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CFNU
CANADIAN FEDERATION OF NURSES UNIONS

TODAY'S NURSE:

What contemporary Canadian nurses need to stay in the workforce for the longevity of their career

Dr. Kim McMillan, RN, PhD, CHPCN(C)

About the CFNU

The Canadian Federation of Nurses Unions (CFNU) is Canada's largest nurses' organization, representing frontline unionized nurses and nursing students in every sector of health care – from home care and LTC to community and acute care – and advocating on key priorities to strengthen public health care across the country. We are proud to advocate for our members and promote the nursing profession on the national level, and we work tirelessly to protect the quality of health care for our patients and our universal public health care system.

Land acknowledgement

From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis and First Nations Peoples that call this land home. The Canadian Federation of Nurses Unions is located on the traditional unceded territory of the Algonquin Anishnaabeg people. As settlers and visitors, we feel it's important to acknowledge the importance of these lands, which we each call home. We do this to reaffirm our commitment and responsibility to improve relationships between nations, to work towards healing the wounds of colonialism and to improve our own understanding of local Indigenous Peoples and their cultures.

Report author

Dr. Kim McMillan, RN, PhD, CHPCN(C), is an Associate Professor of Nursing, University of Ottawa, whose program of research focuses on the intersection of organizational life and ethical, relational and political nursing practice, exploring how nurses experience and navigate their practice within highly complex health care systems.

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MESSAGE FROM LINDA SILAS, CFNU PRESIDENT

Nurses are leaving their jobs in unprecedented numbers across all career stages and for many reasons. As the largest group of health care professionals in Canada, nurses are highly skilled, trained in both clinical skills and leadership, and form the backbone of our health care system.

Canada remains in the middle of a critical nursing shortage. We are falling behind population growth and rising health care demands from an aging population. At a time when human resources are already stretched thin, the health care system simply cannot afford to lose any more nurses.

We must urgently re-evaluate and invest in the needs of today's nurses to ensure nursing is a job of choice in our communities and there are enough nurses to meet population needs. This means listening to nurses and making the changes they care about and that will help keep them in the profession.

For decades, nurses' unions have been advocating for workplace and policy changes that are needed to retain nurses and support them to do their jobs effectively. As early as 2002, the Canadian Nursing Advisory Committee, of which I was a member, recognized an emerging crisis in health human resources. The recommendations from the committee, published in the report *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses*, aimed to address the last nursing shortage by increasing the supply of nurses and improving working conditions. Yet, these challenges remain with us today.

The CFNU built on this foundation by commissioning and publishing key research on the evolving needs of nurses, especially across generations. The first publication of this type was *Retaining and Valuing Experienced Nurses* (2006), followed by *From Textbooks to Texting: Addressing Issues of Intergenerational Diversity in the Nursing Workplace* (2009), and *Bridging the Generational Divide* (2015). Furthermore, several pilot projects enacting the research findings were implemented beginning in 2008 with support from Health Canada through the Research to Action project with positive effect (Silas, 2012). These studies examined how nurses' work life needs change over the course of their careers and contributed to developing CFNU's advocacy priorities. Many of the recommendations put forward in these reports are still relevant today because there has been a persistent throughline of inaction, despite constant advocacy from the CFNU.

We are in a new era of nursing workforce challenges, and the *Today's Nurse* research revisits the breadth of issues that nurses face and looks directly to frontline workers for answers. The expectations of the workforce have changed significantly in recent years, especially since the COVID-19 pandemic. We have seen the rise of the gig economy, growing demand for flexibility and a greater focus on work-life balance across all areas of work. In many ways, nursing as a 24/7 profession with deeply entrenched norms has not kept pace. Nurses are highly educated professionals with options to enter other fields that may better align with their personal and professional priorities if misalignments continue unresolved. Several of these issues are discussed further in CFNU's work on the issues of violence in the workplace, safe hours of work, private for-profit nursing agencies and

nurse-patient ratios. Understanding and responding to evolving needs is a critical role for unions. As the profession changes, the supports and conditions we fight for must also change. The decisions made today will shape the future of nursing in Canada for years to come.

Today's Nurse crystallizes decades of knowledge and research through the voices of nurses themselves, using the framework of respect, engagement and protection. The nurse-led recommendations outlined in this report offer a comprehensive modern roadmap to meet the needs of Canada's nursing workforce in 2025 and beyond.

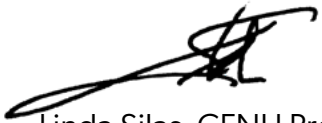
This latest research builds on CFNU's broader body of work aimed at strengthening the nursing workforce, such as *Sustaining Nursing in Canada* (2022), which examined the root causes of nurse attrition across the country and provided policy recommendations to improve retention. In collaboration with World Education Services (WES), the CFNU co-published *Bolstering Pathways to Practice: Empowering Internationally Educated Nurses in Canada* (2025), which explored barriers to integration and actionable solutions to support internationally educated nurses in Canada. Furthermore, the CFNU released *Investing in the Future: Eliminating Financial Barriers for Nursing Students* (2025), a national survey report that revealed the financial stressors facing nursing students and the urgent need for improved supports. Most recently the CFNU released *Redefining Nurse Staffing to Revolutionize Health Care in Canada*, which was a report on the first National Nurse-Patient Ratios Summit in 2024 and which recommended implementing nurse-patient ratios nationally as a key action to stabilize the nursing workforce. These reports, together with *Today's Nurse* and recommendations in Health Canada's *Nursing Retention Toolkit*, form a growing body of evidence and insight to guide decision-makers in building a more sustainable, equitable and resilient nursing workforce.

We have seen the consequences of ignoring early warnings. If past recommendations had been implemented, we might not be in the staffing crisis we now face. Nurses have shared, in detail, the reality of their working lives. It is time to listen. Canada needs every nurse we have – and more. We need them to feel safe, respected and fulfilled, so that they choose to stay in the profession until they are ready to retire.

There has been more than enough analysis and contemplation. Now is the time to act decisively to protect Canada's health care system. We know that if nurses are respected, protected and engaged professionally and personally, they will stay.

On behalf of the Canadian Federation of Nurses Unions, I would like to thank Dr. Kim McMillan and her research team for conducting this critical work. I would also like to express my sincere appreciation to the members of CFNU's project advisory committee Jeannine Arbour of UNA, Matt Hiltz of NBNU, Cait Jarvis of BCNU, Tiffany McEwan (past president) of CNSA and Shrushti Patel of CNSA for their valuable input and guidance in this work.

In solidarity always,



Linda Silas, CFNU President

MESSAGE FROM DR. KIM McMILLAN, RN, PHD, CHPCN(C)

As I reflect on the focus groups and the subsequent findings in this report, I am once again reminded of how much nurses contribute to the Canadian health care system. This report makes clear that nurses are the glue holding this system together. However, they are doing so at great cost, without adequate and necessary supports, resulting in devastating consequences for nurses and the entirety of the Canadian health care system.

Nurses work in environments that increasingly feel unsafe. Nurses feel their safety, both physically and mentally, is increasingly under attack, without adequate measures in place to both prevent and remediate safety violations. Nurses are increasingly experiencing physical violence at work, and their mental health is also declining as a result of current workplace challenges. Nurses are urging employers and governments to take swift action to bolster supports that will keep nurses physically and mentally safe at work, notably, this includes enhanced security measures in workplaces and uncapped employer-funded access to professional mental health services. Nurses are also experiencing daily threats to their professional integrity; current workloads and inadequate resources make it very difficult for nurses to uphold professional standards required of them by licensing bodies. This is not only a matter or protecting nurses' professional licences, it is an urgent matter of patient safety.

Nurses are incredible problem solvers; problem-solving is central to nursing work. Nurses spend tremendous amounts of time in health care settings, and as such have a myriad of tangible, pragmatic and well thought out solutions to some of health care's most pressing problems. Nurses' problem-solving abilities must be better leveraged at all levels of health care decision-making, ranging from decision-making within their own units and departments through to decisions made at provincial and national levels. Nurses must also be more centrally involved in decisions that impact their day-to-day work, particularly pertaining to scheduling and workload. Engaged nurses, whose insights are valued and utilized in decision-making, are more likely to stay in the workforce.

Nurses are highly skilled health professionals who have lifelong learning goals and aspirations and who wish to advance their knowledge and skills across the entirety of their career trajectory. When we give nurses these opportunities, we invest in the welfare of all people in Canada, who deserve access to highly skilled nurses. Doing so also demonstrates much-needed respect for nurses. Nurses are also employees – who deserve the right to articulate work-life boundaries and to have those boundaries respected by employers. Currently this is not the case; repeated and ongoing disrespect for nurses' work-life boundaries is contributing to widespread burnout. Respecting nurses' work-life boundaries is imperative in fostering longevity in the workforce.

What surprised me most in the context of this particular study was the frequency at which nurses spoke of their moral experiences. In my own area of research outside of this particular study, nurses' moral experiences are central to the questions I ask nurses, so I am not surprised when the topic becomes central to an interview or focus group. However, in the context of this study, I did not ask them outright about the moral complexities of their work; I asked them a very pragmatic question: "What do you need to stay in the nursing workforce, in Canada, until you wish to retire?" – yet every focus group quickly evolved into discussions of nurses' moral distress and moral injury, without prompt or probe. I believe this is an incredibly significant finding – suggesting that all of the tangible things that nurses need in their day-to-day work, many of which have emerged in the findings of this study, are also deeply woven into nurses' moral experiences. I believe that when we attend to nurses' central needs – to be protected, to be engaged and to be respected – we will also attend to nurses' needs for morally congruent nursing care, care that is provided in ways that align with nurses' deeply held moral commitments. Doing so will attend to much of the suffering nurses recounted during data collection.

I am incredibly grateful to all the nurses who participated in this research, who took time out of their busy days and schedules to share their experiences – experiences that were likely not always easy to share. Your participation reflects a profound commitment to improving practice environments and strengthening the future of nursing in Canada. This work would not have been possible without your candour – thank you.

I want to acknowledge the Canadian Federation of Nurses Unions for undertaking this important work and for entrusting me and my research team to see it through. Thank you for your ongoing national advocacy and commitment to the nursing workforce.

I would like to acknowledge my research team, who have been instrumental in the execution of this research: Marianne Sofronas, RN, PhD, Research Associate (QC), Chaman Akoo, RN, MScN, Research Associate (BC), and Andrea Bentz, RN, PhD candidate, Research Assistant (ON). Thank you for your dedication to this project and for your ongoing contributions to nursing in Canada.

Lastly, I would like to acknowledge Dr. Sheri Lynn Price, without whom I would not have had this opportunity. Thank you.

Sincerely,

Kim McMillan, RN, PhD, CHPCN(C)

Associate Professor, School of Nursing, University of Ottawa

1.0 Background and project purpose

1.1 Chronic nursing shortage

Canada is experiencing a chronic shortage of nurses exacerbated by the pandemic. This chronic shortage has now resulted in a national staffing crisis (Ahmed & Bourgeault, 2022). There was an estimated shortage of 60,000 nurses for 2022, and it is projected that we will be short over 117,000 nurses by 2030 in the Canadian workforce (Canadian Nurses Association [CNA], 2009; Murphy et al., 2012; Scheffler & Arnold, 2019). Nursing vacancies for the fourth quarter of 2024 were estimated to be 35,760 (StatsCan, 2024).

1.2 Attrition is higher than ever: need recruitment as well as retention strategies

Many of the concerns that see nurses leaving the profession predate the pandemic but have been significantly exacerbated to a level that is now drastically impacting the nursing workforce. In 2010, the mean nurse turnover rate in Canadian hospitals was just under 20% (O'Brien-Pallas et al., 2010). Over a decade later, reports show that now 1 in 4 practicing Canadian nurses intend to leave their current nursing job in the next four years (StatsCan, 2022). While 2025 data from Canadian Federation of Nurses Union members survey suggests 20% of respondents intend to leave their current job, 10% intend to leave the profession and 7% to retire within one year (CFNU, 2025). Urgent strategies are needed to address increased rates of sick leave, unprecedented burnout and early retirement in the nursing workforce following the pandemic (Baumann & Crea-Arsenio, 2023), in addition to nurses who do not return to the workplace following a leave of absence.

1.3 Unsuccessful recruitment strategies

There are not enough new graduate nurses in Canada to address the current shortage: in 2023, there were approximately 12,000 new graduate nurses eligible for licensure in Canada (CASN, 2024). However, new graduates leave the profession at the same rate as more senior nurses (StatsCan, 2022). This suggests that new graduates are not the sole solution to the nursing workforce crisis. Another strategy to offset the Canadian nursing shortage involved increased recruitment of internationally educated nurses [IENs], however, this strategy is currently inadequate (Baumann & Crea-Arsenio, 2023); only approximately one third of IENs in Canada are currently employed in nursing (McGuire-Brown, 2025). Other policy responses to address nursing shortages in Canada were to increase the number of unregulated workers to replace some aspects of nursing work. However, this strategy risks compromising professional care by effectively diminishing the number of registered nurses involved in direct care (Baumann & Crea-Arsenio, 2023).

1.4 Role of retention strategies

In addition to recruitment strategies, it is critical that turnover be managed by attending to retention to keep nurses at all career stages in the workforce, ensuring safe and stable working conditions and quality patient care (O'Brien-Pallas et al., 2010). Retention is also a good economic strategy, with the cost of nurse turnover in terms of lower productivity of new hires [as they learn and adapt to the

environment], and hiring and training new staff estimated as between $5,000-$15,000 (Hayes et al., 2012). In a systematic review of factors influencing retention in hospital nurses (Marufu et al., 2021), nine domains influencing staff turnover were identified.

1. Nursing leadership and management (management style and support, recognition, access to management, visibility of managers, incivility);
2. Education and career advancement (opportunities for education and staff development, career advancement);
3. Organizational (work) environment (organizational and team climate, lack of resources, health and safety concerns, physician dominance impacting professional pride, lack of empowerment in participating in hospital affairs, workplace violence);
4. Staffing levels (low staffing, shortages, inflexible scheduling, lack of access to breaks and time off);
5. Professional issues (job stress and satisfaction, workload, burnout, pressure, emotional exhaustion, skill set outdated, quality of care, autonomy);
6. Support at work (peer support, mentorship, orientation, cynicism);
7. Personal influences (personal health, family caregiving, work-life balance);
8. Demographic influences (age, education, gender); and
9. Financial remuneration.

1.5 Why are nurses leaving?

There is robust literature highlighting nurses' chief concerns, which include chronic staffing shortages, psychologically unsafe work environments and consequential burnout. Collectively these factors have resulted in increased leave of absences, intent to leave the nursing profession and actualized attrition – across all career stages in nursing (StatsCan, 2022). As the largest group of health care professionals, nurses understand the terrain and what is needed to sustain the health care system in the long term. It is critical that we listen to and document what nurses need to stay in the nursing workforce in the current Canadian health care climate, as has been done in the recent *Nursing Retention Toolkit* published by Health Canada (Health Canada, 2024). The comprehensive toolkit, accounting for micro, meso and macro levels, provides instrumental guidance in fostering retention at all career stages.

2.0 Study purpose and research questions

The purpose of this study was to examine the needs of the modern Canadian nurse as an employee, noting that today's workers and the landscape of the workforce are changing in ways that include employees' greater need and demands for work-life balance. It is important to examine how nurses' needs and demands have also been affected by this evolution in the broader Canadian workforce.

2.1 Research question(s)

1. a. What do Canadian nurses across career stages feel they need to stay in the profession for the longevity of their careers?
   b. In particular, what is needed to make a job attractive to a nurse, including hours of work, support, workload?
2. What are current motivators that keep nurses in the workforce, and how do nurses believe these motivators could be better leveraged to enhance long-term retention?

3.0 Comprehensive literature review

Literature review methodology

This review outlines current knowledge on nursing retention from international academic literature. Qualitative focus group methodology was utilized following an integrative review of relevant empirical and conceptual (Whittemore & Knafl, 2005) literature from 2000 to 2025. Findings include individual characteristics of nurses, interpersonal components of nurses' relationships with others in the context of their work environment, and organizational factors that support or jeopardize retention. With individual characteristics we include features that impact retention of nurses at different career stages and in different nursing roles. Interpersonal components encompass mentorship, professional collaboration, leadership practices, as well as bullying, incivility and lateral violence. Organizational and systemic factors comprise aspects of the work environment, compensation, staffing, acuity and organizational justice. The literature reports predominantly on the registered nurse experience, demonstrating a gap in knowledge on retention of licensed practical nurses, registered psychiatric nurses, advanced practice nurses and nurse practitioners.

3.1 Individual characteristics

Although a small subset of the literature examined the individual characteristics of nurses as a factor impacting retention, these studies overwhelmingly pointed to organizational strategies to enable nurses to thrive in the workplace. The most frequently examined was exhaustion. Nurses' intention to leave is directly predicted by levels of exhaustion (Rahnfeld et al., 2023). Among Canadian perioperative nurses, emotional exhaustion was associated with decreased job satisfaction and increased intention to leave (Lee et al., 2020). Emotional exhaustion coupled with high job demand heightened intention to leave (Rahnfeld et al., 2023).

Other individual factors included motivation, self-sacrifice and value congruence. A study of newly licensed nurses in Quebec reported that motivation due to internal or external pressure was positively associated with intention to leave, as opposed to motivation associated with a sense of satisfaction or valuing one's work (Fernet et al., 2017). In a qualitative study of Canadian nurses, self-sacrifice as an individual quality and an aspect of unit culture had detrimental effects on recruitment and retention (Ciezar-Andersen & King-Shier, 2021). Finally, an American study argued that nurses whose values matched their organization's values had higher retention; the authors also recommended enhancing nurse-patient ratios and professional autonomy (Dotson et al., 2014).

3.1.1 Professional identity

The ability to enact one's professional identity, practice to one's full scope, have one's expertise recognized and engage in high-involvement work practices all enhanced retention as long as workload remained manageable (Mlambo et al., 2021). Nurses' professional self-image is linked to their work environment; the opportunity to develop professionally, be cognizant of organizational changes, valued as professionals and enjoy autonomy in carrying out their work mediated intention to leave (Chênevert et al., 2016; Kilroy et al., 2022). High-involvement work practices and colleague support were also shown to alleviate burnout (Kilroy et al., 2022). For public health nurses in Canada, retention required ongoing training, meaningful work and adequate time to do their jobs (Armstrong-Stassen & Cameron, 2005). In a study of home care nurses in Ontario, intent to remain

employed was associated with higher nurse-evaluated quality of care delivery, greater variety of patients and greater meaningfulness of work (Tourangeau et al., 2017).

