Nursing Through Crisis

A Comparative Perspective

Table of contents

4 **Executive summary**

6 **Introduction**

Part 1 - Public policy implications

10 **Our research lens**

11 **Impacts on practice environment**

12 Vulnerabilities to COVID-19

17 Scope

18 Skills mix

25 Work-life balance

29 Support

35 **Impacts on health**

36 Mental health and wellbeing

48 Burnout

54 **Outcomes**

55 Projecting departure outcomes: leaving a nursing position and the profession

61 **Retention**

70 **Part 1: Conclusion and recommendations**

Part 2 - Nursing programming implications

81 Our research lens

82 Comparison of sectors

83 The population

84 Outcomes: mental health

87 Demands, control and support

96 Outcomes: potential departures

99 Comparison of domains

100 The population

101 Outcomes: mental health

104 Demands, control and support

110 Outcomes: potential departures

113 Part 2: Conclusion and commitments

Nursing programs

117 Advanced Clinical Practice Fellowship (ACPF) program

118 Leadership and Management for Nurses program

120 Mentorship for Nurses program

121 Nursing Student and Preceptor Long-Term Care program

Appendices

123 Appendix A - Demographics

131 Appendix B – Conceptual models used in this research

134 Appendix C – Measuring mental health and wellbeing in the workplace

137 Appendix D – Sector mapping

138 Appendix E – Support for increasing the number of RNs in Ontario

Please use the following when citing this report:
Registered Nurses' Association of Ontario. (2022). Nursing Through Crisis: A Comparative Perspective. May 12.

Executive summary

The nursing profession has been protecting and caring for Ontarians during all phases of the pandemic. However, the unrelenting stress of the pandemic has taken a tremendous toll on the health and wellbeing of Ontario nurses, those across Canada and internationally. Between May and July 2021, during Ontario's third wave, RNAO distributed a detailed survey about the impact of the pandemic on nurses across the country. Nursing Through Crisis: A Comparative Perspective presents the findings that emerged out of this survey and compares the results to similarly focused surveys, including RNAO's 2021 Ontario-based Work and Wellbeing Survey, the Canadian Healthy Professional Worker Partnership (HPWP) survey, and the University of South Australia's Australian and International survey from which the Canadian survey was modelled.

The surveys reveal that in the face of inordinate stress, with high work demands and little support from employers or government, nurses have been tested like never before. And, yet, they have continued – nursing through this crisis to give safe and compassionate care to patients, residents and clients. The majority of nurses have now reached their limit. A significant percentage of Canadian nurses across all nursing sectors and domains have experienced severe or extremely severe levels of depression, anxiety, and stress, with higher percentages among hospital nurses and front-line workers. Over 75 per cent of Canadian nurse respondents were classified as burnt out, with higher percentages among hospital nurses and front-line workers compared to other sectors or domains.

Some nurses have already left the profession. In the Canadian survey 69 per cent of respondents planned to leave their positions within five years; 42 per cent of those planned to leave the profession either by retiring or by seeking employment in another field. Our findings confirm that the nursing profession is in crisis.

RNAO insists that urgent action from health system employers and the government is needed to build RN careers. That re-build begins by implementing the following recommendations:

1. Repeal Bill 124 (Ontario's wage restraint legislation) and refrain from extending or imposing further wage restraint measures
2. Immediately increase the supply of RNs by: expediting applications and finding multiple pathways for internationally educated nurses (IEN) to practise in Ontario; and increasing enrolments and funding in four-year baccalaureate (BScN) programs, second entry/compressed programs and RPN-to-BScN bridging programs by 10 per cent per year for seven years, and compressing RPN-to-BScN bridging programs to two years
3. Develop and fund a Return to Nursing Now program to attract RNs back to Ontario's nursing workforce
4. Support nurses throughout their careers by expanding the Nursing Graduate Guarantee, reinstating the Late Career Nurse Initiative and bringing back retired nurses to serve as mentors to new graduates and IENs
5. Establish a nursing task force immediately to make recommendations on matters related to the retention and recruitment of RNs

While the recommendations RNAO advocates are necessary to confront the nursing crisis, the association has also developed four programs to better support Ontario nurses, provide them with professional development opportunities, enhance their work and wellbeing and contribute to a healthy work environment. They include:

1. Advanced Clinical Practice Fellowship (ACPF) program
2. Leadership and Management for Nurses program
3. Mentorship for Nurses program
4. Nursing Student and Preceptor Long-Term Care program

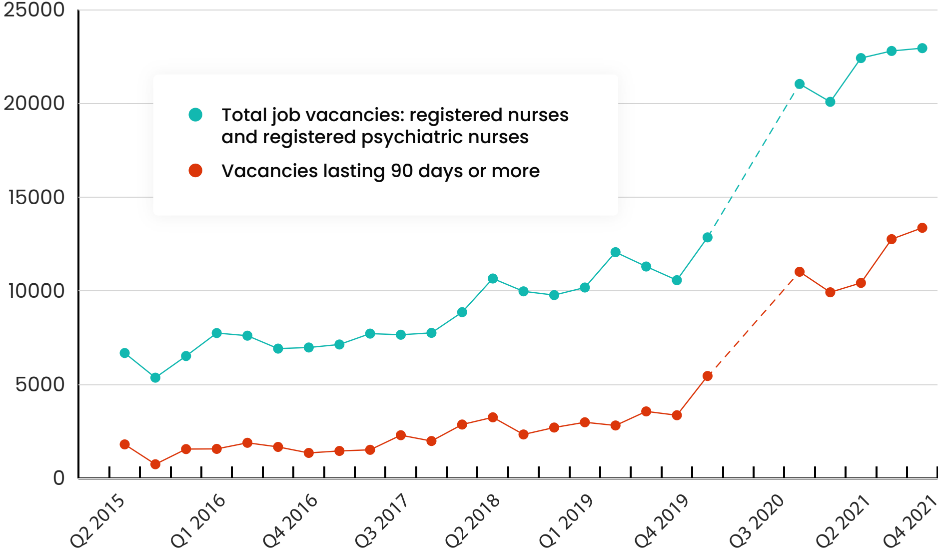
With these employer and government interventions and RNAO's support programs, the nursing profession can emerge from this crisis and continue contributing to the effective functioning of Ontario's health system and the health of Ontarians.

Introduction

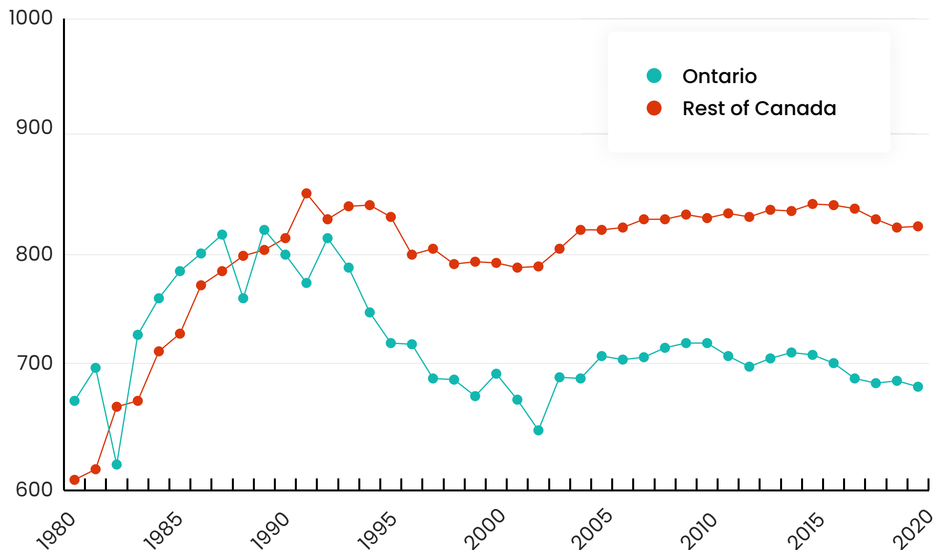
Since January 2020, nurses across Canada and around the world have been on the front lines of an unrelenting battle with COVID-19 and its variants. As of Jan. 17, 2022, 2,759,991 people in Canada had tested positive for the COVID-19 virus, resulting in 31,530 lives lost and many thousands more left to grieve. Throughout the pandemic, nurses have fought tirelessly to save the lives of those in their care, while also doing the best they can to protect themselves and their families.

The COVID-19 pandemic arrived in Canada in the context of a decades-long registered nurse (RN) understaffing problem—especially in Ontario. It has ushered in a new, deeper crisis in RN staffing.

Job vacancies



RN/NP-to-population ratios: Ontario vs. rest of Canada



Nurses have been resilient in the face of inordinate stress throughout the pandemic. They have had to find ways to adapt and reach out for help when necessary. Yet, there are limits to what nurses can endure, and for how long.

Stress due to short staffing and excessive workloads has been a chronic concern for Ontario RNs for many years. The long-standing and detrimental impact of RN understaffing on patient care and nurse wellness is well documented in several national surveys and RNAO's own research. For example, in 2000, RNAO recommended developing a guideline for creating healthy work environments for nurses to stabilize and strengthen the nursing profession in Ontario.

The pandemic has amplified these concerns. From the outset, anecdote and rumour pointed to the emergence of a fully-fledged nursing crisis. Over and over, RNs and NPs have talked about experiencing stress and burnout, about colleagues leaving their jobs and the profession and about doing the same, absent change.

In response, RNAO surveyed Ontario RNs, NPs and nursing students in February 2021, during the second wave of the pandemic. The survey — **RNAO's Work and Wellbeing Survey (Work and Wellbeing survey)** — provided evidence of an emerging nursing health human resource crisis.

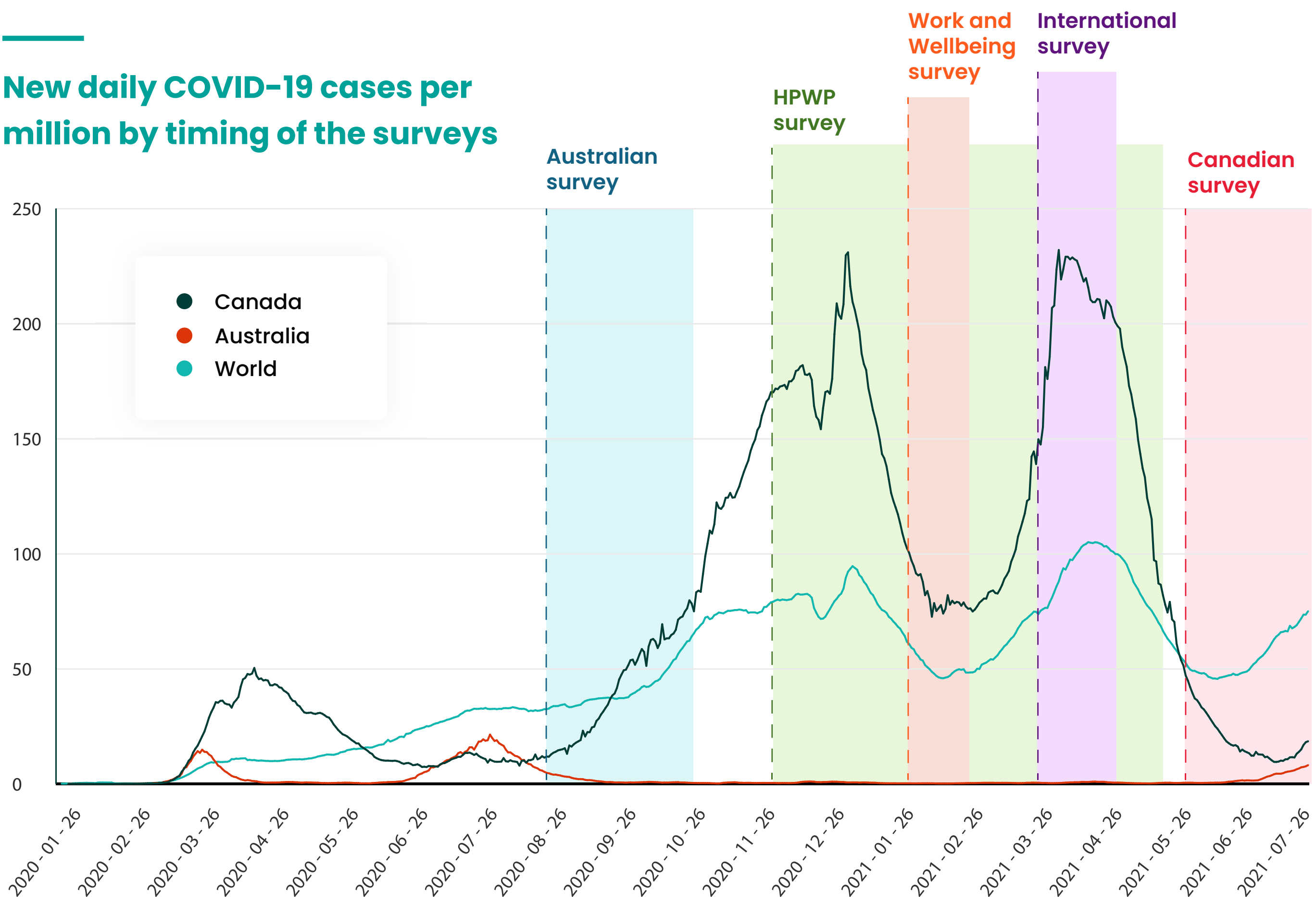
The survey reveals that the effective functioning of Ontario's health system is at risk post-pandemic given reported intentions of survey respondents to leave their jobs and the nursing profession. *"The magnitude of potential departures by retirement or by changes in career paths calls for an immediate response from health system employers and government. Workforce planning measures must be immediately implemented and, most critically, retention strategies must be urgently triggered. Without this action, the province risks being forced to contend with a nursing shortage that could seriously compromise health care in Ontario."*

Workforce planning measures must be immediately implemented and, most critically, retention strategies must be urgently triggered. Without this action, the province risks being forced to contend with a nursing shortage that could seriously compromise health care in Ontario.

On the heels of the alarming results of the Work and Wellbeing survey, RNAO distributed a much more detailed survey on the impact of the pandemic on the nursing workforce. This survey aimed to determine the factors fuelling the emerging nursing crisis and the policy responses needed to address it. This survey was based on one originally developed by the University of South Australia (UniSA)'s Rosemary Bryant AO Research Centre. UniSA distributed the **original survey to nurses and midwives across Australia (Australian survey)**; they then adapted it for distribution to **nurses around the globe (International survey)**. It was then contextualized for distribution across **Canada (Canadian survey)**.

Between May 21 and July 31, 2021, during Ontario's third wave, 5,200 nurses from across Canada — primarily RNs from Ontario — responded to the Canadian survey (see Appendix A for discussion about demographics)

New daily COVID-19 cases per million by timing of the surveys



The results for the Canadian survey are very similar to those for the Work and Wellbeing Survey — nursing is facing a human resource crisis across Canada. This is unsurprising in light of the length of the pandemic, its intensity across the country and the role of nurses in fighting COVID-19. The Australian and International surveys also showed elevated stresses among their respective nursing populations, though the results were less extreme in Australia, perhaps reflecting significantly lower COVID case counts and deaths in Australia during the response period.

In addition to its partnership with UNiSA, RNAO also collaborated with the University of Ottawa-based **Healthy Professional Worker Partnership** to support a survey of seven different professions in Canada, including nurses **(the HPWP survey)**. The HPWP survey found that respondents across all seven professions were adversely affected by the pandemic in terms of mental health, distress and presenteeism; nurses were negatively affected as much or more than other survey respondents.

While the five surveys discussed in this report do not all lend themselves to easy comparison, individually and collectively they confirm the existence of a nursing human resource crisis internationally, in Canada and, more particularly, in Ontario. This crisis is compromising the ability of nurses to care for people during this pandemic and is threatening to break the health system.

While triggered by the onset of the global pandemic and policy responses to the pandemic, the scope and scale of the nursing human resources crisis revealed in these five surveys suggest that this crisis will not resolve with the end of the pandemic. They confirm RNAO's decades-long argument that our health system needs to be supported with real health human resource planning. As the conditions that preceded and precipitated this crisis were the outcomes of decades of flawed public policy, the resolution of this crisis will require many years of corrective and sustainable policy. And nurses will require relief after the cumulative stresses of the pandemic. We cannot have a well-functioning health system if the nursing profession is in crisis. The two are interdependent.

PART 1

Public policy implications

Our research lens

Many factors determine whether a work environment is healthy for nurses. RNAO's Conceptual Model for Healthy Work Environments for nurses groups these factors into three categories: individual work context (micro level), organizational context (meso level) and system or external context (macro level).

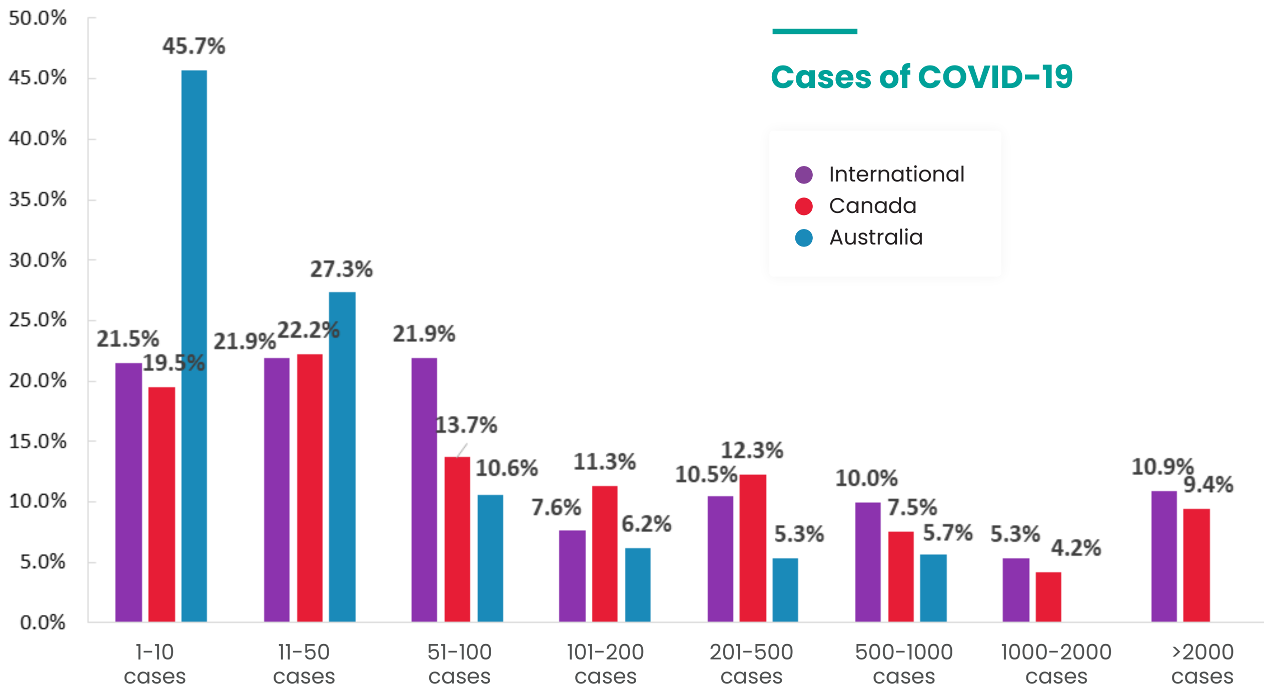
Factors at all three levels (individually or in combination) affect the health and wellbeing of nurses. They also impact on the quality of patient and societal outcomes and organizational and system performance. Because it is the combination of factors and components that determines the nature of the work environment and influences individual experiences, interventions to promote healthy work environments must target multiple levels and components of the system – indeed, the system as a whole.

In this part of the report, we analyze macro and meso level factors and make public policy recommendations for healthier work environments for nurses (see Appendix B).

Impacts on practice environment

Vulnerabilities to COVID-19

Canadian and International respondents reported practising in workplaces with higher numbers of confirmed or suspected COVID-19 cases than respondents to the Australian survey.



Unsurprisingly, a higher number of Canadian survey respondents indicated that they had tested positive than international or Australian nurses. Canadian nurses were less likely to attribute their positive test to workplace exposure, but workplace exposure remains a large risk. A clear majority of those who tested positive indicated that the positive test led to work-related distress; more International and Australian respondents than Canadian respondents reported work-related distress.

	International	Canada	Australia
Have you tested positive for COVID-19?	8.8%	10.2% Yes 0.3% Results pending	3% Yes 1.2% Results pending
If you tested positive, do you believe this was acquired due to workplace exposure?	66.7% Yes	48.6% Yes 37.7% No 13.7% Don't know	85.8% Yes
If positive, have you experienced any work-related distress associated with this (e.g. stigma, sense of letting colleagues down)?	58.8% Yes	56.2% Yes 43.8% No	67.5% Yes

Personal vulnerability

Just over one in five Canadian respondents reported a particular vulnerability to COVID-19 because of a pre-existing health condition. Nearly all of these vulnerable nurses still worked.

20.6%
had prior conditions putting them at high risk of getting COVID-19

87.3%
said yes when asked "If at high risk, did you still work?"

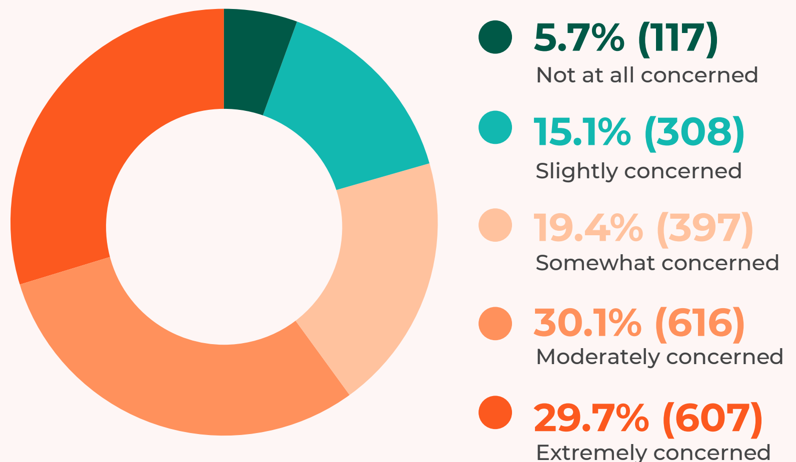
Survey comparison

Work and Wellbeing survey

Virtually all (95.7 per cent) of the respondents in this survey indicated their work had been impacted by the pandemic to some extent.

Consistent with the results of the Canadian survey, **most respondents in RNAO's Work and Wellbeing survey (Ontario) had substantial concerns** (29.7 per cent extremely, 30.1 per cent moderately) about work-related risks to their health due to COVID-19.

Level of concern about work-related risks to your personal health due to COVID-19



International survey **Australian survey**

International and Australian respondents reported similar levels of pre-existing health conditions to Canadian respondents.

	International	Canada	Australia
Prior conditions putting the nurse at higher risk of getting COVID-19	22.3%	20.6%	18.7%

Workplace vulnerabilities

Only half of Canadian respondents reported their workplaces had a pre-pandemic plan in place. That percentage increased to well over 90 per cent by the time of the study. Over half of Canadian respondents ranked the pre-pandemic preparedness as fair or worse; this improved to less than 20 per cent at the time of the study. Canadian nurses largely rated themselves "somewhat or more confident" in their infection prevention and control (IPAC) practice after training.

Workplace preparedness pre-pandemic

48.3%
had plan

54%
preparedness fair or worse

44%
no designated area

Current preparedness

93.4%
had plan

18.8%
preparedness fair or worse

16.9%
no designated area

98.2%
somewhat or better confidence after IPAC training

Survey comparison

Responses to all three surveys showed gaps in availability of and training on personal protective equipment (PPE). Only half reported their workplaces had a pre-pandemic plan in place. In all surveys, respondents reported the percentage of preparedness jumping to over 90 per cent by the point at which they were filling in the surveys. Respondents largely rated themselves somewhat or more confident in their IPAC training, with Canadian percentages being very high.

