iran identified weak managerial support and perceived injustice in resource allocation as the main motivators for nurses' intention to leave [14]. The erosion of professional dignity, stemming from lack of managerial support, feelings of worthlessness, and perceived imbalance in support (where patient rights charters overshadow support for nurses), further fuels nurse attrition [15]. Leadership behaviors and organizational culture are pivotal factors influencing nurse retention and controlling healthcare costs [16]. While existing literature primarily uses quantitative approaches to identify retention predictors [17], complex social phenomena, such as the ways in which leadership and managerial factors influence nurse retention, require qualitative exploration of lived experiences to uncover the underlying mechanisms involved[18, 19].

This study addresses this critical gap by asking*: How do Iranian nurses perceive the leadership and managerial factors affecting their retention*? Building on the limitations of existing theoretical models and quantitative evidence, this qualitative study seeks to uncover the underlying mechanisms through which leadership and managerial factors influence nurses' decisions to remain in the profession. By drawing on nurses' lived experiences, the study aims to generate context-specific knowledge that can inform leadership practices and workforce policies in Iran and other low- and middle-income countries (LMICs).

Aims

The aim of this study was to explore leadership and managerial factors influencing nurse retention as perceived by clinical nurses.

Methods

Study Design

This study employed a qualitative method using a conventional content analysis approach. Qualitative research is a systematic and subjective method that enhances insight, understanding, and awareness of human experiences. Inductive methods, as a core component of qualitative analysis, provide a comprehensive framework for examining complex phenomena. This process involves deep engagement with data through careful reading and interpretation, allowing researchers to identify patterns and discover underlying meanings [18, 19]. Conventional content analysis was chosen for its inductive approach to extracting context-dependent patterns from nurses' narratives, free from pre-existing theoretical constraints [20].

Participants

This qualitative study involved 15 registered nurses employed in public and private hospitals in Iran. Participants were purposively selected based on their first-hand experiences and knowledge of the phenomenon under study, and sampling continued until data saturation was achieved. Most participants were recruited from public teaching hospitals and private hospitals in Tehran (n = 12). To achieve maximum variation in organizational and clinical experiences, three additional participants were recruited from hospitals in other Iranian cities. Participants worked in critical care, emergency, internal medicine, surgery, and pediatric wards. Public hospitals included in the study were teaching hospitals, which generally experience higher patient volumes and heavier workloads than private hospitals because of lower service costs and broader insurance coverage. This diversity of participants provided a comprehensive understanding of how leadership and managerial practices influence nurse retention across different clinical and organizational settings.

Researcher's Position and Reflexivity

The first author (R.H.), who conducted all interviews, is a PhD nursing student with several years of clinical nursing experience. This professional background facilitated rapport with participants, who viewed the interviewer as familiar with the realities of nursing practice and therefore felt comfortable discussing sensitive experiences related to leadership and retention.

The research team recognized that the first author's clinical experiences could also influence data collection and interpretation. To minimize this potential bias, the interview guide was collaboratively developed by the research team, and open-ended questions and probing techniques were used to encourage participants to describe their own experiences rather than confirm the researcher's assumptions. For example, when participants described supportive managerial experiences that differed from the interviewer's prior expectations, these accounts were explored further through additional probing rather than being interpreted through previous experiences.

Throughout the study, the first author maintained reflective field notes documenting personal assumptions and methodological decisions. These reflections, together with coding and category development, were regularly discussed with the co-authors until consensus was achieved, thereby enhancing reflexivity and the trustworthiness of the analysis.

Data Collection

Data were collected between late August 2024 and early July 2025 through 15 in-depth semi-structured interviews conducted by the first author (R.H.). Participants chose the time and location of each interview. Interviews were conducted face-to-face in quiet spaces like hospital libraries and university offices to ensure comfort and facilitate open discussion. Each interview lasted 40-60 minutes (average duration = 50 min). First, the researcher spoke with each potential participant,

explained the research objectives and questions, and, if willing to participate, determined a suitable time for the interview. Each interview was audio-recorded with participants' consent to ensure data accuracy. Field notes were taken during and after each session to record contextual details and non-verbal cues. The prepared interview guide included several open-ended questions to allow participants to describe their perceptions, experiences, and challenges regarding leadership and managerial factors affecting their retention in the nursing profession. The interview guide (Supplementary File 1) was pilot-tested with two nurses outside the study and revised for clarity. To explore participants' responses further, probing questions such as "What do you mean?", "Can you give an example?", "What was your experience?", "Could you explain a bit more about this?" were used to guide and confirm their statements. At the end of each interview, participants were asked, "Is there anything about this topic that you have experienced that I haven't asked about?" Participants were thanked at the end of each interview and could contact again if they had any questions or wished to share recently recalled information.

Sample Interview Guide (Core Question and Example Probe)

Core Question:

- " How do the actions or decisions of your direct managers (e.g., head nurses, supervisors) affect your desire to stay in your job?"