Practicing to one's full scope of practice was associated with enhanced retention among Canadian critical care nurses (Phillips et al., 2024). In a systematic review of job satisfaction among critical care nurses, autonomy was significantly related to job satisfaction (Dilig-Ruiz et al., 2018). A study of oncology nurses in Ontario highlighted organizational practices that attract and retain nurses: professional recognition and opportunities for professional development were critical to job satisfaction and organizational commitment (Bakker et al., 2010). In a large international study, having greater independence and control over their practice area and greater involvement in decisions impacting patient care were significant factors in nurses' likelihood to remain in nursing (DeCola & Riggins, 2010). In a study of Canadian public health nurses, autonomy was the most important factor in job satisfaction, though it may become problematic when combined with an excessively heavy workload (Graham et al., 2011). Among public health nurses in Ireland, professional status, interaction and autonomy contributed most to job satisfaction (Curtis & Glacken, 2014).

3.1.2 Generational nursing

Comparative studies showed that nurses from different generations share some common features. Nurses across generations in Ontario and Alberta prioritized the same incentives: reasonable workloads and manageable nurse-patient ratios (Tourangeau et al., 2013). Quebec nurses from Generation X and Y had similar perceptions of their work environment and intentions to leave (Lavoie-Tremblay et al., 2011). Despite these similarities, to support retention at all career stages – early-career, mid-career and senior nurses nearing retirement – it is important to consider generational differences. There is a great deal of variability in how different generations are defined in literature; therefore this review considered tenure in the profession, stratified from 0-5 years, 6-15 years and >15 years.

3.1.3.1 Early-career nurses

Early-career and newly graduated nurses are those who are just entering practice or have less than 5 years of experience. Early-career nurses face a multitude of challenges that lead to heightened turnover: adjusting to the realities of the profession, integrating into a new organization and team, and acquiring the skills and expertise to function independently (Song & McCreary, 2020). In a study of new nurses in Canada, high job demands and lack of support from co-workers were related to intention to leave (Peterson et al., 2011). For newly graduated nurses in Quebec, high anticipated turnover was observed among those expressing an imbalance between effort and reward and lack of social support (Lavoie-Tremblay et al., 2008). Newly graduated nurses in Atlantic Canada were less likely to leave if they integrated a nursing practice model and internalized their organization's goals (Rhéaume et al., 2011).

3.1.3.2 Mid-career nurses

With developing skills and expertise based on 6-15 years in practice, mid-career nurses prioritized positive work environments, possibilities for career development, and congruence between their values and those of their organizations. For mid-career intensive care unit nurses in Ontario, increased retention was linked to a positive work environment, which included respect, flexibility, rewards, team building, staffing, education and extraprofessional benefits (Lobo et al., 2012). An American study found nurses with both job satisfaction and opportunities for career development showed higher

retention (Yarbrough et al., 2017). Leiter et al (2009) reported that a mismatch between personal and organizational values was associated with a greater susceptibility to burnout and a stronger intention to quit among Generation X mid-career nurses.

3.1.3.3 Late-career nurses

Late-career or senior nurses are those with over 15 years of experience. Studies reported that this generational cohort had the highest rates of retention and job satisfaction, and the lowest intention to leave (Pressley & Garside, 2023). This was observed among American nurses (Blake et al., 2013; Klaus et al., 2012), public health nurses in Ireland (Curtis & Glacken, 2014), and Canadian nurses in Alberta (Osuji et al., 2014) and Ontario (Wilson et al., 2008). Because late-career nurses play an important role in mentorship and sharing expertise with the next generation, it is important to implement strategies to ensure they remain in the workforce for as long as they would like (Health Canada, 2025). Some have recommended lower workloads and flexible scheduling to delay retirement for senior nurses, as well as workplace modifications following ergonomic principles to decrease injury and improve productivity (Health Canada, 2025; Stichler, 2013).

There is also evidence that senior nurses want to continue being challenged in their practice with training opportunities, performance evaluations and professional recognition (Armstrong-Stassen et al., 2014; Mlambo, 2021). A systematic review of interventions that promote retention and job satisfaction of experienced nurses in health care settings identified teamwork, mentoring and leadership opportunities, and in-depth orientation (Lartey et al., 2014). Kwok et al (2016) recommended that collective agreements include provisions to retain nurses nearing retirement.

3.1.3 Considerations for rural and remote nursing

Nurses practicing in rural and remote settings have unique practice environments and work-life considerations. The challenges and complexities of rural nursing practice intersect with long-standing power inequities inherent in rural marginalization and resource scarcity which call for additional considerations for recruitment and retention. As McCallum and colleagues (2024) have pointed out, rural practice differs significantly from what is taught in nursing schools, and recruitment efforts that glorify northern nursing risk unintentionally endorsing colonial systems that continue to threaten Indigenous communities.

Financial incentives can potentially support nursing recruitment and retention in rural and remote areas in the short term, but long-term efficacy is low (Russel et al., 2021). An umbrella review on the recruitment and retention of nurses in rural, remote or isolated regions supported the use of financial incentive programs (Mbemba et al., 2013). Tuition reimbursement for recent graduates from rural and remote communities increased recruitment in underserved communities in Canada (Baumann & Crea-Arsenio, 2023). Recruitment and retention in rural and remote parts of Canada can be enhanced by way of providing additional educational opportunities and support for the families of recruits (Kulig et al., 2015). Retention is strengthened by access to additional rural and remote nursing-specific training (Russel et al., 2021), including the necessary supports to ensure nurses feel confident in delivering care that is trauma-informed and culturally safe (Webb et al., 2023). Other factors that impact rural nurse retention include obtaining leadership roles, higher professional autonomy, collaborative relationships and teamwork, and access to information and communication technologies. In addition, investment in community infrastructure, a sense of belonging in the community and an appreciation of a rural lifestyle were all associated with rural and remote nurse

retention (Henderson Betkus & MacLeod, 2004; Mbemba et al., 2013; Roberge & Lavoie, 2008; Stewart et al., 2011; Tallman & Bruning, 2005).

3.1.4 Internationally educated nurses and racialized nurses

There is a gap in peer-reviewed literature on retention of IENs and racialized nurses. Two studies emerged from the literature search on IENs, but they did not address retention. However, they did outline the obstacles that IENs encounter in establishing their practice in new countries, providing direction for where to target interventions. In the first study, a qualitative study of Ontario IENs, participants identified hurdles at every step: the migration process, navigating the regulatory system, attaining educational standards, meeting language requirements and integrating into the workplace (Blythe et al., 2009). In a discussion paper on diversity and the work environment, Kingma (2008) examined the consequences of nurse migration. They argued that greater diversity offers opportunities for excellence in transcultural nursing, pointing to the International Council of Nurses' position statement on ethical nurse recruitment (International Council of Nurses [ICN], 2018). However, it can also be fertile grounds for discrimination, harassment and isolation. Although international career moves can be personally and professionally rewarding for nurses, promoting job satisfaction and excellence in practice while supporting retention, there are also drawbacks and costs. These include exploitation that is compounded by language barriers, lack of regard for IENs' expertise and past work experience, and the professional toll of 'deskilling' – the loss of skills due to lack of regular practice or active use (Kingma, 2008).

As with IENs, there is sparse literature on nurse retention for racialized nurses. Two studies with cross-cutting themes that highlight the individual, organizational and systemic costs of not addressing discrimination and violence towards racialized nurses were found in the literature search. The first study is a critical interpretive study on how interpersonal, institutional and structural racism intersect with the professional experiences of racialized nurses in Canada (Beagan et al., 2023). Participants experienced racism from nursing education instructors, patients, colleagues and managers from their entry to nursing education, persisting throughout their careers. Racialized nurses experienced interpersonal racism in the form of comments and actions from patients; but what impacted them more significantly was the lack of support from colleagues and managers. Institutional racism was described as extra scrutiny, heavier workloads and absence in leadership opportunities. Structural racism manifested as assumptions of incompetence, invisibility and, at times, hyper-visibility and expectations of assimilation (Beagan et al., 2023).

Second, a qualitative study examined the everyday nature of gendered and racialized violence towards nurses (Choiniere et al., 2010). The data showed that nurses' work is dangerous, precarious, and fraught with tensions and violence that are informed by gender, race, class and culture. These findings have even greater resonance considering the increased diversity of the Canadian population and nursing profession, including the growing numbers of IENs. The authors also argued that the gendered assumptions about nurses' work served to devalue care, contributed to a diminished appreciation of nursing work and a normalization of violence, which was further exacerbated for racialized nurses (Choiniere et al., 2010).

3.2 Interpersonal components

Mentorship and professional collaboration are critical elements of a supportive work environment, impacting other factors pertaining to retention. In a systematic review of factors impacting nursing retention, efforts to improve organizational culture and the work environment were found to foster greater collaborative relationships among nurses, with managers and other health professionals, which, in turn, would support organizational commitment, or a nurse's desire to remain employed with their current institution (Marufu et al., 2021). In this section, we review data on collaboration and mentorship within the nursing profession (intra-professional), as well as collaboration with health professionals outside nursing (inter-professional).

3.2.1 Intra-professional collaboration and mentorship

Relationships with nursing colleagues are critical to retention. An integrative review of job satisfaction among primary care nurses reported that the quality of relationships among staff and recognizing the value of colleagues was an important factor in nurses' intention to leave (Halcomb et al., 2018). A qualitative study of nurses in British Columbia reported that decisions to leave practice were influenced by ineffective working relationships and gaps in leadership support (Hayward et al., 2016). This finding was supported by Fernet and colleagues (2021): among French-Canadian nurses, turnover intention was mediated by supportive relationships with immediate supervisors and co-workers.

Nowhere is mentorship more important than in the integration of new nurses, especially newly graduated nurses. Formal and informal mentorship have the potential to transform workplace cultures and environments, help nurses become competent and efficient in their roles, increase professional skills and contribute to retention (Berezuik, 2010). In a systematic review of interventions that health care organizations could undertake to increase retention of new nurses, Salt and colleagues (2008) found that the most effective strategy was a 3–6-month preceptorship program, with a more recent systematic review of nurse residency programs effectiveness on new graduate nurse retention (Mohamed & Al-Hmaimat, 2024) advocating for residency programs spanning a minimum of 12 months. Halcomb et al (2018) reported that retention was highest when interventions such as mentoring and in-depth orientations were used to support staff. Mentorship relationships extended far beyond the formal orientation period, and the relational connection with a more experienced colleague was highly valued by new nurses in Canada, contributing to their sense of empowerment, engagement and self-actualization (Dames, 2019; Ferguson, 2011). Conversely, the absence of a mentor for new nurses contributed to a sense of chronic stress and lack of employer support, leading to sick calls/absenteeism as a coping mechanism (Dames, 2019).

Mentorship also benefits mentors. A phenomenological study of intergenerational preceptorship among nurses in Eastern Canada showed that both parties reported feeling affirmed and challenged: preceptees had direction to navigate a path towards competence, and preceptors benefited from the opportunity to hone their teaching approaches (Foley et al., 2020). A Canadian hospital developed an initiative in forensic psychiatry to encourage nurses over age 55 to remain in the workforce by providing opportunities to coach new graduate nurses, which was beneficial to retention for both groups (Thorpe et al., 2009).

Despite these promising findings, it is important to point out that nursing shortages and attrition – the departure of nurses from their positions or from the profession – complicate mentorship and intra-professional collaboration. Senior staff nurses in Ontario reported feeling immense pressure to

continuously mentor new graduates, which contributed to burnout among senior nurses and a lack of confidence and perceived lack of support in new graduate nurses (McMillan et al., 2023). In a review article, Bally (2007) argued that the impact of mentorship on organizational culture should be investigated as a long-term solution rather than a short-term task. Since the goals and qualities associated with strong mentorship and strong leadership were closely aligned, mentoring programs rooted in organizational cultures would lead to improved staff retention and job satisfaction (Bally, 2007).

3.2.2 Inter-professional collaboration

Positive collaborative relationships with inter-professional colleagues, particularly physicians and surgeons, contributed to job satisfaction and retention. In a study of Italian hospital-based nurses, the quality of inter-professional relationships was an important factor in nurses' sense of belonging and swayed their decision to leave their job (Galletta et al., 2013). Among Canadian perioperative nurses, the nurse-physician relationship was significantly related to job satisfaction (Lee et al., 2020). An ethnographic study of operating room nurses in Canada also showed that nurse retention was enhanced by professional recognition and positive relationships with surgeon colleagues (Laflamme et al., 2019). In a study of pediatric intensive care nursing in Canada, acquiring nursing expertise and mutual respect between nurses and physician colleagues was a key factor in retention; the authors attributed this shift to breaking down the power imbalance that exists between nursing and medicine (Mahon, 2014). Among intensive care nurses in Manitoba, poor nurse-physician collaboration was one important aspect influencing nurses' intent to leave their practice environment (Sawatzky et al., 2015).

3.2.3 Leadership practices

Leadership practices and their association to nursing retention are presented in two themes: studies on specific leadership styles and perceived quality of leadership.

Leadership styles

In a systematic review of leadership styles and their effect on work environment and the nursing workforce, Cummings and colleagues (2010) concluded that transformational and relational leadership styles, those that emphasized relationships as the foundation for effecting positive change, were associated with higher nurse job satisfaction than were leadership styles based on task completion. Another systematic review examining the relationship between managers' leadership practices and retention (Cowden et al., 2011) found a relationship between transformational leadership, supportive work environments and nurses' intentions to remain in their current position. Findings remain consistent as cited in a recent systematic review (Ystaas et al., 2023). In a realist review on whether local nurse leaders can positively influence nurse retention, Cardiff et al (2023) concluded that person-centered, transformational and resonant leadership practices positively influence nurses' intent to stay within their workplace or organization.

The impact of authentic leadership or transparent and ethical leader behaviour based on information sharing and receiving input for decision-making was also linked to job satisfaction and retention of new graduate nurses in Canada (Fallatah & Laschinger, 2016; Fallatah et al., 2017). Authentic leaders fostered personal and organizational identification, leading to nurses' enhanced confidence in their ability to manage work-related challenges, ultimately impacting retention (Fallatah et al., 2017). By supporting professional practice environments, authentic leaders enhanced new graduate nurses'

job satisfaction (Fallatah & Laschinger, 2016). In Taiwan, authentic leadership also mediated junior and senior nurses' intention to leave but could not overcome organizational challenges such as poor work environment and burnout (Lee et al., 2019). In a study of Saudi nurses (Alilyyani et al., 2022), authentic leadership had a positive, significant and direct relationship with team effectiveness, nurses' work engagement and psychological safety, which decreased turnover intentions. Findings on this topic were mixed, however. A scoping review of the impact of leadership strategies used in emergency rooms reported that no leadership strategy directly influenced nurse intention to stay, retention, intention to leave or turnover (Horvath & Carter, 2022).

Perceived quality of leadership

Some scholars examined how nurses' perceptions of leadership quality impacted retention. A study of Italian intensive care unit nurses reported that nurse managers who engaged in authentic listening, communication and participation capabilities positively impacted nurses' quality of working life and job satisfaction (Cosentino et al., 2023). For Australian medical-surgical nurses, a manager who was perceived to be a good leader, was visible, consulted with staff, provided praise and recognition, and offered flexible work schedules positively impacted retention and staff satisfaction (Duffield et al., 2011). The importance of strong nurse-supervisor relationships was also demonstrated in a study of Italian nurses, influencing workplace well-being and turnover intention (Portoghese et al., 2015). Examining how pediatric intensive care unit nurses perceived the leadership features of Magnet hospitals, Blake et al. (2013) reported they significantly impacted intent to leave. In a Swedish study, unsupportive work environment and low leadership quality both resulted in lower job satisfaction and increased nurses' intention to leave the workplace (Rosengren & Friberg, 2024). Among nurses in Alberta, Canada, growth opportunity and supervisor support had a significant positive effect on job satisfaction, career satisfaction and organizational commitment (Osuji et al., 2014). Conversely, for nurses in the Philippines, nurses working for a manager exhibiting toxic leadership behaviours, such as neglecting employees' well-being, engaging in humiliation and intolerance, had lower job contentment, higher stress levels, frequent absenteeism and a higher intention to leave the profession (Labrague et al., 2020).

3.2.4 Workplace incivility

Workplace incivility, which includes bullying, abuse, conflict and lateral violence, is a persistent and escalating problem in nursing. It contributes to unhealthy work environments, decreased job satisfaction, ineffective patient care, increased stress, increased hospital costs and nurse attrition (Alsadaan et al., 2024; Bennett & Sawatzky, 2013). In a systematic review and meta-analysis examining workplace bullying, Galanis and colleagues (2024) reported correlations between workplace bullying and job stress, burnout and secondary traumatic stress. American-based nurses who were verbally abused by their colleagues reported lower job satisfaction and organizational commitment, and a poor perception of their work environment (Budin et al., 2013). Among newly graduated nurses in Canada, workplace bullying significantly predicted job turnover intention (Favaro et al., 2021). Zullo and colleagues (2022) took this argument further in a study of emergency room nurses in Eastern Canada; they demonstrated that unaddressed verbal abuse from colleagues, patients and visitors caused occupational disappointment – a feeling of disheartenment with one's career choice. Occupational disappointment impacted nurses' practice, mental health and retention when leaders and organizations failed to support nurses and mitigate abuse (Zullo et al., 2022).

It can be tempting to see incivility as an interpersonal issue to be remedied with training on interpersonal skills; but as Croft & Cash (2012) argue, this stance is both ineffective and harmful. First, it

casts blame on individual nurses, failing to see structural contributors to incivility. Policies such as zero tolerance offer surveillance as a solution, without addressing root causes. In fact, nurses who engage in incivility are often protected by those in power, making abusive behaviour tolerated and normalized. Addressing incivility, bullying and lateral violence is critical to enhance retention, and doing so must focus on work environment, organizational structures and leadership practices. The literature is clear that organizational structures and processes, working conditions, the devaluation of caring at the institutional level and nurses' lack of decision-making authority play a significant role in horizontal violence (Alsadaan et al., 2024; Blackstock et al., 2018; Croft & Cash, 2012). In a study of Quebec nurses, Trépanier et al (2021) concluded that poorly designed and stressful work environments were fertile grounds for bullying behaviours. Workload positively predicted exposure to bullying behaviours, but only when job recognition and social support were low (Trépanier et al., 2021).

