



►► Nursing Retention and Safe Care Understaffing, Moral Injury, and Workforce Stability in Canada

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October 2026

Nursing shortages in Canada are widely recognized, but current policy responses still focus primarily on recruiting new staff rather than addressing why nurses are leaving the profession at alarming rates. As a result, retention challenges are intensifying and pushing the system toward a breaking point. Against this backdrop, the experience of one nurse illustrates how an overloaded, under resourced environment can quickly push even committed new nurses to the edge of burnout and out of the workforce.

An emergency department nurse at Saskatoon's Royal University Hospital, Jacelyn Wingerter, just eight months into her career, describes how the chaos of an overloaded system impacted her. She works in an ER built for 35 beds that routinely has around 100 patients needing treatment. Every shift is short staffed because colleagues are already burned out and leaving. Despite entering the profession to help people, Wingerter reports feeling "defeated", cycling between exhaustion, moral distress, and fear of making mistakes in unsafe conditions, and openly questions how long she can stay at Royal University Hospital before she too has to walk away from emergency nursing to protect her health^{1 2 3}.

Her experience captures the central policy problem in nursing retention: nurses are not only leaving because the work is demanding, but because health systems no longer reliably provide the conditions needed for safe care, professional judgment, and sustainable practice.

The strongest evidence to date indicates the declines in nurse retention are driven by the following factors:

- Chronic understaffing
- Emergency room overflow
- Interpersonal stress
- Moral injury
- Poor schedule control
- System capacity pressures
- Weak transition supports
- Workload intensity

A recruitment-first response is inadequate because it does not address the conditions that push nurses out. At the organizational level, Raelynn Douglas's *The Billion Dollar Blindspot* argues that health

care turnover is not just an HR issue, but a hidden operational and financial liability. When excessive nursing turnover becomes normalized, it erodes capacity, continuity of care, and workforce morale while diverting millions of dollars from health system budgets priorities. This reinforces the idea that addressing nurse retention and workplace well being is a core strategy for system sustainability and fiscal stewardship⁴.

A strong policy response should frame nursing retention as a system issue and pursue an integrated strategy. The approach must combine:

- Safer staffing
- Better shift-work management, including limits on mandatory overtime
- Psychological safety
- Stronger escalation pathways
- Transition-to-practice supports⁵

►► Why retention has become a systems problem

Canada's nursing shortage is often framed as a hiring and recruitment issue, yet evidence shows that it is a complex crisis driven by retention failures linked to unsafe workloads, poor work design and structural pressures on nurses⁶. Nurses are leaving roles where workloads, staffing levels and skills mix are unrealistic, generating sustained stress, moral distress and burnout that make it untenable to carry ongoing clinical and ethical responsibility in chronically over burdened systems⁷. Canadian data also show that nursing leadership has a direct role in shaping nurses' mental health in these conditions, underscoring that leadership practice is itself a retention lever, not just an HR function⁸.

These reports strengthen the argument that retention is embedded in a broader capacity crisis: nurses are being asked to provide care in increasingly improvised and undignified conditions⁹.

These anecdotes turn abstract workforce discussions into concrete policy failures. That same logic appears repeatedly in the research. Nurses report leaving when workload, burnout, inadequate support, and unsafe conditions make full participation in the system unsustainable¹⁰. Canadian survey data show that nurses are repeatedly exposed to potentially psychologically traumatic events such as severe human suffering, life threatening illness or injury, and physical assault. These exposures are significantly associated with symptoms of PTSD, depression, and anxiety, reinforcing how unsafe environments translate directly into mental health risks and retention problems¹¹.

According to CIHI derived estimates, Saskatchewan has more hospital beds per capita (2.1 per 1000) than most provinces (1.7 per 1000); however, this rate has been decreasing faster than other provinces. Also, Saskatchewan's hospitalization rate and length of typical hospital stay are among the highest in Canada. When higher than average hospitalization and longer stays coincide with a faster than average decline in bed supply, emergency departments face intensified crowding and prolonged waits for inpatient beds. These are symptoms of a broader, wicked health system problem rather than isolated failures of emergency care¹².