Example Probe:

- " Can you describe a specific experience in which the behavior or decisions of nursing leaders or managers influenced your willingness to remain in the nursing profession? "

Closing Question:

- " If you could change one thing about how leaders manage nurses here, what would it be?"

Ethical Considerations

This study was conducted as part of a PhD nursing dissertation after receiving ethical approval code (IR.SBMU.PHARMACY.REC.1403.130) from the Regional Ethics Committee of Shahid Beheshti University of Medical Sciences, Tehran. All participants were fully informed about the objectives, procedures, confidentiality, and their right to withdraw at any time without consequences. Prior to interviews, written informed consent was obtained from each participant, ensuring their voluntary and informed participation. Audio files were anonymized using identification codes, and encrypted files were stored on a password-protected organizational server.

Data Analysis: Data collection and analysis proceeded concurrently, with emerging findings informing subsequent participant selection through purposive sampling until data saturation was achieved. Data analysis was conducted concurrently with data collection using Graneheim and Lundman's five-step content analysis method [21]: (A) Interviews were transcribed verbatim and read several times to gain an overall understanding of their content; (B) Meaning units relevant to the research question were identified; (C) Initial codes were generated; (D) Codes were grouped into conceptual subcategories based on similarities and differences; and (E) Subcategories were further abstracted into broader categories reflecting the latent content of participants' experiences.

Following initial coding, codes with similar meanings and conceptual relatedness were systematically compared and grouped into preliminary subcategories based on shared patterns and underlying meanings. These subcategories were then further abstracted into broader categories representing the latent content of participants' experiences. The initial coding was conducted by the first author (R.H.) and subsequently reviewed and refined through several analytical meetings with the research team until consensus was reached regarding the final coding framework, subcategories, and categories.

To enhance analytical rigor, the first five interview transcripts were independently coded by two researchers (R.H. and V.Z.). Coding discrepancies involving approximately 20% of the initial codes were resolved through discussion until consensus was achieved**.** Thereafter, coding decisions and category development were continuously discussed with all co-authors throughout the analytical process. MAXQDA software (VERBI GmbH, Berlin, Germany) was used for data management. Table 1 illustrates representative examples of the analytical progression from meaning units to condensed meaning units, codes, subcategories, and categories.

Table 1. Representative examples of the analytical progression from raw interview data to categories

Meaning Unit (Participant quotation)	Condensed Meaning Unit	Initial Code	Subcategory	Category
"...the supervisor joined us during the staff shortage, helped us with patient care, and encouraged us. His presence gave us the strength to stay." (P1)	Supervisor provided practical help and emotional encouragement during staff shortage.	Emotional and practical support	Crisis advocacy	Human-centered leadership
"...the matron stood up for me when the physician blamed me unfairly. Her support was truly encouraging." (P2)	Matron defended the nurse against unfair blame.	Managerial advocacy	Nurse advocacy	Human-centered leadership
"...the new matron invited nurses who had resigned to return because she valued them and cared about their working conditions." (P5)	Manager showed genuine concern for nurses and encouraged former staff to return.	Valuing nurses	Attention to professional concerns	Human-centered leadership
"...when preparing the work schedule, she always considered our requests whenever possible." (P5)	Manager considered nurses' scheduling requests.	Flexible work arrangements	Flexible work scheduling	Structuring for resilience
"...priority was always given to senior nurses with	Favoritism created feelings of unfair	Perceived injustice	Merit neglect	Systemic invisibility

Meaning Unit (Participant quotation)	Condensed Meaning Unit	Initial Code	Subcategory	Category
close relationships to the head nurse. That unequal treatment made me want to leave." (P6)	treatment and intention to leave.			

Trustworthiness

To ensure the trustworthiness of the findings, the four criteria proposed by Lincoln and Guba, namely credibility, dependability, confirmability, and transferability, were applied [22]. Credibility was established through prolonged engagement with participants, purposive sampling with maximum variation, member checking, and peer debriefing. Dependability was ensured by maintaining a transparent analytical process and conducting independent coding of the first five interviews by two researchers, followed by consensus discussions to resolve discrepancies. Confirmability was strengthened through external auditing by two PhD-qualified researchers with expertise in qualitative research, as well as ongoing discussions among the research team throughout the coding and analytical process. Transferability was enhanced by recruiting participants with diverse demographic and professional backgrounds from public and private hospitals in Tehran, as well as from hospitals in several other Iranian cities.

Results

The findings presented in this paper are part of a PhD nursing dissertation exploring leadership and managerial factors affecting nurse retention. Table 2 shows some demographic characteristics of the study participants.