Nursing leadership plays an important role with regards to workplace incivility (Ota et al., 2022). In a discussion paper, Bennett & Sawatzky (2013) argued that emotional intelligence could equip nurse leaders to recognize early signs of negative behaviours, leading to more positive workplace environments. In an Ontario-based study, authentic and supportive leadership practices showed a negative direct effect on workplace bullying, which in turn had a positive impact on emotional exhaustion and job satisfaction, lowering turnover intentions (Spence Laschinger et al., 2012). However, the role of nurse managers with regards to incivility has additional complexity. While there is evidence indicating that the way incivility is addressed depends on a manager's ability to recognize it, which supports the need for adequate training and institutional support for nurses entering leadership roles (Croft & Cash, 2012). In a study of Canadian staff nurses, supervisor incivility and cynicism were strongly related to nurses' perceptions of job satisfaction, organizational commitment and turnover intentions (Spence Laschinger et al., 2009). In a survey of Quebec nurses on the impact of abusive leadership practices, Lavoie-Tremblay and colleagues (2016) reported that while transformational leadership practices could lower intention to leave, abusive leadership practices compounded intention to leave both one's position and the nursing profession.

A study of Canadian nurses reported that informal organizational alliances and the misuse of organizational processes and procedures predicted lateral violence, which in turn predicted turnover intentions (Blackstock et al., 2015). To address bullying, incivility and lateral violence, scholars call for increased organizational transparency and accountability, and clear policies to bolster fairness and expose the misuse of processes and authority (Atashzadeh Shoorideh et al., 2021; Blackstock et al., 2015; Croft & Cash, 2012).

3.3 Organizational and systemic factors

This section reviews organizational factors that impact nursing retention. These factors are aspects of healthy nursing work environments: settings where nurses are able to be productive, provide good quality care and have job satisfaction (Blake et al., 2013), and settings that foster effective nursing leadership, effective communication and teamwork, and where nurses have professional autonomy (Mabona et al., 2022). Healthy work environments also include elements reviewed above, such as teamwork, leadership, autonomy, role clarity and professional recognition; in this section, we examine the organizational aspects of healthy work environments. These elements are also pertinent for enhancing the quality of working life for nurses. Quality of working life describes personal feelings and perceptions of one's work. Quality of working life for nurses is dependent upon organizational factors

(Sibuea et al., 2024). Organizational components of healthy work environments that also impact quality of working life, namely organizational justice, staffing, workload, acuity, work-life interference and compensation, are discussed.

3.3.1 Ethics and organizational justice

Organizational justice refers to how employees perceive the fairness of decisions, policies and actions of an organization. It also includes fair interactions, procedures and the allocation of resources, all of which impact job satisfaction and retention (Zahednezhad et al., 2021). Studies supported the relationships between organizational justice, affective commitment or one's sense of belonging and alignment with the values of an institution, and turnover intention among nurses in Ontario (Perreira et al., 2018) and in Iran (Zahednezhad et al., 2021). With regards to ethical climate, a longitudinal study of Canadian nurses reported that incongruence between nurses' individual values and those of the organization was associated with burnout, low job satisfaction and increased staff turnover (Kaya et al., 2020; Shao et al., 2018). Finally, in a study of novice critical care nurses in the United Kingdom, moral distress, which occurs when a nurse cannot pursue a morally correct course of action due to institutional constraints, was significantly negatively correlated with intention to stay (Witton et al., 2023).

3.3.2 Staffing, workload and acuity

Staffing, workload and acuity are well studied with respect to many facets of nursing work, including retention. A large international study of nurses' attitudes towards their work environment showed that staffing and workload were unanimous concerns: 92% of nurses faced time constraints, and 96% felt that spending more time with individual patients would have a significant impact on patient health (DeCola & Riggins, 2010). Staffing and workload continue to be pressing nursing concerns (Boudreau & Rhéaume, 2024; Maghsound et al., 2022). Statistically significant parameters influencing likelihood to stay in nursing included having sufficient staff, greater involvement in decisions impacting their work, and improved work-life balance (Boudreau & Rhéaume, 2024; DeCola & Riggins, 2010).
A qualitative study of nurses in British Columbia reported that intention to leave was influenced by high patient acuity and increased workload (Hayward et al., 2016). Optimizing staffing was identified as a critical improvement to enhance work environment and patient care by Alberta nurses (Heistad et al., 2022).

3.3.3 Work-life interference

Work-life interference occurs when the role pressures from work and family domains are mutually incompatible in some respects (Greenhaus et al., 1997). Work-life interference has a direct relationship with occupational turnover intentions (Van der Heijden et al., 2009), negatively effects mental health, decreases work satisfaction, increases burnout (Gynning et al., 2024) and increases sick leave – disproportionately for women (Marti et al., 2023). New nurses in Ontario reported a link between work-life interference, burnout and intention to leave (Boamah & Laschinger, 2016).

3.3.4 Compensation and financial incentives

It is widely agreed upon that on a global scale, nurses are underpaid for their level of expertise and responsibility, and that salaries have not kept up with the cost of living. Despite this, compensation did not figure prominently in the literature on retention. What literature does exist is mixed. Some

literature, as noted in a recent systematic review, highlights the limitations of pay increases to support long-term retention of nurses (Bimpong et al., 2020). Other authors – for example, Irish public health nurses – reported that pay was the least important contributor to job satisfaction (Curtis & Glacken, 2014), while literature suggests increased compensation contributes to enhanced retention and job satisfaction for nurses working in primary and community care (Halcomb et al., 2018). Pay equity – receiving equal pay for work of equal or comparable value – does support job satisfaction (Doleman et al., 2024).

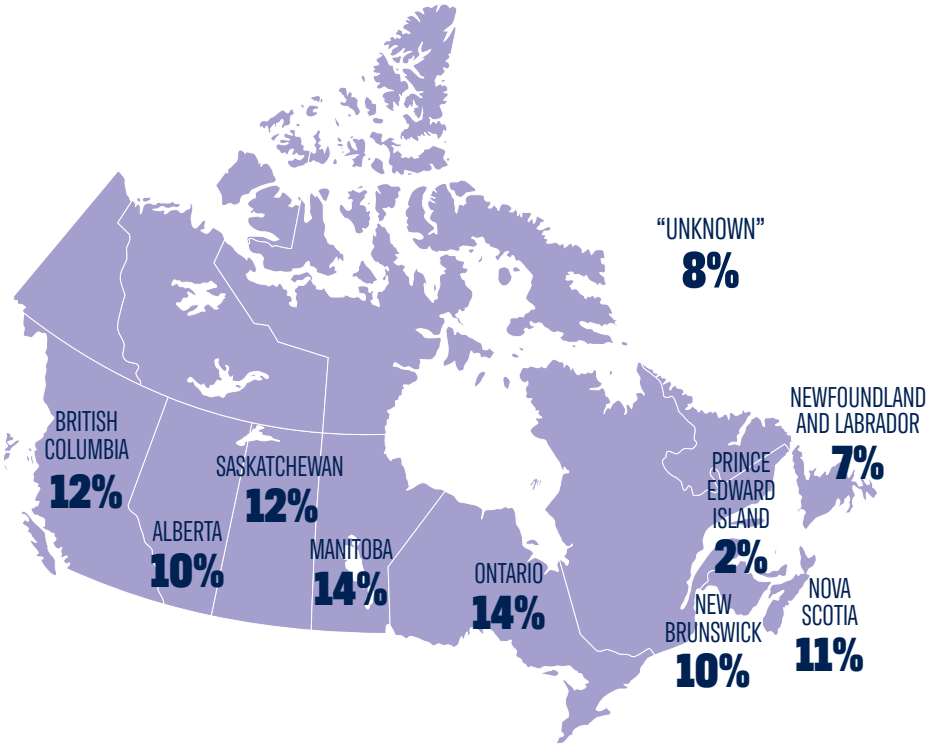
4.0 Methods

Study design was guided by Sally Thorne's (2016) interpretive description, a qualitative approach designed to provide practice-relevant knowledge to the discipline of nursing. Both in-person and virtual focus groups were conducted with nurses in nine provinces. Recruitment channels included those provided through CFNU networks and the researchers professional nursing networks. In-person data was collected at seven provincial nursing union annual general meetings and one provincial coordinators' meeting throughout 2024. Additional focus groups were conducted virtually throughout 2024 and early 2025. These recruitment strategies were deliberate to ensure nurses in a variety of clinical and geographic areas and across varying career stages were represented in the data. Recruitment materials were distributed to provincial union members via their provincial union and were shared widely on provincial nursing social media group pages. The goal was to conduct three focus groups per province; however, some provinces were more difficult to recruit from, notably Atlantic Canada. In total 22 focus groups were conducted: three per province in Alberta, British Columbia, Manitoba, Ontario and Saskatchewan; two per province in New Brunswick, Nova Scotia and Prince Edward Island; one in Newfoundland and Labrador. Focus groups were guided by one broad question: what do you need to stay in the nursing workforce in Canada until you wish to retire. Probing questions were used to elicit experiences in nurses' careers where these needs were and were not met. This provided contextual data to examine the consequential nature of needs – met and unmet. Focus group length averaged one hour, with some extending to 1.5 hours. Focus group size averaged seven participants, which was ideal for facilitating high levels of involvement and supported ease of moderation of what proved to be an emotional topic (Morgan, 1992; 1996). Sociodemographic data was also collected to provide in real-time data, which allowed for targeted recruitment efforts when needed. Targeted recruitment attempts mid-way through data collection sought to recruit more early-career nurses, stronger representation from Atlantic Canada and from BIPOC nurses. As noted in the sociodemographic data presented below, these targeted recruitment attempts were not entirely successful. These are notable limitations to be taken into consideration when interpreting findings.

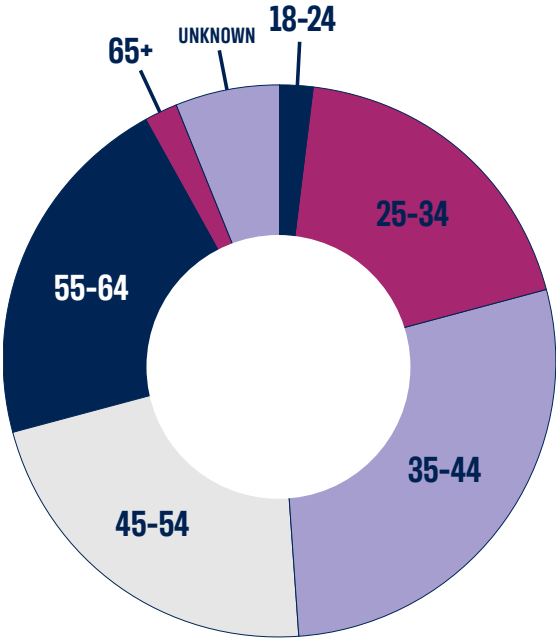
5.0 Findings

5.1 Sociodemographic data

Participants by province

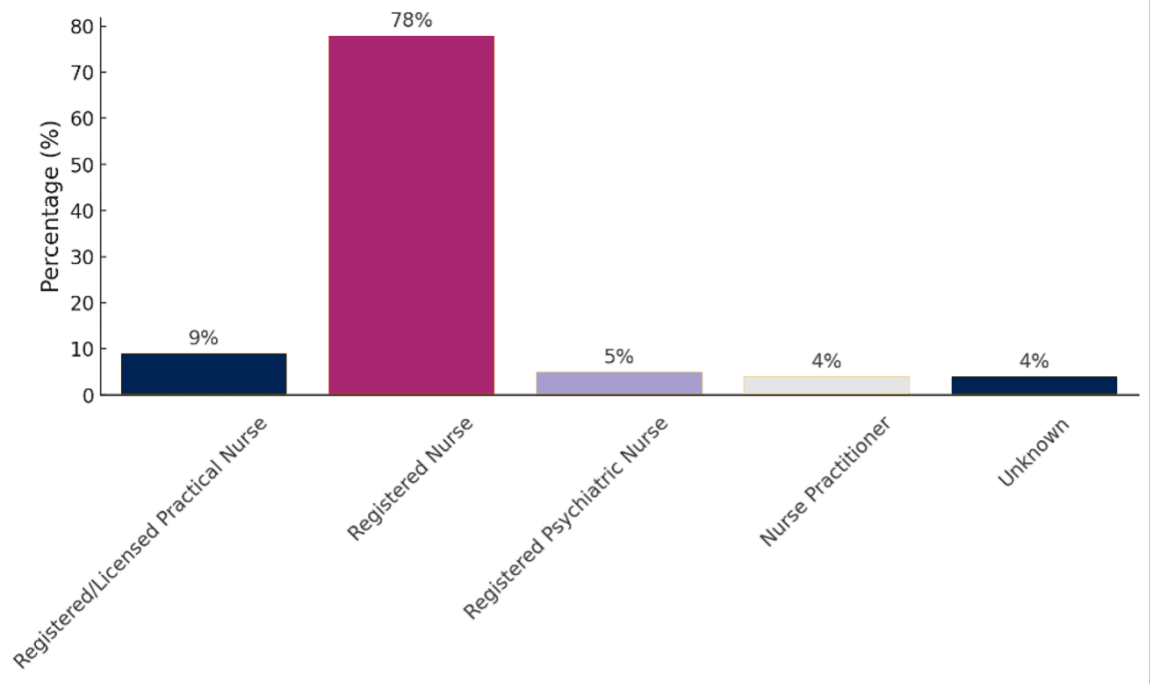


Participants by age

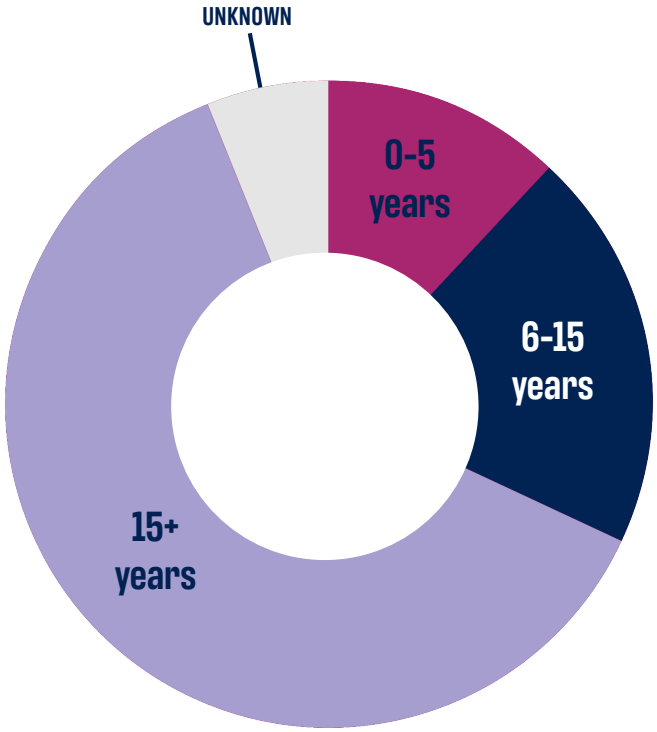


Nurses 18-24 years of age – **2%**
Nurses 25-34 years of age – **19%**
Nurses 35-44 years of age – **28%**
Nurses 45-54 years of age – **22%**
Nurses 55-64 years of age – **21%**
Nurses of age greater than 65 years – **2%**
Unknown – **6%**

Participant by professional title

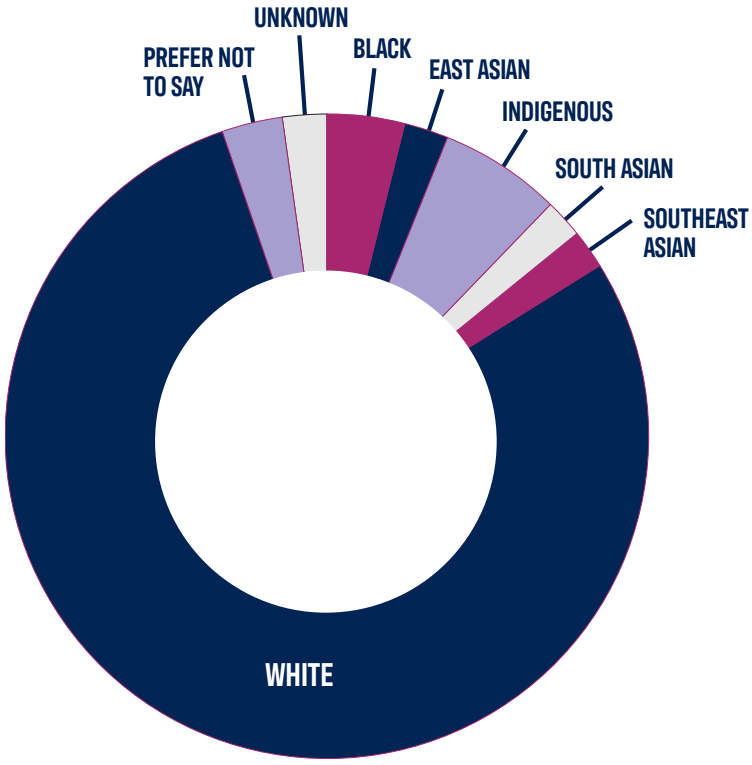


Participants by years in nursing practice



Nurses with 0-5 years in nursing practice – **12%**
Nurses with 6-15 years in nursing practice – **20%**
Nurses with 15+ years in nursing practice – **62%**
Unknown – **6%**

Representation by race**



Black – **4%**
East Asian – **2%**
Indigenous – **6%** [Metis 4%, First Nations 2%, Inuit 0%]
South Asian – **2%**
Southeast Asian – **2%**
White – **77%**
"Prefer not to say" – **3%**
Unknown – **2%**

*Categories derived from Canadian Institute for Health Information (CIHI) categories [rationale: ability to map data to larger data sets]

**Categories derived from CIHI (2022) *Guidance on the Use of Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada* [rationale: ability to map data to larger data sets]

Sociodemographic survey data was completed by approximately 90% of nurse participants. Some surveys were partially completed; missing data are represented as "unknown". Based on demographic data, our sample representation by province was as follows: Alberta 10%; British Columbia 12%; Manitoba 14%; New Brunswick 10%, Newfoundland and Labrador 7%; Nova Scotia 11%; Ontario 14%; Prince Edward Island 2%; Saskatchewan 12%; unknown 8%. Representation by age: nurses 18-24 years of age 2%; nurses 25-34 years of age 19%; nurses 35-44 years of age 28%; nurses 45-54 years of age 22%; nurses 55-64 years of age 21%; nurses greater than 65 years of age 2%; unknown 6%. Representation by professional title: registered/licensed practical nurse 9%; registered nurse 78%; registered psychiatric nurse 5%; nurse practitioner 4%; unknown 4%. Representation by years in nursing practice: 0-5 years 12%; 6-15 years 20%; greater than 15 years 62%; unknown 6%. Internationally educated nurses 2%, non-internationally educated nurses 94%; unknown 4%. Representation by current workplace*: community and/or public health 30%; hospital 44%; long-term care 11%; rural and remote 7%; other 2%; unknown 6%. Representation by current specialty*: cardiovascular 2%; community health 19%; critical care 4%; emergency 13%; gastroenterology <1%; gerontology 10%; hospice/palliative care 5%; medical/surgical 10%; neonatal <1%; oncology 2%; orthopedics <1%; pediatrics 3%; perinatal 3%; perioperative 3%; psychiatric/mental health 8%; public health 8%; wound/ostomy 4%; unknown ~6%. Representation by race**: Black 4%; East Asian 2%; Indigenous 6% [Metis 4%; First Nations 2%; Inuit 0%]; South Asian 2%; Southeast Asian 2%; White 77%; "prefer not to say" 3%; unknown 2%.