	International	Canada	Australia
Workplace preparedness pre-pandemic	**45.9%** had a plan	**48.3%** had a plan	**53.2%** had a plan
Current preparedness	**95.7%** had a plan **96.9%** somewhat or better confidence in IPAC training	**93.4%** had a plan **98.2%** somewhat or better confidence in IPAC training	**94.3%** had a plan **76.9%** somewhat or better confidence in IPAC training

Workplace vulnerabilities: a pre-pandemic plan

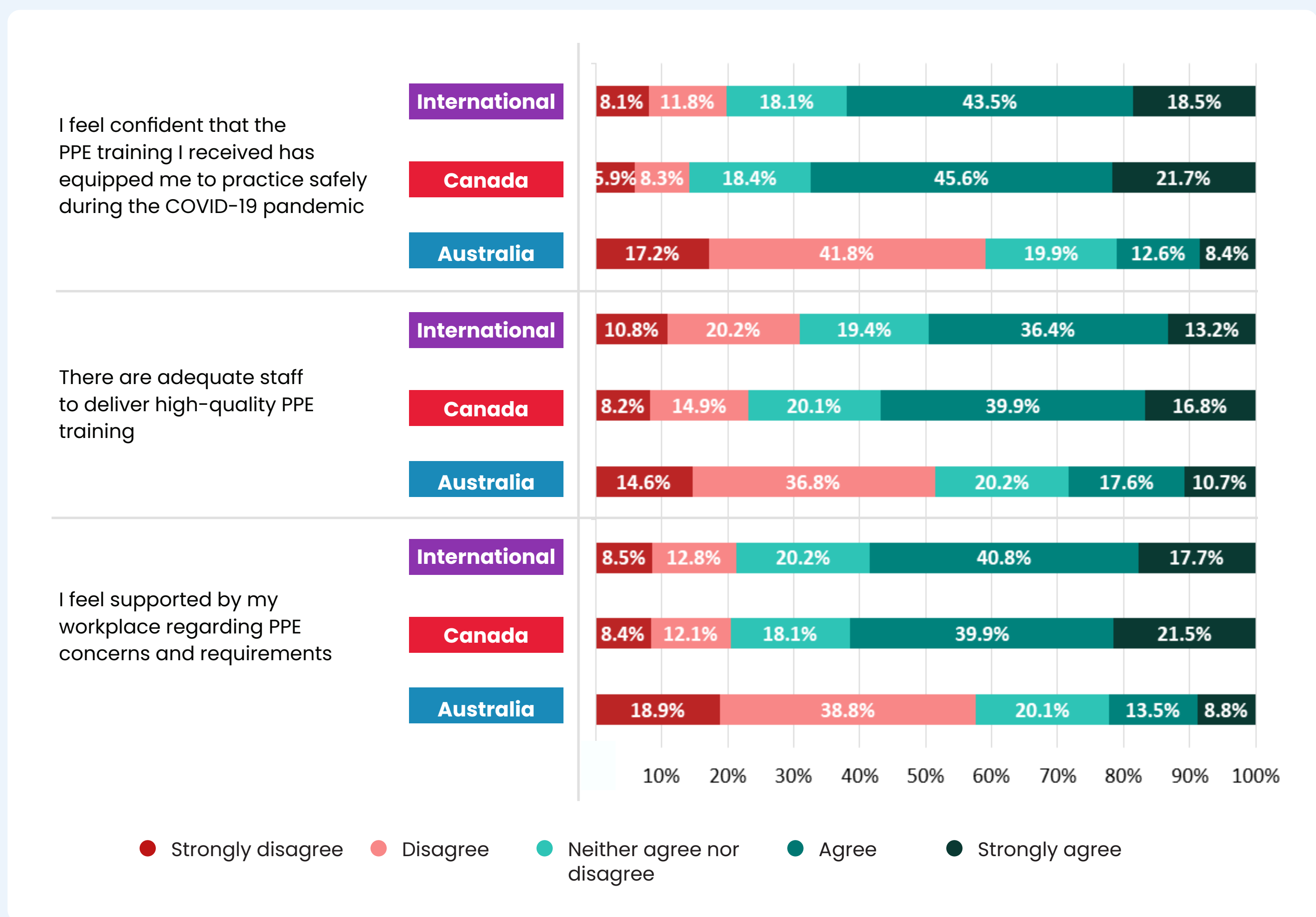
only
67.3%
felt confident to practice safely during the pandemic

only
56.7%
felt that there was adequate staff to deliver high quality PPE training

only
61.4%
felt supported by their workplace with respect to PPE concerns and requirements

Survey comparison

Responses to all three surveys showed gaps in availability of and training on PPE. However, Australian respondents reported feeling much more vulnerable in their workplaces regarding issues related to PPE supply, training and workplace support.



Conclusion

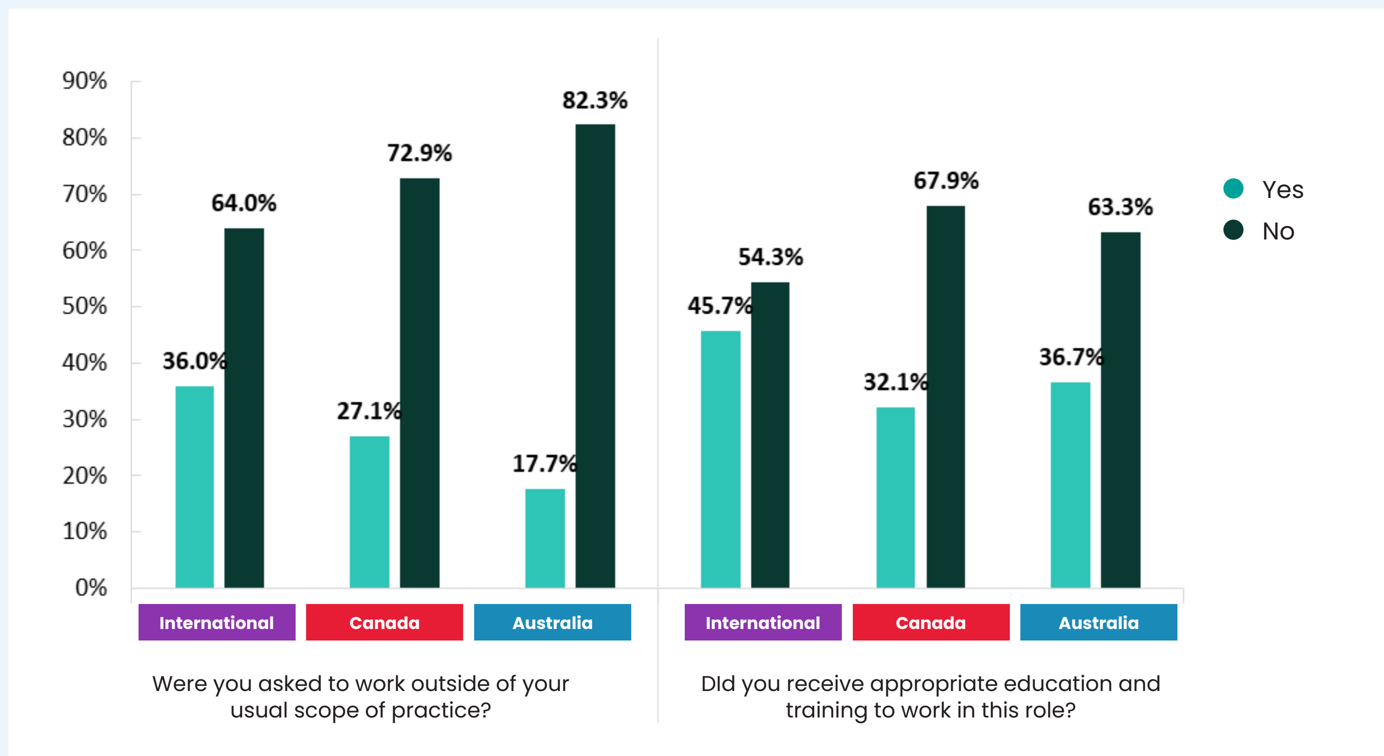
Vulnerabilities reported by nurses in these surveys included practising in workplaces with high numbers of confirmed or suspected COVID-19 cases, and the prevalence of COVID-19 positive nurses. Personal vulnerabilities such as pre-existing health conditions and concerns about work-related risks to personal health were also reported. Workplace vulnerabilities included a lack of pre-pandemic planning and vulnerabilities in respect to PPE. The results of these surveys illustrate significant vulnerabilities related to the COVID-19 pandemic faced by many nurses.

Scope of practice and training

The Canadian survey revealed that more than one-quarter of nurses were asked to work outside their usual scope of practice during the pandemic. Of those, more than two-thirds stated they did not receive the appropriate education and training.

Survey comparison

Considerably more respondents to the International survey (36 per cent) worked outside their usual scope of practice than respondents to either the Canadian survey (27.1 per cent) or the Australian survey (17.7 per cent). However, of those that were asked to work outside their scope of practice, International survey respondents were more likely (45.7 per cent) than Canadian survey respondents (32.1 per cent) or Australian survey respondents (36.7 per cent) to have received appropriate education and training.



Conclusion

These three surveys revealed that a significant minority of nurses were asked to work outside their scope of practice; of these, a majority did not receive appropriate education and training to work in the new role. This suggests increased stress on nurses and potential negative impact on patient care.

Work-related concerns: staffing levels, skills mix and workload

When asked about work-related concerns resulting as a consequence of the pandemic, the most frequently identified concerns by Canadian nurses were staffing levels, skills mix and managing workload.

Nurses speak out

Workload has increased. No extra staffing I'd (sic) support. Feel unable to take needed time off as this will in turn leave my colleagues short-staffed.

- Canadian survey respondent

Nurses are being asked to do more with less time and staffing under significant stress.

- Canadian survey respondent

Personal concerns: Per cent "moderately or extremely concerned"

60.3%
expressed concerns about staffing levels (number of staff/ratios of staff to patients/ clients)

53.8%
expressed concerns about skills mix (number/ratios of the right kinds of staff)

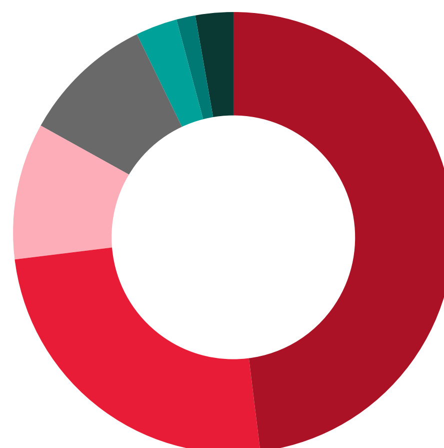
53.3%
expressed concern about managing workload

Nearly half of the respondents reported a significant increase in their workload during the pandemic, while less than 15 per cent reported significantly increased staffing. A significant minority (27.1 per cent) of nurses were asked to work outside their usual scope of practice during the pandemic. Of those 27.1 per cent, just over two-thirds (67.9 per cent) who had been asked to take on a new role stated they did not receive the appropriate education and training to work in that role.

A significant majority of respondents (57.9 per cent) reported that their organizations resorted to limiting staff vacation time to manage workplace demand. A minority of respondents (37.3 per cent) took less vacation that they were entitled to; a majority of those respondents (52.6 per cent) did so to accommodate a request from their employer to restrict their vacations. A minority (35.8 per cent) were mandated to limit their vacations.

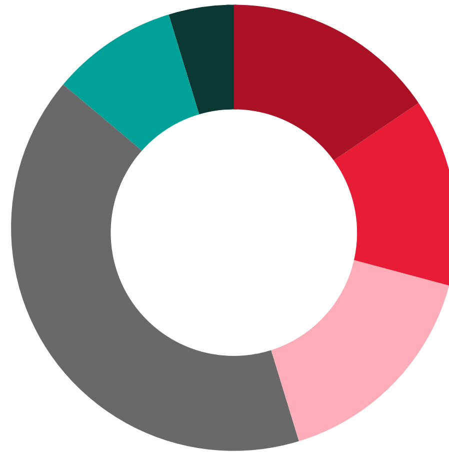
Changes in workload during the pandemic

How has your workload increased during the pandemic changed?



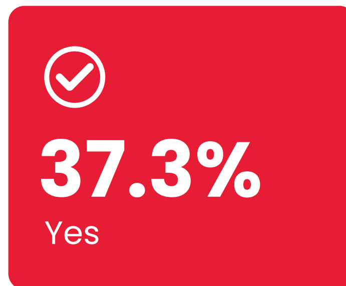
- **48.3%** Significantly increased
- **24.9%** Moderately increased
- **10.1%** Slightly increased
- **9.6%** No change
- **3.1%** Slightly decreased
- **1.5%** Moderately decreased
- **2.6%** Significantly decreased

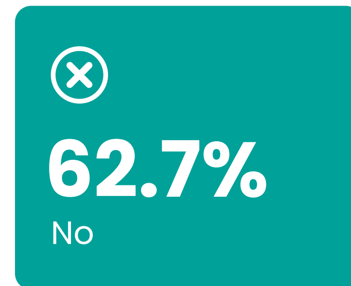
Has your organization had to increase the number of staff rostered for each shift to cope with demand?



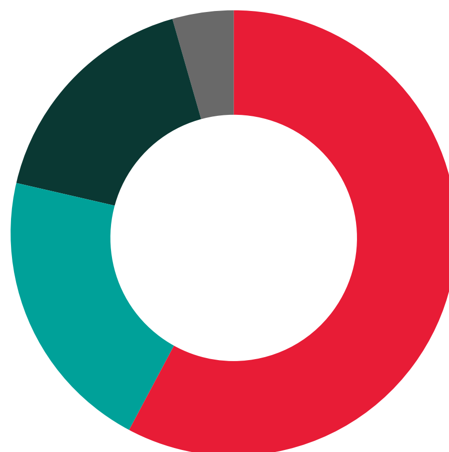
- 14.8% Significantly increased
- 13% Moderately increased
- 15.4% Slightly increased
- 38.7% No change
- 8.8% Don't know
- 9.3% Not applicable

Has your workplace recruited student nurses to support the regular workforce to cope with demand?



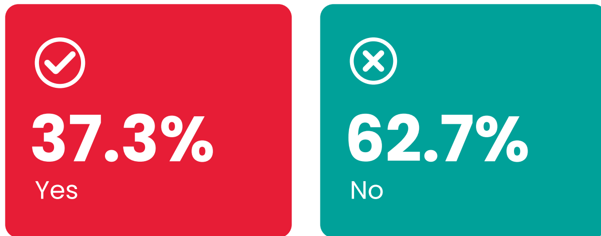


Has your organization limited vacation time to cope with demand?

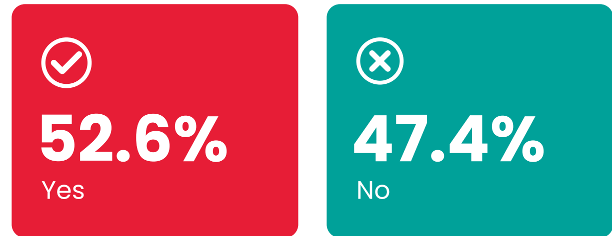


- 57.9% Yes
- 20.9% No
- 16.8% Don't know
- 4.4% Not applicable

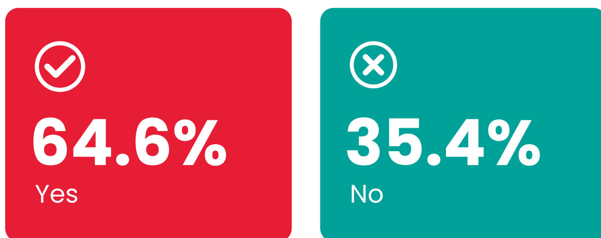
Did you take less vacation time than you were entitled to?



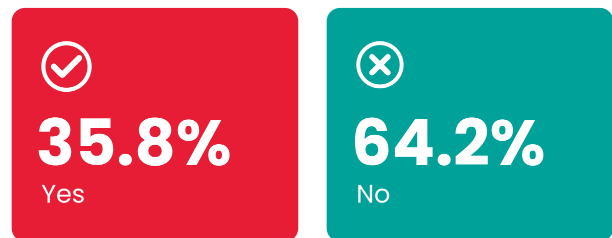
Did you agree to a request to voluntarily reduce your vacation days?



Was this a voluntary reduction in vacation time?



Were you mandated to reduce your vacation days/time off?



Staffing, skills mix, workload and nurse wellbeing

Respondents who were moderately or extremely concerned about staffing levels, skills mix and workload had significantly higher scores across these three top work factors for depression, anxiety, stress, disengagement and exhaustion, compared with those who were not at all, slightly or somewhat concerned across the three work factors.

Survey comparison

Work and Wellbeing survey

The findings in this survey support those in the Canadian survey. This survey suggests a correlation between high levels of stress and a desire for fewer hours of work post-pandemic. Hours of work – an inverse proxy for staffing levels – appears to be correlated with stress levels. All together, the survey results are strongly suggestive of a shortage of nursing staff.

We (are) short staff, workload is more, staff burn out, we are expected to do more.

- Work and Wellbeing survey respondent

International survey | Australian survey

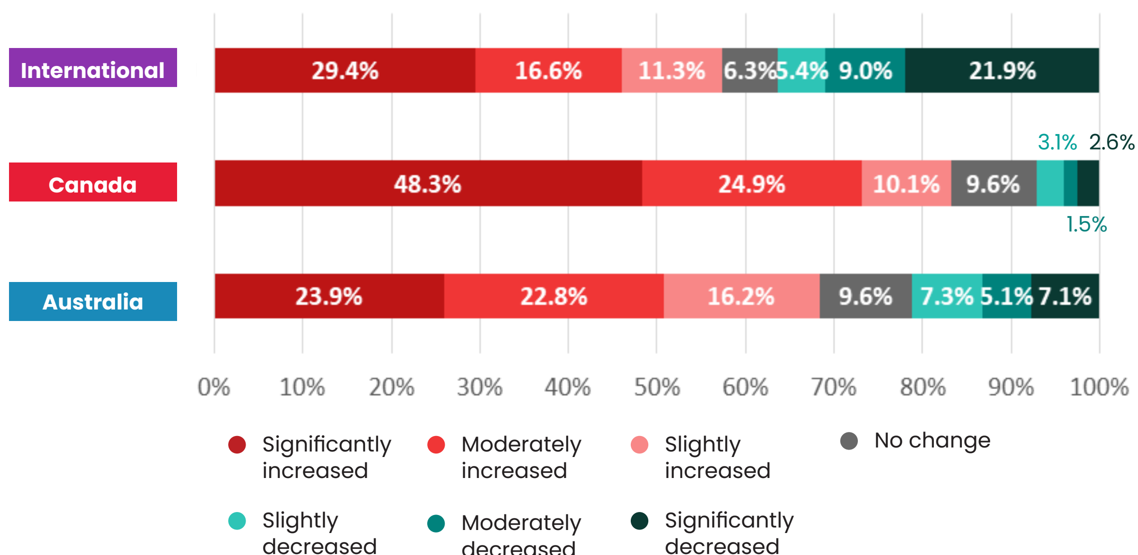
When asked about work-related concerns, in keeping with the results of the Canadian survey, a high percentage of respondents to the International and Australian nurses surveys identified concerns with staffing levels, skills mix, and managing workload. Respondents to the International survey had reported higher levels of concern than Canadian respondents.

Personal concerns: Per cent "moderately or extremely concerned"

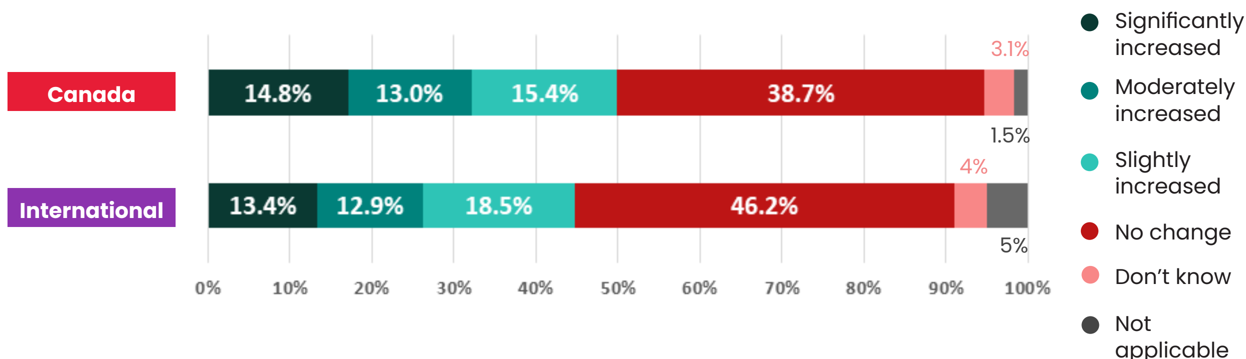
	International	Canada	Australia
Managing my workload	54.9%	53.3%	43.3%
Staffing levels (number of staff/ratios of staff to patients/clients)	67.4%	60.3%	53.2%
Skills mix (number/ratios of the right kinds of staff)	57.6%	53.8%	51.4%

Although Canadian nurses reported a greater increase in workload, the Australian and International surveys revealed similar responses from workplaces to increased demand for services during the pandemic. For example, respondents to the International survey reported that very few workplaces increased staffing, but did turn to students to respond to increased demand. A majority of respondents to the International survey also reported that their organizations resorted to limiting vacation time, as detailed in the graphs that follow.

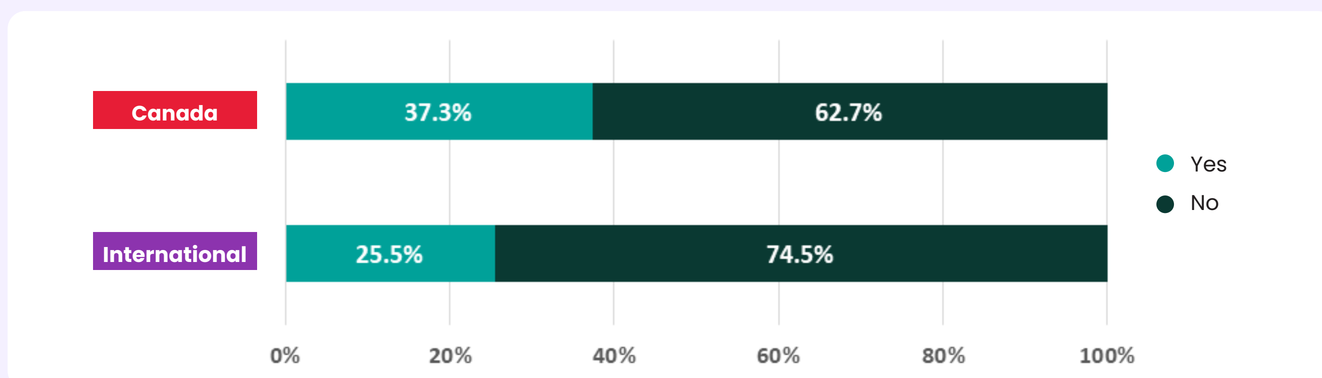
Did your workload change during the pandemic?



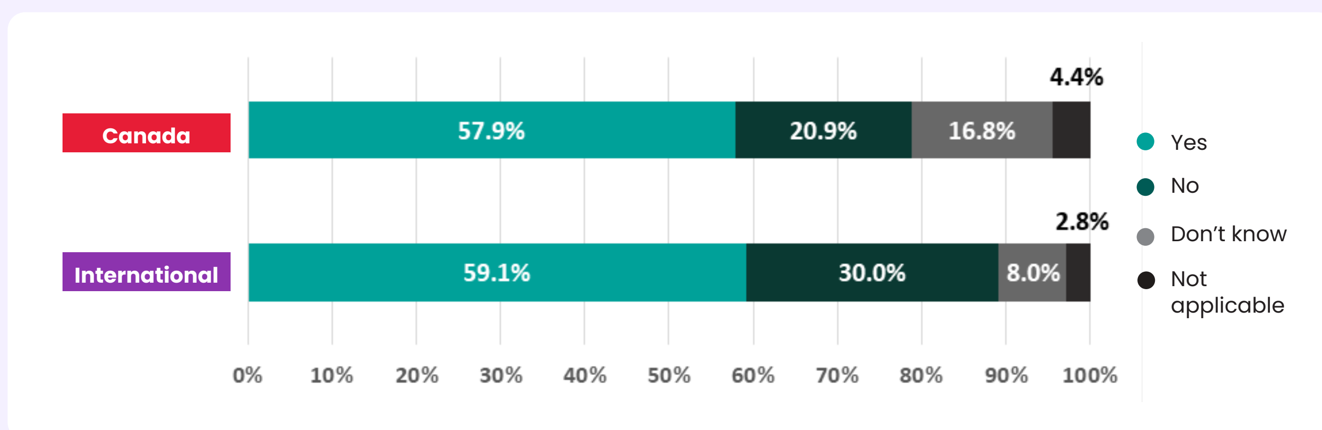
Did your organization increase staffing to cope with demand?



Did your workplace recruit students to cope with demand?



Did your organization limit vacation time to cope with demand?