Table 2. Socio-Demographic Characteristics of Participants (Anonymized)

Participants ID	Age-Ranges	Hospital Type	Clinical Department
1	31-35 years	Private	ER*
2	31-35 years	Public	ICU**
3	31-35 years	Public	CCU***
4	31-35 years	Private	NICU****
5	26-30 years	Public	Medical ward
6	31-35 years	Private	Surgical ward
7	31-35 years	Public	CCU
8	26-30 years	Public	ICU
9	41-45 years	Private	Pediatric
10	36-40 years	Public	NICU
11	41-45 years	Private	Medical ward
12	46-50 years	Public	ICU
13	36-40 years	Private	Surgical ward
14	36-40 years	Private	ER
15	46-50 years	Public	Medical ward

*Emergency room ** Intensive Care Unit *** Cardiac Care Unit **** Neonatal Intensive Care Unit

Data analysis in the present study led to the emergence of eight categories of leadership and managerial factors affecting nurse retention. Three categories reflected positive leadership and managerial factors: "Human-Centered Leadership," "Structuring for Resilience," and "Value Reflection." Five categories reflected negative leadership and managerial factors: "Systemic Invisibility," "Hierarchical Disconnect," "Context-Blind Policy Imposition," "Relationship-Based Discrimination," and "Blaming Culture." Table 3 presents the categories and their corresponding subcategories.

Table 3. Categories and Subcategories of Leadership and Managerial Factors Affecting Nurse Retention

Category	Subcategory

1. Human-Centered Leadership	Crisis Advocacy
	Nurse Advocacy
	Attention to Professional Concerns
2. Structuring for Resilience	Flexible work scheduling
	Conflict Resolution
	Workflow Optimization
3. Value Reflection	Symbolic Recognition
	Professional Dignity Preservation
	Appreciating efforts
4. Systemic Invisibility	Merit Neglect
	Uniform Performance Perception
	Reducing nurses to routine task performers
5. Hierarchical Disconnect	Unidirectional Communication
	Humiliating Conduct
	Criticism Intolerance
6. Context-Blind Policy Imposition	Field-disconnected decision-making
	Unrealistic Expectations
	Workload Pressure Neglect
7. Relationship-Based Discrimination	Favoritism over Merit
	Unequal Opportunity Distribution
	Inequality in auditing errors
8. Blaming Culture	Minor Error Magnification
	Impossible expectation
	Humiliating Responses

1. Human-Centered Leadership

Managers who are present during crises and provide tangible support strengthen nurses' sense of organizational belonging and encourage them to remain in the profession. This category comprised

three subcategories: crisis advocacy, nurse advocacy, and attention to professional concerns. Together, these subcategories describe how managers' supportive presence, advocacy, and responsiveness to nurses' personal and professional needs fostered trust, enhanced resilience, and made it easier for nurses to cope with challenging working conditions.

One of nurses said: "Conditions were when we were short-staffed and the ER was extremely crowded. I remember the supervisor joining us during the peak of that busyness, helping with tasks, and trying to energize us. This kind of presence gave us strength to stay and continue." (p1)

Another nurse stated:

"The matron stood up against the physician's irresponsibility and his attempt to make me look like a criminal, and that was really encouraging to me. Such managers motivate you to continue your work as a nurse" (p2).

Or another nurse said:

"The head nurse tried her best early on to correct my mistakes in the friendliest way possible and stood behind me and supported me well at the beginning. Maybe without that support, I couldn't have stayed and continued." (p6)

Collectively, these experiences suggest that nurses perceived managerial support not merely as assistance with daily clinical work, but as a meaningful expression of professional recognition, fairness, and shared responsibility. Managers' active presence during difficult situations and their willingness to advocate for nurses strengthened trust, reinforced nurses' sense of being valued, and increased their willingness to remain in the profession despite challenging working conditions**.**

2. Structuring for Resilience

Analysis of nurses' experiences showed that managers could strengthen resilience by creating supportive organizational structures that facilitate retention. This category consisted of three subcategories: flexible work scheduling, conflict resolution, and workflow optimization. These subcategories illustrate how managerial practices that promoted work-life balance, constructive interpersonal relationships, and efficient work processes created a supportive environment that encouraged nurses to remain in their positions.

A nurse said:

"We had a head nurse who we really enjoyed working with. She always considered our requests when scheduling and tried to implement them as much as possible. Because of this, we wanted to stay in that ward." (p5)

Or another nurse said:

"Our head nurse had this ability to resolve conflicts if you had a problem with a colleague. If there was an issue, she would listen to both sides, and without judging anyone, she would try to resolve the conflict. By managing conflicts without judgment, she institutionalized mutual respect, and this characteristic increased our job satisfaction working in that ward." (p6)

Or another nurse mentioned:

"After the new matron started, we had a lot of new staff. Additionally, she called many colleagues who had resigned during the previous manager's time and invited them back to work. Some colleagues who had left returned when they saw the new manager's different approach. I would say the managerial difference was that they valued the staff more and held them in higher regard. It matters to her that staff don't work under difficult conditions and staff shortages." (p15)

These experiences illustrate that supportive organizational practices helped nurses cope with workplace challenges and strengthened their intention to remain in the profession.

3. Value Reflection

Analysis of nurses' lived experiences showed that recognizing and valuing nurses' contributions reinforced their sense of professional worth and strengthened their commitment to remain in nursing. This category included three subcategories: symbolic recognition, professional dignity preservation, and appreciating efforts. Together, these subcategories reflect how meaningful acknowledgment of nurses' work, even though simple symbolic gestures, enhanced motivation and professional commitment.