5.2 Focus group findings and recommendations

Focus group data revealed three anchoring needs: to stay in the Canadian workforce nurses need to be protected, engaged and respected. Nurses clearly articulated how these needs can be met, offering rich reflections about the significance of those needs and the consequences when they are not met. Across the career trajectory, there are slight yet nuanced differences in how these needs can be met. When these nuances are present in the findings, additional sections have been added to highlight this. For the purposes of this report, nurses have been loosely grouped into three career stages based on trends in the data: early-career nurses, mid-career nurses and senior nurses. These categories were created by participants self-identification. Self-identification of career stage was important in accurately capturing the needs of nurses as driven by their own understandings of their own career stage and trajectory. The structuring of this section includes three main sections: "protect us", "engage us" and "respect us". Each main section is further organized by two subsections "what nurses said", which provides a synthesis of findings with exemplary quotes, followed by findings-driven recommendations.

5.2.1a Protect us: what nurses said

Nurses described in detail the numerous ways in which they felt unsafe and at risk within their work environments, as one nurse explained: "I do not believe anyone [working as nurse right now] feels safe… we are always on edge, waiting for something bad to happen… nurses need to feel safe in the workplace, wherever that is." Four interconnected dimensions of safety were identified: professional, moral, mental and physical. Nurses viewed the protection of these four dimensions not only as essential to their well-being but also as foundational to the delivery of safe and high-quality patient care. Nurses emphasized the urgent need for their safety needs to be recognized and protected.

5.2.1.1 Protect our professional integrity

In the context of ongoing staffing shortages and unsafe working conditions, nurses reported feeling that their professional integrity was under constant threat. Across all focus groups, nurses described the persistent fear that their nursing licenses were at risk due to the impossibility of meeting regulatory standards within current work environments. One nurse expressed the gravity of this risk: "Every shift I work, a patient is at risk because of our [poor] staffing… we're working under risk to our license." This sentiment was echoed by others, who described a heightened continuous anxiety in their clinical practice: "I am frightened something bad is going to happen, every day, every hour." Nurses directly attributed this fear to employer decisions that placed them in unsafe situations, impeding their ability to meet professional and regulatory expectations: "It's our license, always on the line when employers make these [unsafe workload] decisions. They [employers] have set us up so that we cannot meet our regulatory standards."

Many nurses felt powerless in these situations, forced into roles and responsibilities they believed jeopardized patient safety. As one nurse described, "I cannot practice safety. I'm doing [reporting] workloads every day. You go home so defeated; you feel like you're torturing patients." Despite these concerns, the formal mechanisms designed to address unsafe work were widely regarded as ineffective. Nurses who consistently submitted workload reports described the process as burdensome and its outcomes disappointing. Others admitted to no longer reporting safety concerns due to the time-consuming nature of the process and the persistent lack of organizational accountability.

Beyond the immediate pressures of scheduled shifts, nurses felt that conditions of "patient abandonment" were wrongfully leveraged to pressure nurses into extending shifts to make up for organizational shortcomings and inabilities to secure adequate baseline staff. One nurse poignantly stated: "After my 12-hour shift, that patient is no longer my patient. I was scheduled for a 12-hour shift, I completed my 12-hour shift, now it's your [employer's] problem if you didn't staff the unit appropriately, it's not my fault you haven't hired enough staff, it's not my problem."

Nurses also expressed growing disillusionment with their nursing regulatory bodies, which they believed were failing to fulfill their mandate to protect the public. Nurses are witnessing a nationwide erosion in the quality and safety of patient care and expressed frustration at the silence of regulatory institutions in the face of these escalating risks. Nurses emphasized that public protection and nurse protection are inherently interconnected, stating: "protecting the public also means protecting us", but they felt increasingly abandoned by their regulatory bodies. As one nurse asked pointedly, "Why doesn't our college protect us?"

These accounts reflect not only a professional crisis but a deep ethical rupture in the social contract between nurses, their employers and the systems meant to support both care providers and the public. Nurses made clear that safeguarding professional integrity is not solely the responsibility of individual nurses but must be structurally supported through responsive governance, adequate staffing and meaningful regulatory engagement.

5.2.1.2 Protect our moral integrity

Nurses across all career stages described persistent and profound threats to their moral integrity in their day-to-day work, primarily rooted in the ongoing inability to provide safe and quality nursing care. These constraints were directly related to inadequate resourcing and unsupportive work environments. Working within these constraints left nurses feeling "like we're letting patients down while being pushed to be better and faster". Many nurses articulated that their roles had been reduced to task completion under strict time constraints, challenging their abilities to engage in the relational and humanistic aspects of nursing that once brought them joy and meaning in their work. In addition to individual patient care, nurses expressed feelings of moral failure over their inability to reach and adequately support entire populations facing systemic barriers to care. One nurse lamented: "It is so heartbreaking as a nurse seeing vulnerable groups [new migrants; unhoused; seniors] fall through the cracks. They are humans that deserve care. Health care is a human right." Nurses viewed the system's structural failure to uphold that right as morally incongruent with the central tenets of the nursing profession. Nurses repeatedly felt that "the burden of the [broken] system is put on us", which is a harshly misplaced burden, one that weighs heavy on nurses. Nurses are "…really trying to break out of that [history], we shouldn't carry this burden, we're in a fight to try and change that", but that fight comes with significant costs to nurses moral well-being.

Nurses' moral integrity was also compromised when they were unsuccessful in advocating for the needs of patients, whether in efforts to navigate complex systems or to secure necessary resources for the provision of safe care. One nurse shared: "I want to reduce all the barriers to me helping my clients, and I want to advocate for them… [when I can't] this I find the most draining thing." Another echoed this sentiment, stating: "All I've ever wanted to do is care for my patients the way I've been trained to and do the job I thought I was signing up to do." Nurses who raised concerns about unsafe conditions were often met with resistance or outright dismissal: "Every single one of my questions were either dismissed, deflected, not answered or ignored."

The emotional toll of these experiences manifested as both moral distress and, over time, moral injury. Nurses described moral distress as a recurrent feeling that arose when they were doing their best but knew that systemic limitations prevented them from meeting the standards of care they believed patients deserved. As one nurse described, "That's moral distress… when you're doing your best, but you know you could do better if you had a little bit of help [additional resources]… just a little bit more." The chronic nature of these experiences led to exhaustion and helplessness: "The moral distress is exhausting. And no one seems to care. You can write incident reports until you're blue in the face. But no one cares."

While moral distress was often described as episodic, moral injury was described as a more enduring and cumulative experience – an internalized sense of professional and moral failure that transcended time. One nurse explained: "I feel like everything that I do is just never enough… we all know that nobody's getting the best of us. And that weighs so heavy on my heart, and it makes me so sad for our patients because people deserve better." Another described moral injury as follows: "I would go in, and for 16 hours I would give my all. My empathy… I would hold my bladder, I wouldn't eat, I wouldn't take breaks, because that was what was needed of me to give my patients the best care I could give. But it came to the point of even that was still never enough. I would come home and just collapse in my doorway because I was still never enough for my patients."

These ongoing violations of moral integrity had a significant impact on nurses' intentions to remain in the profession, with early-career nurses also expressing disillusionment. As one early-career nurse shared, "I'm already thinking about what I'd do if I left nursing. I'm considering going into the trades." Another added: "Something has to change. If me, at five years, [I] am thinking about leaving the profession entirely, I know I'm not the only one."

Nurses traced much of the moral erosion they experienced to a health care system increasingly governed by budgetary logic. They perceived that cost, rather than patient care, had become the central driver of decision-making: "The patient is no longer at the center – money is at the center… decisions are being made strictly because of cost." This emphasis on financial metrics, rather than patient outcomes, was experienced as particularly demoralizing when resources were directed away from direct care: "Being spent on developing process after process, while patients are dying in our emergency rooms."

Nurses called for a shift toward decision-making processes guided by what they described as "meaningful patient-driven outcomes," arguing that such a reorientation would result in "a very different picture" of what health system priorities ought to be. The widespread sense of moral conflict articulated by nurses reflects not only their professional commitment to patient-centered care but also the urgent need for systemic reforms that address the moral dimensions of nursing work as a matter of organizational and policy accountability.

5.2.1.3 Protect our physical health

Nurses across a variety of practice areas and settings described significant threats to their physical safety in the workplace. Discussions of physical health were overwhelmingly centered on personal safety, with a strong emphasis on the prevalence of violence against nurses, as noted by the following quote: "I need to feel safe in my job. I need to be able to go to work and be pretty confident at the end of the day that I'm going to come out and I'm not going to have been assaulted, and that doesn't happen anymore. It doesn't happen for almost any of us anywhere anymore." Nurses described feeling unsafe both within health care facilities and in the surrounding environments. For example, nurses

working in large urban hospitals reported repeated break-ins to their vehicles and, in some cases, physical assaults in staff parking lots. One nurse recounted: "Several nurses got attacked just walking to their cars."

Rural, community and public health nurses similarly shared experiences of physical risk, often exacerbated by the isolated nature of their roles. These nurses frequently worked alone in small clinics or provided home care in areas with limited cellular reception, inadequate security infrastructure and an absence of clear safety protocols. Entering unfamiliar or unsafe homes was routine, with nurses describing exposure to threats such as aggressive animals ("attacked by dogs"), domestic violence and unsafe living environments – for example, "with black mold." Despite the risks, nurses felt unsupported by their employers and limited in their ability to refuse unsafe work: "We have such a limited right to refuse unsafe work."

Emerging forms of violence in online spaces were also highlighted, with nurses reporting increased exposure to harassment and reputational attacks via social media. One nurse shared: "A patient can slander a nurse online, and there really isn't anything the nurse can do." The absence of institutional policies to address such incidents left nurses feeling vulnerable and unprotected. Nurses expressed frustration that, despite working in highly policy-driven organizations, policies addressing violence against nurses were often absent or poorly developed. One nurse illustrated this discrepancy: "We have a policy on how to give an enema, but we don't have a policy for what to do if a nurse gets abused at work."

While the presence of hospital security staff to support nurse safety was welcomed in principle, nurses described numerous examples of undertrained and ill-prepared personnel who failed to intervene effectively during violent incidents. One nurse stated, "[They are] not being adequately trained, not knowing how to deal with certain situations, leaving nurses vulnerable and unsafe," while another recalled, "We have security guards who tell us that they don't feel safe going near a patient – well, that kind of defeats the purpose." Nurses stressed that if security is to be part of the solution, those assigned to these roles must be "confident trained security who's going to be ready to back nurses up in a situation."

Employers often responded to safety concerns by offering additional training to nurses, such as non-violent crisis intervention or brief sessions on self-protection. Such interventions were viewed as inadequate and reflective of a broader trend of shifting responsibility for safety onto individual nurses. One nurse recounted: "We spoke with our managers about that [our physical safety concerns]... we got a little in-service on self-protection from a retired police officer." Rather than addressing the structural contributors to workplace violence, such measures were seen as superficial and insufficient.

When violence did occur, nurses emphasized the need for employer follow-through and accountability for perpetrators – support that was frequently lacking. One nurse stated, "There's no recourse to keep [perpetrators] accountable." Instead, nurses reported employers often sympathizing with the aggressor, as illustrated by a nurse of 30 years, who was told following an assault: "Well, that individual is going through cancer treatment". In response, the nurse reflected: "My husband is also going through cancer treatment – does that give me the right to [act violently]?" Nurses perceived that organizational priorities were skewed toward patient satisfaction, often at the expense of nurse safety: "They're [employers] so focused on patient satisfaction they're not caring about us [nurses], how we're feeling working in unsafe conditions all the time." Additionally, some nurses described feeling blamed after experiencing workplace violence, recounting incidents of being summoned to managerial meetings to explain their actions: "Being pulled into the manager's office and asked what I could have

done differently [to prevent being assaulted]." These experiences discouraged reporting altogether. One nurse summarized, "We have signs all over the hospital that say, you know, violence will not be tolerated – but it is tolerated, and then nurses, the frontline staff, are like, I'm not even going to bring it forward because the manager backs up the perpetrator and not me."

The cumulative impact of working in fear and without adequate support led to emotional and physical exhaustion. One nurse captured this sentiment: "I can't go to work and feel unsafe like this every day. It's exhausting." Others reflected on how a lack of institutional response following violent incidents made them consider leaving the profession altogether: "Not having the support of my employer made me consider for the first time in my nursing career leaving nursing."

Nurses were clear in their calls for meaningful organizational action to prevent and respond to violence. They identified chronic understaffing and long patient wait times as core drivers of aggressive behavior and urged health care organizations to address these systemic issues. When violence does occur, nurses expect timely follow-up, accountability for perpetrators and unequivocal support from leadership.

In recognition of the persistent risks they face, many nurses advocated for the introduction of hazard pay in high-risk context, particularly in situations involving critical staffing shortages. One nurse explained: "Hazard pay... for nurses working in high-risk areas or situations, or under [predetermined] staffing ratios, they get extra pay assuming that it's a hazardous level. I know it doesn't change the situation, it doesn't make it safer, but at least you can feel like you're compensated for like a really terrible shift that put you in unsafe situations. That's not going to fix the issue, but at least it gives the nurses some sense of compensation [for being put at risk]."

Nurses across diverse settings described pervasive threats to their physical safety, including workplace violence, unsafe environments and inadequate employer protections. They expressed frustration with inadequate support structures. Nurses called for systemic change, emphasizing the need for structural protections, institutional accountability and hazard pay in high-risk contexts to address the emotional and physical toll of unsafe working conditions.

Special considerations for inclement weather

Nurses also raised concerns about the lack of adequate employer supports during severe weather events. Nurses shared examples of being expected to report to work during snowstorms and other hazardous conditions, regardless of personal risk. Those who lived at a distance from the hospital described feeling pressure to find a way to work, despite unsafe travel conditions. One nurse explained the moral and professional conflict this created, noting they felt guilted into coming to work even when personal safety was compromised.

To address this, nurses proposed the development of localized response plans that prioritize staff safety during inclement weather. One suggestion included implementing a "fan-out" system to identify and contact nurses living within a specific radius of the hospital – such as walking distance – who could safely report to work. Nurses proposed that those able to do so should be compensated with premium pay for their efforts and availability under hazardous conditions.

Nurses also critiqued employer responses which often placed the burden on nurses to assume personal risk or absorb additional costs. For instance, some were encouraged to stay in hotels between shifts at their own expense, a solution nurses found unreasonable and unsupportive. They

emphasized that structural policies must account for geographic, financial and safety considerations in a way that does not penalize or endanger staff.

5.2.1.4 Protect our mental health

Nurses across all focus groups emphasized that the collective mental health of the nursing workforce is at an all-time low. As one nurse noted, "Staff are really struggling mentally." Nurses were clear in their assertions that the nature of nursing work disproportionately puts nurses at risk for experiencing traumas, noting: "What we are expected to do in this job is not normal… it causes trauma." The deterioration in nurses' mental health has profound impacts, not only on nurses' personal lives but also on their professional capacities. Nurses expressed frustration with the predominant institutional focus on individual responsibility for mental health, such as self-care practices, in the absence of meaningful structural supports. Many viewed this framing as harmful and dismissive, given that much of the psychological trauma nurses experience is a direct result of systemic working conditions. One nurse stated: "If one more person tells me about self-care… it's yet another level of gaslighting." Nurses emphasized that what is needed is not more self-directed coping mechanisms but robust employer-provided mental health supports that respond to the ongoing and repeated traumas embedded in their work. As one nurse explained, "We [nurses] need more mental health resources… there's no emotional supports for us." Current mental health benefits were viewed as entirely insufficient: "Our mental health benefits are a joke."

Nurses argued mental health support must be: "More than giving us an Employee Assistance Program [EAP] card [business card]." They noted that current benefits cap, such as ten EAP sessions, falls far short of addressing the depth and continuity of support required to treat work-related trauma: "Ten EAP sessions are not near enough." Instead, nurses called for uncapped access to mental health care delivered by a range of professionals, including psychologists, psychotherapists, counselors (including grief counselors) and social workers. The rationale for this was clear: "It allows us to start and finish treatment. When we only have like $750 a year, we're not getting a lot of sessions, and lots of times one event opens a box – all the things nurses have tucked away, put on a shelf for years – they come out… It [psychological trauma] doesn't stop because you've run out of benefit money… unlimited coverage allows nurses to actually get well, so they don't have to leave [therapy] half undone."

Nurses described how psychological trauma in nursing work is often cumulative, with repeated exposures compounding over time. As one nurse powerfully expressed, "Piling these little traumas on top of little traumas on top of little traumas… you cannot go through life piling all of these work traumas on top of each other." To address this ongoing accumulation of harm, nurses want access to real-time debriefing support from licensed mental health professionals, including while on shift: "There needs to be a trained mental health professional on call for immediate debriefing, the way it's supposed to happen." Only a small number of nurses had ever experienced formal debriefing, but those who had underscored its transformative value: "Having formal debriefing, in real-time debriefing, allows me to maintain passion for my job. It's been a real game changer for me, knowing now I can go home and feel okay."