Conclusion

Nurses working during the COVID-19 pandemic experienced increases in workload and inadequate staffing levels. And over half of the nurse respondents in the Canadian, Australian and International surveys were moderately or extremely concerned about skills mix. In all three surveys, a minority of respondents reported that organizations or workplaces increased staffing and recruited students to meet the demands.

Over half of the nurses in the Canadian and International surveys reported that their organizations limited their vacation time to cope with demand. Workload, staffing levels and skills mix were three factors that created additional burdens to nurses working during the pandemic.

Work-life balance

Nurses speak out

My work life balance is gone. When I leave work, I am too stressed to enjoy my young family. I feel irritable and angry and frustrated with my kids which makes me guilty and sad.

- Canadian survey respondent

Imbalanced work-life balance where more time has been spent thinking about work outside of working hours. Not being able to gather with friends has changed the way I cope with stressful situations.

- Canadian survey respondent

The Canadian survey asked respondents about challenges they had balancing work and personal responsibilities. Of greatest concern to respondents was their ability to manage "the personal needs of their family/the people I live with."

Personal concerns: Per cent moderately or extremely concerned

43.1%
Managing the personal needs of my family/the people I live with

10.9%
Losing my shifts/hours/work due to children schooling from home

13.0%
Losing my shifts/hours/work due to other caregiving responsibilities

Significant minorities of respondents in this survey were also responsible for child care or other caregiver responsibilities. High percentages of respondents noted that caregiver responsibilities increased moderately or significantly during the pandemic.

Nurses' caregiver responsibilities

30.8%
Child care responsibilities

23.8%
Other caregiver responsibilities

79.8%
Caregiver responsibilities increased moderately or significantly during pandemic

Survey comparison

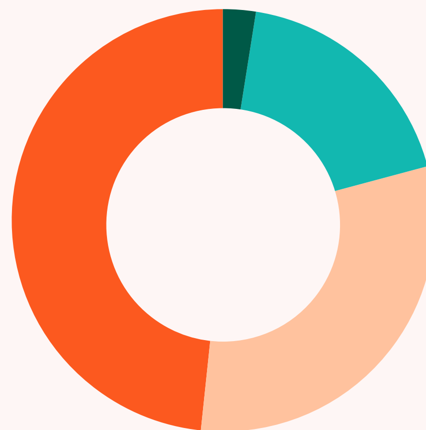
Work and Wellbeing survey

The Work and Wellbeing survey asked respondents to assess the extent to which the pandemic affected their work-life balance. Almost 80 per cent responded “a good deal” or “to a great extent”.

I cannot safely practice and care for my family at the same time. I’m on the wait list for multiple daycares.

- Work and Wellbeing survey respondent

To what extent has the COVID-19 pandemic affected your work/life balance as a nurse?



2.6% (53) Not at all

18.2% (371) Somewhat

31% (630) A good deal

48.2% (981) To a great extent

HPWP survey

Time pressure was noted as a significant “non-work” stressor by respondents across all professions and was notably significant in the academic and midwifery context.

Nursing respondents reported “work overload” as their top “work stress.” Stresses including “work overload” in one domain (work stress) and “time pressure” in the domain of non-work stress suggests the difficulty with work-life balance nurses were experiencing.

International survey | Australian survey

Compared to Canadian nurses, a higher percentage of nurses who responded to the International and Australian nurses indicated a struggle with work-life balance in their responses to “managing the personal needs of my family/the people I live with”. International and Australian survey respondents were also more likely to be concerned about losses of shifts, hours or work.

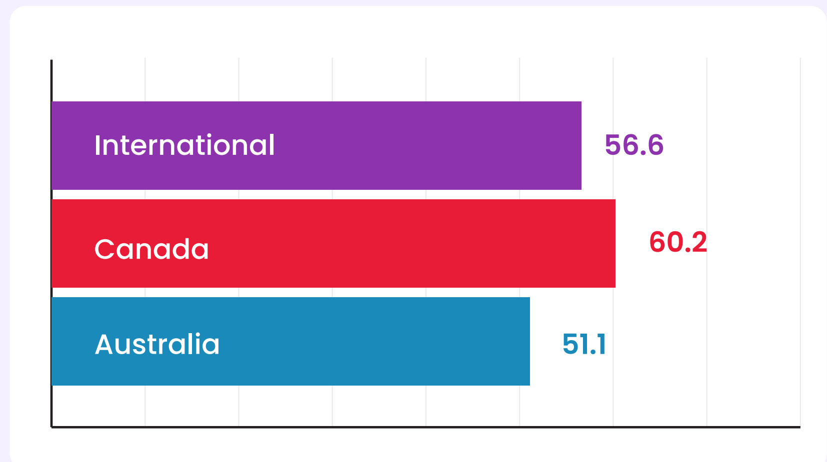
Personal concerns associated with work-life balance	International	Canada	Australia
Managing the personal needs of my family/the people I live with	51.7%	43.1%	44.2%
Losing my shifts/hours/work due to children schooling from home	24.5%	10.9%	14.9%
Losing my shifts/hours/work due to other caregiving responsibilities	24.4%	13%	No data

Significant minorities of nurses in the Canadian, International and Australian surveys noted child care responsibilities and other care responsibilities. Respondents to the International survey were most likely to identify child care obligations. Caregiver responsibilities also increased for a large majority of respondents, with respondents to the Canadian survey being most likely to face increased responsibilities.

Nurses’ caregiver responsibilities	International	Canada	Australia
Child care responsibilities	42.3%	30.8%	34.3%
Other caregiver responsibilities	25.5%	23.8%	20.9%
Caregiver responsibilities increased moderately or significantly during pandemic	71.1%	79.8%	69.4%

Work-life conflict: Mean scores

While respondents to all three surveys indicated moderate levels of work-life conflict, Canadian nurses recorded the highest mean score.



Conclusion

Nurses in these three surveys demonstrated concerns with work-life balance as they struggled to care for their ill patients and meet the needs of their family. In these surveys, nurses reported a moderate level of work-life conflict. The impact of COVID-19 did not just remain in the workplace; it also made day-to-day life outside of work extremely difficult for these nurses.

Support

Nurses speak out

We have felt dispensable and disrespected in a time when we have given up so much personally and professionally and risked the health and safety of ourselves and our loved ones.

- Canadian survey respondent

I would visit family frequently prior to covid-19 but felt isolated during the covid-19 pandemic due to quarantine rules and decisions to self-isolate from fears of potentially exposing them to the virus...

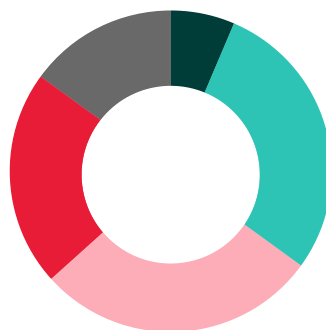
- Canadian survey respondent

When asked if adequate support services allowed the nurses to spend time with their clients, only

35%

of Canadian survey respondents either **agreed** or **strongly agreed**.

Adequate support services allow me to spend time with my patients/clients



6.6% Strongly agree

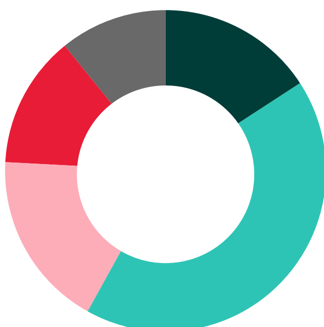
28.4% Agree

28.4% Disagree

21.7% Strongly disagree

14.9% Not applicable

Supervisory staff supportive of the nurses



16% Strongly agree

42.1% Agree

17.8% Disagree

13.5% Strongly disagree

10.6% Not applicable

When asked if supervisory staff were supportive of the nurses, only

58.1%

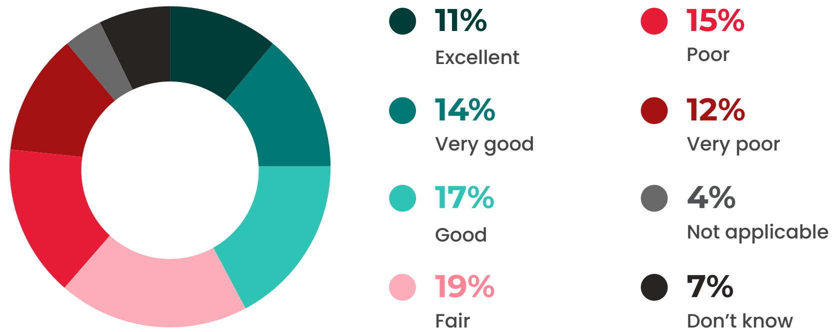
of respondents either **agreed** or **strongly agreed.**

When asked if they had access to workplace psychological or mental health supports, only

42%

of Canadian respondents reported **good to excellent** access to support.

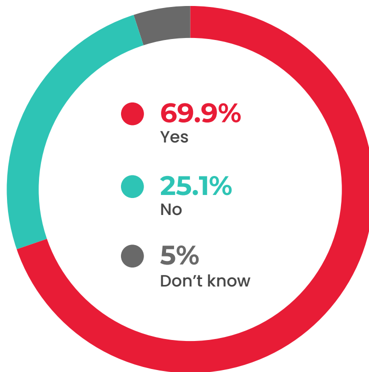
Access to workplace psychological or mental health supports



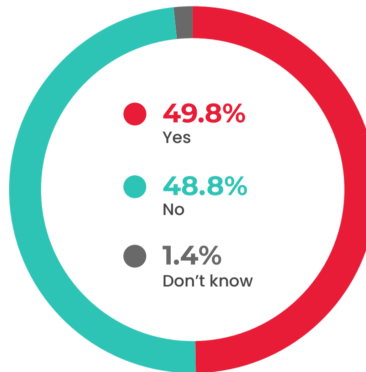
Percentage of Canadian nurses reporting support and abuse

Canadian respondents reported experiencing community support for their work. However, they also reported experiencing abuse by the public or by clients, particularly at work.

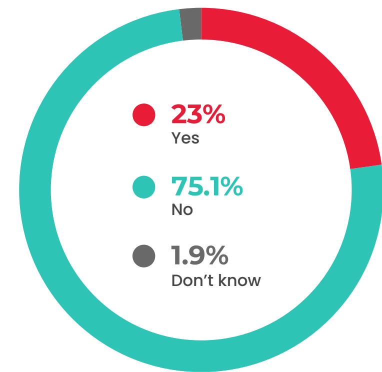
Have you experienced or felt community support for your work?



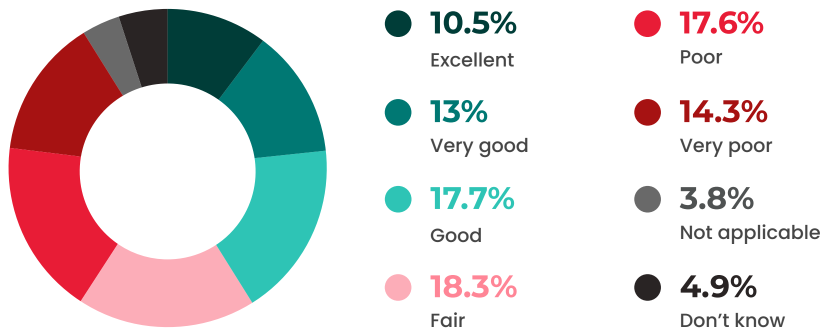
Have you experienced abuse by public / clients at work?



Have you experienced abuse or threats by public outside of work?



Preventing abuse of staff (for example, physical or verbal harassment)



When asked if there were supports in place to prevent abuse of staff, only

41.2%

of Canadian respondents reported **good to excellent** supports.

Survey comparison

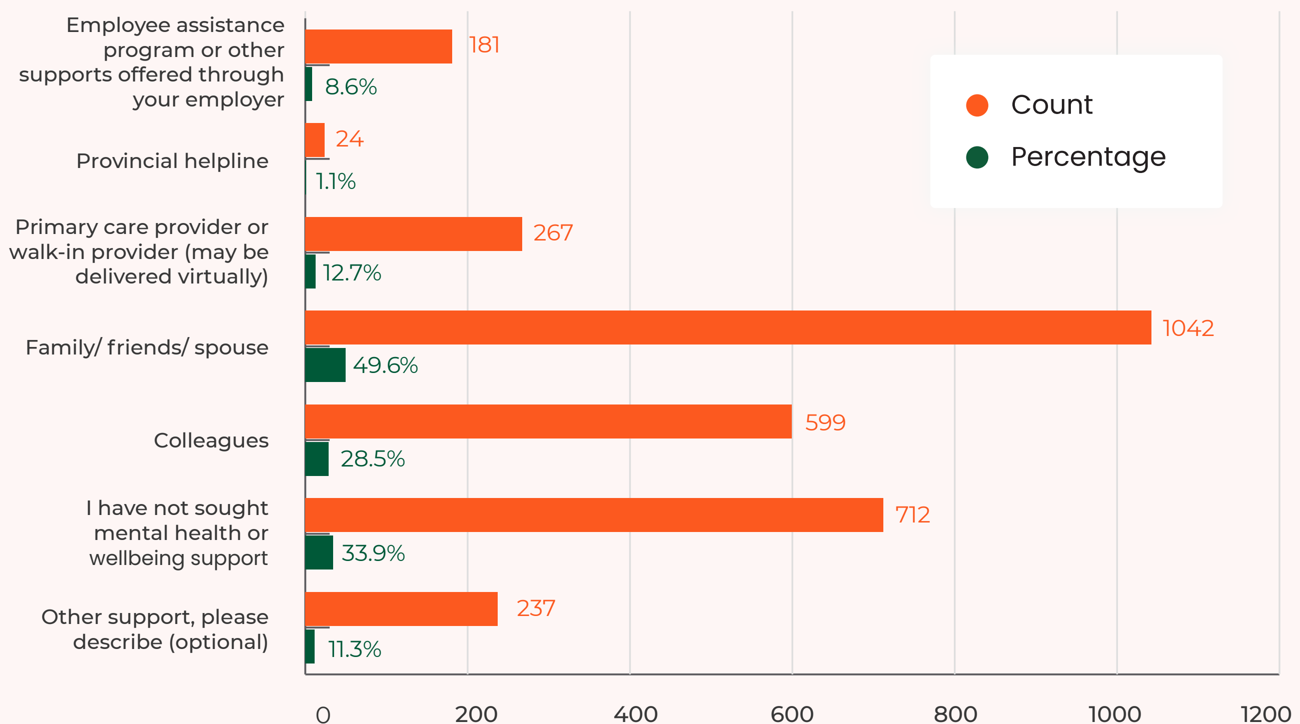
Work and Wellbeing survey

A majority of the 2,100 respondents sought support for their mental health or wellbeing from a wide variety of sources. By far the largest source of support was family and friends. A significant minority did not seek support.

Pressure and lack of support from supervisor and administration are my main source of stress.

– Work and Wellbeing survey respondent

Sources of support



Respondents feel more constrained about discussing their work experience with family than they do with their employers. This is due to a concern for imposing a burden on family and friends. Nevertheless, family and friends are the first resort of respondents seeking support, as noted above. And a significant minority – 14.8 per cent "always" and 14 per cent "often" – feel discouraged from discussing their work experiences outside of the workplace, which presents a challenge.

Nurses reported that the weakest support came from government. The strongest support came from RNAO, with support from employers in between.

HPWP survey

The majority of workers surveyed or interviewed reported experiencing a mental health issue due to the pandemic, across all seven professions canvassed in this study. Women were more likely than men to experience a mental health issue; self-assessment of mental health was consequently low for the predominantly female professions surveyed – nursing, midwifery and teaching.

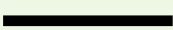
60%
of respondents reported making changes to their work in response to mental health issues.

57%
of respondents contemplated taking a leave of absence from work.

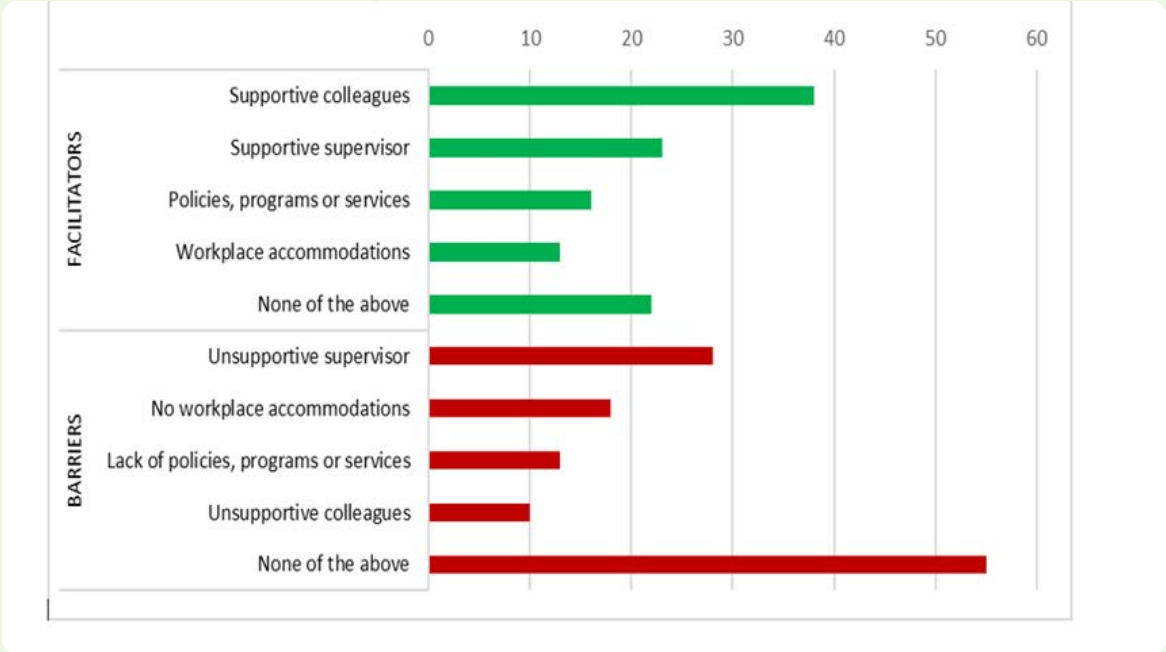
Approximately
31%
of respondents actually reported taking a leave.

Only
76%
of those report returning to work after their leave of absence.

The survey identified supports and barriers to both taking a leave of absence due to mental health issues and returning from the leave. For example, respondents identified supportive colleagues and supervisors as facilitators to returning to work after a leave of absence due to mental health issues; but unsupportive supervisors and a lack of workplace accommodations, policies and programs formed barriers.



Percentage of facilitators and barriers identified by all respondents who returned to work after a leave of absence



International survey | Australian survey

In the International, Canadian and Australian surveys, nurses were asked to respond to the following statements:

1. **There is nursing leadership present in the workplace environment.**

The presence of nursing leadership reported by International (m = 2.79) and Australian (m = 2.60) respondents was close to the neutral midpoint, indicating neither agreement nor disagreement. However, the Canadian score (m = 2.43) was closer to the disagree point.

2. **There is praise and supervisory support present in the workplace environment.**

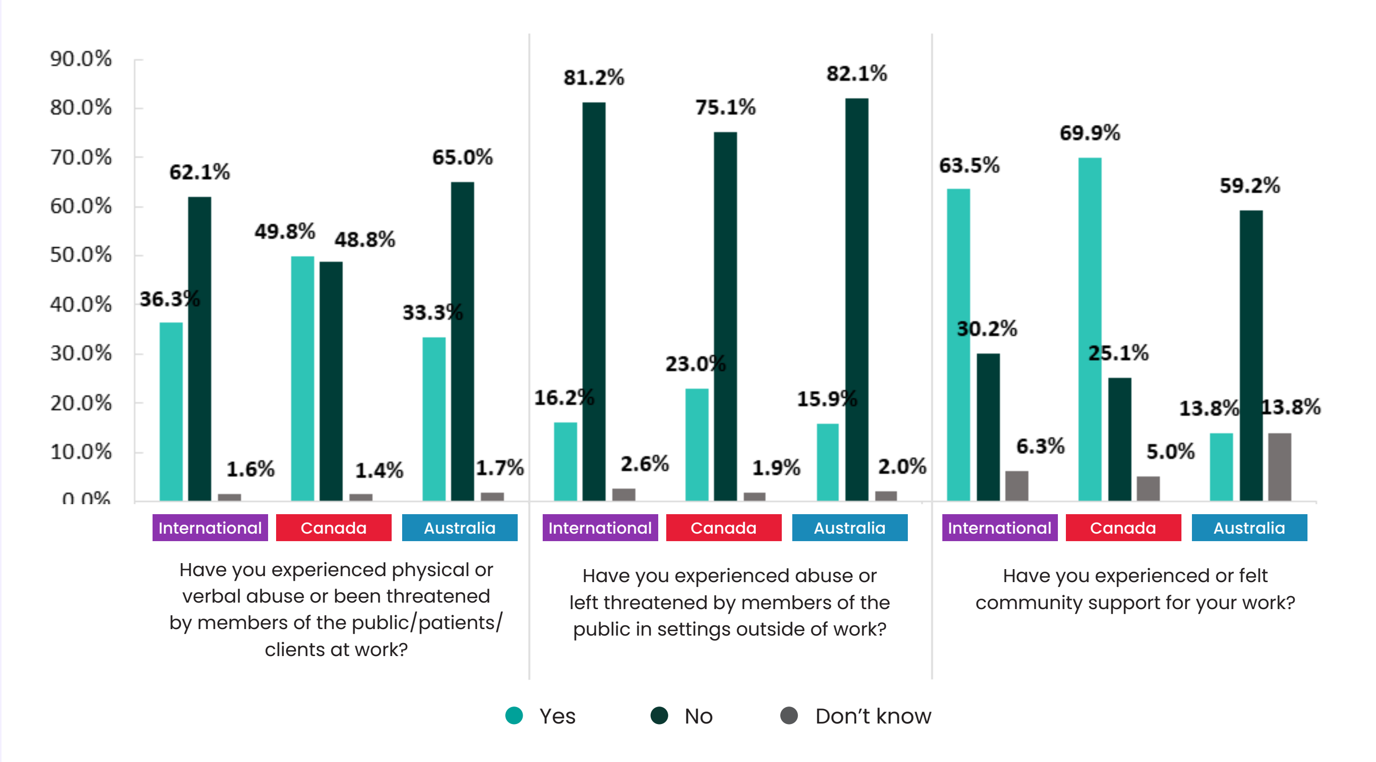
The presence of the praise and supervisory support reported by International (m = 2.86), Canadian (m = 2.59) and Australian (m = 2.64) respondents, was close to the neutral midpoint, indicating neither agreement nor disagreement. Canadian respondents demonstrated a lower mean score than respondents in the other two surveys.

	International	Canada	Australia
Nursing leadership	m = 2.79	m = 2.43	m = 2.60
Praise and supervisory support	m = 2.86	m = 2.59	m = 2.64

*A Likert scale was used with strongly disagree = 1; disagree = 2; agree = 3; strongly agree = 4.

Canadian respondents more universally reported experiencing community support for their work than Australian and International survey respondents. But Canadian respondents also reported experiencing more abuse by the public or clients – particularly at work.

Percentage of nurses reporting patient/public abuse and community support



Conclusion

The results of the surveys demonstrated the crucial need for more support for nurses working during the COVID-19 pandemic. Canadian nurses reported: a lack of adequate support services to allow them to spend time with their patients/clients; a lack of supervisory support; and a lack of access to workplace psychological or mental health supports. For those experiencing mental health issues, the HPWP survey reported that supportive colleagues and supervisors were needed for nurses to take a leave of absence and to also return to work. In RNAO's Work and Wellbeing survey, respondents reported a need for more support from both government and employers.

To keep nurses healthy and functioning in the practice environment, supports must be implemented soon. We discuss the impact of support on retention of nurses in the Retention section.

Impacts on health

Mental health and wellbeing

Depression, anxiety, stress

On average, using the Depression Anxiety Stress Scale – 21 (DASS-21) (see Appendix C), Canadian nurses reported mild scores of depression and anxiety, and normal to approaching mild symptoms of stress during COVID-19.

My mental health has taken a huge toll from the pandemic. I'm currently struggling with severe anxiety, post traumatic stress disorder and severe depression due to the pandemic and my work environment.

- Canadian survey respondent

DASS-21 mean scores

Depression score	Anxiety	Stress
Mild symptoms **(m = 10.7)**	Mild symptoms **(m = 8.49)**	Normal, approaching mild symptoms **(m = 13.8)**

*Scores on each category of DASS-21 are interpreted differently; for example, a score of 8.48 on the anxiety scale is in the mild range, while a score of 13.8 on the stress scale is in the normal range.