One of nurses said:

"Just after that very difficult shift, the matron came and thanked us verbally; it created a really good feeling for us. When you see your managers value the work you do, you gain motivation to stay and temporarily cope with the hardships." (p1)

Another nurse said:

"Delivering health and support packages to our doorsteps during COVID conveyed the feeling 'we remember you.' You know, when the system values you as its employee, it unconsciously makes you value it too, and you stay and work as long as you can." (p3)

Or another mentioned:

"Appreciation has a big impact. Something I experienced before that motivated me to continue in my profession. When you are appreciated, you think, 'See, they see how hard I work, the troubles I go through'; it's okay; eventually, the bosses see." (p13)

These experiences suggest that even simple expressions of appreciation strengthened nurses' professional identity and encouraged them to remain in nursing.

4. Systemic Invisibility

Nurses described organizational and managerial failure to recognize individual performance and professional contributions as an important factor reducing their motivation to remain in nursing. This category comprised three subcategories: merit neglect, uniform performance perception, and reducing nurses to routine task performers. Together, these subcategories illustrate how overlooking professional competence, treating all performance similarly regardless of quality, and viewing nurses merely as task performers contributed to feelings of discouragement and professional disengagement.

A nurse said:

"One gets disillusioned working in this system, a system where it doesn't matter if your work is good or not! It's enough to be present. No one pays attention to the quality of work you provide!" (p12)

OR another nurse said:

"Nurses who didn't show up for extra shifts or were absent were fined minimally and weren't given extra shifts the next month, but we, who had no absences, had mandatory overtime every month. I think anyone can understand how hard it is to stay in such a situation." (p3)

OR another nurse said:

"The system wants you as a routine machine; just do the specified tasks without fuss and leave. When they look at you as a machine, you gradually become disillusioned with staying in that system." (p13)

These experiences suggest that organizational failure to recognize merit and acknowledge individual contributions weakened nurses' sense of professional value, thereby diminishing their motivation to remain in the profession.

5. Hierarchical Disconnect

Hierarchical disconnect reflected nurses' experiences of ineffective communication and managerial behaviors that weakened professional self-esteem and reduced their willingness to remain in the profession. This category consisted of three subcategories: unidirectional communication, humiliating conduct, and criticism intolerance. Together, these subcategories describe how limited dialogue, disrespectful interactions, and negative responses to criticism undermined nurses' trust in leadership and organizational commitment.

One of nurses said:

"The top-down view of managers and that physician-centered culture in our hospitals is upsetting; it takes away your motivation to stay, for you who didn't study little to reach your current position – studied for six years and struggled a lot and you are still working hard." (p4)

These experiences suggest that hierarchical communication reduced nurses' sense of professional autonomy and reinforced feelings of being undervalued within the organization.

Another one said:

"I worked for a while in a hospital where the matron was absolutely not open to criticism. Any staff member who talked to them about any protest, even a small one, would be met with the response, 'Well, you can resign; we don't need staff...' They were not at all open to criticism. When faced with such behavior, you ask yourself, 'Why should I stay here and continue?!" (p10)

Such managerial responses discouraged open communication and weakened psychological safety, making nurses less willing to remain in the organization.

Another nurse mentioned:

"In the hospital, sometimes from higher-ups, who sometimes might even be your own colleagues (who were once nurses), you face disrespect or a lack of kindness. This makes you feel bad. You feel that someone who was once your own colleague, now that they are a manager, sees themselves as superior or different." (p14)

6.Context-Blind Policy Imposition

This category describes managerial decision-making that failed to consider the realities of clinical practice and consequently increased nurses' occupational burden. It included three subcategories: field-disconnected decision-making, unrealistic expectations, and workload pressure neglect. Collectively, these subcategories illustrate how policies that overlooked frontline conditions intensified work-related stress and diminished nurses' willingness to remain in the profession.

One of nurses said:

"Managers see nurses like machines that must work flawlessly. They shouldn't protest about the situation or shortages and just say yes to whatever is dictated to them! Can such conditions be tolerated?!" (p5)

These experiences indicate that managerial expectations, when detached from the realities of clinical practice, created feelings of frustration and diminished nurses' willingness to remain in the profession.

Another nurse said:

"They said you must do 70-80 hours of mandatory overtime per month, for a very small amount of money that you're ashamed to tell anyone! How can one convince themselves to stay and suffer for this amount?" (p13)

Participants perceived excessive workload combined with inadequate compensation as evidence that organizational policies failed to acknowledge the practical challenges of frontline nursing.

Or another nurse mentioned:

"After the new building opened, the previous wards weren't closed, and effectively, with the same number of staff, the number of beds doubled. When we protested that the old building wards were supposed to close, they told us, 'If you're unhappy, resign!' Can you imagine how one can stay and continue in the face of such a response?!" (p9)

7. Relationship-Based Discrimination

Nurses described relationship-based discrimination as a significant barrier to retention because personal relationships were often prioritized over fairness and organizational regulations. This category comprised three subcategories: favoritism over merit, unequal opportunity distribution, and inequality in auditing errors. Together, these subcategories demonstrate how perceived organizational injustice and preferential treatment eroded trust in managers and negatively affected nurses' intention to remain in their workplace.