For the majority, however, such support was absent. Nurses spoke about the lack of even basic follow-up after critical incidents: "There's no mandatory check-ins [after critical or violent events] – there's no mandatory requirements for nurses to be asked 'are you ok' before returning to the workplace, and I think that's terrible… we [after experiencing a traumatic event] have to go right into the next patient room." Nurses highlighted this as a critical gap, especially when compared to how

other first responders and frontline professionals are supported after trauma. Nurses perceived this discrepancy as a form of systemic inequity that further contributed to unsafe working conditions.

Nurses also advocated for the formal recognition of mental health within existing sick leave policies, including the ability to take designated mental health days. However, as with physical health-related absences, many described feeling guilted, interrogated or ridiculed when requesting time off for psychological reasons. In the absence of these supports, nurses felt pressure to continue working through trauma, which they found deeply unsettling. Nurses noted how pervasive the normalization of experiencing trauma was, which for them reflected how culturally engrained and structurally embedded these harms towards nurses had become. Nurses thought it peculiar, having to work through these traumas daily in the work and made multiple references to "crying rooms" in nursing, questioning "what other profession has a crying room on every unit, every floor [I've ever worked on] has one, it's a particular spot on every unit where nurses go to cry [on shift]."

Nurses were clear that their requests were not excessive but constituted the bare minimum of what should be expected in this line of work. As one nurse plainly stated, "Our request to have our mental health cared for by employers is not unreasonable – it's the bare minimum." Nurses expressed urgency for systemic trauma-informed reforms to employee mental health supports in their workplaces – changes they see as essential not only to their own well-being but also to the sustainability and safety of patient care.

Special considerations: support and integration of internationally educated nurses (IENs)

Nurses across the country expressed deep concern about the treatment and welfare of internationally educated nurses (IENs) within the Canadian health care system. Non-IEN nurses described the experiences of their IEN colleagues as profoundly unjust and structurally unsupported. Several nurses stated that IENs were "absolutely thrown to the wolves" by both provincial governments and employers. They shared accounts of IENs arriving in Canada to minimal support – provided with "a furnished rental, a bit of money for groceries and then left on their own." Without adequate resources, orientation, or structural safeguards, IENs were placed in precarious and often unsafe work environments.

Nurses recounted instances in which IENs experienced racism from both patients and fellow staff members. These incidents were compounded by the lack of institutional mechanisms to support or protect IENs from such harm. As one nurse stated, "They were set up to fail by the system." The treatment of IENs was described as "horrific", and nurses were critically aware of the ethical implications of recruiting nurses internationally without corresponding investments in safe, supportive and culturally responsive integration processes.

In addition to the lack of support provided to IENs themselves, non-IEN nurses reported that they received no guidance or education on how to support IEN integration in their own workplaces. This left many feeling unprepared and unsure of how to create inclusive and culturally safe environments for their colleagues. Nurses viewed this lack of preparation as both unfair to IENs and detrimental to team cohesion. One nurse reflected, "They [IENs] need to be supported. We have an ethical commitment to not just bring them here and have them be bullied and feel unsafe to speak up – there's got to be support structures put in place and safeguards for them."

These accounts reveal an urgent need for comprehensive integration strategies for IENs, including anti-racism training for all staff, culturally safe work environments and structural protections that ensure

IENs are not left isolated or vulnerable. Nurses called for coordinated efforts by health care organizations and provincial governments to fulfill the ethical obligations inherent in international recruitment practices.

5.2.1.5 Management matters

Across focus groups, nurses emphasized that employers hold the greatest influence over nurses' safety and well-being, particularly through the role of frontline management. Unit managers were consistently identified as pivotal figures in shaping nurses' daily experiences – they are instrumental in both protecting and harming nurses. The presence, or absence, of supportive management had profound implications for nurses' sense of safety, professional fulfillment and retention. Nurses recounted that when supportive leadership was lacking, they felt unable to ask for help and were not given the resources or guidance needed to do their jobs effectively. As one nurse explained, "That's why I left. I knew the manager would not have my back. One mistake – and I'll be thrown under the bus." Conversely, when nurses had supportive managers, they described feeling valued, respected and more inclined to remain in their jobs. One nurse shared, "There's been times where I thought about quitting, and then I just felt so appreciated and valued and given [positive] feedback, and I'm reminded of why I do what I do. And that is really powerful." Another articulated the long-term impact of supportive leadership: "The single most important thing that keeps me in my job is a supportive leadership team. I get professional development opportunities and paid education to be able to maintain the core competencies I need to do my job."

Nurses emphasized that managers must be "present", meaning regularly engaged with unit operations, aware of staff needs, and involved not only when a unit issue arose. Managers who were embedded in daily practice "create a world of difference in work culture," with nurses linking their presence to improved morale and reduced workplace conflict. Many nurses criticized current management approaches as being predominantly "reactive in nature," which fostered tension, reduced trust and created toxic environments.

Nurses were adamant that unit managers need to be nurses, however, described increasingly alarming trends of "nurse manager" titles being replaced by "unit manager" titles, noting: "They used to be called nurse manager [positions], now they've changed them all… facility manager… unit manager." Consequently, nurses witnessed increasing trends of replacing nurse managers with managers lacking nursing backgrounds, noting: "It's not that nurses aren't applying to the positions, they aren't being hired." This was troubling to many, who shared multiple examples of non-nursing managers failing to understand the scope and complexity of nursing practice. One nurse reflected: "They don't understand the nursing team they are leading." Another added, "They don't even know what nursing scope of practice is. That is very problematic."

Nurses felt that organizational structures treat management and nursing as "two distinct entities" supported by "current leadership models" that "reinforce that dichotomy." Nurses viewed this fragmentation as a missed opportunity for integrating management with clinical expertise. They advocated for intentional manager development among nurses, stating: "Nurses should be encouraged and given every opportunity to develop as managers… we need nurses leading nurses." Nurses strongly believed that well-supported nurse leaders could positively transform health care environments: "We need strong nursing managers… when you have a strong [nurse manager], it changes the workplace."

However, nurse acknowledged that the transition from clinical to managerial roles is often unsupported. Nurses who had taken on management roles described being unprepared: "The problem is, we have managers without managerial training." Another explained: "Unit managers are nurses that all of the sudden became a manager. Who taught them how to be a manager? Who taught them leadership skills? How to lead a team?" Nurses called on employers to invest in the leadership potential of their existing nursing workforce: "Take a nurse that's been there seven years… send them to management training. Educate them on how to be a highly functional manager… develop these teams… promote from within – and you grow your team. And then you end up with excellence."

Mid-career nurses who were previously interested in management positions described hesitancy due to structural risks and insufficient compensation. Union protection was an important consideration: "I have no interest in leaving a union-protected position to go into a management position where I make almost the exact same amount of money, in some cases less… with zero protection." Others cited a lack of authority as a deterrent: "Nurse managers are very limited in what they can do… it blows my mind how little control managers have to make decisions [for their own units]." Former nurse managers echoed this sentiment, reflecting that when they simply "gave them [nurses] their negotiated contractual rights", they were reprimanded by higher-level administrators. This was deeply upsetting for these former nurse managers, and they acknowledge: "Our nurses work their butts off. They work hard."

Nurses described the treatment of nurse managers as deeply concerning. "No one [at the administrator level] is treated worse than a nurse manager," one nurse stated. Many observed unmanageable workloads and unrelenting demands across multiple units: "Managers doing two, three, four units, it's not feasible." This led to burnout and emotional withdrawal: "You're trying to go to management to talk to them about stuff, and they're also burned out… they've just shut down." Nurses spoke of the organizational instability that follows frequent management turnover: "When management isn't consistent, when the support for your team constantly leaves, you never feel like you've got that team leader… you never feel supported."

This erosion in nurse-administration collegiality was especially troubling for senior nurses who had witnessed more collaborative leadership models earlier in their careers. A nurse with over four decades of experience reflected: "I'm a little bit baffled as to where we've gone so terribly wrong with administration." Others described how poor management practices, particularly toward senior nurses, contributed to workplace trauma: "We've [senior nurses] been through a lot of crap… the traumas, the abuse, we carry a lot of scars… so it doesn't take much for a manager to pick those scabs… and they do… it happens to older nurses repeatedly. Then they wind up on stress leave, medicated, they don't come back, then they have to retire out… I want that to stop."

Nurses called for enhanced accountability structures for managers, questioning: "What are the standards for management? What are their markers for success?" They recommended anonymous routine opportunities to assess managerial performance, particularly in high-turnover environments: "When nurses are leaving units in droves, do exit interviews to figure out why people are leaving." When discussing the constellation of challenges associated with nurse management roles, nurses were perplexed that health care institutions that utilize evidence-based practice as the driver of care delivery do not leverage evidence-based knowledge as it pertains to organizational leadership: "I don't know why basic organizational psychology isn't applied to the work setting."

Nurses identified frontline management as a critical determinant of workplace safety, professional satisfaction and retention, emphasizing that supportive nurse managers fostered morale and stability,

while unsupportive or non-nursing managers contributed to burnout and attrition. Nurses were deeply concerned about the declining presence of nurse-led leadership, the lack of managerial training and authority, and the disconnect between clinical practice and administrative decision-making. Nurses called for investment in nurse leadership development, accountability structures for management, and evidence-informed organizational practices that value and integrate clinical expertise into leadership roles.

5.2.1b Recommendations to protect nurses

1. Federal, provincial and territorial governments must mandate legislated nurse-patient ratios to protect care quality and reduce burnout.

Introduce legislation establishing evidence-informed minimum nurse-patient ratios across care settings, like those begun in British Columbia and Nova Scotia. Monitor compliance and link accountability mechanisms to workplace accreditation or public reporting. The implementation of minimum nurse-patient ratios should be a prerequisite for receiving federal health transfers.

2. Provincial and territorial governments should establish jurisdictional legislation to mandate employer accountability for workplace safety, and to strengthen accountability and enforcement.

Provincial and territorial governments should legislate minimum standards for nurse safety policies, including mandatory follow-up procedures after violent incidents, and improve protections for refusing unsafe work.

3. Employers should implement mandatory standardized employer-delivered training for all security personnel.

Employer-enforced standardized training for all hospital and community security personnel, emphasizing de-escalation and nurse support. Require health care organizations to report and publicly disclose data on workplace violence incidents and response outcomes.

4. Employers must fund uncapped trauma-informed mental health supports for nurses.

Employers eliminate caps on mental health benefits in nursing contracts to allow ongoing care for cumulative workplace trauma. Employers embed licensed mental health professionals within health care facilities for real-time debriefing and psychological support. Employers introduce mandatory psychological check-ins following critical incidents, modeled after best practices in emergency services.

5. Federal, provincial and territorial governments must strengthen staffing accountability mechanisms to protect nurses' licensure and patient safety.

Governments in collaboration with unions and employers must reform workload reporting processes. Standardize and digitize workload reporting mechanisms at the provincial level and centralize data to provide impactful real-time insights that inform staffing decisions, identify risk trends and drive system-level accountability. Employers address critical delays in administrative review of reports. Provincial governments mandate regular staffing audits in facilities with high rates of nurse attrition, critical incidents or sick leaves. Provincial and territorial governments require health care employers to demonstrate how staffing decisions align with regulatory standards and clinical safety requirements, with oversight by external bodies.

6. Employers and accreditation bodies should embed moral safety as a measurable outcome in health system evaluation.

Employers integrate moral safety indicators (e.g., ethical distress reporting, unmet care needs) into health care quality and accreditation standards. Require health authorities to demonstrate how resource decisions are guided by patient-centered outcomes, not solely budgetary constraints – there is a direct correlation between nurses' lack of moral safety and stringent austerity measures, notably under-resourcing. Employers collect data and monitoring of moral safety, reporting to joint occupational health and safety committees. Occupational health and safety committees review data, particularly ethical concerns raised by staff, track patterns of moral distress, and develop responsive interventions in collaboration with frontline clinicians. Require employers to take action to improve nurses' moral safety based on recommendations from joint occupational health and safety committees. Require health care organizations to report and publicly disclose data on moral safety indicators and response outcomes. Consider linking such mechanisms to workplace accreditation.

7. Employers should build nurse leadership capacity and reform frontline management structures.

Reintroduce nurse-led management models and require all unit managers have a nursing background to ensure clinical insight informs operational decisions. Establish formal nurse manager development programs that include training in leadership, conflict resolution and labor relations. Create necessary protections for nurse managers to foster retention, which could include sufficient vacation and sick time coverage, overtime regulations and the exploration of possible unionization structures. Implement standardized feedback mechanisms for frontline nurses to evaluate organizational management structures, including anonymous staff feedback mechanisms and required exit interviews in high-turnover areas to identify and address leadership-related retention risks.

5.2.2a Engage us: what nurses said

From nurses' perspectives, many of the challenges facing the nursing profession, particularly issues of recruitment, retention and attrition, as well as broader problems within the Canadian health system, stem from a long-standing reluctance by employers, health authorities, and provincial and federal governments to recognize nurses' knowledge and expertise. Nurses see themselves as vital knowledge brokers, possessing deep insights into how to address persistent workplace and systemic issues. They believe that, if given the opportunity, they could make meaningful contributions to improving both care delivery and the work environment. Engagement in these areas is also pivotal in nurses' career longevity: "What's going to keep me longer [in this job] is being involved in decisions." However, their expertise remains underutilized at both the system-wide (macro) and organizational (micro) levels. Nurses emphasized that increasing their role in decision-making processes would support workforce retention: "What will help keep us is valuing us for our knowledge."

5.2.2.1 Engage us as key knowledge brokers with system-level knowledge

Nurses spoke candidly about their long-standing frustrations with systemic issues that they have been raising for decades, concerns that, in their view, have repeatedly "fallen on deaf ears." They frequently discussed their foresight regarding key challenges in access to care. As one nurse expressed, "We've [nurses] been telling you [employers, politicians] for 20 years that we were going to be in this mess. Why have you not done anything to mitigate this? The nursing homes, the mental health system, it's all crashing."

Nurses expressed that the ongoing dismissal of their knowledge paired with their limited representation in health care decision-making has led to significant inefficiencies and poor resource allocation. As one nurse stated, "There's a lot of time and money wasted on short-term solutions that actually go nowhere. There's too much trial and error [in employer decision-making]." They believed that if employers slowed down their reactive approach and meaningfully engaged nurses, "maybe they'd actually save money and come up with something more effective and long-term." Nurses found it both perplexing and frustrating that they are often excluded from conversations about improving efficiency in care delivery, despite their practical expertise. As one nurse noted, "Nurses know how to make anything efficient. You ask a group of nurses how to make something more resource-efficient, and they will – we know how to be cost-effective." They described themselves as "solution finders" yet emphasized the "total absence of frontline [nurses] in these processes." Additionally, nurses highlighted major disconnects between current funding priorities and actual system needs. "Patients can't get what they need; they can't even access care," one nurse explained. "Patients and families can't navigate the system because it's so broken, so fractured." Meanwhile, governments invest in high-profile projects, "build a multimillion-dollar hospital when we can't staff the one we already have", or they "buy fancy new technologies" instead of addressing the foundational issues compromising care.

Nurses spoke about the significant influence of provincial and federal politics on both the nursing profession and the delivery of health care services. They expressed concern over what they described as a wide and persistent gap between politicians who make health system decisions and the health care professionals responsible for delivering care. Nurses advocated for narrowing this gap through the formal integration and engagement of health care professionals, including nurses, in political decision-making spaces. As one nurse stated, "Health care needs to be managed by people in health care and not politicians." Nurses emphasized the need for individuals with clinical experience to be present within government and opposition structures, asserting that they "want people that have been working in it [health care] to be within the government or opposition, to be able to have a say or speak up and have a voice and have that voice heard." Some nurses wanted invitations to present at provincial and national caucus meetings, arguing that when "they've [politicians] never walked a mile in a nurse's shoes", policies are less likely to reflect the realities of nursing practice. One nurse urged politicians to "come spend a shift with us, see what we do" before making decisions that directly impact nursing work. The reinstatement of the national chief nursing officer was welcomed. Nurses advocated not only for the continuation of the national role but also called for more substantial influence and authority in shaping health policy. Specifically, they recommended the establishment of provincial chief nursing officers in every province, with meaningful decision-making power in matters of health care delivery. This, they argued, would help ensure that nursing perspectives are not only heard but embedded within the governance structures that shape health system outcomes.

5.2.2.2 Engage us in decisions that directly impact our day-to-day work

Nurses expressed a strong desire to be involved in employer-led decision-making processes: "What we need is for our employers to listen to us." However, they reported that in practice decisions were often made without their input. Even when nurses were invited to participate, many perceived the engagement as superficial and lacking genuine intent to consider their perspectives. One nurse described the dynamic: "This is their [employers'] way of listening, they bring you a problem, ask for a solution, but then tell you that your solution – no, it's a no, we don't have money for that. Well, you're not respecting our professional opinion and what we're telling you we need to do our job."
The exclusion of nurses from decisions that directly affect their daily work contributed to feelings of alienation and disconnection from the broader health care team. As one nurse noted, "There's never a

discussion to treat us like part of the team… to ask us, 'How are we going to problem-solve this?' It's 'we've [leadership] decided this is what you're [nurses] going to do.'" These experiences highlight a recurring sense among nurses that their professional knowledge and frontline expertise are undervalued in organizational decision-making.

Scheduling

The most frequently cited area in which nurses sought greater decision-making authority was the scheduling of their work. Nurses emphasized that scheduling needs vary significantly across their career trajectory, and that current scheduling models fail to accommodate these diverse needs. Across all career stages, nurses expressed a desire for increased flexibility and meaningful engagement in the development of their work schedules. Nurses acknowledged that, historically, job security in nursing was harder to attain, which often required accepting inflexible and poorly designed schedules simply to secure employment. However, nurses noted that this context has shifted dramatically. With widespread nursing vacancies, nurses now feel that employers must change historically rigid scheduling practices accordingly. As one nurse asserted, "Employers now need to adjust to us, not us adjusting to them [and their rigid schedules]."