Comparison with International survey

On the DASS-21 scale, respondents to the International survey had similar scores to Canadian respondents, with mean scores of depression and stress in the normal range, and anxiety in the normal – approaching mild – range. In the Canadian survey, mild mean scores were demonstrated in the categories of depression and anxiety, while stress symptoms were normal, approaching mild symptoms. Canada, however, had the highest scores in all categories.

Comparison of International and Canadian DASS-21 Mean Scores

	International	Canada
Depression	Normal **(8.32)**	Mild **(10.7)**
Anxiety	Normal, approaching mild **(7.70)**	Mild **(8.49)**
Stress	Normal **(12.3)**	Normal, approaching mild **(13.8)**

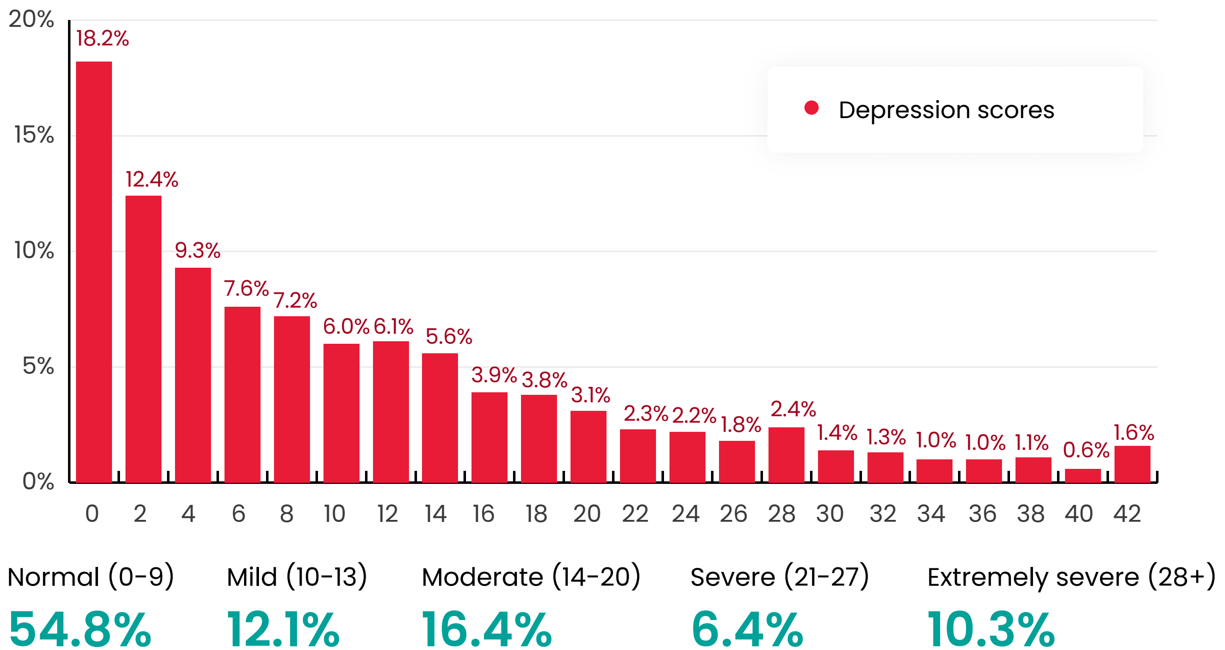
*Scores on each category of the DASS scale are interpreted differently explaining why a score of 8.49 on the anxiety scale is in the mild range whereas a score of 13.8 on the stress scale is in the normal range.

Distribution of DASS-21 scores

The distribution of DASS-21 scores demonstrates that despite the rather low mean scores, a significant minority of International and Canadian survey respondents experienced severe or extremely severe depression, anxiety and stress.

Distribution of depression scores by percentage of responses

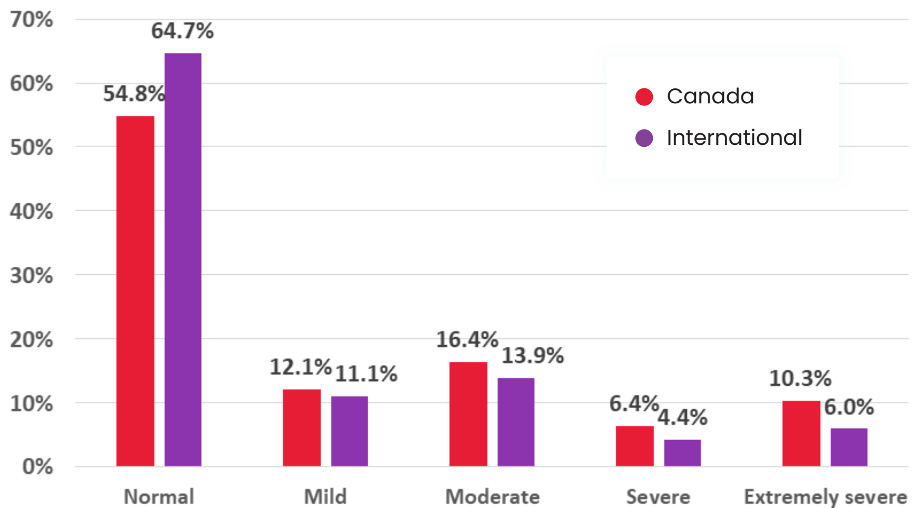
The distribution of depression scores demonstrated that a **significant minority (16.7 per cent)** of nurses experienced severe or extremely severe depression during the pandemic.



Comparison with International survey

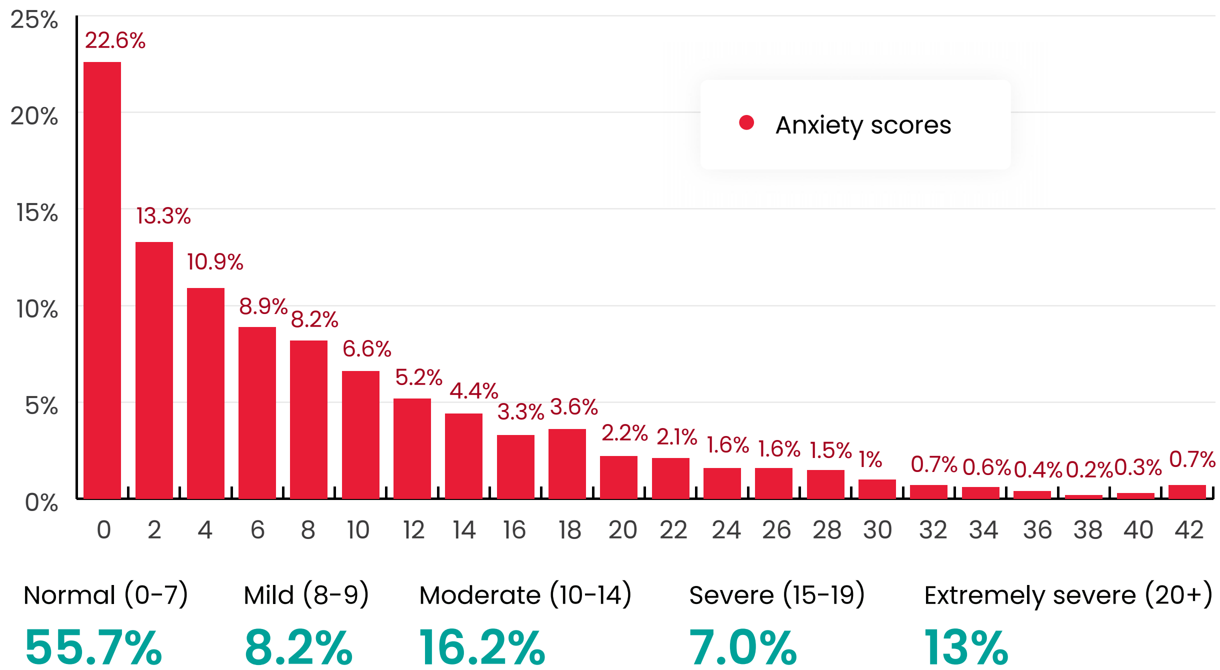
Depression scores: Canadian survey vs. International survey

The distribution of depression scores demonstrated that a **significant minority of Canadian nurses (16.7 per cent) and international nurses (10.4 per cent)** experienced severe or extremely severe depression during the pandemic.



Distribution of anxiety scores by percentage of responses

The distribution of anxiety scores demonstrated that a **significant minority (20.0 per cent)** of nurses experienced severe or extremely severe anxiety.



Normal (0-7) **55.7%**

Mild (8-9) **8.2%**

Moderate (10-14) **16.2%**

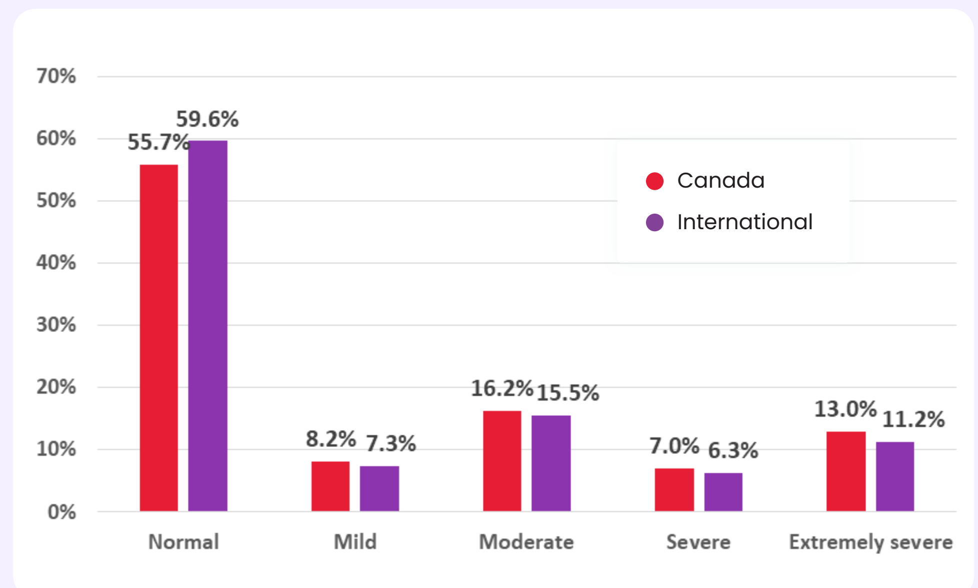
Severe (15-19) **7.0%**

Extremely severe (20+) **13%**

Comparison with International survey

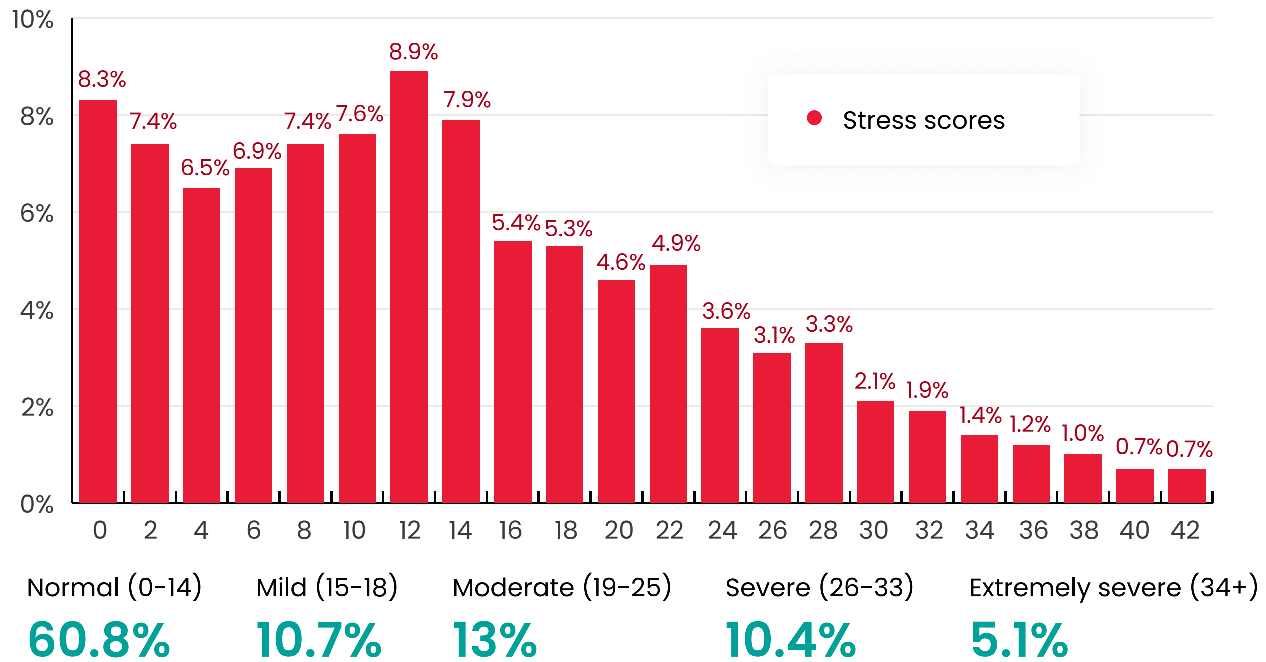
Anxiety scores: Canadian survey vs. International survey

The distribution of anxiety scores showed that a **significant minority of Canadian (20.0 per cent) and International (17.5 per cent)** survey respondents experienced severe or extremely severe anxiety during the pandemic.



Distribution of stress scores by percentage of responses

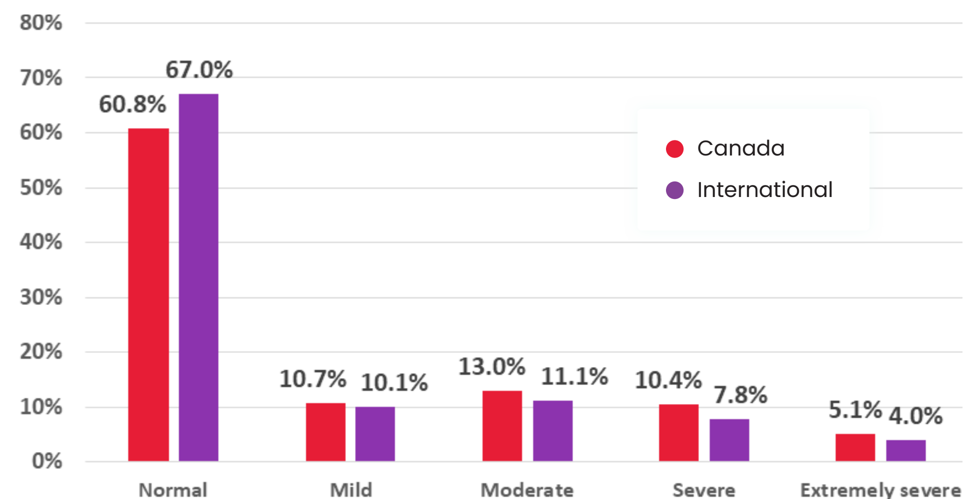
The distribution of stress scores demonstrated that a **significant minority (15.5 per cent)** of nurses experienced severe or extremely severe stress during the pandemic.



Comparison with International survey

Stress scores: Canadian survey vs. International survey

The distribution of stress scores showed that a **significant minority of Canadian nurses (15.5 per cent) and international nurses (11.8 per cent)** experienced severe or extremely severe stress.



Percentage of respondents to each DASS-21 item

The profoundly adverse effects of the pandemic on the wellbeing of nurses are disguised by the mean scores and by the percentage of respondents across the sub-scales. Responses to the individual items making up the DASS-21 scale best reveal the struggles of nurses to maintain health and wellbeing during the pandemic.

Test Statement	Percentage where the statement applied "considerably" or more in the past week
I found it hard to wind down	41.4%
I was aware of dryness of my mouth	33.9%
I couldn't seem to experience any positive feeling at all	19.7%
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	13.0%
I found it difficult to work up the initiative to do things	29.2%
I tended to overreact to situations	19.9%
I experienced trembling (e.g. in the hands)	9.2%
I felt that I was using a lot of nervous energy	21.2%
I was worried about situations in which I might panic and make a fool of myself	16.5%
I felt that I had nothing to look forward to	19.8%
I found myself getting agitated	27.4%
I found it difficult to relax	34.5%
I felt down-hearted and blue	27.8%
I was intolerant of anything that kept me from getting on with what I was doing	20.1%
I felt I was close to panic	12.7%
I was unable to become enthusiastic about anything	18.7%
I felt I wasn't worth much as a person	15.4%
I felt that I was rather touchy	20.6%

DASS-21 scores by age

Depression by age

The scores of younger nurses on the depression sub-scale were considerably worse than the average across all ages. **Nurses aged 21 to 25 years,** for example, **experienced the highest levels of depression**, with 28.9 per cent in the severe or extremely severe range.

Categorization of depression by age – DASS-21 Scale						
Age	**Normal**	**Mild**	**Moderate**	**Severe**	**Extremely severe**	**Total**
20 or less	57.1%	28.6%	0.0%	14.3%	0.0%	100%
21–25	40.9%	8.2%	22.0%	11.9%	17.0%	100%
26–30	40.3%	11.1%	24.8%	7.7%	16.1%	100%
31–35	45.1%	13.8%	19.6%	6.9%	14.5%	100%
36–40	47.9%	15.5%	19.6%	6.8%	10.2%	100%
41–45	45.8%	15.7%	18.6%	7.6%	12.3%	100%
46–50	57.1%	10.6%	17.5%	5.4%	9.4%	100%
51–55	54.3%	10.8%	15.5%	6.4%	13.0%	100%
56–60	61.0%	14.6%	12.6%	6.2%	5.6%	100%
60 or older	77.5%	9.6%	8.0%	2.7%	2.2%	100%
Missing	51.2%	7.0%	9.3%	9.3%	23.3.0%	100%
Total	54.8%	12.1%	16.4%	6.4%	10.3%	100%

Anxiety by age

As with the depression sub-scale, **nurses aged 21 to 25 years scored worst on the anxiety sub-scale**, with 44 per cent reporting severe or extremely severe anxiety.

Categorization of anxiety by age – DASS-21 Scale						
Age	**Normal**	**Mild**	**Moderate**	**Severe**	**Extremely severe**	**Total**
20 or less	57.1%	0.0%	28.6%	14.3%	0.0%	100%
21–25	22.6%	10.1%	23.3%	13.8%	30.2%	100%
26–30	33.0%	10.1%	24.2%	11.1%	21.5%	100%
31–35	45.1%	9.8%	20.4%	9.1%	15.6%	100%
36–40	50.6%	9.8%	17.4%	8.7%	13.6%	100%
41–45	49.6%	10.1%	17.2%	6.3%	16.8%	100%
46–50	56.8%	8.2%	16.3%	7.9%	10.9%	100%
51–55	60.5%	8.6%	13.5%	4.1%	13.3%	100%
56–60	65.5%	7.4%	14.3%	6.1%	6.6%	100%
61 or older	81.7%	4.0%	8.7%	2.2%	3.3%	100%
Missing	60.5%	4.7 %	9.3%	4.7%	20.9%	100%
Total	55.7%	8.2%	16.2%	7.0%	13.0%	100%

Stress by age

Again, nurses aged **21 to 25 years also experienced the most stress**, with 28.3 per cent living with severe or extremely severe levels of stress during the pandemic.

Categorization of stress by age – DASS-21 Scale						
Age	**Normal**	**Mild**	**Moderate**	**Severe**	**Extremely severe**	**Total**
20 or less	85.7%	14.3%	0.0%	0.0%	0.0%	100%
21–25	44.0%	11.3%	16.4%	17.0%	11.3%	100%
26–30	44.1%	12.8%	19.9%	14.1%	9.1%	100%
31–35	49.5%	14.5%	14.2%	14.9%	6.9%	100%
36–40	55.8%	10.2%	16.2%	11.3%	6.4%	100%
41–45	52.1%	13.6%	10.6%	14.4%	9.3%	100%
46–50	59.5%	11.8%	16.0%	9.7%	3.0%	100%
51– 55	63.1%	8.6%	11.4%	11.7%	5.3%	100%
56– 60	68.4%	9.7%	12.2%	8.4%	1.3%	100%
60+	84.4%	7.3%	5.6%	2.0%	0.7%	100%
Missing	62.8%	7.0%	16.3%	7.0%	7.0%	100%
Total	60.8%	10.7%	13.0%	10.4%	5.1%	100%

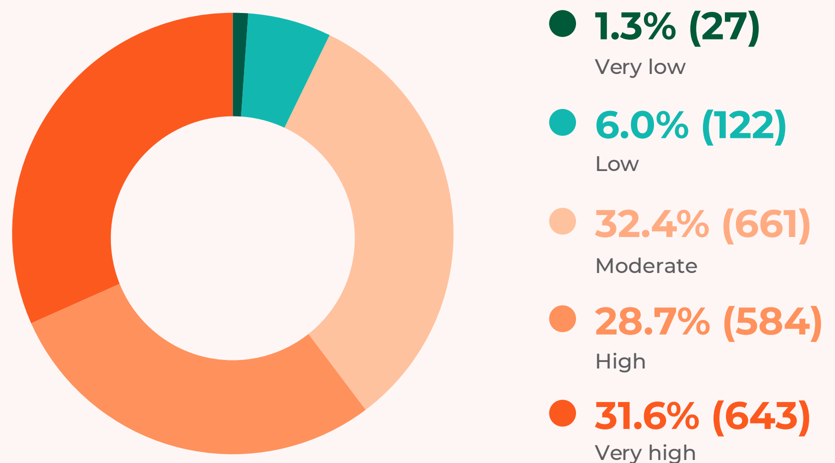
Survey comparison

Work and Wellbeing survey

Stress

How would you rate the level of stress you have experienced in your job due to the pandemic?

Job stress was widespread and profound (31.6 per cent of respondents indicated very high stress, 28.7 per cent high and 32.4 per cent moderate).



Reported job stress levels due to the pandemic were high for all age groups, with the highest in the **early to mid-career group.**

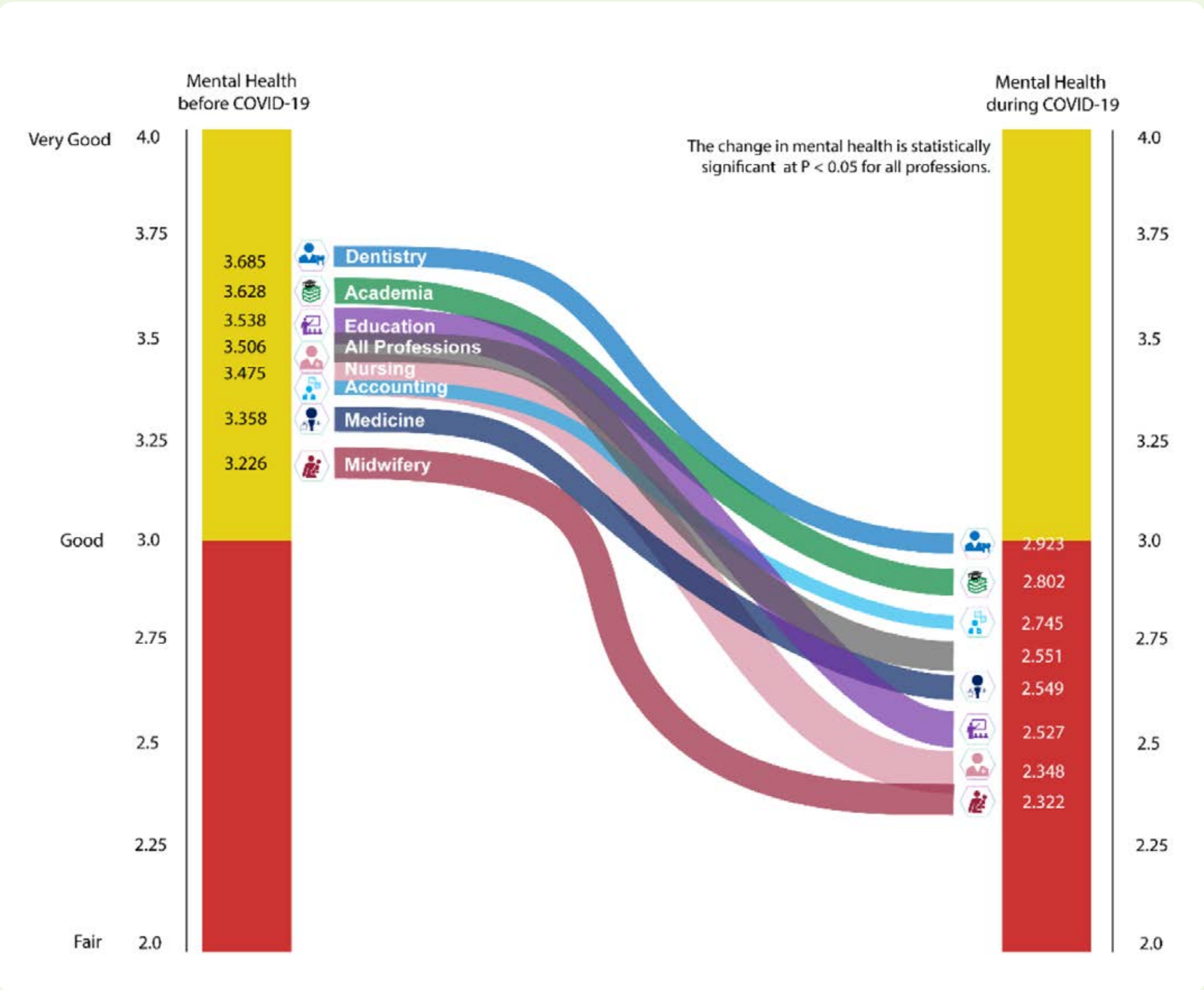
Very high stress levels peaked in the 41 to 45 age group, before tapering off moderately in nurses in higher age groups.