One of nurses said:

"Priority was always with senior staff; the head nurse scheduled any shift they wanted for them, or even, you might not believe it, they had priority in choosing break times too. When you see this level of differential treatment, you can't stay and tolerate it. You want to leave." (p11)

These experiences suggest that favoritism weakened nurses' trust in managerial fairness and reduced their sense of belonging to the organization.

Another nurse said:

"The matron had taken anyone she liked out of the COVID patient sections, and we were working full-time in those wards. Such discrimination, especially in those critical conditions, was really agonizing." (p2)

Participants perceived unequal treatment during demanding clinical conditions as a violation of organizational justice, which further discouraged their intention to remain in nursing.

Or another nurse mentioned:

"If senior staff made a mistake, the head nurse did nothing, but woe betide us newcomers if we made the slightest mistake...." (p5)

8. Blaming Culture

Blaming culture reflected managerial practices characterized by disproportionate attention to minor mistakes while overlooking nurses' overall performance and contributions. This category consisted of three subcategories: minor error magnification, impossible expectation, and humiliating responses. Together, these subcategories illustrate how punitive reactions, unrealistic

expectations, and public humiliation created fear, frustration, and a growing desire to leave the profession.

One of nurses mentioned:

"After 18 hours of work and a tough, intense shift, the head nurse would start shouting at me in front of everyone during the morning shift handover for forgetting an IV label. This was sometimes very painful for me. I thought to myself I should look for another job." (p13)

Or another nurse said:

"If the slightest follow-up is missed by you, you face improper treatment. Maybe you unintentionally forgot that follow-up, maybe you were busy or didn't get to do it. Now one head nurse does this by yelling and getting on your nerves, another makes sarcastic remarks, and it completely lowers your status." (p14)

These accounts suggest that nurses did not perceive occasional mistakes as opportunities for learning but rather as situations that exposed them to criticism and humiliation. Such punitive managerial responses weakened psychological safety, diminished professional confidence, and gradually reduced nurses' willingness to remain in the profession.

Or another nurse mentioned:

"Minor things that might happen at work, insignificant and trivial things, which are met with strong reactions from the head nurse. Many times, I've been reprimanded and interrogated over minor issues. Also, such bad behaviors sometimes tire me out, and I ask myself, 'Why am I still here?!" (p7)

Discussion:

This qualitative study provides an in-depth understanding of how leadership and managerial practices influence nurse retention within the Iranian healthcare system. Overall, the findings suggest that nurses' decisions to remain in the profession are shaped by a dynamic interplay between supportive leadership behaviors and organizational practices. Human-centered leadership, structuring for resilience, and value reflection emerged as key factors that strengthened nurses' professional commitment and intention to stay. In contrast, systemic invisibility, hierarchical disconnect, context-blind policy imposition, relationship-based discrimination, and blaming culture undermined nurses' motivation and organizational attachment. Collectively, these findings indicate that nurse retention extends beyond staffing shortages and financial considerations and is profoundly influenced by everyday leadership practices, perceptions of fairness, organizational support, and workplace culture. The theoretical perspectives discussed in the following sections are presented solely as interpretive lenses to contextualize the findings and were not used to guide data collection, coding, or category development.

Human-Centered Leadership (Category 1)

Human-centered leadership emerged as one of the strongest facilitators of nurse retention. Participants perceived managers' presence during crises, advocacy, and genuine concern for nurses' well-being as signs of organizational support that strengthened belonging, resilience, and willingness to remain in the profession. These findings suggest that supportive leadership fostered retention not only by providing practical assistance but also by communicating respect, shared responsibility, and recognition of nurses' professional contributions. Viewed through the lens of Relational Coordination Theory, these findings may be interpreted as illustrating how trust and supportive manager–nurse relationships strengthen professional commitment. These findings are consistent with previous studies demonstrating that perceived organizational support, relational

coordination, and supportive leadership enhance job satisfaction and intention to stay while reducing turnover intention[23-29]. In the Iranian healthcare system, where heavy workloads and hierarchical organizational structures often limit nurses' sense of organizational support, visible managerial presence during clinical challenges may have particular importance in reinforcing professional recognition and encouraging retention[30, 31].

Structuring for Resilience (Category 2)

Structuring for resilience highlights how managerial practices that supported nurses' daily work strengthened their capacity to cope with demanding clinical environments and encouraged them to remain in the profession. Participants described flexible work scheduling, responsive attention to their needs, effective conflict resolution, and efforts to improve working conditions as important organizational resources that enhanced resilience and organizational commitment. These findings suggest that nurses were more willing to remain in the profession when managers reduced unnecessary workplace stress and created conditions that increased their sense of control over every day work. Such practices appeared to strengthen resilience by enabling nurses to adapt more effectively to ongoing organizational pressures rather than merely helping them cope with isolated stressful events. Viewed through the lens of Conservation of Resources Theory, these findings may be interpreted as illustrating how managerial practices that preserve valued resources, such as autonomy, emotional energy, and work-life balance, contribute to sustained professional commitment[32]. Previous studies have likewise shown that flexible scheduling, supportive conflict management, and fair organizational practices improve work-life balance, job satisfaction, and nurse retention[33-35]. Within the Iranian healthcare system, where chronic staffing shortages and heavy workloads often limit nurses' control over their work environment, relatively simple

managerial actions, such as flexible scheduling and constructive conflict management, may have a disproportionately positive influence on resilience and retention.