Despite raising concerns about scheduling and rotation design, nurses reported that their feedback was frequently ignored or dismissed. Nurses were particularly frustrated that their schedules were often designed by individuals outside the profession, with little to no understanding of the demands of shift work. One nurse described the disconnect within the context of her work area: "The finance department made our [new] rotations. Finance doesn't work shift work. They work eight to four, they get holidays off… they got no input from nurses at all."

Several mid- and late-career nurses reflected on earlier models of scheduling in which unit nurse managers were responsible for creating shift schedules. Nurses recalled that nurse managers, being familiar with the specific needs of both the unit and individual staff members, were able to design schedules that supported adequate shift coverage, promoted staff morale and contributed to reduced turnover. As one nurse noted, "They [employers] have really gotten away from that," explaining that scheduling is now largely centralized.

Nurses reported that when individuals unfamiliar with the profession are responsible for schedule development, violations of collective agreements often occur. One nurse explained: "The staffing office does all kinds of things, but that's not what our [collective] agreement says." Others echoed similar concerns, noting the added burden of having to advocate for contractual compliance: "We shouldn't have to be having these conversations [with staffing and management], it's in the collective [agreement]." These accounts reflected a broader sentiment that excluding nurses from scheduling decisions not only undermines workplace satisfaction but also leads to operational inefficiencies and breaches of nurses' contractual rights.

Concerns were also raised regarding emerging scheduling technologies. In particular, nurses expressed unease about pilot projects involving the use of artificial intelligence (AI) to develop schedules. One nurse remarked: "AI doesn't understand what a person is, or what the needs [of nurses and units] are," underscoring a lack of human understanding in such automated systems. Nurses feared that the complexity of human factors, clinical environments and team dynamics could not be adequately captured by scheduling technologies.

Nurses expressed a strong desire for increased autonomy in determining the structure of their work hours, including the ability to choose between eight- and twelve-hour shifts, or a combination thereof, based on their career stage and personal life circumstances. As one nurse emphasized, "Nurses want to be able to have some control over their own schedule, instead of shoving a schedule down their throat." Nurses who had experienced a variety of shift lengths throughout their careers spoke about the importance of aligning work schedules with life stages as a means of supporting their well-being. One nurse reflected: "Twelve hours versus eight hours, and I've done both, and depending on the point of my life, I liked one versus the other, and it kind of went back and forth depending on what was going on, but the ability to choose that would be a game changer [for nurses]."

Traditional nursing rotations are no longer desirable for a large proportion of Canadian nurses. Many nurses called for "rotation changes so that there's better [work-life] balance, or everybody's going to go casual." Nurses viewed the health system as lagging significantly behind in adapting to the realities of today's workforce. As one nurse explained, "We want that ability to have different [work] experiences, we don't want to be so stuck in one spot. The system is so far behind in recognizing that. It's a different mindset now." Nurses stressed the need for flexible scheduling practices that acknowledged and respected the complexity of their lives. One nurse noted, "There's divorces, and there's childcare, and then there's aging parents, and there's partners that are working out [of town], so different things. And everybody has their thing."

Nurses were perplexed by the continued rigidity of scheduling practices and the lack of meaningful reform over time. As one nurse put it, "I really don't understand in this day and age why we can't have some facet of scheduling accommodations for different seasons of life." Many described how current scheduling models fail to reflect evolving societal norms and demographic shifts. For instance, nurses noted that Canadians are increasingly delaying parenthood and seeking diverse professional experiences before "settling down" – if they choose to at all. As a result, early-career nurses are typically more inclined to work multiple jobs, engage in short-term contracts or move between workplaces, rather than committing to a single employer for decades as was more common in previous generations.

Nurses also highlighted how economic factors, such as the rising cost of living and inaccessibility of home ownership, have shifted the financial priorities of early-career nurses, who may not view long-term employment with a single institution or early retirement as desirable or feasible goals. Despite these realities, nurses believed nursing work structures had not evolved to reflect these changing needs. Nurses shared numerous ideas for introducing greater scheduling flexibility, stressing that such changes were entirely feasible. However, they viewed historical resistance from employers and governments as the primary barrier. As one nurse concluded, "We have to look at different ways. Just because we did it that way for the past 50 years doesn't mean it's working… it's not working. It can be done [differently]. Administration and governments need to just take a deep breath and go, okay, let's try it."

Across several focus groups, nurses identified the rigid and outdated nature of scheduling practices as a key factor driving the increasing appeal of agency nursing. Agency nursing work was described as offering greater flexibility, autonomy and mobility – qualities that many nurses found lacking in traditional employment structures. The ability to travel, select shifts according to personal needs and earn higher wages in a challenging economic climate were cited as incentivizing agency nursing. Nurses emphasized that this kind of autonomy often outweighed the benefits of accruing seniority.

Nurses caring for aging parents emphasized the urgent need for scheduling flexibility, identifying themselves as part of the "sandwich generation" – those simultaneously responsible for the care of both children and aging family members. The demands of balancing familial obligations with professional responsibilities were described as immense. Nurses with children similarly expressed the need for schedules that aligned with their family routines. A common request was for the option to work a consistent shift, whether days, evenings or nights, rather than rotating through multiple shifts. Others emphasized the importance of being able to select a full-time-equivalent [FTE] that matched their caregiving responsibilities. As one nurse explained, "To stay in nursing, I need an [FTE] that works for my family… currently [I'm working above my desired FTE] and I'm dying a slow death." Nurses described how rigid scheduling structures created significant conflict between their roles as caregivers and as health care professionals. One nurse stated bluntly: "Being a nurse is not compatible with being a parent. Employers try to make you put your child second [to your job]." Several nurses shared that they had left certain nursing positions entirely due to the lack of willingness on the part of employers to engage in conversations about schedule flexibility to support family life and additional caregiving responsibilities outside of nursing work.

Additionally, nurses expressed interest in job-sharing opportunities. However, nurses reported that despite the inclusion of job-sharing provisions in some collective agreements, employer resistance remained a significant barrier.

Nurses described current work environments as incompatible with the demands of full-time or FTE hours, citing significant impacts on their health and overall well-being. One nurse stated plainly: "Full-time in this current work environment is not feasible. It's not healthy. I believe that. I don't really care where you work. It doesn't matter what area, it's just not healthy, because it's too much." In response to the physical, emotional and psychological toll of full-time work, many mid-career nurses reported choosing to reduce their hours to part-time in order to protect their health and achieve a more sustainable work-life balance. However, they acknowledged that this often came at a cost, particularly the loss of access to employer benefits, but was deemed as a significant but necessary trade-off.

This tension between professional and personal well-being was also echoed by advanced-practice nurses, including nurse practitioners (NPs) and registered nurses (RNs), in administrative and leadership roles. These nurses expressed a desire for part-time options that simply did not exist within their current roles. As one nurse explained: "I'm in a nursing leadership role, and the only option to do that is full-time. And I find that's a really hard balance for me as a mom with young children. I just find that really challenging – feeling that I have to forfeit my professional goals because I don't fit into the mold of, like, what I typically should work as in a type of leadership role. I am working an FTE that I don't want to, but I also don't want to let go of my career. I have major job satisfaction right now, which is why I am staying in the FTE that's above the number of hours I want to work. I do feel it in my home life… and that's difficult."

Nurses in these roles desire the ability for part-time work arrangements, serving to mitigate some of the trade-offs nurses are currently forced to make between their professional aspirations and personal responsibilities.

Nurses advocated for opportunities to hold partial FTEs in more than one workplace without penalty, emphasizing that diversification could serve as a protective factor against burnout. As one nurse proposed, "The longer I stay as a full-time nurse on one unit, the faster I burn out… let me diversify my skill set… let me keep a 0.5 FTE in a high-acuity area, be flexible with my rotation, and let me go work

a 0.5 FTE term in the community, because I find that rewarding – because I'm really burnt out in acute care… give me that option." Nurses noted that the diversity of experiences this arrangement afforded contributed to their continued job satisfaction. However, they were also acutely aware of the financial trade-offs associated with such flexibility. As one nurse remarked, "My pension takes a hit." Others noted that working part time slows the accumulation of seniority, yet they believed these sacrifices were necessary to avoid burnout: full-time employment, they explained, would have driven them out of the profession entirely. Several nurses recalled a time when holding two FTEs within the same institution was also permitted, an arrangement they felt significantly enhanced their job satisfaction and professional fulfillment. One nurse reflected: "When I started [17 years ago], you could hold two FTEs. I could work a [partial] FTE in mental health and a [partial] FTE in ICU [intensive care unit]. I want to balance those skills and live out the two career dreams I have. That was totally supported, whereas now you can only hold one point code… then I had to choose, and I think, why would you take a nurse that has all this experience and not allow them to flourish?"

Senior nurses described how they utilized several of the strategies described above throughout their career, and how doing so culminated in their ability to stay in the nursing workforce for the longevity of their careers. These now senior nurses intentionally avoided full-time roles early in their careers, recognizing that the demands of full-time would have been unsustainable. One nurse shared: "I'm an old gal, and the thing that's kept me here is the flexibility. I haven't worked full time most of the time. Had I had to do shift work, work full time and balance [life], I'd be long gone." Flexibility, particularly the ability to work reduced hours, was consistently identified as essential to maintaining a career in nursing over time. Other senior nurses emphasized that what had sustained them throughout their careers was the ability to find work environments that supported flexible scheduling models, such as part-time positions or self-scheduling. Notably, many had intentionally moved between roles or settings rather than remaining with a single employer for decades. One nurse reflected: "As an old nurse, I've been fortunate enough to find ways to stay in nursing. My shelf life is about five years at any given place… 25 years ago I also found a unit that self-scheduled – it was wonderful. It kept a lot of nurses."

Senior nurses emphasized the need for scheduling practices that acknowledge the biological and professional realities of aging. Many expressed a desire for increased flexibility in the later stages of their careers, including exemption from night shifts and on-call duties, the ability to reduce their hours to partial point codes and access to job-sharing arrangements. However, nurses reported that obtaining such accommodations often required formal medical accommodations, something they viewed as an unnecessarily medicalized response to the natural aging process. As one nurse explained, "For us nurses over 60, [we] would really benefit from some form of accommodations that don't require going through physician-ordered accommodations." The ability to scale back gradually from full-time hours as retirement approached was seen as essential to both nurse well-being and retention. Yet nurses described systemic barriers to such transitions. One senior nurse shared: "I've been full-time my whole career… I want to be able to go to my employer now and say: can I work a 0.8 FTE?" and noted that current organizational structures made such requests unfeasible. The lack of flexibility was particularly frustrating given the increasing demands placed on senior nurses despite their changing physical capacity: "As we age in the workforce, we need less workload, not more."

Many senior nurses also described making difficult decisions to leave high-acuity areas they were passionate about, often after decades of service, because the work environments no longer supported their needs. These nurses transitioned into lower-acuity areas, with more consistent scheduling. These transitions were made out of necessity due to inflexible work structures and a perceived lack of appreciation. One nurse recounted: "I left emergency nursing after 27 years.

I love the ER [emergency room], but the environment I had to work in changed dramatically over the years… to work in those conditions is horrendous… I left. Now I'm so appreciated, but my curiosity is not peaked like in the ER… what I'd very much like is to be back in the ER."

Job sharing

The division of one full-time FTE between two nurses was identified as a promising strategy to support senior nurses in remaining in the workforce while also contributing to the development of early-career nurses. One nurse suggested: "Job sharing for older nurses like me, instead of just… ending my career, it would be nice if I could have somebody else [to] job share for a couple years. Then you don't lose my knowledge to the newer people coming on board, [I can] help with that mentoring." This sentiment was echoed by early-career nurses, particularly those in high-acuity areas, who expressed a strong interest in having experienced mentors at the bedside: "I want there to be more incentive for senior nurses to come back to the bedside – that would be wonderful." Mid-career nurses also reflected on the impact senior nurses had on their own development and retention. One nurse shared: "My god, they could do anything… they saved us [newer nurses] so many times… I learned so much… you just want to work there forever [when you have that senior nurse support]."

These accounts collectively underscore nurses' need for modernized scheduling practices that reflect the evolving realities of the nursing workforce across the career trajectory, and support nurses achieving their professional goals and aspirations while supporting their need for work-life balance.

Workload

Nurses consistently reported feeling deeply disconnected from decisions related to nursing workloads and the ongoing reduction of essential resources required to provide quality care. As one nurse observed, "It doesn't matter where we are in the system, the resources have been stripped so bare that we can't – we just simply can't provide good care", another nurse reiterated: "we're run off our feet… the workload is just too much". Over the past decade, nurses described witnessing substantial increases in workload without corresponding improvements in support or staffing levels. As one nurse stated, "In the last 10 years, it's [workload] continued to get worse, not better, and we never see any improvement." This worsening workload was understood to be symptomatic of a pervasive organizational culture grounded in expectations to "do more with less," a mentality nurses identified as a key contributor to burnout: "It's always the mentality of 'do more with less', less staff – but how can we do more… that's how you foster burnout."

Nurses attributed these unmanageable workloads to their exclusion from workload planning and staffing decisions. Nurses voiced concern that current staffing decisions are made without adequate consultation or understanding of current care delivery realities. One nurse explained: "The employer will look at how many people are on the unit. And they say: 'You have enough on your unit.' It shouldn't be up to them to say that you have the right amount of people on your unit." The result, according to nurses, is a widespread experience of being overwhelmed and unsupported. One nurse captured this sentiment starkly: "We're [nurses] already drowning, and they [employer] keep pulling the lifejacket away from us – it feels like they're holding our head under water."

Workload was also directly linked to nurses' sense of work-life balance. Nurses suggested that adequate staffing and workplace supports naturally foster healthier work environments. As one nurse put it, "When you have the right number of staff, the right amount of supports in the workplace, work-life balance solves itself." Several nurses indicated they would be more willing to increase their

work hours, or even consider returning to full-time work, if the work environment improved. For example, one nurse stated: "If the work environment went back to a healthy one where I felt supported and safe and not burnt out all the time… [I'd be willing to pick up extra shifts]." Another added: "Whereas, if you make these work environments more attractive and healthier, then people who are working part-time would pick up more [shifts]… when we can get better working conditions, more nurses may convert to full-time."

A commonly proposed solution nurses wanted to see was the implementation of legislated nurse-patient ratios across the country. Nurses believed that ratios would restore their ability to provide the best possible standard of care: "Patient ratios could give us our ability to care for the patients the way that we are supposed to." They further argued that legislated ratios would serve as a necessary safeguard against employer practices that overburden nurses: "They would restrict our employer from putting more patients onto our shoulders." Nurses also viewed ratios as a mechanism for increasing organizational accountability: "Patient ratios would do a lot towards holding the employer accountable for how they treat us." Finally, nurses identified the potential for nurse-patient ratios to improve workplace culture and retention. They believed that safer staffing would lead to greater job satisfaction and a renewed desire to stay in the profession. As one nurse expressed, "If ratios come, I would get a lot more satisfaction out of my work, doing a better job." Nurses also believed ratios would create some necessary changes to workplace cultures, which have become increasingly toxic in response to a health care system in crisis, "patient ratios would go a long way to helping improve workplace culture".

Special considerations: uncompensated workload for nurses managing patient caseloads

Nurses in roles involving ongoing patient case management, meaning nurses who are responsible for an ongoing patient roster (complex care nursing case managers, community nursing teams) – particularly registered nurses (RNs) and nurse practitioners (NPs) in primary care or outpatient settings – described significant challenges in taking time off due to the absence of backfill coverage. When these nurses take vacation or personal leave, their work is left unattended, resulting in a backlog of clinical responsibilities upon their return. In many cases, this leads to extended hours, either catching up on accumulated work or managing urgent issues while off-duty. One nurse explained: "At the end of the day, people's health isn't part-time. So who's covering when I'm not supposed to be at work? So on my days off, I'm still having to try to navigate patient care." Nurses in these roles often reported that they are not eligible to claim overtime, meaning this additional work is performed without compensation. This experience was especially common among nurse practitioner participants, who noted that this lack of structural support undermines both their well-being and the sustainability of their roles.

Special considerations: expanding nurse practitioner scope and subsequent workload

Nurse practitioners spoke at length about the rapidly expanding scope of their clinical responsibilities and the growing complexity of their patient care roles. Nurse practitioners noted that their workloads have increased significantly in recent years, often without any corresponding adjustments to support structures, such as limits on caseload volumes, protected time for administrative tasks or additional human resources. This expansion of scope and responsibility was described as occurring in the absence of safeguards, raising concerns about both quality of care and practitioner burnout.

Nurse practitioners also identified the need for collective agreements and compensation models that better reflect the unique nature of their work. One key concern was related to on-call pay. Nurse

practitioners drew a clear distinction between the clinical responsibilities of a nurse practitioner on call, such as diagnosing patients and initiating treatment, and those of a registered nurse or licensed/registered practical nurse on call, whose scopes of practice do not include these extended-class duties. Despite this difference, nurse practitioners noted that all groups receive the same hourly on-call pay, which they viewed as inequitable and unreflective of the complexity and accountability associated with the nurse practitioner role. These concerns signal a need for more nuanced and differentiated policy frameworks that recognize the distinct clinical contributions and workload burdens of nurse practitioners.

Scheduling and workload impact on preceptorship and mentorship

Senior nurses reflected on their long-standing involvement in precepting multiple generations of nurses over the years. While many had taken on this role for decades, the past five years were described as particularly challenging due to increasingly unmanageable workloads and high staff turnover, which resulted in senior nurses being asked to preceptor more frequently than ever before. Despite a strong commitment to supporting the next generation of nurses, both senior and mid-career nurses emphasized that preceptorship responsibilities were not being adequately reflected in their workloads, contributing to widespread burnout, diminished motivation and, in some cases, an outright refusal to take on learners. As one nurse expressed, "I love to teach and I love to mentor, but the last few years, the pressures at work, the expectations at work are really high… I'm feeling maxed out… I cannot take on the weight of an additional learner, will you please stop asking me."

When asked what changes were needed to make preceptorship sustainable, nurses emphasized that teaching must be formally recognized in workload planning. One nurse stated: "There has to be a structure that if I take a learner, some of my job needs to be taken away. I can't do my job to full capacity and also be precepting someone… it [teaching] takes time."