Stress levels are high or very high for a strong majority of all age groups up to 55. Even beyond that age, there is a substantial minority experiencing high or very high pandemic-related stress at work.

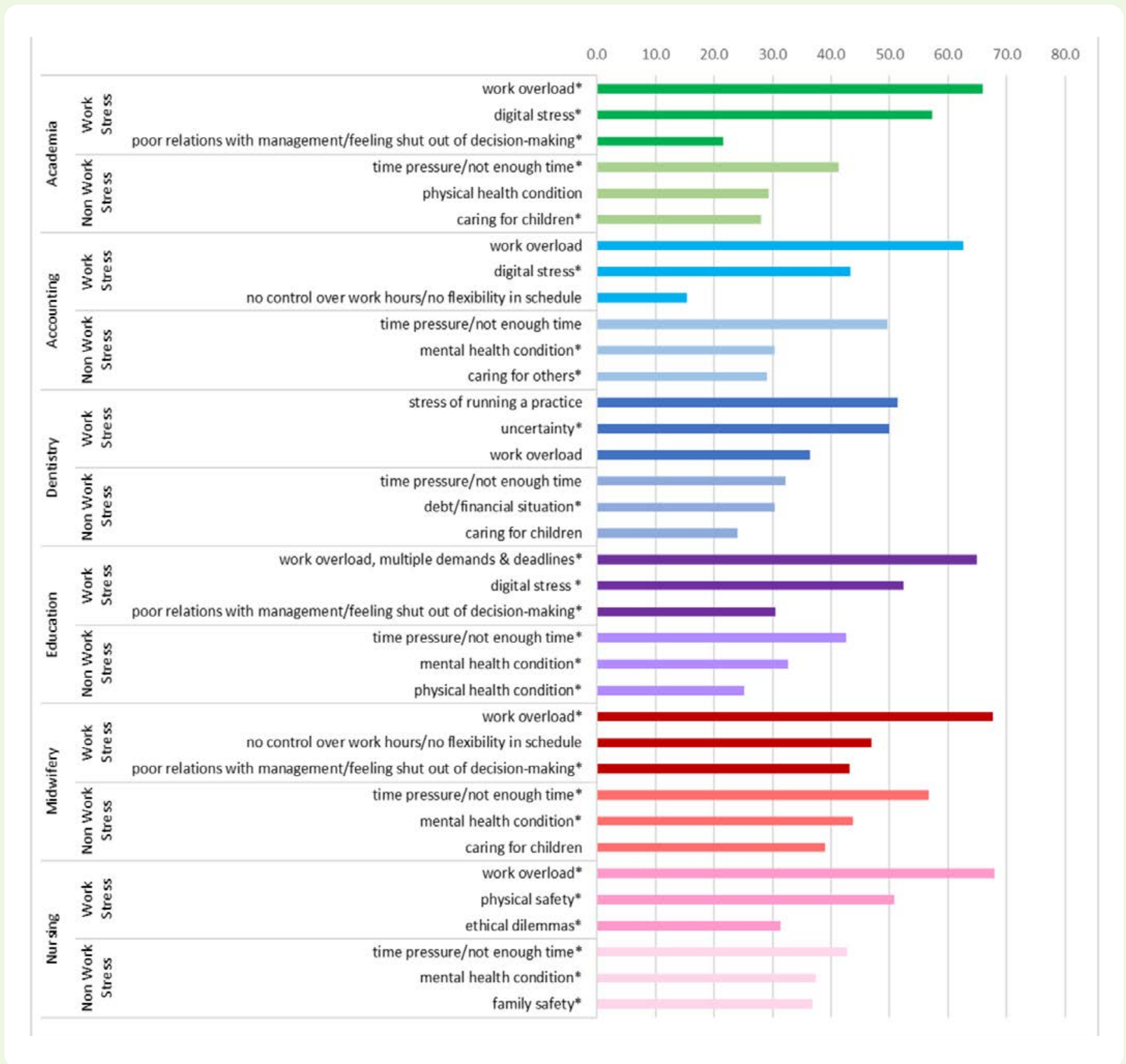
HPWP survey

All seven professions surveyed experienced increased work and non-work stress, especially in predominantly female professions. Specifically, in the nursing profession, work stress was reported as higher than non-work stress; “work overload” was the greatest stressor among nurses in this survey. Mental health during the pandemic was correspondingly – and notably – lower for workers in professions where women predominate, such as nursing and midwifery.

Decline in mental health during COVID-19



Top three sources of work and non-work stress during the pandemic by profession



Burnout

Burnout was measured by the Oldenburg Burnout (OLB) Inventory (see Appendix C), which measures exhaustion and disengagement. Suggested clinical cut-off scores are 2.25 for exhaustion and 2.1 for disengagement. Mean scores for exhaustion and disengagement were both above the suggested clinical cut-offs, implying widespread burnout among the Canadian nurses.

My work has become my priority. This leaves me with nothing left to give at home. I have worked to the point of burnout and am now on a sick leave for my mental health.

- Canadian survey respondent

Canadian nurses' average scores from Oldenburg Burnout Inventory of Canadian nurses

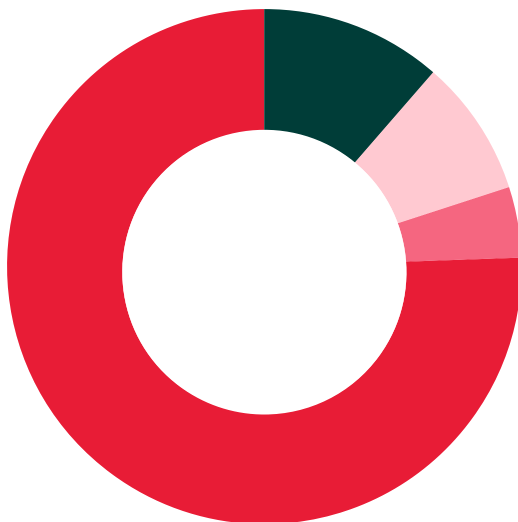
Exhaustion

M=2.76

Disengagement

M=2.5

Indeed, just 11.4 per cent of responding Canadian nurses scored as, "normal" while 75.3 per cent were burnt out – both exhausted and disengaged. This widespread burnout provides some insight about what life is like for a large percentage of Canadian nurses. It also implies that leaving their position or their profession may be a future reality for these nurses.



11.4% Not exhausted and not disengaged

8.6% Exhausted

4.6% Disengaged

75.3% Burned out

Burnout by age

Burnout was prevalent across all age groups, with the highest incidence of burnout experienced by younger nurses. For example, over 91 per cent of those aged 26 to 30 years met the criteria for burnout. It is notable that prevalence of burnout of those in the age ranges between 31 and 45 was only slightly less than in the younger age ranges.

Age	Normal	Disengaged only	Exhausted only	Burned Out	Total
20 or less	28.6%	28.6%	0.0%	42.9%	100%
21-25	1.9%	4.4%	9.4%	84.4%	100%
26-30	2.6%	1.3%	4.5%	91.6%	100%
31-35	5.6%	2.4%	5.2%	86.8%	100%
36-40	4.9%	2.6%	9.8%	82.6%	100%
41-45	9.5%	4.1%	3.3%	83.1%	100%
46-50	8.4%	4.5%	11.4%	75.7%	100%
51-55	11.3%	3.0%	9.1%	76.6%	100%
56-60	15.9%	7.0%	9.5%	67.7%	100%
60+	27.5%	8.9%	12.6%	51.0%	100%
Unknown	12.8%	0.0%	7.7%	79.5%	100%
Total	11.4%	4.6%	8.6%	75.3%	100%

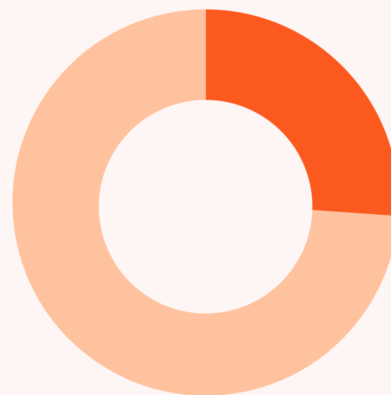
Survey comparison

Work and Wellbeing survey

Burnout

Have you taken time off to manage stress, anxiety or other mental health issues related to your work during the pandemic?

A significant minority of nurses (26.2 per cent) took time off to manage stress, anxiety or other mental health issues related to working during the pandemic, or to prevent or deal with burnout.



26.2% (549)
Yes

73.8% (1545)
No

Nurses are burning out and will likely leave their jobs due to the increasing demands. The problem lie (sic) as nurses burn out they are often blamed for not doing enough, working hard enough, or feel that they are not doing enough...

- Work and Wellbeing survey respondent

Burnout has made me leave a department I love and felt like I had a calling for. I feel greatly unappreciated.

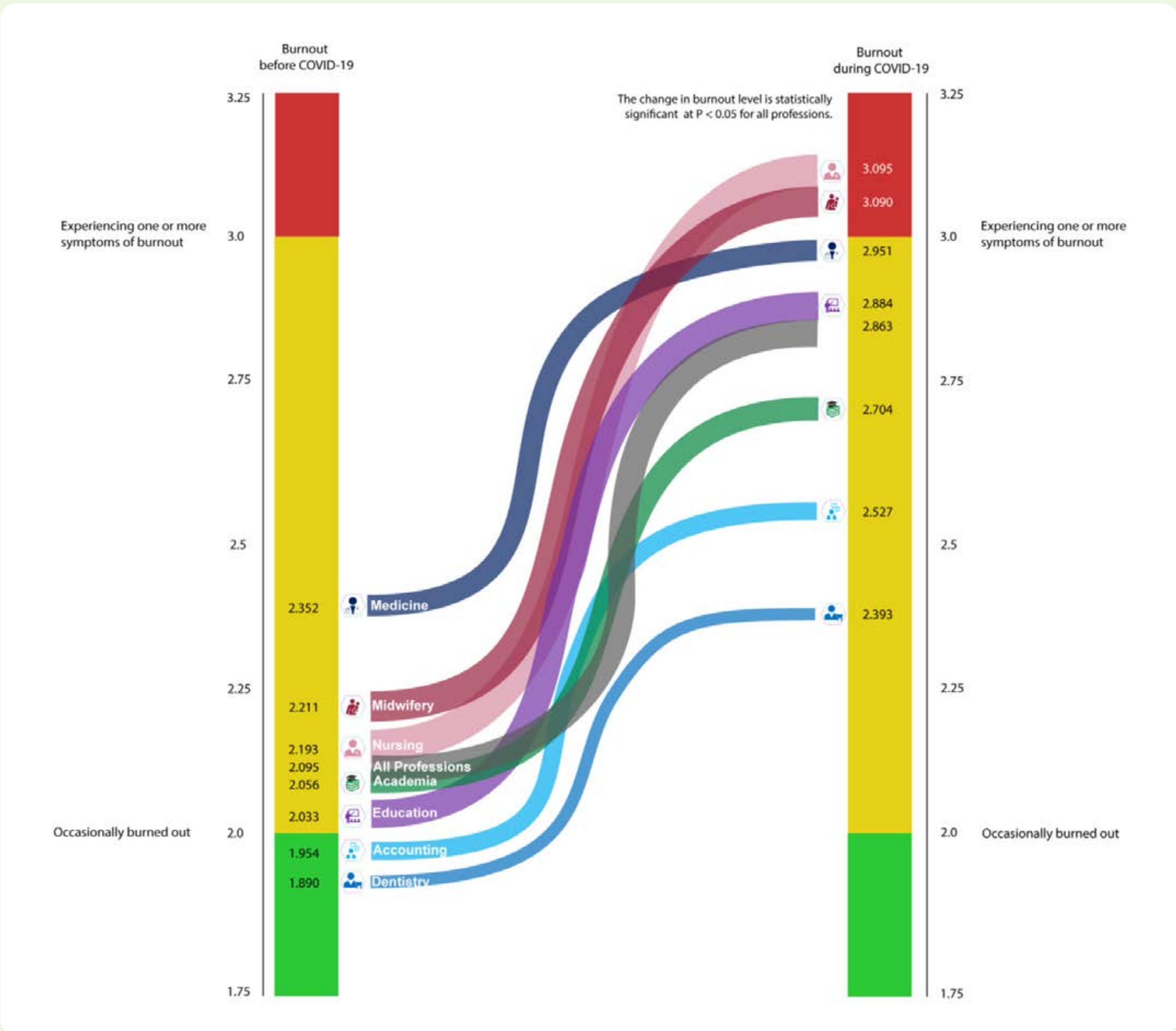
- Work and Wellbeing survey respondent

HPWP survey

Burnout

Rates of burnout have also increased during the pandemic. Prior to the pandemic, most professions were within the “occasionally burned out” range; the pandemic has caused several professions to shift into the “experiencing one or more symptoms of burnout” range. Again, the trend is most pronounced for professions where women predominate – nursing and midwifery.

Increase in burnout during COVID-19



International survey | Australian survey

Burnout

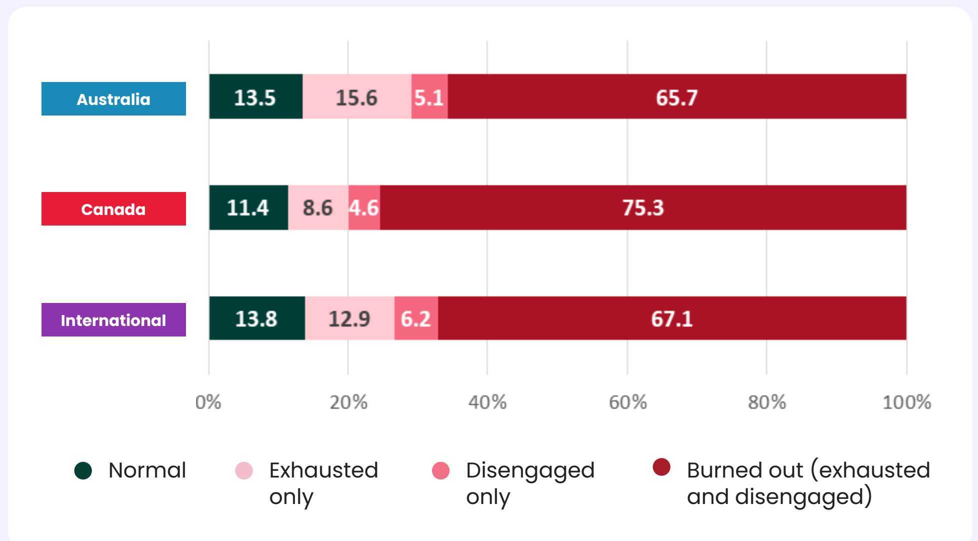
Burnout was measured by the OLB Inventory (see Appendix C). In the Australian, Canadian and International surveys, the mean scores for both exhaustion and disengagement were above the suggested clinical cut-offs; this implies widespread burnout among the nurses in all jurisdictions surveyed. Canadian participants had slightly higher levels of exhaustion and disengagement than participants in the other two surveys; Australian survey participants had the lowest levels of disengagement and exhaustion when compared to International or Canadian participants.

Burnout: mean scores

	International	Canada	Australia
Exhaustion	m = 2.63	m = 2.76	m = 2.60
Disengagement	m = 2.60	m = 2.50	m = 2.32

International comparisons of burnout by percentage

The following results demonstrate a high percentage of burnout among International, Canadian and Australian survey respondents. Canadian nursing scores indicated a higher percentage of burnout.



Conclusion

The impact of COVID-19 on nurses' mental health and wellbeing were discussed in all surveys. The HPWP survey showed a decline in mental health because of the pandemic, and identified workload as the highest source of stress.

In the Canadian survey, despite the rather low symptoms of depression, anxiety and stress as a group, distribution of scores illustrated that a significant percentage of nurses had severe or extremely scores in each of the three categories. Similarly, responses to individual items comprising the DASS-21 illustrated the prevalence of significant issues with nurse mental health and wellbeing. The impact of the pandemic on nurses is more clearly seen when analyzing responses to specific statements. For example, a significant minority of nurses reported that statements such as these had applied to them "considerably or more in the past week":

> *I found it difficult to work up the initiative to do things*

> *I felt I wasn't worth much as a person*

> *I felt that life was meaningless*

A significant minority of respondents in the younger age groups experienced higher levels of depressions, anxiety and stress, with nurses aged 21 to 25 years experiencing the highest levels.

Finally, all surveys showed symptoms of burnout among nurse respondents. In the Australian, Canadian and International surveys, large percentages of nurses indicated that they were burned out, implying that leaving their position or profession could become the only option for these nurses.

Outcomes

Projecting departure outcomes: Leaving a nursing position and the profession

Nurses speak out

I loved being a nurse but it quite honestly isn't worth the risk and the workload when the government is your employer... The only person who will look out for me is me apparently!

- Canadian survey respondent

Feelings of isolation, helplessness, burnout. Wish I could leave the profession, wonder how I will survive this...

- Canadian survey respondent

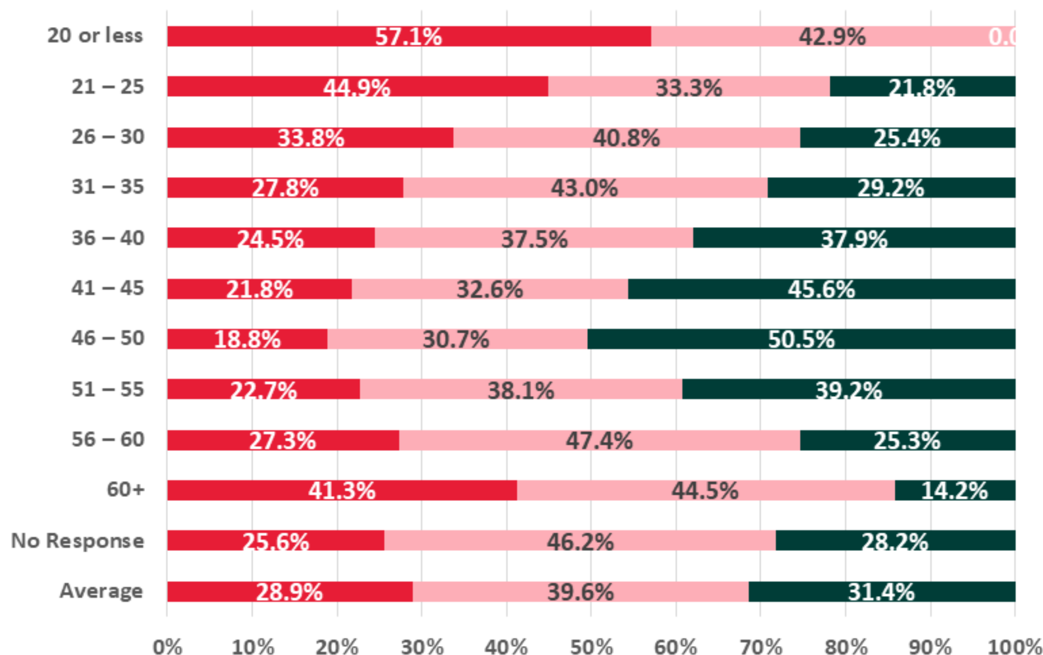
Plans to leave a nursing position

Of the 5,200 nurses who participated in the Canadian survey, a high percentage — 28.9 per cent — planned to leave a current position within the next 12 months. The potential for leaving a position within the next one to five years was 39.6 per cent. Urgent action is needed to advance stability of the nursing workforce.

Age impacted the respondents' plans to leave their position. Nurses aged 30 and under reported a greater intention to leave their position within the next five years. Nurses over 55 were also more likely to leave their positions than other age groups.

Plans to leave position vs. age

- Yes, plan to leave within the next 12 months
- Yes, plan to leave within the next 1 - 5 years
- No, plan to leave within the next 5 years



Nurses’ plans to leave nursing profession

Estimated potential departures from the nursing profession in the next five years

Of the 69 per cent of nurses who plan to leave their positions in the next five years, **42 per cent** plan to leave the nursing profession altogether, whether by retiring or seeking employment in a field other than nursing.

29.4%
Plan to retire

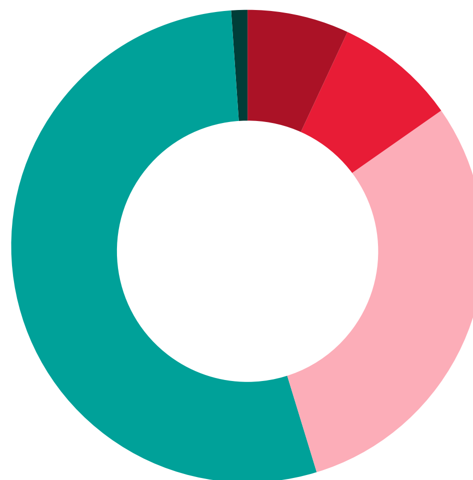
12.6%
Plan to leave the profession for another field

25.7%
Undecided

32.3%
Plan to stay in nursing

Likelihood of departure from the nursing profession after the pandemic

About 45 per cent of nurses indicated that they were somewhat likely, moderately likely or very likely to leave the nursing profession after the pandemic.



7.1%
Very likely

8.4%
Moderately likely

29.8%
Somewhat likely

53.6%
Not at all likely

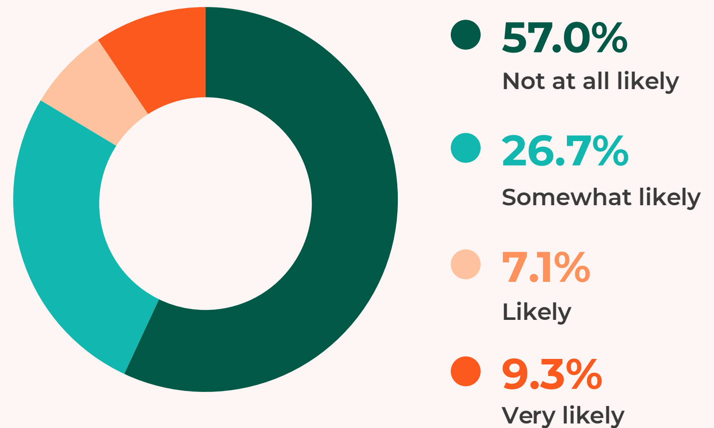
1.1%
No data

Survey comparison

Work and Wellbeing survey

The results of the Canadian survey mirror those of the Work and Wellbeing survey. A slim majority of respondents to the Work and Wellbeing survey (56.9 per cent) were not at all likely to leave nursing after the pandemic, but an alarmingly high percentage of respondents indicated they were very likely (9.3 per cent) or likely (7.1 per cent) to leave nursing for a different occupation after the pandemic.

Nurses' plans to leave the nursing profession



Probability of leaving nursing by stress levels

Similar to the Canadian survey, the probability of leaving nursing rose when reporting very high stress levels.

Stress levels	Not likely	Somewhat likely	Likely	Very likely	NR	Total
Very high stress	36.1%	29.1%	10.6%	17.4%	6.8%	100%
High stress	54.9%	26.6%	8.4%	6.2%	3.9%	100%
Moderate stress	66.3%	23.4%	2.7%	3.8%	3.8%	100%
Low stress	75.4%	11.5%	2.5%	4.9%	5.7%	100%
Very low stress	70.4%	22.2%	0.0%	3.7%	3.7%	100%
No response	47.0%	21.2%	1.5%	7.6%	22.7%	100%
Average	53.9%	25.3%	6.6%	8.8%	5.5%	100%

HPWP survey

The HPWP survey reveals that about one-third of nurse participants considered leaving their position or the profession. The effects of distress, presenteeism, declining mental health and burnout were found to increase the intention to leave either the organization or the profession itself.