National analyses now characterize emergency department crowding as "a problem of hospital overcrowding and strained resources in the broader social and health care systems," reflecting intertwined challenges in acute care bed capacity, long term care and home care, staffing shortages, increasingly complex patient needs and gaps in community and primary care access¹³. Recent data show that half of admitted patients spend more than 16 hours in the emergency department and one in ten more than 48 hours, while over one in seven emergency visits are for conditions that could have been managed in primary care, signaling upstream access deficits¹⁴. The crisis in emergency departments reflects deeper and worsening social pressures including substance use, homelessness, family instability, rising poverty, and affordability challenges. These social pressures increasingly present in acute care settings. Emergency departments have become the system's de facto safety net and the choke point for hospital admissions. When no inpatient beds are available, emergency physicians and nurses are forced into difficult triage decisions about who receives care first, often under conditions of prolonged bed and resource scarcity.

These dynamics are not separate crises but manifestations of a system-wide capacity mismatch spanning social, community, and institutional domains. As the Canadian Association of Emergency Physicians has emphasized, "ER overcrowding and long wait times aren't emergency department problems they're system problems". Policy responses must address upstream social determinants, in-hospital capacity constraints, and downstream care transitions in an integrated manner rather than focusing only on emergency department processes¹⁵. System issues must be addressed when considering approaches to nursing retention. Workload, hours of work, and flexibility are central employment considerations, leading to some nurses avoiding full-time positions to preserve schedule control and recovery time¹⁶. As more experienced nurses reduce hours or leave, support networks, mentoring relationships, and unit cohesion may weaken, making already difficult workplaces even harder to sustain¹⁷. To assess this problem, the following section reviews key evidence from recent research.

►► Evidence and analysis

Financial analysis shows that Canada's current approach is fundamentally unsustainable. Demographic and fiscal pressures are rapidly outstripping the capacity of health and long term care systems to cope.

- Seniors represent 19% of the population yet consume about 45% of healthcare spending.
- Per capita costs for an 85 year old are roughly three times those for a 65 year old.
- Overall health expenditures near 12% of GDP and are projected to rise further as the last Baby Boomers reach 85 by 2051.
- Long term care demand is expected to grow from 1.5 million Canadians in 2019 to 2.3 million by 2031, pushing total long term care costs toward \$60 billion by that date.

Governments could face incremental health and long term care pressures on the order of 2 percentage points of GDP by 2051. This is an unsustainable trajectory that underscores the urgency of rethinking how Canada organizes and funds care¹⁸.

Beyond the financial constraints, the 2022 Canadian study on moral, ethical, and professional dilemmas provides one of the strongest foundations for this brief. Nurses described distress when physicians ignored their assessments, when families demanded treatment that the nurses believed prolonged suffering, and when scarce resources forced morally distressing decisions about who would receive timely care¹⁹. These findings suggest that retention is strongly shaped by whether nurses can safely provide care that remains consistent with their ethical and professional standards²⁰. Complementary Canadian analyses highlight that leaders play a critical role in mitigating these stressors through advocacy, transparent communication, and structured mental health supports. These directly affect whether nurses remain in practice²¹.

The 2026 Saskatchewan provincial audit identified the issue of inefficiency of relying on short-term staffing approaches. The audit examined the Saskatchewan health authority's reliance on travel nurses. These are nurses hired through an external agency to work short term, temporary assignments in health facilities, primarily to relieve staffing shortages and reduce overtime for permanent staff. Between 2019–20 and 2023–24, spending on travel nurses increased from about \$2.1 million to nearly \$98.8 million. The auditor warned that reducing this reliance without strengthening recruitment and retention of permanent staff risks shifting pressure onto full-time nurses through higher overtime and burnout. The audit's

recommendation to build internal float pools and to monitor how changes in travel nurse use affect overtime underscores that staffing, retention, and capacity are fundamentally linked policy problems, not separate operational issues²².

A 2025 study adds an interprofessional dimension that strengthens the policy analysis. It found that physicians, management, and co-workers could all be sources of stress and that these stressors could affect psychological safety and patient care. This means that leadership quality, team culture, conflict management, and reporting safety are core retention issues rather than secondary workplace concerns²³.

The 2026 CFNU nurse practitioner retention report broadens the argument from bedside experience to workforce design. It found minimal overall job satisfaction and that more than one-third of participants were thinking about or planning to leave their current position, with inadequate compensation, burnout, and excessive workload among the leading drivers. The report also highlights concerns about transition-to-practice supports, professional recognition, schedule control, work-life balance, and safe staffing, all of which bear directly on whether nurses remain in full-time or long-term practice²⁴.