Similarly, nurses underscored the importance of protecting orientation time for those receiving preceptorship. Nurses recounted numerous instances where orientees were pulled from their orientation shifts to cover patient assignments due to staffing shortages, a practice they viewed as deeply problematic and unacceptable. One nurse explained, "They need their orientation, they should not be pulled off early, that's not even a question, but [the employer] uses them as staff." A nurse who had repeatedly experienced this during their own orientation stated: "We want to be set up for success, but we're being set up for failure." This lack of protected orientation was seen as a significant contributor to attrition: "It's certainly a huge reason they [new nurses] don't stick around." Nurses wanted to see clear monitoring and enforcement mechanisms implemented, including penalties for employers who inappropriately reassign nurses during their orientation period.

In addition to one-on-one preceptorship, senior nurses expressed a desire to mentor through more formalized roles integrated into their point codes. They envisioned positions where senior nurses could dedicate part of their FTE to mentorship activities without being assigned direct patient care responsibilities, and they distinguished this role from nurse educator roles: "These mentorship positions would need to be completely separate from educators; their role is different." However, nurses expressed concern that even if such roles were established, they too could be at risk of being pulled to cover patient assignments if monitoring and enforcement mechanisms were not in place. One nurse reiterated this concern: "They cannot be pulled into baseline staffing."

Nurses identified several additional benefits to formalized mentorship roles. One was the opportunity for senior mentors to support multiple preceptors simultaneously, alleviating some pressure that has

been put on relatively inexperienced nurses who are increasingly tasked with onboarding others. As one nurse noted, "We've got young nurses who are now the most senior nurse on the floor, who are now precepting new nurses coming on, and that's what we're constantly seeing." This not only placed undue responsibility on early-career nurses but also undermined quality mentorship. Nurses further emphasized the importance of individualized learning, noting the limitations of standardized orientation models. One nurse explained, "There has to be consideration that for various individuals, some take longer [to learn particular things]... people struggle with different aspects [of learning]... orientation needs to be personalized... what are your learning needs and how can we best address those?"

Mentorship was also described as a key factor in prolonging the careers of senior nurses. Senior nurses expressed a strong desire to contribute to the profession through mentorship, viewing it as both a retention strategy and a way to "give back." As one nurse stated, "If you want to keep senior nurses, you need to give them the opportunity to feel that they're giving back." Many expressed a deep sense of responsibility to support new staff. One nurse shared: "I feel very, very strongly about my responsibility to new staff." Some senior nurses who had left high-acuity areas due to a lack of flexible work arrangements expressed a strong interest in returning, specifically to provide mentorship. One nurse stated: "If I had a magic wand to give myself a job tomorrow, I'd like to be a nurse mentor [in the ER]. I would be able to give my best, my knowledge, my experience, my mistakes, to somebody else... I think I'd be good at it."

Several nurses nearing retirement reported delaying their departure in order to support early-career nurses entering a health system in crisis. As one nurse explained, "I'm staying for the younger ones, to support, to instill knowledge." Yet they acknowledged the personal cost of doing so: "At what point do I lose my soul [in this job]?" Despite these sacrifices, many felt a strong moral obligation to remain: "We've got to stay to help these young nurses." These motivations were grounded in their own early-career experiences, when mentorship and support were more robust. One nurse recalled: "When I graduated in 1989, I had support. I had people who answered my questions, who did not belittle me, who helped me do something the first time. And that makes a difference." Nurses expressed frustration at the erosion of those supports over time, describing current orientation conditions as "absolutely abysmal."

Throughout these discussions, nurses consistently identified scheduling and workload as two central pillars that must be addressed to improve work-life balance. However, they believed that employers had yet to consider the full scope of what supporting work-life balance truly entails. As one nurse explained, "What I don't think they've [employers] started to look at is the broader picture of [supporting] work-life balance."

To advance sustainable improvements in scheduling, workload and beyond, nurses wanted greater nursing representation at all levels of decision-making, including within executive leadership. One nurse posed the question: "How valuable would it be to have a nurse on the leadership team, to have places for nurses within executive leadership, so that decisions would better benefit nurses on the floor?" Crucially, nurses argued that those nurses in leadership roles must hold equal decision-making power to their non-nursing counterparts, which they felt was not currently the case. They emphasized that meaningful nurse influence across organizational hierarchies would lead to more effective and supportive decisions regarding care delivery and working conditions.

5.2.2b Recommendations to engage nurses

1. Employers, unions, and federal, provincial and territorial governments must embed frontline nurses in organizational and system-level decision-making.

Establish formal advisory bodies composed of frontline nurses at organizational and provincial/territorial and federal government levels to provide input on policies, staffing models and care delivery planning. Mandate nurse representation with decision-making power on health care executive teams, boards and governance committees at the organizational and provincial/territorial and federal government levels. Employers and provincial/territorial and federal governments develop feedback mechanisms (e.g., regular forums, digital submissions) that allow nurses to propose solutions and track how their input is used.

2. Employers and unions must reform scheduling practices to include nurse-led flexible models that meet patient need and adhere to collective agreements.

Employers work with unions to reinstate unit-based nurse-led scheduling where feasible and in accordance with collective agreements, or embed mandatory nurse representatives within centralized staffing teams. Offer self-scheduling options and standardized access to both 8-hour and 12-hour shift rotations. Build infrastructure to support job-sharing and dual positions across units or sectors.

3. Employers and unions must establish formal protected mentorship and preceptorship roles within nursing full-time equivalents (FTEs).

Employers work with unions to designate dedicated mentorship FTEs, separate from clinical educator roles, with protected time and compensation. Provide mentors with robust supports to succeed in these roles. Ensure workload adjustments, notably reduced patient assignments, for preceptors, and prohibit orientees from being counted in baseline staffing. Implement enforcement mechanisms to prevent inappropriate shift reassignment. Consider linking such mechanisms to workplace accreditation.

4. Appoint a Chief Nursing Officer (CNO) in each province and territory to work alongside the federal CNO and existing provincial/territorial CNOs, ensuring nursing expertise is embedded in jurisdictional health system governance.

Provincial governments should establish, where they do not already exist, provincial chief nursing officers (CNOs) with decision-making authority. All federal, provincial and territorial CNOs should be provided with sufficient staff and resources to fulfill their mandate.

These CNOs must have formal authority to participate in high-level policy, funding and workforce planning decisions, particularly those impacting nursing practice, staffing and retention. Their roles should include direct engagement with ministries of health, health authorities and legislative bodies to ensure nursing perspectives shape health care priorities. Their roles should also include funded access to a supportive office. The federal government should also mandate frontline nurses' consultation on federal, provincial and territorial policies that CNOs are consulted on.

5.2.3a Respect us: what nurses said

Nurses emphasized the critical importance of being respected as skilled professionals, not only in their daily work but also in how the nursing profession is valued by employers and governments more

broadly. Nurses discussed various ways in which respect for nurses was lacking – feeling respected was rare, even though nurses believed that as educated professionals they deserved respect, and linked career satisfaction directly to respect: "Nurses are highly intelligent, very articulate, very capable professionals… nursing has the potential to be an amazing career… but we need to be respected… and we're not." To convey respect, nurses need to be treated as skilled professionals who require ongoing professional development opportunities and career progression opportunities, who are entitled to the benefits earned, and who know their boundaries best. Nurses also described how respect can be shown across the career trajectory, providing examples for early-career, mid-career and senior nurses. Retention efforts were also discussed as an essential way to demonstrate respect for nurses across the career trajectory but in particular for mid-career and senior nurses.

5.2.3.1 Respect us as skilled professionals

Nurses made clear that their designation as professional workers entitled them to a certain degree of respect. However, nurses frequently described a disconnect between what they believed respect ought to look like versus how they felt it was conveyed in the workplace. Nurses often described symbolic gestures of appreciation, such as generic email accolades, and the everyday actions of employers, which failed to demonstrate meaningful respect or recognition towards nurses. While employers often circulated email messages commending nurses for their hard work and dedication, nurses noted that such gestures were perceived as disingenuous in the absence of corresponding structural or relational support. What nurses encountered in their day-to-day work lives conveyed a sense of dehumanization. As one nurse succinctly stated, "You're a number, you're not a person, you're a number doing a job." This sentiment was echoed by others who felt their individuality, expertise and professional contributions were consistently disregarded. One nurse remarked: "They [employers] don't care who you are or what you bring to the table, don't care about the expertise you bring – that's how they treat us." Nurses' accounts highlight a pronounced discrepancy between their expectations of professional respect in the workplace and the realities of their lived experiences.

5.2.3.2 Provide us with ongoing professional development opportunities

Nurses across all career stages and practice settings were unequivocal in asserting that professional development is a cornerstone of safe, competent and ethical nursing care. They emphasized that ongoing education, whether formal or informal, should be an expectation within the role of a licensed professional. However, in practice, such opportunities were described as scarce, difficult to access and frequently devalued: "Career development can be as simple as offering educational opportunities within the work environment… currently there's zero [career development opportunities]," one nurse noted. When educational time was provided, it was often "hijacked by the employer" and repurposed for mandatory workplace training rather than professional growth. Mandatory training was perceived by many nurses as being driven primarily by employer liability rather than nurses' clinical learning needs: "They don't actually care what nurses need [educationally] to provide patient care."

Beyond this reallocation of limited educational time, the pursuit of optional professional development was actively discouraged. Nurses described prohibitively complex application processes, lack of shift coverage, absence of managerial approval, and no funding support as routine barriers. Instead, nurses are increasingly expected to develop critical skills on the job while managing full patient assignments. One nurse described the unrealistic nature of this approach: "They're [educators] interrupting you, showing you [profoundly complex patient care technology], scooting it around from nursing station to nursing station while we're still caring for our patients… that seems like a pretty big skill to [try to] learn while we're [busy] providing patient care."

Similar issues arose with mandatory training requirements, which nurses were often expected to complete outside of paid hours and without relief from clinical duties: "No one replaces you to give you the opportunity to work [on mandatory training], you need to do that on your own time… you're requiring me to do this to do my job, but you're not giving me the time to do it." Nurses were particularly critical of the expectation to self-monitor for important updates communicated solely through email. Given the demands of clinical practice, nurses described email-based communication as ineffective and inappropriate: "I already have hundreds of emails from my employer in my inbox. If you want me to know something, you need to come and physically tell me… I'm not going through my work inbox on my own, unpaid time. That's *my* time."

There was strong consensus that all professional development activities, whether optional or mandatory, should be completed during paid time and outside of patient care responsibilities: "This is a work-required skill, so the employer needs to provide it and pay for it." However, nurses noted that in most workplaces, this standard was not upheld: "Even getting an additional certification [that positively impacts patients], it's on your own time, it's not supported, it's not integrated into [your work]," one nurse shared. On the rare occasions that training occurred during paid time, nurses described it as "a breath of fresh air" and a signal of respect from the employer.

Paradoxically, acquiring additional certifications or advanced competencies often resulted in what nurses described as punishment: "The current work environment, which is so unstable, is a deterrent… each new responsibility you take on is more of a burden… once I have that [upskilling], I'm responsible for sicker patients [with no additional resources]… it makes work even worse." Others echoed this experience: "If you have the certification, you get extra duties." Rather than being celebrated, advanced skills became a mechanism for increasing workloads without commensurate support, time off or compensation.

In some cases, advanced certification also created logistical challenges related to scheduling, particularly when time off or shift swaps were desired. Nurses explained that those with specialized skills could only be backfilled by staff with the same qualifications, significantly limiting flexibility: "Which is a smaller pot of nurses… so it made my work-life balance even worse." As a result, some nurses deliberately avoided professional development to preserve manageable working conditions.

Nurses called for a culture shift in which advanced competencies were acknowledged, supported and celebrated. They emphasized that employers should proactively invest in nurses' professional development by offering fiscal support, flexible scheduling and internal opportunities, rather than requiring nurses to independently seek, fund and accommodate educational pursuits on their own time. Nurses expressed the desire for employers to demonstrate a genuine interest in their career aspirations, but noted: "Not once in my career have I been asked what my career goals are. Are there particular things you'd like to learn in this job?"

Underlying these concerns was a broader critique of how nurses' value is conceptualized by health care organizations and governments. Nurses described a persistent focus on monetary cost: "Costs, resources, how costly we are as nurses," which they saw as reductionist and incomplete. In contrast, nurses defined their value in relation to their contributions across the continuum of care and their impact on quality outcomes for patients, families and communities. They expressed deep frustration that the sacrifices they make in service are too often invisible or unappreciated.

5.2.3.3. Provide us career progression opportunities

Nurses across various care settings and career stages highlighted a persistent lack of vertical career progression opportunities, particularly for those seeking to remain in frontline clinical roles. While the profession was initially attractive due to its diverse employment opportunities across sectors and geographical locations, nurses reported that most available movement was lateral rather than upward. As one nurse observed, "Currently there are lots of opportunities to change where you work [location]... but then where do I go from here? I can [go to another area], but I can't go up, I'm just bouncing around on the same level, there's only lateral movement."

This lack of professional advancement contributed to feelings of stagnation. One nurse reflected: "Even in my own career, I'm just kind of stagnant now. There is no real opportunity for growth. So, if there was opportunity [for horizontal progression], maybe that would reinvigorate some of that passion that is waning as I get older, because there's just nothing in terms of opportunity." Nurses expressed a desire for more robust and structured opportunities for professional development within their units and departments. They envisioned mechanisms to support both skill expansion and recognition as key to reigniting professional passion and strengthening retention.

Nurses who pursued advanced education, such as a Master of Nursing or a combined Master's nurse practitioner (NP) degree, encountered additional structural barriers. Many described returning to their previous roles as registered nurses (RNs) despite their additional qualifications, with little to no recognition or compensation for their additional expertise. As one nurse shared, "They [workplaces] don't actually have a position [for their advanced qualifications] – my qualifications are not recognized or valued." This led to frustration and demotivation, particularly when the practical application of advanced knowledge was not rewarded: "I completed my master's – and I get 25 cents more an hour. It is really not financially lucrative in any capacity to do that at all."

In addition to the lack of role recognition, nurses reported minimal institutional support during their graduate studies. Nurses recounted having to constantly switch shifts to accommodate academic schedules, often without access to educational leave or financial support. These constraints contributed to feelings of being undervalued by their employers: "Why do they [employers] make it so hard for us?" Some nurses noted that this lack of support prompted them to seek employment elsewhere upon completing their degrees, often in roles or organizations that actively valued and utilized their advanced education. In these cases, the absence of employer support was viewed as a missed opportunity to retain highly skilled nurses.

Conversely, a small number of nurses shared experiences of being granted educational leaves of absence and other forms of institutional support while pursuing graduate studies. These cases were acknowledged as exceptions rather than the norm. When asked about the impact of this investment, one nurse emphasized: "You have more commitment to the facility," underscoring the potential retention benefits of supporting nurses' academic and professional growth.

These findings highlight nurses' needs for clear career progression opportunities that move beyond lateral mobility, providing meaningful progression, formal recognition of academic achievement, and workplace structures that actively support nurses' pursuit of lifelong professional growth. Without these mechanisms, nurses risk professional stagnation.

5.2.3.4 Honour the benefits we are entitled to and have earned

Nurses across all focus groups discussed frequent and frustrating challenges accessing a range of employment benefits to which they were contractually entitled, particularly vacation and various forms of leave. Nurses reported needing to "fight" for leave days explicitly outlined in collective agreements, including bereavement and personal leave. This ongoing struggle contributed to a broader perception of organizational disrespect. As one nurse noted, "You have to fight for every single leave day you take," adding that when such requests were granted, it was "shocking."

Vacation denial emerged as a central and universal theme, with nurses describing repeated instances of denied vacation requests, even for events of significant personal importance. Nurses expressed frustration that this occurred despite their entitlement to the time off: "We have earned that time… but it's pulling teeth to get it off." Early-career nurses were disproportionately impacted, as one nurse observed: "In my organization, if you're in the first five years of your career, you are not getting any vacation granted, yet they [employer] send these emails of 'take your vacation, your time off is important to us.'"

The most striking example of this disconnect was the consistent denial of vacation for early-career nurses' weddings, an issue raised in nearly half of the focus groups. One nurse recounted: "I wasn't granted vacation to go to my own wedding… so I had to find a workaround… using a family day… to attend my own wedding." This rigid approach to vacation approval contributed directly to nurse attrition, particularly among new hires. A mid-career nurse reflected: "Why are the nurses you're orientating every month leaving? Because they can't get vacation."

In response to these barriers, many early-career nurses shifted to casual employment to gain control over their schedules. One nurse explained: "We have some younger nurses who drop to casual during the summer because that's the only way they get schedule flexibility… then pick up a term in the fall… you can work casual, and you can work full-time hours, make your own schedule… choose when to come to work and when not to come to work."

Mid-career and senior nurses found these circumstances deeply disheartening and offered practical strategies to improve vacation access for early-career nurses. For instance, several advocated for the creation of designated relief lines: "You need to actually be able to take your vacation when you would like to take vacation. There should be relief lines so that people are able to get vacation over the summer, and in areas where we know that there's specific needs to be filled, put out relief lines to cover vacation for those younger nurses."

Nurses also described the workaround strategies often required to secure time off in the absence of approved vacation, such as orchestrating complex shift swaps. These practices were identified by nurses as problematic for three reasons: (1) they resulted in physically and mentally taxing stretches of work; (2) they placed undue pressure on colleagues to accommodate switches, often requiring them to work beyond their FTEs; and (3) they unintentionally signaled to employers that vacation denial was manageable, as staff found alternative means to take time off.

Discussions about vacation and leave entitlements frequently turned toward the broader issue of seniority. While nurses acknowledged the value of seniority, they highlighted its limitations in a contemporary fluid workforce. One key concern was the lack of seniority portability across employers, unions or roles, which constrained nurses' career mobility and long-term job satisfaction. Nurses described feeling trapped in positions they no longer found fulfilling solely to preserve their

accrued benefits. As one nurse stated, "You get 20 years into your pension and ask, 'could I leave?' But I have seniority, vacation time… I'll just stick it out. We're bound [to our employer]."

Others who did leave found themselves penalized: "I worked my way up to seniority there [in another union]. Unfortunately, when I left, I couldn't take those hours [into a new job]. They were not portable… that's very prohibitive for people." This concern was echoed by licensed/registered practical nurses (LPNs/RPNs) who bridged to registered nurse (RN) roles. Despite years of service, they found their prior seniority unrecognized, resulting in significant pay reductions: "Transition of LPN to become RNs. They're already an employee but they actually take a pay cut when they become an RN, initially. Which seems unfair. They could have 20 years' experience [as an LPN] and are a really great asset to a team."