Of the seven professional groups canvassed through the HPWP survey, **nurses demonstrated the highest intention to leave.**

39%
of nurses indicated they had thought about leaving their health-care facility.

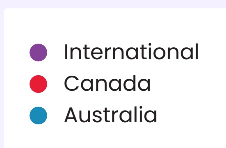
31%
had thought about leaving their profession.

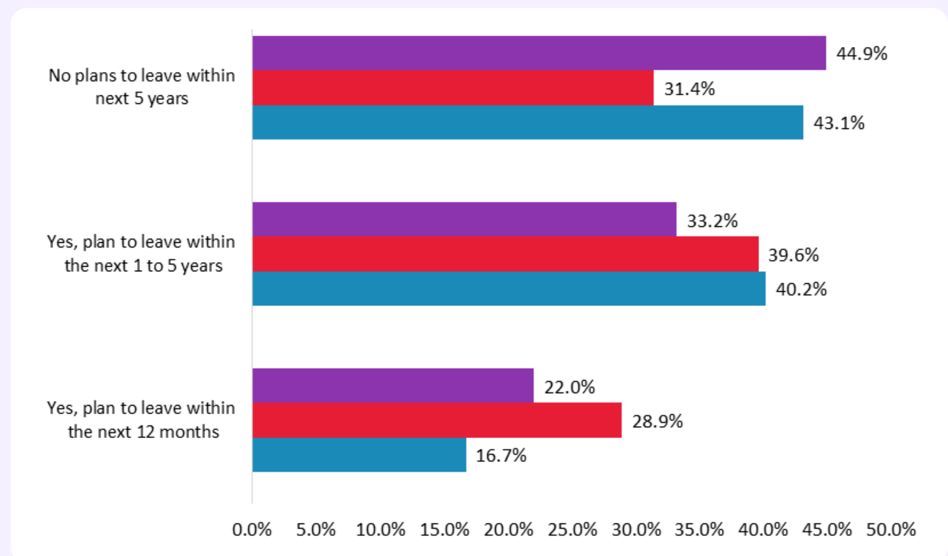
International survey

Australian survey

The International and Australian surveys indicated the potential for elevated levels of departures from a nursing position, consistent with the Canadian survey. Canadian respondents were more likely to leave.

Responses regarding intentions to leave current position





Intention to leave the profession

Of those intending to leave their positions, a significant percentage either plans to leave the profession or is undecided about staying.

International survey

17.1%
Plan to leave

22.5%
Undecided

Canadian survey

12.6%
Plan to leave

13.8%
Undecided

Nurses’ plans to leave nursing profession by age

Percentage of nurses who plan to leave the nursing profession by age (asked of those planning to leave their positions in the next five years)

Other than those planning to retire, the greatest percentage of nurses who plan to leave the profession are nurses aged 26 to 35 years and 41 to 45 years. This table suggests that nurses over 55 are very likely to retire soon.

Age range	Plan to retire	Leave nursing for another field	Undecided	Stay in nursing
20 or less	0.0%	0.0%	0.0%	100%
21–25	0.0%	13.9%	30.3%	55.7%
26–30	0.0%	17.5%	36.8%	45.7%
31–35	0.0%	19.9%	38.8%	41.3%
36–40	0.0%	13.0%	37.3%	49.7%
41–45	0.8%	18.5%	39.2%	41.5%
46–50	11.0%	14.1%	41.7%	33.1%
51–55	40.6%	16.6%	19.4%	23.5%
56–60	61.9%	7.6%	12.4%	18.2%
60+	73.0%	3.3%	7.4%	16.3%
No response	17.9%	25.0%	35.7%	21.4%
Average	29.4%	12.6%	25.7%	32.3%

Comparison with Work and Wellbeing survey

Potential RN departure by age

The Work and Wellbeing survey also found that the probability of leaving nursing is impacted by the age of the nurses, with younger age cohorts showing a higher potential to leave the profession.

Nurses in their mid-20s to mid-30s are already leaving in elevated numbers. The survey suggests potential departures of:

13%
for nurses 26 to 30 years old

13.3%
for nurses 31 to 35 years old

Potential for departure from profession by retirement eligibility

Canadian nurses who indicated that they would leave their employer in the next five years were asked about their intention to leave the profession. Potential departures depend upon retirement eligibility. Those currently eligible to retire are most likely to retire (74.0 per cent) as opposed to leaving the profession (4.8 per cent). Just 14.4 per cent said they would not leave, while 6.8 per cent were undecided. The risk of retirement for those eligible in the next five years drops to 58.4 per cent, while slightly more (15.8 per cent) will stay. When the eligibility to retirement is over five years, the chances of leaving the profession rise to 17.1 per cent, but the risk of retirement virtually vanishes (2.0 per cent). Nurses who are not nearing retirement age are more likely to continue working (44.7 per cent) or are undecided (36.2 per cent).

The large number of undecided respondents indicate the importance of retention initiatives, particularly for nurses not yet eligible to retire.

Leave profession?	Eligibility for retirement (by count and percentage)				
	Now	Within the next five years	More than five years away	No Response	Total
Yes	22 (4.8%)	29 (8.5%)	189 (17.1%)	0 (0.0%)	240 (12.6%)
Undecided	31 (6.8%)	59 (17.3%)	399 (36.2%)	0 (0.0%)	489 (25.7%)
I plan to retire	339 (74.0%)	199 (58.4%)	22 (2.0%)	0 (0.0%)	560 (29.4%)
No	66 (14.4%)	54 (15.8%)	493 (44.7%)	3 (100.0%)	616 (32.3%)
Valid total	458 (100.0%)	341 (100.0%)	1,103 (100.0%)	3 (100.0%)	1,905 (100.0%)

Comparison with Work and Wellbeing survey

Almost a quarter of respondents (22.2 per cent) are eligible to retire, and many say they plan to retire soon:

1.6% immediately

9.3% within 1 year

16.3% within 2 years

Free text comments from respondents indicate that some have already retired or left nursing.

There is little consistency in the relationship between retirement plans and reported stress. Respondents experiencing very high stress are most likely to stay longer, but they are also more likely to retire immediately or after the pandemic than they are to stay two to four years. This suggests different respondents experience high stress quite differently, and that other factors are important in retirement decisions.

Retention

Retention factors

Many respondents who indicated that they were planning to leave the profession or planning retirement specified measures that would persuade them to stay in the profession or defer retirement.

The top retention factor for nurses planning to leave the profession was better workplace supports. Other retention factors include reduced workload, ability to adjust work schedules, improved benefits and better career development opportunities.

The **top retention factor** was **better workplace supports** **68.3%**

Other retention factors:

63.3% Reduced workload

58.3% Ability to adjust work schedules

55.4% Improved benefits

43.4% Better career development opportunities

Overall, potential retirees were less likely to indicate retention strategies that would persuade them to stay. But many still favoured the following strategies:

43.8% Ability to adjust work schedules

38.1% Reduced workload

32.5% Improved benefits

29.9% Better workplace supports

21.5% More mentoring opportunities

Retention factors for Canadian nurses planning to leave the profession or retire

When it comes to retention strategies, there is considerable overlap between nurses who indicated they were planning to leave the profession and those planning to retire. The top retention factor for those considering leaving was better workplace supports. The top retention factor for those planning to retire was the ability to adjust work schedules. Nevertheless, all retention strategies must be considered.

Keep from leaving		Defer retirement	
Reduced workload	**63.3%**	Reduced workload	**38.1%**
Limits on overtime	**18.3%**	Limits on overtime	**7.5%**
Better workplace supports	**68.3%**	Better workplace supports	**29.9%**
Benefits	**55.4%**	Benefits	**32.5%**
Ability to adjust work schedule	**58.3%**	Ability to adjust work schedule	**43.8%**
Better access to mentoring	**24.6%**	More opportunities to mentor other nurses and spend less time in direct care	**21.5%**
Working to full scope of practice	**17.9%**	Working to full scope of practice	**10.4%**
Career laddering/progression to management	**30.8%**	Career laddering/progression to management	**6.8%**
More opportunities to develop your nursing career	**43.3%**		
Increased access to childcare	**15.4%**		
Access to full-time employment	**11.7%**		
Other	**33.8%** 14.2% wrote “improved pay” as a retention factor.	Other retirement deferral incentives	**21.5%** 3.9% wrote “improved pay” as a retention factor.

Support and retention

Access to workplace mental health supports vs. plans to leave current nursing position

Access to workplace mental health supports is a critical retention factor. The worse the access to workplace mental health supports, the more likely – or sooner – the respondents plan to leave their current positions.

Access to supports	No plans to leave within next 5 years	Yes, plan to leave within the next 1 to 5 years	Yes, plan to leave within the next 12 months	Total
Excellent	41.9%	34.2%	23.9%	100%
Very good	37.1%	38.4%	24.5%	100%
Good	35.1%	40.9%	24.0%	100%
Fair	31.4%	39.8%	28.8%	100%
Poor	23.6%	43.4%	33.0%	100%
Very poor	19.2%	39.0%	41.9%	100%
Not applicable	39.8%	33.3%	26.9%	100%
Don't know	30.3%	41.5%	28.2%	100%
No response	29.4%	58.8%	11.8%	100%
Total	31.4%	39.6%	28.9%	100%

Supervisory staff supportive of nurses vs. plans to leave current nursing position

Similarly, the presence of supportive supervisory staff reduces the chances of nursing leaving their current positions, and the absence of it increases the chances of early departure.

Degree of agreement	No plans to leave within next 5 years	Yes, plan to leave within the next 1 to 5 years	Yes, plan to leave within the next 12 months	Total
Strongly agree	39.3%	34.4%	26.3%	100%
Agree	33.5%	40.5%	26.0%	100%
Disagree	25.1%	42.9%	32.0%	100%
Strongly disagree	21.1%	39.6%	39.3%	100%
Not applicable	36.6%	39.2%	24.2%	100%
No response	25.8%	38.7%	35.5%	100%
Total	31.4%	39.6%	28.9%	100%

Supervisory staff supportive of nurses vs. likelihood of leaving nursing profession

Respondents who agree that supervisory staff are supportive of nurses are less likely to leave the nursing profession. However, the relationship between supportive supervisory presence and the likelihood of leaving a specific nursing position is not as evident as it is for plans to leave the profession altogether.

Degree of agreement	Not at all likely	Somewhat likely	Moderately likely	Very likely	Total
Strongly agree	60.0%	27.1%	3.9%	9.0%	100%
Agree	60.3%	27.8%	6.7%	5.2%	100%
Disagree	42.9%	37.7%	14.6%	4.7%	100%
Strongly disagree	38.4%	34.4%	11.9%	15.2%	100%
Not applicable	65.0%	23.3%	5.8%	5.8%	100%
No response	50.0%	30.0%	10.0%	10.0%	100%
Total	54.2%	30.1%	8.5%	7.1%	100%

Support and wellness

Access to workplace mental health supports vs. average wellness scores

There is a strong correlation between assessed access to workplace mental health supports and eight summary wellness categories. For each indicator, as one's access to workplace mental health supports improves, health status improves. That is, scores fall for negatives like stress, anxiety, depression, disengagement and exhaustion, and they rise for positives like vigour, dedication and absorption.

Access Assessment	Stress	Anxiety	Depression	Disengagement	Exhaustion	Vigour	Dedication	Absorption
Excellent	9.48	5.42	6.55	2.15	2.40	2.89	4.70	4.08
Very good	11.03	6.36	7.52	2.28	2.54	2.62	4.28	3.78
Good	13.16	7.83	9.30	2.45	2.74	2.24	4.00	3.50
Fair	14.60	8.66	10.66	2.60	2.87	1.97	3.65	3.26
Poor	17.78	11.42	14.65	2.74	3.00	1.86	3.41	3.06
Very poor	20.29	13.88	18.68	2.89	3.13	1.47	2.99	2.72
Not applicable	7.86	4.61	7.16	2.07	2.26	2.46	4.55	3.94
Don't know	9.38	4.84	6.64	2.42	2.59	2.25	4.05	3.49
No response	7.50	3.50	6.17	2.21	2.44	0.03	4.59	3.55
Total	13.86	8.49	10.74	2.51	2.76	1.58	3.86	3.41

Supervisory staff that is supportive of nurses vs. average wellness scores

There is also a strong correlation between supervisory staff support and wellness scores. As one moves across the spectrum from very strong disagreement to very strong agreement, the scores for negative outcomes such as stress, anxiety, depression, disengagement, and exhaustion fall, showing improvement along this progression. And the scores for positive outcomes (vigour, dedication and absorption) rise - also showing improvement.

Level of agreement	Stress	Anxiety	Depression	Disengagement	Exhaustion	Vigour	Dedication	Absorption
Strongly agree	11.9	7.2	8.3	2.26	2.53	3.29	4.16	3.66
Agree	13.0	7.9	9.3	2.44	2.71	2.80	3.67	3.22
Disagree	15.3	9.7	12.8	2.68	2.92	2.31	3.26	2.86
Strongly disagree	19.6	12.7	17.2	2.92	3.15	1.78	2.81	2.49
Not applicable	10.3	5.1	8.1	2.30	2.53	2.80	3.59	3.27
No response	12.9	8.6	9.9	2.44	2.72	0.03	0.05	0.04
Total	13.9	8.5	10.7	2.51	2.76	1.58	2.11	1.86

Adequate support services allowing time for patients/clients vs. average wellness scores

Agreement that there is adequate support to allow time for patients again shows the same positive correlation with wellness scores. There is a slight but notable exception: this positive correlation does not hold when going from “agreement” to “strong agreement” for the stress, anxiety and depression measures.

Level of agreement	Stress	Anxiety	Depression	Disengagement	Exhaustion	Vigour	Dedication	Absorption
Strongly agree	10.97	6.96	8.16	2.19	2.42	3.57	4.47	3.82
Agree	10.74	6.06	7.34	2.28	2.54	3.44	4.33	3.77
Disagree	14.63	9.33	10.97	2.61	2.87	2.65	3.66	3.24
Strongly disagree	19.96	13.40	17.44	2.90	3.18	1.97	3.10	2.79
Not applicable	10.89	5.10	8.30	2.28	2.51	3.33	4.16	3.78
No response	10.21	5.60	7.71	2.31	2.62	3.41	4.19	3.61
Total	13.86	8.49	10.74	2.51	2.76	2.89	3.86	3.41

Survey comparison

Work and Wellbeing survey

Retention factors

The Canadian survey identified workplace supports followed by reduced workload as top retention factors for potential departers. These retention factors are also identified as important in the Work and Wellbeing survey.

Increase in support for early and mid-career nurses

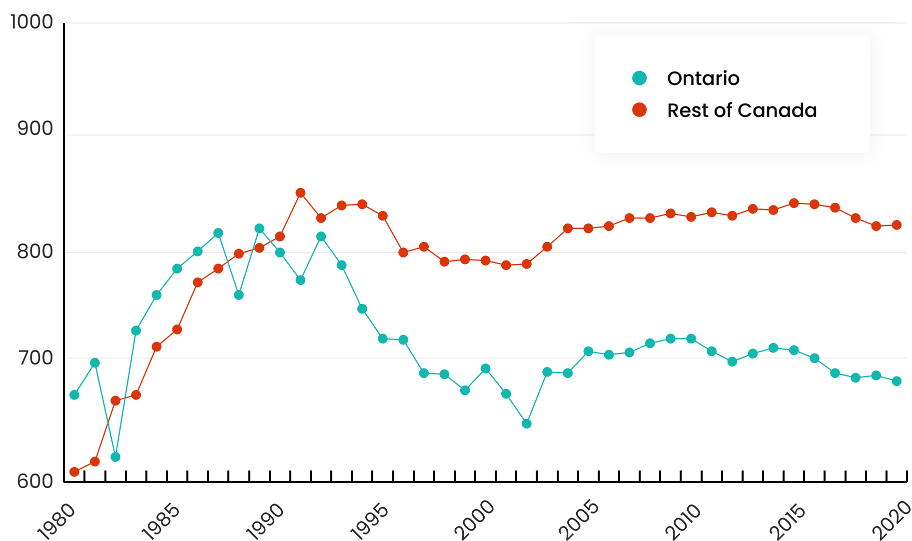
The effect of the pandemic seems to be compounding the recent pattern of nurse workforce participation dropping in early career age groups – specifically, nurses 26 to 35 years old – with loss rates much above the normal three per cent. This survey suggests these pre-pandemic loss rates will increase significantly. More than 20 per cent of nurses aged 26 to 35 indicates they are likely or very likely to leave the profession.

Respondents' assessment of employer support is also age-related: younger nurses rate employer support lower than do older nurses. Notably, employer support and likelihood to leave the profession seem to be correlated. The survey also shows that Ontario could be facing increased departure rates for mid-career nurses.

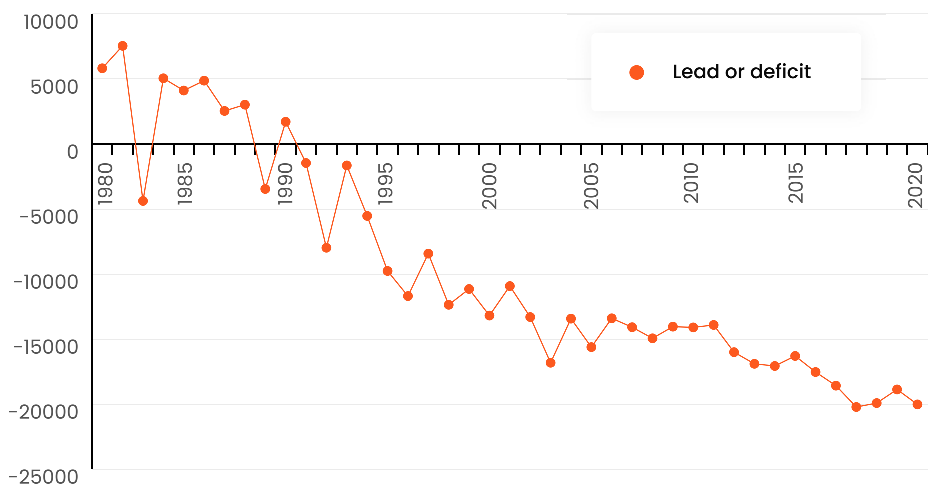
Increase in staffing levels

The survey suggests a correlation between high levels of stress and the likelihood of leaving the nursing profession. The survey also suggests a correlation between high levels of stress and a desire for fewer hours of work post-pandemic. Hours of work – an inverse proxy for staffing levels – appear to be correlated with stress levels. The survey results strongly suggest a shortage of nursing staff. This correlates with the fact that Ontario has the lowest combined RN- and NP-to-population ratio of all the provinces and territories.

RN- and NP-to-population ratios: Ontario vs. rest of Canada



Ontario lead or deficit in RNs and NPs vs. rest of Canada



PART 1

Conclusions and recommendations

In the face of excessive stress and lack of support throughout the pandemic, nurses have continued to struggle to provide safe, ethical and compassionate care. But nurses have reached their limit both here in Canada and around the world, as the surveys we reviewed for this report clearly illustrate. Nurses have been asked to work in settings with a high prevalence of COVID-19, particularly Canadian nurses. A significant minority of nurses has been asked to work outside their scope of practice without appropriate education or training. A majority of Canadian nurses have not only been asked to care for very ill patients at a time of poor staffing, but they have also been asked to meet the needs of their family – to keep themselves, patients and loved ones safe. They have been asked and expected to do too much!

Despite the tremendous burdens nurses have experienced during the pandemic, they have been offered little support. For example, half of the nurses in the Canadian survey reported that their organizations took away vacation time to cope with staffing demands. Canadian nurses also reported a lack of adequate support services in the practice environment to allow them to spend time with their patients, a lack of supervisory support and a lack of access to workplace psychological or mental health supports. In RNAO's Work and Wellbeing survey, nurses pointed to the absence of support from both employers and government. Those views were echoed in responses to the Canadian study, with nurses pointing to the Ontario government's refusal to repeal wage restraint legislation, Bill 124, in the context of the pandemic, staffing shortages and excessive workloads.

All of the surveys we reviewed revealed the profound and damaging impact of COVID-19 on the mental health of nurses. The HPWP survey results showed a decline in mental health resulting from the pandemic, and identified workload as the highest source of stress. The Canadian survey demonstrated that a significant percentage of nurses experienced severe or extremely severe levels of depression, anxiety and stress, with nurses aged 21 to 25 years experiencing the highest levels. And a large percentage of Canadian nurses suffered from burnout.

The Work and Wellbeing survey and the Canadian survey foretold Ontario's current nursing human resource crisis. In the Canadian survey, a high percentage of nurses noted a plan to leave a current position within the next twelve months. The potential for leaving within the next one to five years was even higher. Of those intending to leave their position, almost half indicated that they were "somewhat likely" to "very likely" to leave the profession by changing careers or retiring.

The overall survey findings confirm that nursing is in crisis. The effective functioning of Ontario's health system, the health of Ontarians and the future of nursing in Ontario are at tremendous risk.

Recommendations

RNAO insists on urgent action from health-care system employers and government to build RN careers in Ontario by implementing the following recommendations:

1. **Repeal Bill 124 and refrain from extending or imposing any further wage restraint measures**

2. **Immediately increase the supply of RNs by:**

    a. expediting applications and finding multiple pathways for internationally educated nurses (IEN) to become NPs, RNs and RPNs in Ontario

    b. increasing enrolments and corresponding funding in four-year baccalaureate (BScN) programs, second entry/compressed programs and RPN-to-BScN bridging programs by 10 per cent per year for seven years, and compressing RPN-to-BScN bridging programs to two years in length

3. **Develop and fund a Return to Nursing Now Program to attract RNs back to Ontario's nursing workforce**

4. **Support nurses throughout their careers by expanding the Nursing Graduate Guarantee, reinstating the Late Career Nurse Initiative and bringing back retired nurses to serve as mentors to new graduates and IENs**

5. **Establish a nursing task force immediately to make recommendations on matters related to retention and recruitment of RNs**

We now turn to providing a brief rationale for these crucial recommendations, based on our findings in this report.

Rationale for recommendations

1 Repeal Bill 124 and refrain from extending or imposing any further wage restraint measures

Ontario's Bill 124 has capped salary increases for public and broader public sector workers, including nurses, at one per cent – far below the rate of inflation – resulting in a real loss of income. In their free text responses, many Ontario respondents to the Canadian survey identified Bill 124 as a symbol of disrespect and disregard, and as an important reason why they are leaving the profession or seeking better opportunities elsewhere.

> *Covid and Bill 124 makes me feel devalued as a nurse.*
>
> - Canadian survey respondent

> *Covid not only has negatively impacted my nursing and health provider colleagues overall mental health but also having Bill 124 - really makes people wish they chose a different field to work in.*
>
> - Canadian survey respondent

2 Immediately increase the supply of RNs by:

a. expediting applications and finding multiple pathways for internationally educated nurses (IEN) to become NPs, RNs and RPNs in Ontario

IENs experience bottlenecks and barriers at all phases of the registration process. The backlog of IEN applicants for registration in Ontario has been growing for over a decade, and has continued escalating during the pandemic. According to the most recent report from the Office of the Fairness Commission, the number of applications for registration in Ontario exceeds 26,000. It is urgent that all qualified IENs have their paths to nursing employment expedited as quickly as possible to end the tragic waste of their badly needed skills.