Value Reflection (Category 3)

Value reflection demonstrates that meaningful recognition of nurses' efforts reinforced their sense of professional worth and strengthened their willingness to remain in the profession. Participants described both symbolic appreciation and acknowledgment of their contributions as powerful signals that their work was valued, thereby enhancing motivation, commitment, and resilience. These findings suggest that recognition strengthened nurses' confidence in their professional role and reinforced their sense of belonging within the organization. As an interpretive lens, Social Cognitive Theory helps explain how positive managerial feedback may enhance nurses' self-efficacy, while visible appreciation reinforces organizational norms that value professional contributions[36]. Similarly, the findings indicate that expressions of appreciation contributed to psychological safety by helping nurses feel respected, valued, and confident that their contributions were recognized, thereby strengthening organizational commitment and encouraging retention[37]. Within the Iranian healthcare system, where nurses often report limited professional recognition despite demanding working conditions, even simple expressions of appreciation may have a disproportionately positive influence on professional commitment and retention. These interpretations are consistent with previous research demonstrating that managerial recognition and appreciation enhance nurses' intention to remain in their workplace[24].

Systemic Invisibility (Category 4)

Systemic invisibility reflects nurses' experiences of feeling that their professional competence, commitment, and quality of care were insufficiently recognized by managers and the organization.

Participants perceived that high-performing and less committed nurses were often treated similarly, reducing their motivation and weakening their intention to remain in the profession. These findings suggest that nurses interpreted the lack of recognition not simply as an absence of appreciation but as evidence that individual effort and professional competence were undervalued, gradually weakening their organizational commitment. Viewed as an interpretive lens, Organizational Justice Theory helps explain how perceived deficiencies in distributive, procedural, and interactional fairness may contribute to these experiences[38-43]. Within the Iranian healthcare system, where heavy workloads and limited organizational resources may constrain performance evaluation and recognition, strengthening fair managerial practices may play a critical role in improving nurse retention.

Hierarchical Disconnect (Category 5)

Hierarchical disconnect reflects nurses' experiences of limited dialogue with managers, dismissive responses to criticism, and disrespectful interactions that weakened professional self-esteem and organizational commitment. Rather than feeling heard, participants often perceived that questioning managerial decisions was discouraged, reducing their willingness to express concerns or contribute to organizational improvement. These findings suggest that limited opportunities for open communication gradually weakened nurses' trust in leadership and reduced their sense of influence over their work environment, making continued organizational commitment more difficult. Viewed as an interpretive lens, the concept of organizational silence helps explain how fear of negative consequences may discourage nurses from expressing concerns or participating in organizational improvement[44]. This interpretation is consistent with previous studies showing that organizational silence is associated with lower job satisfaction, reduced work engagement, and stronger intentions to leave the organization[45]. Within the hierarchical and physician-

centered culture of many Iranian healthcare settings, fostering open communication and psychologically safe leadership may therefore be essential for strengthening nurse retention.

Context-Blind Policy Imposition (Category 6)

Context-blind policy imposition reflects nurses' perceptions that managerial decisions were often made without adequate consideration of the realities of frontline clinical practice. Participants described unrealistic expectations, excessive mandatory overtime, and policies that overlooked staffing shortages as major sources of frustration, ultimately reducing their willingness to remain in the profession. These findings suggest that nurses were more likely to become disengaged when managerial decisions failed to reflect the practical realities of patient care, creating a perception that organizational expectations were disconnected from everyday clinical practice.

This interpretation is consistent with findings reported by Kalateh et al., who found that nursing managers in Iran often face human resource shortages and limited managerial authority, leading to decisions that are difficult to implement in clinical settings[46]. Huntington et al. likewise reported that the disconnect between managerial decision-making and frontline nursing practice negatively influences nurses' intention to remain in the profession[47]. Within the Iranian healthcare system, where persistent staffing shortages and resource constraints place considerable pressure on nursing services, ensuring that managerial decisions are informed by frontline clinical realities may strengthen nurses' trust in leadership and improve retention.