This interpretation is reinforced by the Canadian Centre for Policy Alternatives report *Failure, by Design*, which found that 55 per cent of Ontario hospitals ran deficits in 2024-25 and linked underfunding to bed shortages, staffing instability, and worsening recruitment and retention pressures²⁵. These sources suggest that retention failure is not simply an outcome of individual burnout. It is a predictable result of environments that normalize overload. Current policy risks treating a structural retention crisis as a series of costly short-term staffing emergencies. A more proactive investment in nurse retention could redirect spending toward a stable, sustainable workforce rather than continually financing the consequences of its erosion.

►► Policy Options

The policy question is not whether governments should respond, but how they should respond to a workforce problem that is also a care-quality and system-capacity problem. The options below compare strategies to assess which response best addresses the structural conditions driving nurses out of full-time and long-term practice. Because nursing retention is a wicked problem shaped by staffing, scheduling, leadership, workplace culture, and hospital capacity, the most effective option will be the one that addresses these pressures together rather than in isolation.

OPTION	DESCRIPTION	ADVANTAGES	LIMITATIONS
Recruitment first strategy	Expand hiring and training seats without major changes to workplace conditions or hospital capacity	Can improve short-term vacancies and public messaging	Does not resolve understaffing, unsafe scheduling, moral injury, or over-capacity care environments
Workplace retention strategy	Focus on scheduling, leadership, psychological safety, mental health supports, and mentoring	Directly addresses many day-to-day reasons nurses leave	Can be undermined if hospitals remain chronically over capacity and underfunded
Integrated retention and capacity strategy	Combine workplace reform with stable funding, bed planning, and health human resource governance	Best fits the evidence because it addresses both organizational and structural drivers	Requires coordination across governments, employers, educators, regulators, and unions

►► Recommended policy direction

The preferred policy direction is an integrated retention and capacity strategy. This approach needs to define nursing retention as a core health-system performance issue because the same conditions that drive nurses out also undermine patient safety, emergency department flow, and organizational resilience²⁶.

Priority measures should include:

- Stable hospital operating funding, bed-capacity planning, and long-range workforce planning so “chair care,” emergency overflow, and unsafe staffing are addressed as policy failures rather than normalized workarounds.
- Enforceable staffing and shift-work standards, including limits on mandatory overtime, minimum recovery time between shifts, and more predictable scheduling so nurses are not forced out of full-time work to protect their well-being²⁷.
- Strengthen psychological health and safety protections through clear reporting and response mechanisms, anti-bullying policies, supervisor training, conflict-resolution processes, and accountability for harmful workplace conduct. Nursing leaders should be equipped to create respectful, supportive environments and provide proactive mental-health supports, given their role in shaping nurses’ well-being and mitigating burnout^{28, 29}.
- Implement structured transition-to-practice programs, formal mentorship, and accessible organizational mental-health and wellness supports. Programs should provide new nurses with a structured curriculum, guided clinical experience, trained preceptors and mentors, and sufficient time for knowledge transfer as they move into professional practice³⁰. These supports should be embedded in broader retention strategies that protect experienced nurses’ well-being and sustain their capacity to provide mentorship and clinical leadership.

►► Public policy implications

The anecdote that opens this brief illustrates how a nurse’s decision to reduce overtime or reconsider the sustainability of a career can be shaped by system-level conditions, including chronic understaffing, excessive overtime, emergency-department overcapacity, and inadequate opportunities for rest³¹.

This has direct implications for public policy. A response focused on recruitment will not resolve the underlying workforce crisis unless governments also address the systemic conditions that undermine retention: excessive workloads, mandated overtime, inadequate staffing, unsafe ratios, unhealthy work environments, and gaps in workforce planning³². In effect, nurses are too often expected to sustain under-resourced systems through personal sacrifice. This is a burden many can no longer absorb.

Emergency-department pressures also reflect wider policy gaps. Unmet mental health and substance-use needs, homelessness, and limited access to community-based care leave emergency departments functioning as a default point of care for people with complex needs. CIHI reports that 93% of patients experiencing homelessness who were admitted to hospital entered through the emergency department. Substance-use disorders and schizophrenic disorders were among the most common reasons for hospitalization³³.

The evidence consistently shows that retention depends on safe staffing, manageable workloads, ethical practice conditions, and system capacity. An integrated retention and capacity strategy directly addresses these drivers and offers the most effective path to stabilizing the nursing workforce. Without urgent policy action, however, the conditions driving nurses out of the profession will persist, deepening workforce instability and intensifying pressures on nurses.



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