IEN applications for registration with CNO

	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009
New applicants	-	6,315	4,556	4,710	3,758	2,967	1,115	3,635	4,123	5,517	4,870	3,878	3,303
Applicants actively pursuing licensing	-	14,633	14,574	13,331	9,581	12,374	11,985	13,941	19,253	14,316	11,313	9,335	7,118
"Inactive" applicants (applicants who had no contact with your organization in the reporting year)	-	5,080	4,608	3,550	4,725	1,909	3,577	3,936	4,072	4,557	3,637	2,166	4,649
Applicants who became fully registered members [1]	3,235	2,220	2,040	1,989	1,461	1341	1,635	1,467	742	1,761	1,012	772	739
Applicants who became fully registered members as RNs [2]	1645	1163	900	855	522	338	387	423	-	-	-	-	-

References:

[1] New Registrants Report, 2021. (Feb 11, 2021). College of Nurses of Ontario. Top 10 international countries of education- 2014-2021 overall. Retrieved from https://www.cno.org/globalassets/2-howweprotectthepublic/statistical-reports/new-registrants-report-2021.html

[2] New Registrants Report, 2021. (Feb 11, 2021). College of Nurses of Ontario. Top 10 international countries of education-2014-2021 RN. Retrieved from https://www.cno.org/globalassets/2-howweprotectthepublic/statistical-reports/new-registrants-report-2021.html

In addition to expediting applications, RNAO calls for the development of regulations under the Regulated Health Professions Act that:

- impose time limits on the registration process for IENs
- provide an emergency class of registration for IENs

b. increasing enrolments and corresponding funding in four-year baccalaureate (BScN) programs, second entry/compressed programs and RPN-to-BScN bridging programs by 10 per cent per year for seven years, and compressing RPN-to-BScN bridging programs to two years in length.

Closing the RN employment gap: Increasing RN education seats by 10 per cent per year with no further recruitment efforts [1]

School year	Education action	4-year to WF [2]	2nd Ent to WF [3]	RPN-RN to WF [4]	Total Grads to WF [5]	IENs [6]	Total Gains [7]	Total Attrition [8]	RN WF [9]	Target [10]	Gap [11]
2020-21	Base	3,210	679	540	4,429	1,645	6,074	4,406	97,920	120,101	22,181
2021-22	+870 [12]	3,210	682	516	4,407	1,664	6,072	4,406	99,585	121,998	22,413
2022-23	+130 [13] +900 [14]	3,210	682	516	4,407	1,684	6,092	4,481	101,196	124,184	22,988
2023-24	+10%	3,210	829	562	4,601	1,704	6,305	4,554	102,947	126,172	23,225
2024-25	+10%	3,210	829	1,263	5,302	1,724	7,027	4,633	105,341	128,085	22,745
2025-26	+10%	3,694	912	1,390	5,995	1,745	7,740	4,740	108,340	129,918	21,578
2026-27	+10%	3,794	1,003	1,529	6,325	1,766	8,091	4,875	111,555	131,667	20,111
2027-28	+10%	4,173	1,103	1,682	6,958	1,786	8,744	5,020	115,279	133,329	18,050
2028-29	+10%	4,590	1,213	1,850	7,653	1,808	9,461	5,188	119,553	134,961	15,408
2029-30		5,049	1,335	2,035	8,419	1,829	10,248	5,380	124,421	136,591	12,170
2030-31		5,554	1,468	2,238	9,261	1,851	11,111	5,599	129,933	138,217	8,284
2031-32		6,110	1,468	2,238	9,816	1,873	11,689	5,847	135,775	139,840	4,065
2032-33		6,721	1,468	2,238	10,427	1,895	12,322	6,110	141,987	141,458	-529

References:

[1] Ontario RN student baseline enrolments and attrition rates estimated from: Canadian Association of Schools of Nursing. (2019). Registered Nurses Education in Canada Statistics 2017–2018. https://www.casn.ca/wp-content/uploads/2019/12/2017-2018-EN-SFS-DRAFT-REPORT-for-web.pdf

[2] Estimated number of 4-year BScN graduates entering the workforce (initial enrolment less attrition).

[3] Estimated number of second-entry RN graduates entering the workforce (initial enrolment less attrition).

[4] Estimated number of RPN-to-RN graduates entering the workforce (initial enrolment less attrition).

[5] Estimated total number of RN graduates entering the workforce, equaling the sum of the previous three columns.

[6] Internationally Educated RNs. Exogenous IEN RN additions for 2020-21 set at 1,645, the 2021 CNO figure. For subsequent years, IEN additions were increased at the average annual forecasted rate of growth of Ontario to 2046 – 1.19%. Ontario. (2021). Population projections by age and sex for Ontario. https://data.ontario.ca/dataset/population-projections/resource/31376797-1e4c-4426-ba75-0d93f4bb9f45?inner_span=True.

[7] Sum of previous two columns.

[8] Assumes an annual workforce attrition rate of 4.5%. CNO 2020 attrition rate = 4.8%

[9] The base number comes from CIHI for 2020. Gains and losses are added and subtracted respectively from the starting figure.

[10] The target RN workforce is the size that would make Ontario's RN-to-population ratio equal that of the rest of the country for 2020. It is scaled up annually according to Ontario's projected population growth rate (reference scenario). Ontario. (2021). Population projections by age and sex for Ontario.

[11] The gap is the difference between the projected size of the RN workforce and the target size.

[12] + 628 first-year seats in 2021-22 to 4-year BScN program + 182 first-year seats in 2021-22 to 2nd entry program + 60 first=year seats in 2021-22 to RPN-to-RN program

[13] + 130 first-year seats in 2022-23 to 4-year BScN program

[14] + 900 first-year seats in 2022-23 to RPN-to-RN seats

Increasing enrolment to bolster the RN supply is a timely and robust strategy. RNAO advocates for increasing enrolments, and corresponding funding in four-year baccalaureate (Bachelor of Science in Nursing or BScN) programs, second entry/compressed programs and RPN-to-RN bridging programs by 10 per cent per year for seven years.

RNAO also advocates for compressing RPN-to-BScN bridging programs to two years in length from their current durations of three years. This would help ease shortfalls in nursing supply by shortening the timeline needed for the hundreds of RPNs currently in the application process to become BScN RNs.

3 Develop and fund a Return to Nursing Now Program to attract RNs back to Ontario's nursing workforce

College of Nurses of Ontario (CNO) data identifies thousands of RNs who remain registered with the CNO, but are not participating fully – or at all – in Ontario's nursing workforce. These RNs are:

- working part-time and/or casual but would prefer to be working full-time
- not working in nursing, many of whom are seeking nursing employment
- working in another jurisdiction
- on leave in elevated numbers

RN workforce sources and recruitment targets: CNO 2022

Potential workforce sources	Recruitment targets [1]			
RN Pool	Total	2022-23	2023-24	2024-25
Seeking nursing [2]	2,926	1,500	500	
Working Outside of Ontario	2,830	500	400	300
IENs [3]	13,973	2,000	2,000	2,000
Not seeking nursing [4]	2,166	400		
On leave [5]	3,499	500	500	
Not practising [6]	10,903	2,000		
Preferred Work Status [7]	2,412 FTEs	2,000		
Total		8,900	3,400	2,300

References:

[1] Targets are chosen based on ambitious estimates of the number of possible recruits that might join the workforce in a given year, given the pool. Some pools, like the group seeking nursing employment, will be much more readily drawn into the workforce.

[2] CNO. (2022). Interim Registration Statistics Report 2022. March 14. https://www.cno.org/globalassets/2-howweprotectthepublic/statistical-reports/interim-registration-statistics-report-2022.html. In 2022, 2,926 RN registrants were seeking nursing employment.

[3] RNAO estimates that CNO received 3.436 IEN RN applications in 2020, that a further 7,795 IENs are actively seeking to register with the CNO as RNs, and that another 2,742 have ceased actively seeking Ontario registration.

[4] CNO. (2022). Interim Registration Statistics Report 2022. March 14. https://www.cno.org/globalassets/2-howweprotectthepublic/statistical-reports/interim-registration-statistics-report-2022.html. In 2022, 2,166 RN registrants were not working in nursing and not seeking nursing employment.

[5] another 2,742 have ceased actively seeking Ontario registration.

[5] CNO. (2022). Interim Registration Statistics Report 2022. March 14. https://www.cno.org/globalassets/2-howweprotectthepublic/statistical-reports/interim-registration-statistics-report-2022.html. 3,499 RNs were on leave (CNO 2022), which was 1,062 more than the average of 2,437 for 2015-20.

[6] CNO. (2022). Interim Registration Statistics Report 2022. March 14. https://www.cno.org/globalassets/2-howweprotectthepublic/statistical-reports/interim-registration-statistics-report-2022.html. In 2022, 10,903 Ontario-registered RNs were in the non-practising class.

[7] Based on a special data request on preferred vs. actual work status (full-time, part-time or casual) to CNO, RNAO estimates that if every Ontario RN had their preferred work status, Ontario would gain 2,412 RN FTEs.

4 Support nurses throughout their careers by expanding the Nursing Graduate Guarantee, reinstating the Late Career Nurse Initiative and bringing back retired nurses to serve as mentors to new graduates and IENs

Retention of nurses is critically important during our current nursing crisis. New graduates have reported a need for better access to mentoring, opportunities to develop their career, and access to full-time employment. These younger nurses are leaving the profession, or report an intention to leave in the near future, if supports are not obtained. Late-career nurses are also leaving the profession, or report an intention to leave the profession. Late-career nurses want the ability to adjust their work schedule, and more opportunities to mentor other nurses and spend less time in direct care. Retention of late-career nurses and returning retired nurses to the workforce would benefit new graduates, inexperienced nurses and IENS. RNAO strongly advocates for supporting nurses through their career by expanding the Nursing Graduate Guarantee and reinstating the Late Career Nurse Initiative.

I feel no one in the health organization I work for cares about patients or staff. There is not enough senior staff for all the incoming international nurses and junior nurses.

\- Canadian survey respondent

How to keep younger nurses from leaving the profession?

- Better access to mentoring
- More opportunities to develop their nursing career
- Access to full-time employment

How to encourage late career nurses to remain in the profession?

- Ability to adjust work schedule
- More opportunities to mentor other nurses and spend less time in direct care

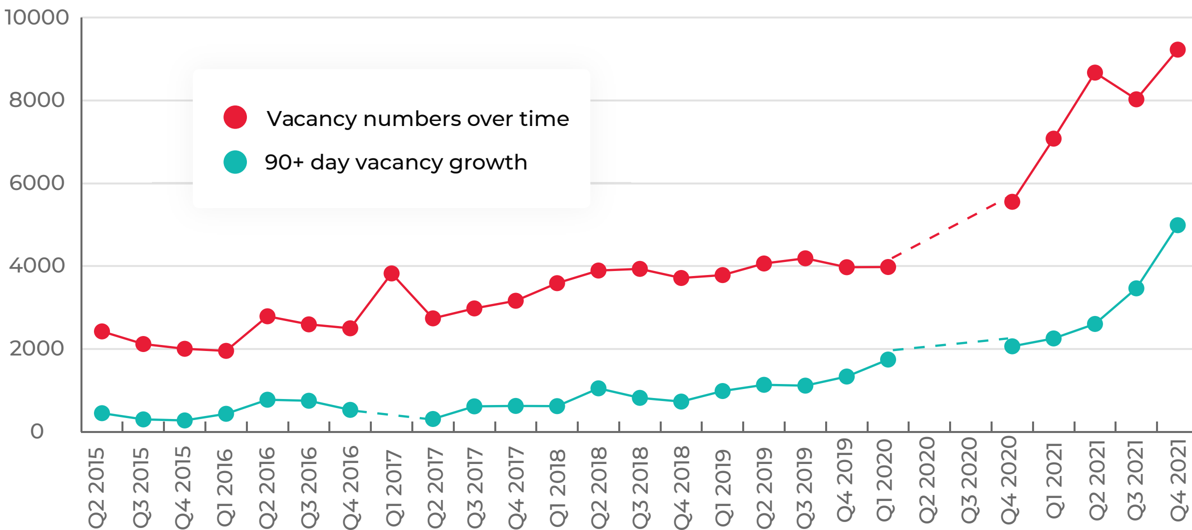
5 Establish a nursing task force immediately to make recommendations on matters related to retention and recruitment of RNs

Items for immediate recommendations and action include:

- increasing full-time employment opportunities
- ensuring competitive salary and benefits across all sectors
- reducing workloads
- increasing opportunities for mentorship and professional development
- increasing occupational health and safety measures and enforcement

Ontario's nursing shortage predates the pandemic by decades, and will remain long after the pandemic ends. Ontario entered the COVID-19 pandemic nearly 22,000 RNs short of the rest of Canada on a per-capita basis. The COVID-19 pandemic ushered in a new, deeper crisis in RN staffing. Statistics Canada vacancy data points to an enormous growth in RN vacancies throughout the pandemic both across the country and here in Ontario. All the while, a backlog of surgeries and treatments has continued to accumulate.

Evidence of a growing RN human resource crisis



Reference:

Statistics Canada. (2021). Job vacancies, second quarter 2021.
https://www150.statcan.gc.ca/n1/daily-quotidien/210921/dq210921a-eng.htm?msclkid=5d3068facfa211ecae51352cce7eabef

The long-standing and detrimental impact of RN understaffing on patient care and nurse wellness is well-documented in several national surveys and RNAO's own research. As long ago as 2005, data from Statistics Canada demonstrated that a high percentage of nurses experienced work overload, which often prevented them from providing high quality care. In 2019, the Canadian Federation of Nurses Unions reported that excessive overtime and unsustainable workloads had led to a decline in nurses' health. It warned, based on evidence of further understaffing, of worse to come – without realizing that a pandemic would start to create massive unforeseen demands less than a year later.

This report joins a long line of research studies demonstrating the serious health consequences for RNs of persistent RN understaffing. According to our findings, many Canadian nurses who continued to work throughout the pandemic reported significant mental health problems, and even more are suffering from burnout. We have laid out the consequences of this above: nurses are leaving their positions and their profession. A nursing retention and recruitment task force is needed – immediately – to address the nursing crisis and to ensure the ongoing viability of Ontario's health system.

References:

1. Canadian Institute for Health Information. (2021). Registered Nurses. https://www.cihi.ca/en/health-workforce-in-canada-highlights-of-the-impact-of-covid-19/a-lens-on-the-supply-of-canadas
2. NNAS Annual Report. (2020). https://www.nnas.ca/wp-content/uploads/2020/09/NNAS-2019-2020-Annual-Report-EN-Final-Sept-11-20.pdf
3. CNO. (2021). Requirements for IENs. https://www.cno.org/en/become-a-nurse/registration-requirements/education/internationally-educated-nurses-competency-assessment-program/faq-iencap
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6. Regulated Health Professions Act, 1991, S.O. 1991, c. 18: Version December 9, 2021. https://www.ontario.ca/laws/statute/91r18
7. Statistics Canada. (2005). National Survey of the Work and Health of Nurses 2005: Provincial Profiles. https://www150.statcan.gc.ca/n1/en/catalogue/11-621-M2006052
8. Stelnicki, A.M. Carleton, R.N. & Reichert, C. (2020). Mental Disorder Symptoms Among Nurses in Canada. Canadian Federation of Nurses Unions. https://nursesunions.ca/wp-content/uploads/2020/06/OSI-REPORT_final.pdf

PART 2

Nursing programming implications

Our research lens

We now turn to an analysis of micro and meso issues using the theoretical lens of Karasek and Theorell's Job-Demand-Control-Support model. This model provides a useful approach for understanding nurse respondents as workers with different roles in a variety of workplace settings, and helps us determine why we noted certain differences among survey participants.

The Job-Demand-Control-Support model also helps explain how variations in job control and support levels in hospital, primary care and long-term and retirement care settings, and in nurses working in direct versus indirect care roles, have noteworthy implications on employees' reactions to high job demands. This, in turn, influences nurses' outcomes related to work and wellbeing. For example, increased job control and social support can create a "buffer effect" that helps decrease the detrimental impact of job demands on employees.

Comparison of sectors

The population

Workplace by sector

We collapsed “workplace” into three broader categories or sectors:

Hospital
(including rehabilitation services and outpatients)

Long-term care and retirement home care
(LTC/RC)

Primary care
(including family practice and community health services)

See sectoral mapping in Appendix D.

Sector by age

Hospital nurse respondents were generally younger than LTC/RC and primary care nurses. For respondents in the 21- to 25-year age group, hospitals had a higher percentage of respondents when compared with LTC/RC and primary care. Primary care had the highest percentage of respondents in the 56- to 60-plus age group compared to the other sectors.

Age group in years	Hospital	Long-term / retirement care	Primary care
Less than 21	0.7%	1.2%	0.0%
21 – 25	10.1%	5.8%	2.2%
26 – 30	16.5%	8.7%	9.1%
31 – 35	13.4%	12.2%	9.1%
36 – 40	10.9%	7.2%	10.8%
41 – 45	8.4%	8.5%	8.9%
46 – 50	10.0%	15.3%	13.0%
51 – 55	10.7%	11.8%	13.9%
56 – 60	11.1%	12.4%	13.5%
60+	8.3%	16.8%	19.5%
Valid total	100%	100%	100%
Estimated average age	41.4	46.0	47.9

Outcomes: Mental health

This section uses the Depression, Anxiety, Stress Scales – 21 (DASS-21) (see Appendix C) to examine the symptomatology of depression, anxiety and stress within the hospital, LTC/RC and primary care sectors. We then examine levels of burnout across these three sectors.

DASS-21 scores

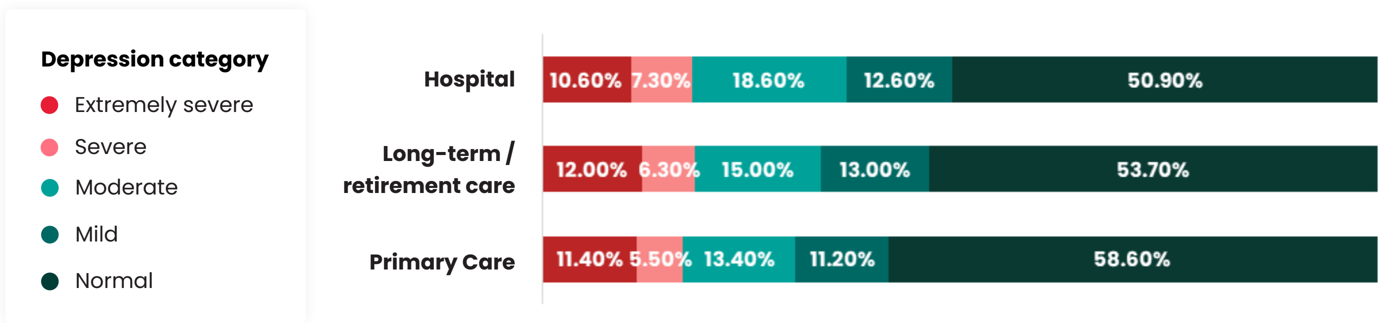
On average, depression scores were slightly higher among hospital nurses, but were either normal or mild in all sectors. The anxiety scale demonstrated mild (although approaching moderate) symptoms for hospital nurses, mild symptoms for LTC/RC nurses, and normal symptoms for primary care nurses. Stress scores were somewhat higher for hospital nurses than the other two sectors (normal approaching mild symptoms). But they were in the normal range for LTC/RC nurses and primary care nurses.

Mean DASS-21 scores by sector

DASS attribute	Hospital	Long-term/ retirement care	Primary care
Depression	Mild **(11.5)**	Mild **(10.9)**	Mild **(10.4)**
Anxiety	Mild, approaching moderate symptoms **(9.5)**	Mild **(8.9)**	Normal **(7.6)**
Stress	Normal, approaching mild symptoms **(14.8)**	Normal **(13.6)**	Normal **(13.5)**

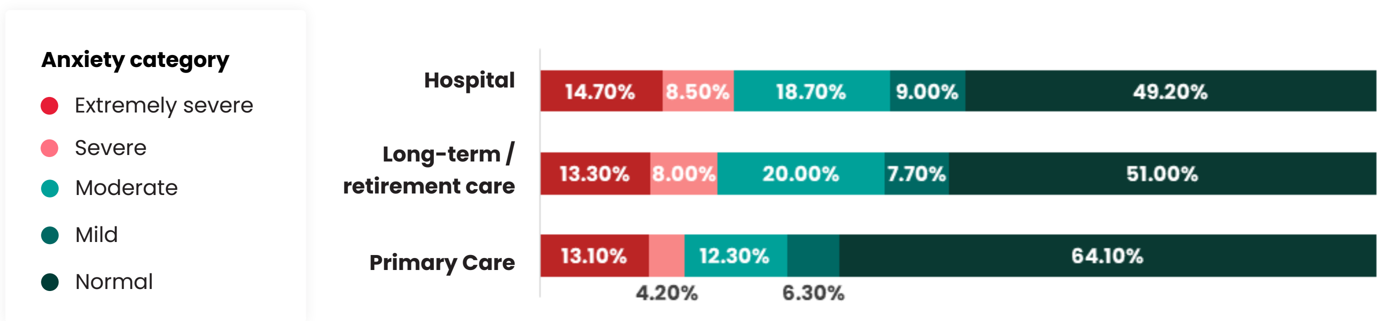
Scores on each category of DASS-21 are interpreted differently; for example, a score of 8.9 on the anxiety scale is in the mild range, while a score of 13.6 on the stress scale is in the normal range (see Appendix C). The distribution of DASS-21 scores for each of the three scales shows that despite the rather low mean scores, a significant minority of respondents in all sectors experienced moderate to extremely severe symptoms of depression, anxiety and stress.

Distribution of DASS-21 depression scores by sector



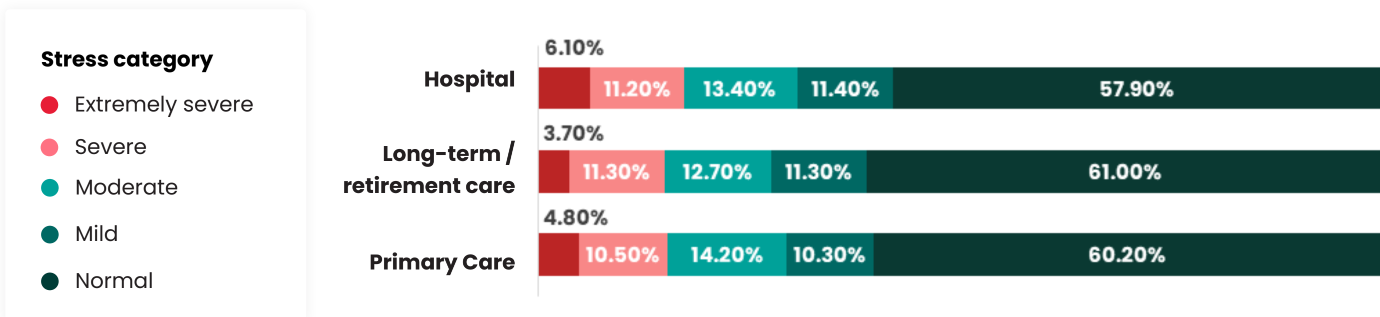
A higher percentage of hospital nurses (36.5 per cent) reported moderate to extremely severe depression, compared to LTC/RC nurses (33.3 per cent) and primary nurses (30.3 per cent).

Distribution of DASS-21 anxiety scores by sector



Similar percentages of hospital nurses (41.9 per cent), and LTC/RC nurses (41.0 per cent) reported moderate to extremely severe anxiety during the pandemic, compared to primary care nurses (29.6 per cent).

Distribution of DASS-21 stress scores by sector



Similar percentages of hospital nurses (41.9 per cent), and LTC/RC nurses (41.0 per cent) reported moderate to extremely severe anxiety during the pandemic, compared to primary care nurses (29.6 per cent).

Oldenburg Burnout Inventory (OLBI) scores

We measured burnout using the Oldenburg Burnout Inventory (OLBI) to assess exhaustion and disengagement (see Appendix C). Suggested clinical cut-off scores are 2.25 for exhaustion and 2.1 for disengagement. Mean scores for exhaustion and disengagement were both above the suggested clinical cut-offs in all sectors, implying widespread burnout. Burnout scores were highest among hospital nurses and lowest among primary care nurses.

OLBI attribute	Hospital	Long-term/ retirement care	Primary care
Disengagement	2.59	2.54	2.41
Exhaustion	2.87	2.77	2.66

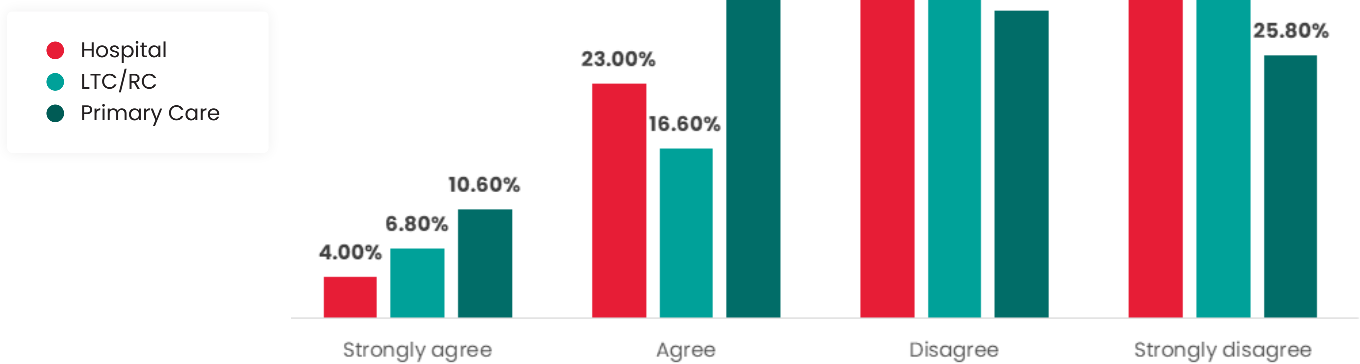
Demands, control and support

Demands

Demands within the workplace were similar among hospital and LTC/RC nurses, and lower among primary care nurses. Demands outside the workplace were similar in all sectors.