Relationship-Based Discrimination (Category 7)

Relationship-based discrimination reflects nurses' perceptions that personal relationships and informal connections were often prioritized over fairness, merit, and organizational regulations. Participants described favoritism in work scheduling, workload distribution, and responses to

clinical errors as experiences that undermined trust in managers and reduced their willingness to remain in the profession. These findings suggest that favoritism weakened retention not only because it created unequal opportunities but also because it reduced nurses' confidence that professional effort and competence would be evaluated fairly. Viewed as an interpretive lens, Social Identity Theory helps explain how preferential treatment of in-group members may reinforce perceptions of exclusion and weaken organizational cohesion[48]. This interpretation is consistent with findings reported by Saadi et al., who found that intra-organizational discrimination contributes to workplace disengagement and nurses' intention to leave [49]. Within the Iranian healthcare system, where managerial discretion may substantially influence access to opportunities and resources, strengthening transparent and merit-based managerial practices may help restore organizational trust and improve nurse retention.

Blaming Culture (Category 8)

Blaming culture reflects nurses' experiences of managerial responses that focused disproportionately on individual mistakes while overlooking their overall performance and professional contributions. Participants described public criticism, harsh reactions to minor errors, and unrealistic expectations as experiences that undermined their professional dignity, created fear of making mistakes, and reduced their motivation to remain in the profession. These findings suggest that punitive managerial responses discouraged nurses from viewing mistakes as opportunities for learning and instead reinforced fear, emotional exhaustion, and reduced confidence in organizational support. Rather than promoting learning and improvement, these punitive managerial practices appeared to weaken organizational commitment and psychological safety. This interpretation is consistent with the review by Okpala et al., which concluded that blaming cultures negatively affect nurse retention, whereas commitment-based management and

learning-oriented organizational approaches can help reduce punitive practices and improve retention outcomes[50]. Within the Iranian healthcare system, where heavy workloads and staffing shortages may increase the likelihood of errors, adopting learning-oriented approaches to clinical errors rather than punitive responses may strengthen psychological safety and improve nurse retention.

The findings of this study should also be interpreted within the broader context of the Iranian healthcare system. Persistent nursing shortages, heavy workloads, centralized managerial structures, limited professional autonomy, and resource constraints appear to intensify the influence of leadership and managerial practices on nurses' decisions to remain in the profession. Under these conditions, leadership behaviors become particularly influential because managers often represent nurses' most immediate source of organizational support, fairness, and professional recognition in an otherwise resource-constrained work environment. Consequently, supportive leadership may partially offset organizational limitations by strengthening nurses' sense of value, fairness, and professional belonging, whereas unsupportive managerial practices may further accelerate turnover intentions.

Although these contextual characteristics are particularly evident in Iran, similar challenges have been reported across many low- and middle-income countries (LMICs). Therefore, the present findings may provide useful insights for healthcare systems facing comparable workforce shortages and organizational constraints, emphasizing that strengthening leadership and managerial practices represents a feasible and potentially high-impact strategy for improving nurse retention, even when financial and structural resources are limited.

Strengths and Limitations

Strengths

This study used a strong inductive qualitative design with in-depth semi-structured interviews, enabling a rich exploration of nurses' lived experiences. Data saturation was achieved through purposive sampling, enhancing the credibility of the findings. The focus on the unique socio-cultural healthcare environment was a strength. Researcher bias was reduced through bracketing, reflective note-taking, member checking, and independent coding by two authors. Peer debriefing and expert validation further strengthened analytical rigor. The findings provide practical insights for healthcare policymakers, emphasizing leadership empathy, procedural justice, and anti-discrimination actions to strengthen retention.

Limitations

Pre-existing professional relationships between researchers and some nurses, despite reflexive efforts, may have influenced data collection. However, these relationships facilitated a level of trust and rapport that may have encouraged participants to share more honest and deeper narratives of their experiences, potentially enriching the data. Like other qualitative studies, this research has limitations in generalizability. Although the results may be transferable to similar settings, they are not generalizable. It is noteworthy that the social and cultural conditions of the society may influence the study results; therefore, similar studies should be designed and implemented in different societies to confirm the findings.

Conclusion

The findings of this qualitative study demonstrate that nurse retention is shaped not only by workforce shortages or financial incentives but, more fundamentally, by everyday leadership and managerial practices. Supportive, human-centered leadership that values nurses, promotes

fairness, and responds to frontline realities strengthens professional commitment, whereas hierarchical, discriminatory, and punitive management practices gradually erode nurses' willingness to remain in the profession. Within the Iranian healthcare system, where resource constraints, high workloads, and physician-centered organizational structures intensify these challenges, transforming leadership from a source of occupational distress into a source of professional support should be considered a strategic priority. These findings also provide valuable insights for other low- and middle-income countries facing similar workforce challenges.

Implications of the Study

Clinical Practice Implications

The findings of this study suggest several practical actions for healthcare organizations. Because Human-Centered Leadership emerged as one of the strongest facilitators of nurse retention, nursing managers should receive competency-based leadership training focusing on crisis support, empathic communication, managerial advocacy, and non-judgmental conflict resolution. Similarly, the findings related to Value Reflection and Hierarchical Disconnect indicate the need for hospitals to establish formal mechanisms that protect nurses' professional dignity, including confidential reporting systems for disrespectful managerial behaviors and structured procedures for addressing workplace conflicts. Furthermore, the Blaming Culture category highlights the importance of replacing punitive responses to clinical errors with constructive feedback and learning-oriented review processes that emphasize system improvement rather than individual punishment. Implementing these strategies may strengthen nurses' psychological well-being, organizational commitment, and retention.