Although seniority was highly valued across all career stages, nurses recognized that rigid seniority structures may hinder retention of newer nurses. One nurse summarized this tension: "We need to keep the value of the seniority; there's something to be said for that. But if you want to keep the younger nurses, you have to appeal to what they want." The use of seniority as the sole criterion for vacation approval was also criticized for fostering competitiveness and toxicity: "It creates such a culture of competitiveness, an unhealthy work environment when submitting vacation."

These narratives highlight the need for more equitable and flexible workforce policies, particularly around leave access and seniority, that support both retention and career satisfaction across the nursing career trajectory.

5.2.3.5 Respect our professional and personal boundaries

Nurses described the persistent violation of both professional and personal boundaries by employers as a key source of dissatisfaction, burnout and diminished morale. These infringements were widely perceived as disrespectful and indicative of an organizational failure to recognize nurses as knowledgeable professionals with defined roles and personal lives: "I'm not just a nurse, I'm a human being, please treat me with respect and realize nursing is not my entire life."

A prominent theme in discussions of professional boundaries was the expectation that nurses complete non-nursing tasks, which included administrative and clerical tasks and the work of other regulated and non-regulated health professionals. Nurses repeatedly emphasized that, despite clearly communicating their roles and responsibilities as nurses, they were routinely required to assume duties outside the nursing role. One nurse expressed: "I spend too much time doing non-nursing duties, clerical duties, dietary duties, housekeeping duties, ordering duties – duties that are not actually nursing duties." Nurses linked these expectations to operational models that function according to traditional business hours, rather than the 24/7 nature of care delivery. As one nurse observed, "Whoever we don't have today in the building… it [that work] falls on the nurse." This issue was particularly acute for those working evenings, nights and weekends: when baseline nursing staff are less than on day shifts, patient assignments tend to be heavier and support staff less available than during daytime hours: "You're carrying more workload with even less people to support you with that increased workload."

The accumulation of non-nursing duties had a measurable impact on job satisfaction and was frequently cited as a reason for considering leaving the profession. As one nurse put it, "These are the things that irk me, that make me want to leave my job, because I can't just do my nursing job." Others linked their satisfaction directly to being able to focus their time and energy on their nursing work:

"My job satisfaction would be a lot higher if the right people were doing the right jobs instead of me doing a lot of things that are not in the nursing role."

Nurses attributed this trend to cost-saving measures, particularly the reduction of support staff hours. One nurse questioned: "Why am I putting together a chart because the employer doesn't want to pay a unit clerk [in the evenings]? Why am I portering? Why is the employer not stepping up? There's a nursing shortage, not a clerk or porter shortage." In some instances, after persistent complaints, additional support staff (e.g., health care aides or personal support workers) were hired. However, this was often accompanied by a reduction in licensed nursing staff on shift, such as the removal of a licensed practical nurse from baseline staffing. Nurses viewed this as a troubling substitution of regulated nursing professionals with less costly unregulated workers, ultimately increasing nurse-patient ratios and exacerbating nursing workloads.

Beyond professional scope, nurses spoke extensively about the disregard for their personal boundaries, particularly around work-life balance. Many emphasized that maintaining this balance is critical to their well-being: "I need to take care of myself as a human who takes care of humans." However, work-life balance was perceived as increasingly unattainable: "Work-life balance is important in our jobs, and there is none right now… To stay [in nursing], I need work-life balance."

Nurses described how their personal time was routinely interrupted by calls and texts from employers and managers urging them to pick up additional shifts, even after they had explicitly communicated boundaries. "I don't want to work full time… nor do I want to be pressured constantly to work," one nurse stated. The relentlessness of these requests was described as both demoralizing and demeaning: "They [employers, managers] don't respect 'no.'" Another reflected, "It's professionally demoralizing and demeaning… it takes a lot to say 'no.' I don't take the privilege of saying 'no' lightly." Nurses highlighted that the inability to disconnect from work even on days off was highly disruptive: "I just feel like I wasn't actually getting days off because I was just constantly being asked to come in, being called all the time to come in for shifts on my day off… it kind of takes over your day."

The expectation that nurses should continuously sacrifice their personal time was widely viewed as unfair and unsustainable: "The expectation that they [employers] just want more out of you… it's like getting blood from a stone." Nurses also described being "guilt-tripped" into picking up overtime or extending scheduled shifts, with emotional appeals that leveraged professional camaraderie: "'Our co-workers working short' is used to guilt us into picking up… because they [staffing department or unit manager] know nurses want to support their peers."

Nurses shared numerous examples of these guilt-inducing interactions. One mother recounted being asked: "Why can't you stay and work, why would you abandon the ward?", to which she replied: "Because I am a mom, I have a life beyond my work." Others described coercive tactics such as the threat of mandating: "I remember my manager saying, 'If you don't volunteer [to extend], I'll mandate you to do it.'" Even calling in sick, a standard and necessary workplace practice, was accompanied by guilt: "I don't want to have to call in, I'd rather be at work, but if I'm calling in, I'm calling in, I don't need the guilt trip." Ultimately, nurses rejected the narrative that staffing shortages are their responsibility to solve: "It's not my problem that the employer didn't staff the unit properly."

5.2.3.6 Respect us across our career trajectories

In addition to the cross-cutting themes noted by nurses at all career stages, there were nuanced differences in how nurses at particular career stages understood respect and coinciding actions to demonstrate respect.

Early-career nurses

Contemporary nurses entering the profession increasingly expect work-life balance to be recognized and upheld by employers. However, early-career nurses reported that this expectation is often unmet in current work environments. Many described full-time nursing positions with rigid scheduling and limited flexibility as undesirable and incompatible with maintaining their mental health and well-being. As a result, numerous early-career nurses intentionally seek casual, term or partial point code positions, and in some cases turn to agency nursing as a means to retain autonomy over their schedules. One new graduate shared how they crafted work-life balance within these constraints: "I never wanted to work full time; I was not interested at all. As a nurse, you can't do full time [with current workloads], so I have a 0.4 FTE. I end up working full time hours with pickups and overtime most of the time anyways. As a new grad, I've really appreciated that flexibility, that's been really helpful to me – I can pick and choose [shifts] for my own mental health. It's worth it for me to maybe not get as high of a mortgage preapproval rate or have a guaranteed income." Early-career nurses did not discuss pension accrual or retirement, even when it was discussed by mid-career and senior nurses within the focus group setting. Early-career nurse engagement in focus group dialogue centered on their current work-life balance and mental health and wellness needs.

This focus on work-life balance and supporting one's mental health and well-being was also acknowledged by mid-career and senior nurses, many of whom observed a generational shift in attitudes toward work. A senior nurse reflected on a conversation with her daughter, now an early-career nurse, who captured this difference succinctly: "You lived to work, mom, and my generation works to live." Other nurses echoed this sentiment, expressing admiration for younger nurses' willingness to prioritize self-care and set boundaries. One mid-career nurse shared: "[Incoming nurses] are not the generation that will work themselves to death, and kudos to them, I don't blame them… I'm of a generation that was told to work myself to death, and I have, and now I'm too burnt out to do anything about it."

Mid-career and senior nurses highlighted that in order to retain the next generation of the workforce, employers must adapt workplace structures and expectations. Several nurses emphasized that newer generations, particularly women, were socialized differently than previous cohorts, raised to advocate for their needs and assert their professional worth in ways that earlier generations were not. As one nurse stated, "They didn't grow up in the same patriarchy the way we did" and, as a result, are more likely to challenge exploitative norms and demand better treatment.

Many senior nurses welcomed this cultural shift, seeing it as an opportunity for long-overdue improvements in nursing work environments. One nurse offered a reflection on how generational change is reshaping expectations within the profession: "Older nurses took a lot of disrespect that new generations won't take… it was kind of generationally accepted to take some disrespect. And now you have a younger generation standing up for themselves."

These insights underscore the importance of responding to evolving generational values in nursing, particularly around work-life balance, autonomy and respect as central components of a forward-looking workforce strategy.

Mid-career nurses

Mid-career nurses described experiences akin to the sandwich generation, expressing a strong desire for workplaces to recognize them as both parents of children and children of aging parents. Nurses emphasized the need for expanded access to family or personal leave days to help manage these responsibilities, which for many mid-career nurses included having to take their child or aging parent to appointments. Mid-career nurses noted that a tremendous amount of this caregiving work falls on the women in the family, even more so when they are also a nurse.

Nurses who were parents wanted access to on-site childcare [in the workplace] to meet the needs of shift workers. Nurses who work rotating or nontraditional hours described significant barriers to accessing conventional childcare services, which often operate on limited schedules that do not accommodate the needs of shift workers. While very few nurses had ever experienced access to workplace-based childcare, those who had reflected positively on its impact. One senior nurse recalled: "The hospital that I worked at [earlier in my career], we had a daycare – it was a wonderful thing, because if your child was sick, you could go over, talk to them, decide on – okay, is this real sickness, or is this just 'want to go home' sickness, and whatnot… that would keep people in nursing."

In the absence of adequate family supports, many mid-career nurses expressed skepticism about their ability to remain in the profession long-term. They noted that current work structures are not designed to support the evolving demands of contemporary family life. As one nurse stated, "It's unrealistic for nurses to work in nursing for 35 years now," highlighting the need for structural reforms that promote sustainable careers over the life course.

Senior nurses

Senior nurses described feeling overlooked and undervalued in their workplaces, despite their extensive experience and long-standing contributions. Several nurses noted a troubling shift in how they were perceived by employers, with one stating: "We're ignored, pushed aside for certain tasks", and another adding: "We're made to feel like our expertise is not needed here." In contrast, senior nurses strongly affirmed the value of their knowledge, asserting, "We have experience, we have things to share."

Senior nurses attributed part of this marginalization to the rapid evolution of health care technology over the past two decades, which has shifted perceptions of nursing competence toward technological fluency. One nurse explained: "We might not be quick with technology, but we are nursing knowledge experts – that's a disconnect that needs to be bridged." Senior nurses expressed a desire to be supported in adapting to technological changes in the workplace through access to tailored training and learning opportunities if needed, without fear of reprisal or judgment. They emphasized that learning supports should be designed with the specific needs of senior nurses in mind.

In the absence of feeling that their knowledge and contributions were respected, some senior nurses, particularly those within five years of retirement eligibility, reported staying in the workforce primarily for financial reasons, namely pension accrual. As one nurse bluntly shared: "That's what's keeping me

here, the benefits [pension], not the working environment, not the lack of respect." Another senior nurse reflected: "For the first time in my [40-year] career, I am only working for [my pension]. I have to work another five years so that my pension is higher. That's the only reason, otherwise I'd be out. I still love my job, I love my clients, but the workplace is not conducive to my age."

These narratives echoed a broader sense of disillusionment among senior nurses, who described feeling increasingly invisible within their workplaces. The lack of recognition and respect for senior nurses at times contributed to a loss of joy in their work, with some indicating that their continued presence in the profession was guided more by necessity than ongoing fulfillment or professional validation.

5.2.3.7 Retaining us is respecting us

Mid-career and senior nurses discussed retention extensively, framing it as both a practical necessity and a fundamental demonstration of respect. Nurses emphasized that retaining experienced nurses is as important as recruiting new ones, yet they felt retention had been consistently overshadowed. One nurse observed: "In human health resource plans, retention… seems to be forgotten," while another added: "Recruitment is important, but you also need to take care of the people that are holding down the fort." Nurses stressed that retention is not only vital to stabilizing the current workforce but also essential to enabling recruitment: "We need to see retention as a way to keep recruitment possible." Nurses pointed to the cyclical benefits of retaining experienced nurses, namely the creation of more stable and supportive work environments that are attractive to new nurses. As one nurse aptly concluded, "We can't recruit our way out of a nursing crisis, it's not going to happen."

Nurses suggested several approaches to incentivize mid-career retention, including service bonuses, recognition awards and targeted incentives for experienced nurses willing to relocate to hard-to-recruit areas. One nurse reflected: "Competitive wages… providing extra stipends for people, not just the new grad stipend that is out there right now… what about me, who's an established nurse, who would be happy to take [incentive] to go work rural emergency… I could do that too, with a three-year return of service."

Across career stages, nurses expressed frustration that most incentives are reactive and short-sighted. Many characterized these programs as superficial "band-aids" failing to address the root causes of nurse attrition. Particularly problematic were incentives tied to mandatory service requirements. Nurses voiced concern that these mechanisms may bind early-career nurses to unsafe or toxic work environments with limited recourse: "You stick somebody new in a toxic environment and force them to stay for a year, do you expect to retain them in the profession?" Others noted that the only way out of these binding service requirements is to grieve the position, a lengthy and emotionally taxing process, especially for early-career nurses.

Nurses were also critical of government programs designed to increase full-time employment uptake through financial incentives. These efforts were widely viewed as ineffective and misaligned with current work realities. Nurses argued that full-time work, under current conditions, poses significant threats to nurses' well-being, "The risks associated with full-time nursing work in current work environments – burnout, psychological distress – are simply not worth it."

Nurses argued that fewer reactionary incentives would be required if core compensation and structural supports were improved. A key priority was increasing baseline salaries, which nurses felt did not reflect their expertise, responsibilities or level of education. One nurse stated: "We are

woefully underpaid for the work we do," while another added: "Our wages aren't keeping up." This was especially frustrating for senior nurses who hit pay and vacation caps early in their careers: "We max out on vacation 10–15 years into the job, that doesn't make sense." For many, salary increases were seen as essential to continued engagement in the profession: "Things I want as a seasoned nurse: I want more money."

Nurses also described benefit packages as insufficient, particularly when compared to other public sector jobs. One nurse noted: "We need better benefits. The city employees who plow the streets have better benefits than us. That's absurd… we have more education." Nurses perceived this disparity as evidence of gendered pay inequity, particularly given the education levels required in nursing. Furthermore, part-time nurses advocated for benefit eligibility, citing the psychological unsustainability of full-time roles in the current environment.

Importantly, nurses emphasized that financial incentives alone are not sufficient to improve retention. "It's [money] always nice, but the fact is that's not the main problem… it's our work conditions." While compensation was viewed as part of a broader solution, nurses were clear that long-term, sustainable retention depends on addressing structural issues, including workload, staffing levels and organizational culture. As one nurse summarized, "Additional compensations are band-aids, the actual problem is not having enough nurses to do the work, the workloads [that creates]." Nurses called for a shift toward substantive, systemic changes to the conditions of nursing work, many of which are addressed throughout this report.

5.2.3b Recommendations to respect nurses

1. Employers and unions must establish paid protected time for professional development, and fund and formalize career progression.

Employers work with unions to establish dedicated and compensated time for professional development, separate from mandatory training. Employers ensure accessible employer-funded opportunities for certification, upskilling and clinical advancement, with scheduling support that does not require nurses to self-navigate complex processes or sacrifice personal time. Employers work with unions to develop clear and compensated clinical career ladders that reward advanced education, specialization, mentorship and leadership within frontline roles. These structures must include financial incentives and reduced patient loads to prevent workload inflation.

2. Employers should introduce relief lines to ensure equitable vacation access through robust staffing planning all year long.

Create designated vacation relief lines to ensure all nurses, especially early-career nurses, can access their entitled time off. This policy would reduce burnout, promote fairness and curb early attrition due to denied vacation, notably amongst early-career nurses.

3. Employers should provide sufficient support staff around the clock every day to remove non-nursing duties from nursing workloads.

Protect nurses' scope of practice and reduce workload strain by ensuring that role clarity is maintained and that nursing time is prioritized for direct patient care, not the completion of non-nursing duties. Increase the hours of support staff, including health care aids, personal support workers and nursing aids, to complete non-nursing duties. Integrate completion of non-nursing duties into existing reporting mechanisms for professional responsibility concerns (PRC), if not already included. Unions

receiving PRCs pertaining to non-nursing duties use this data to identify systemic role creep, advocate for staffing changes and ensure accountability from employers to maintain professional boundaries.

4. Employers must respect and protect work-life boundaries.

Employers implement policies that prohibit off-hour shift solicitation and reduce pressure to work above FTEs. Establish "opt-in policies", whereby nurses must opt in to being contacted off-hours for additional shift requests. Employers enforce accountability for managers or staffing systems that routinely override nurses' personal boundaries.

5. Employers and federal, provincial and territorial governments should develop a comprehensive retention strategy centered on structural reform, not short-term incentives.

Provincial governments need to implement the recently developed federal *Nursing Retention Toolkit* by Health Canada in ways that attend to nurses across their career trajectory (early-career, mid-career and senior nurses) through structural reforms. Federal government funds provincial implementation and monitors compliance. Employers prioritize toolkit items that best meet their nursing retention needs, in consultation with nurse employees.

6. Employers should increase baseline salaries and enhance benefit packages.

Employers provide baseline salary increases to reflect education, expertise and long-term contribution. Expand benefits for part-time nurses, acknowledging that some nurses want to, or need to, work part-time and should not be penalized through a lack of benefits for doing so. Increase service recognition incentives with less stringent conditions (e.g., longevity bonuses, rural placement stipends) for nurses across the career trajectory – not only new graduates. Vacation and pay cap reform to extend career satisfaction beyond the 10–15-year mark. Employers work with unions to explore including the portability of nurse seniority between employers to preserve benefits related to seniority accrual.

Conclusion

Data from this pan-Canadian study highlights that longevity in the Canadian nursing workforce is contingent upon nurses being protected, engaged and respected across the entirety of their career trajectory. While protection, engagement and respect look similar across the career trajectory, important nuances across generations exist and must be attended to in order to meet the needs of a multi-generational workforce. Nurses have made urgent calls for their professional and moral integrity, and physical and mental health to be protected; for their expertise and professional knowledge to be consistently and meaningfully leveraged at all levels of health care decision making, including those that impact their day-to-day work. Nurses must also be respected as skilled professionals – this includes having access to ongoing professional development and career advancement opportunities. Nurses must have their professional and personal boundaries respected and upheld. Nurses who participated in this research provided robust, well-thought out and actionable ways in which governments and employers can meet these pressing needs. Opportunities to increase nurses' longevity in the workforce and, subsequently, strengthen and stabilize the national nursing workforce are plentiful, responsive and swift action is now necessary.

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