Policy Implications

At the policy level, the findings related to Relationship-Based Discrimination, Systemic Invisibility, and Hierarchical Disconnect support integrating leadership competencies related to fairness, respectful communication, transparency, and staff support into the performance evaluation criteria for nursing managers. In addition, because participants consistently described humiliating managerial behaviors and punitive organizational cultures as barriers to retention, national nursing authorities and healthcare policymakers should develop organizational standards that promote psychologically safe work environments, prohibit disrespectful managerial practices, and establish accountability mechanisms for monitoring respectful leadership behaviors. Such policy initiatives may contribute to improving nurse retention in Iran and provide practical guidance for other low- and middle-income countries facing similar workforce challenges.

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

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Ethics declarations

Ethics approval and consent to participate: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This study was conducted as part of a PhD nursing dissertation after receiving ethical approval code (IR.SBMU.PHARMACY.REC.1403.130) from the Regional Ethics Committee of Shahid Beheshti University of Medical Sciences. Written informed consent was obtained from each participant before starting the interviews, ensuring their voluntary and informed participation.

Consent for publication

Not Applicable.

Competing interests

The authors declare no competing interests.

Author contributions

R.H., R.M., V.Z., F.G., and L.V. conceived the study and performed the data analysis. R.H., V.Z and L.V. performed the data collection and drafted the manuscript. L.V, R.M., V.Z., and F.G. contributed their experience and reviewed the manuscript. V.Z reviewed and revised the idea and study design and received the grant. R.M and L.V. helped edit the manuscript and participated in checking the auditability of the findings. All authors have read and approved the final manuscript. V.Z. and R.H. are the guarantors of this work and take all responsibilities for this study.

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Table 1. Representative examples of the analytical progression from raw interview data to categories

Meaning Unit (Participant quotation)	Condensed Meaning Unit	Initial Code	Subcategory	Category
"...the supervisor joined us during the staff shortage, helped us with patient care, and encouraged us. His presence gave us the strength to stay." (P1)	Supervisor provided practical help and emotional encouragement during staff shortage.	Emotional and practical support	Crisis advocacy	Human-centered leadership
"...the matron stood up for me when the physician blamed me unfairly. Her support was truly encouraging." (P2)	Matron defended the nurse against unfair blame.	Managerial advocacy	Nurse advocacy	Human-centered leadership
"...the new matron invited nurses who had resigned to return because she valued them and cared about their working conditions." (P5)	Manager showed genuine concern for nurses and encouraged former staff to return.	Valuing nurses	Attention to professional concerns	Human-centered leadership
"...when preparing the work schedule, she always considered our requests whenever possible." (P5)	Manager considered nurses' scheduling requests.	Flexible work arrangements	Flexible work scheduling	Structuring for resilience
"...priority was always given to senior nurses with close relationships to the head nurse. That unequal treatment made me want to leave." (P6)	Favoritism created feelings of unfair treatment and intention to leave.	Perceived injustice	Merit neglect	Systemic invisibility

Table 2. Socio-Demographic Characteristics of Participants (Anonymized)

Participants ID	Age-Ranges	Hospital Type	Clinical Department
1	31-35 years	Private	ER*
2	31-35 years	Public	ICU**
3	31-35 years	Public	CCU***

4	31-35 years	Private	NICU****
5	26-30 years	Public	Medical ward
6	31-35 years	Private	Surgical ward
7	31-35 years	Public	CCU
8	26-30 years	Public	ICU
9	41-45 years	Private	Pediatric
10	36-40 years	Public	NICU
11	41-45 years	Private	Medical ward
12	46-50 years	Public	ICU
13	36-40 years	Private	Surgical ward
14	36-40 years	Private	ER
15	46-50 years	Public	Medical ward

*Emergency room ** Intensive Care Unit *** Cardiac Care Unit **** Neonatal Intensive Care Unit

Table 3. Categories and Subcategories of Leadership and Managerial Factors Affecting Nurse Retention

Category (Theme)	**Subcategory (Subtheme)**
1. Human-Centered Leadership	Crisis Advocacy
	Nurse Advocacy
	Attention to Professional Concerns
2. Structuring for Resilience	Flexible work scheduling
	Conflict Resolution
	Workflow Optimization
3. Value Reflection	Symbolic Recognition
	Professional Dignity Preservation
	Appreciating efforts
4. Systemic Invisibility	Merit Neglect
	Uniform Performance Perception
	Reducing nurses to routine task performers
5. Hierarchical Disconnect	Unidirectional Communication
	Humiliating Conduct

	Criticism Intolerance
6. Context-Blind Policy Imposition	Field-disconnected decision-making
	Unrealistic Expectations
	Workload Pressure Neglect
7. Relationship-Based Discrimination	Favoritism over Merit
	Unequal Opportunity Distribution
	Inequality in auditing errors
8. Blaming Culture	Minor Error Magnification
	Impossible expectation
	Humiliating Responses