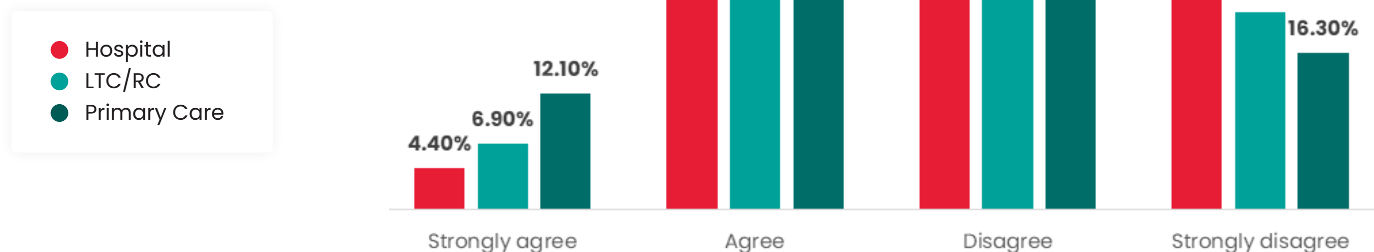
Demands within the workplace

Enough staff to get the work done



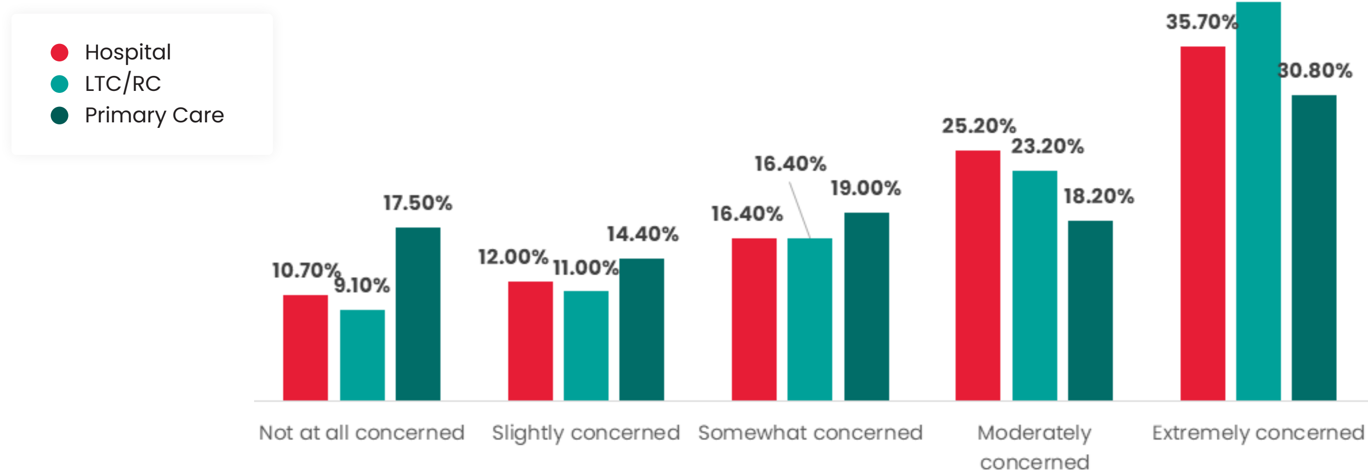
The majority of nurses in all sectors reported they did not have “enough staff to get their work done”. A higher percentage of hospital nurses (72.9 per cent) and LTC/RC nurses (76.6 per cent) disagreed or strongly disagreed with the statement, compared to 56.0 per cent of nurses in primary care.

Enough time and opportunity to discuss patient/client care problems with other nurses



When asked if they had “enough time and opportunity to discuss patient/client care problems with other nurses,” a lower percentage of nurses in hospitals (38.4 per cent) agreed or strongly agreed to the statement, compared to LTC/RC nurses (44.0 per cent) and primary care nurses (53.9 per cent). Results in all sectors were low, especially when considering the importance of discussing patient/client problems with other nurses.

Managing workload

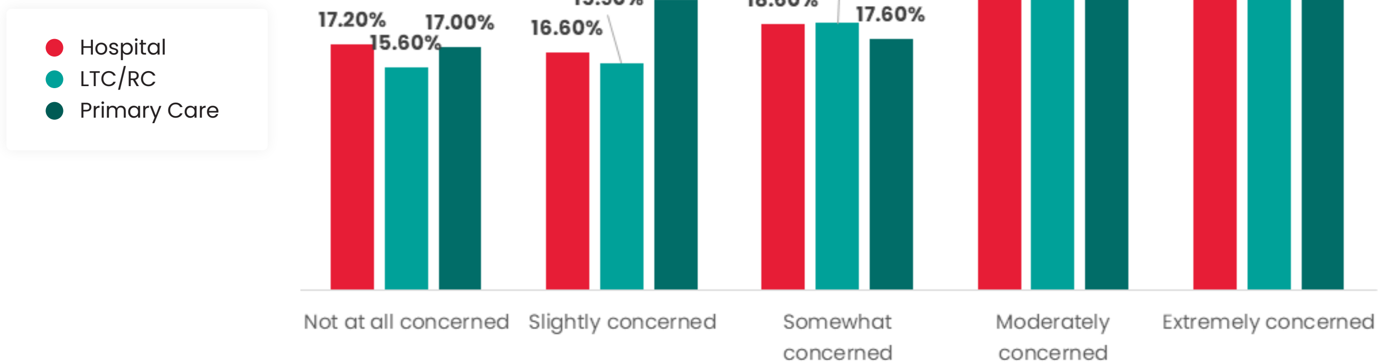


In all sectors, nurses were moderately or extremely concerned about managing their workload. A greater percentage of nurses in hospital settings expressed moderate or extreme concern (60.9 per cent) and LTC/RC (63.5 per cent), compared to a lower percentage (49.1 per cent) in primary care.

Demands outside the workplace

A large majority of nurses in all sectors reported an increase in caregiving responsibilities during the pandemic.

Concerns about managing the personal needs of family/cohabitants



A large minority of nurses in all sectors were moderately or extremely concerned about managing the personal needs of their family or other people living with them: 49.9 per cent in LTC/RC, 47.7 per cent in hospitals and 45.0 per cent in primary care.

Child care responsibilities at home

	Hospital	Long-term/ retirement care	Primary care
Yes	31.4%	32.4%	34.5%
No	68.6%	67.6%	65.5%

A significant minority of nurses in all sectors had child care responsibilities at home, with a slightly higher percentage in primary care (34.5 per cent), compared to nurses in hospitals (31.4 per cent) and LTC/RC settings (32.4 per cent).

Other caregiver responsibilities (excluding child care)

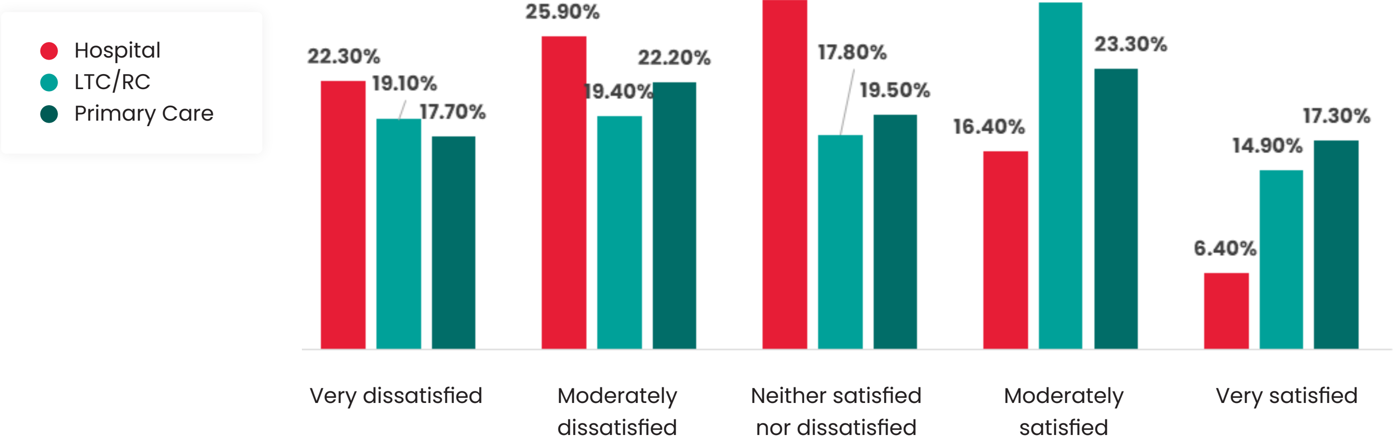
	Hospital	Long-term/ retirement care	Primary care
Yes	20.5%	27.7%	28.5%
No	79.5%	72.3%	71.5%

A significant minority of nurse respondents in all sectors had other caregiver responsibilities, with a higher percentage in primary care (28.5 per cent), and LTC/RC (27.7 per cent), compared to respondents working in hospitals (20.5 per cent).

Control

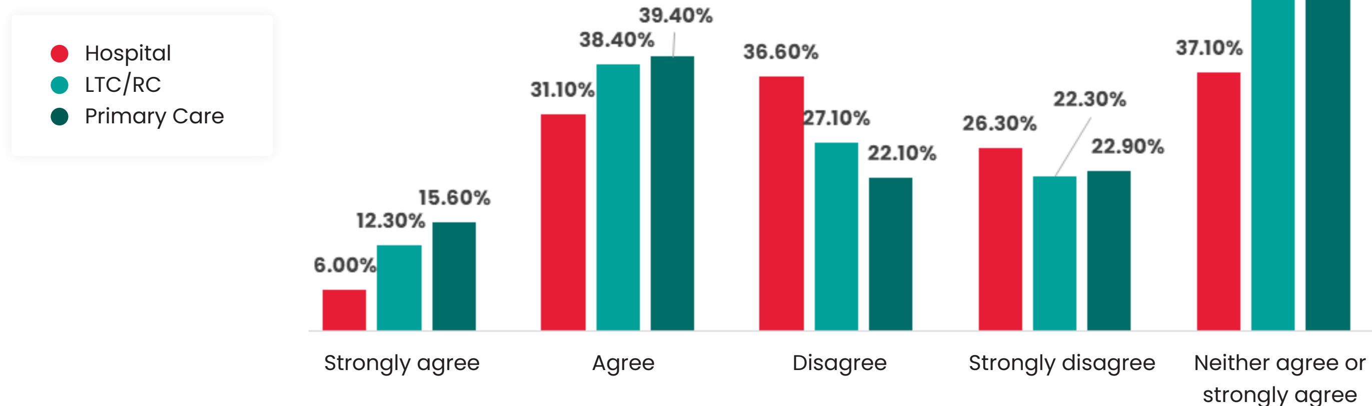
Lower percentages of hospital nurses reported experiencing control in the workplace. In contrast, the highest percentages of nurses experiencing control worked in LTC/RC settings.

Participation in organizational decision making



Only 22.8 per cent of hospital nurses were moderately satisfied or very satisfied with their participation in organizational decision making, compared to 43.7 per cent of LTC/RC nurses and 40.6 per cent of primary care nurses.

Staff nurses are involved in the internal governance of the health service (for example, practice and policy committees)



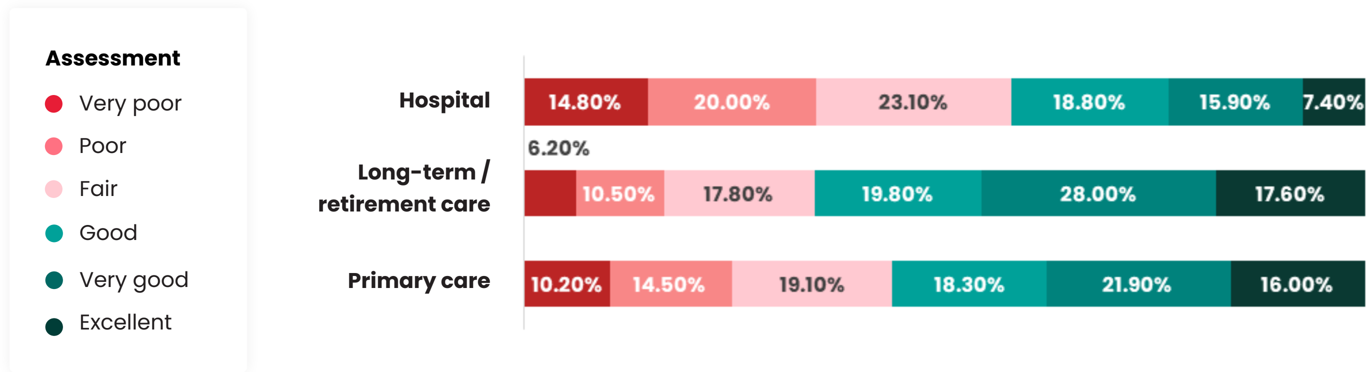
Only 37.1 per cent of hospital nurses agreed or strongly agreed with the statement "staff nurses are involved in the internal governance of the health service," compared to 50.7 per cent of LTC/RC nurses and 55.0 per cent of primary care nurses.

Before making conclusions related to controls mitigating high workplace demands, it is essential to also examine supports as a buffering variable.

Supports in the workplace

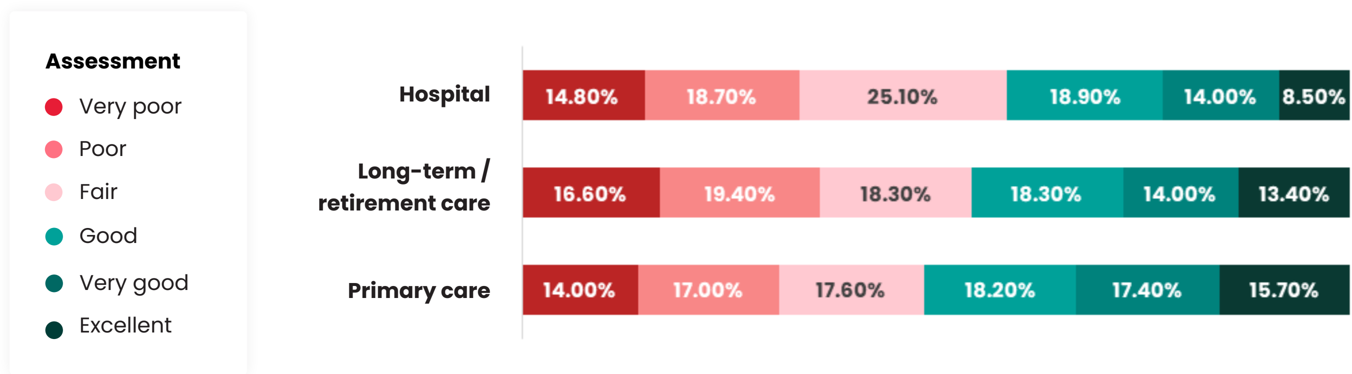
A lower percentage of hospital nurses reported workplace supports compared to nurses in LTC/RC and primary care on all survey items. Results were similar among LTC/RC nurses and primary care nurses.

Support for new graduates or inexperienced staff



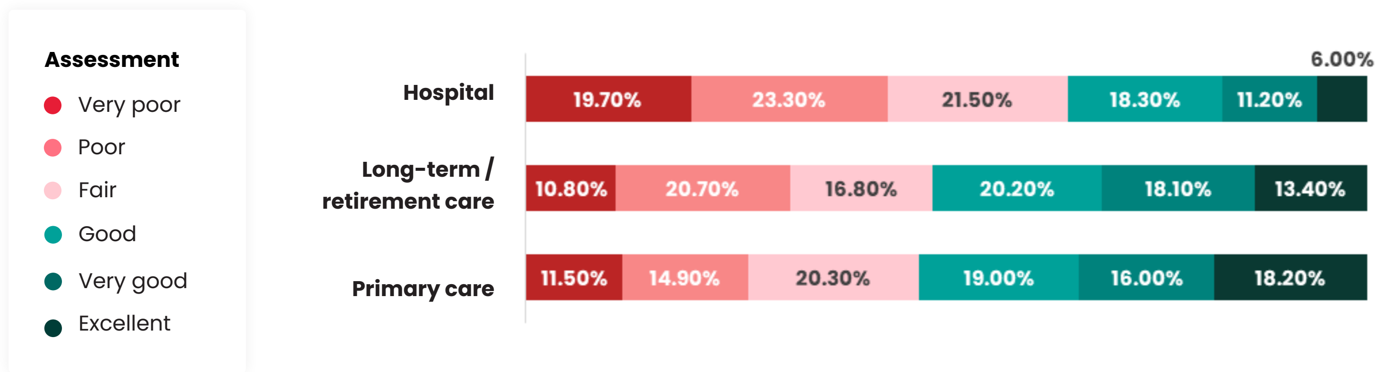
"Support for new graduate nurses or inexperienced staff" was reported as low ("poor or very poor") across all sectors, particularly in the hospital setting (34.8 per cent), compared to 16.7 per cent of LTC/RC nurses and 24.7 per cent of primary care nurses.

Access to workplace psychological or mental health support



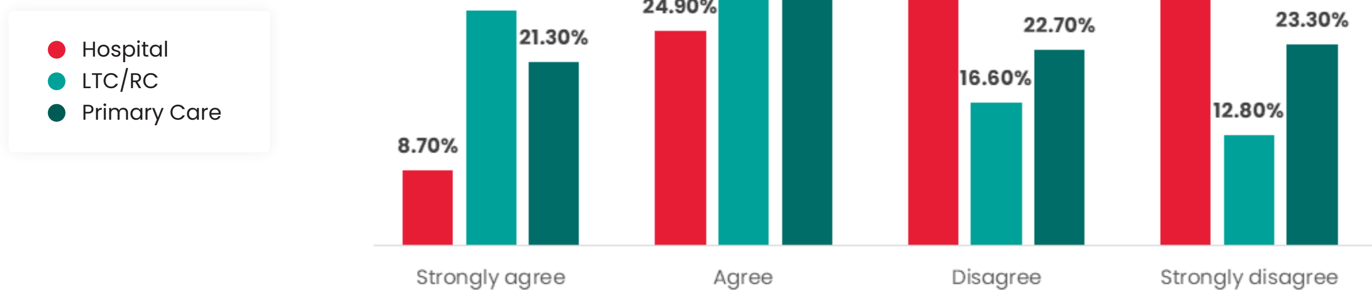
Significant numbers of nurses in all sectors noted lack of access to psychological or mental health support. A lower percentage of hospital nurses (22.5 per cent) reported very good or excellent support compared to 27.4 per cent of LTC/RC respondents and 33.1 per cent of primary care respondents.

Preventing abuse of staff (for example, physical or verbal harassment)



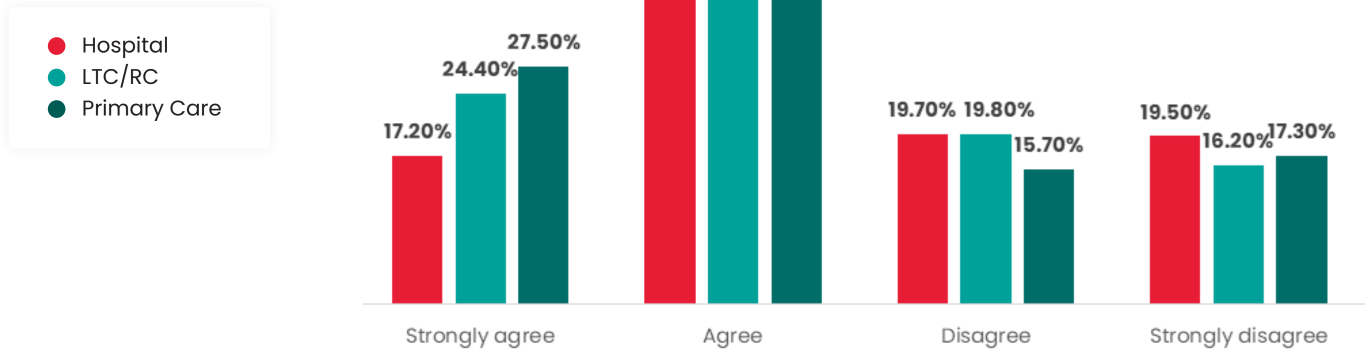
Although prevention of staff abuse was low among all sectors, a higher percentage of hospital respondents (43.0 per cent) reported that prevention of abuse was in the poor or very poor range, compared to LTC/RC respondents (31.5 per cent) and primary care respondents (26.4 per cent).

A director of nursing who is highly visible and accessible to staff



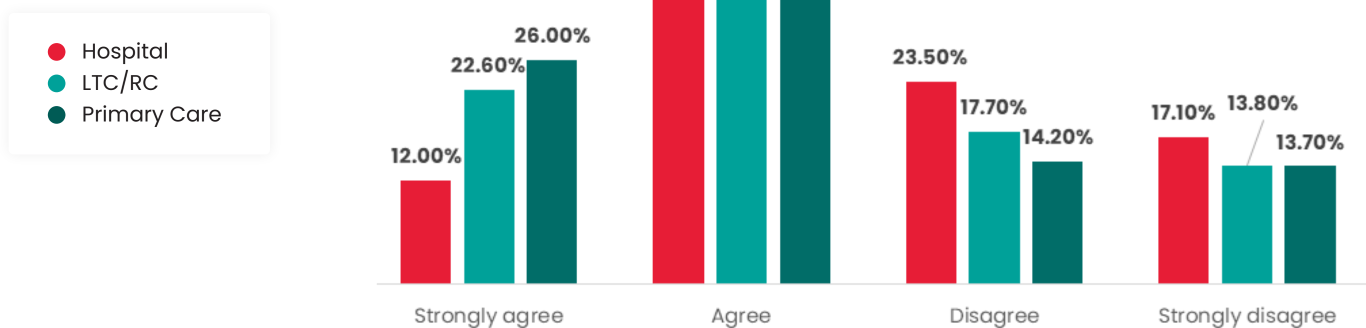
Compared to those working in primary care (54.0 per cent) and in hospitals (33.6 per cent), the majority of LTC/RC nurses (70.6 per cent) agreed or strongly agreed that their director of nursing was highly visible and accessible in their facility, providing them with a sense of support.

A nurse manager who is a good manager and leader



A majority of nurse respondents in all sectors agreed or strongly agreed that that they had a nurse manager "who is a good manager and leader". Results across the sector were similar: hospital nurses (60.8 per cent), LTC/RC nurses (64.0 per cent) and primary care nurses (67.0 per cent).

A supervisory staff that is supportive of the nurses



A lower percentage of hospital nurses (59.4 per cent) agreed or strongly agreed that their supervisory staff was supportive of nurses. A higher level of supervisory staff support was reported by LTC/RC nurses (68.5 per cent) and primary care nurses (72.1 per cent).

Conclusion

In all sectors, a significant minority of nurse respondents reported symptoms of depression, anxiety and stress, with slightly higher scores among hospital nurses compared to LTC/RC and primary care nurses. Burnout was prevalent in all sectors, with the highest incidence among hospital nurses. Although workplace demands were similar among hospital nurses and LTC/RC nurses, a higher percentage of hospital nurses reported greater workplace demands compared to primary care nurses. Compared to the other sectors, lower percentages of hospital nurses reported adequate workplace control and supports, which may explain the higher percentage of depression, anxiety, stress and burnout among this group.

Primary care nurses experienced lower levels of burnout and symptoms of anxiety than nurses in the other two sectors. A lower percentage of primary care nurses experienced greater workplace demands compared to hospital and LTC/RC nurses, which may help to explain the lower reports of anxiety and burnout.

Outcomes: potential departures

High percentages of respondents planned to leave either their positions or the profession. A higher percentage of hospital nurses had plans to leave their position within the next one to five years when compared to LTC/RC nurses and primary care nurses. A higher percentage of hospital nurses were also more likely to leave the profession altogether.

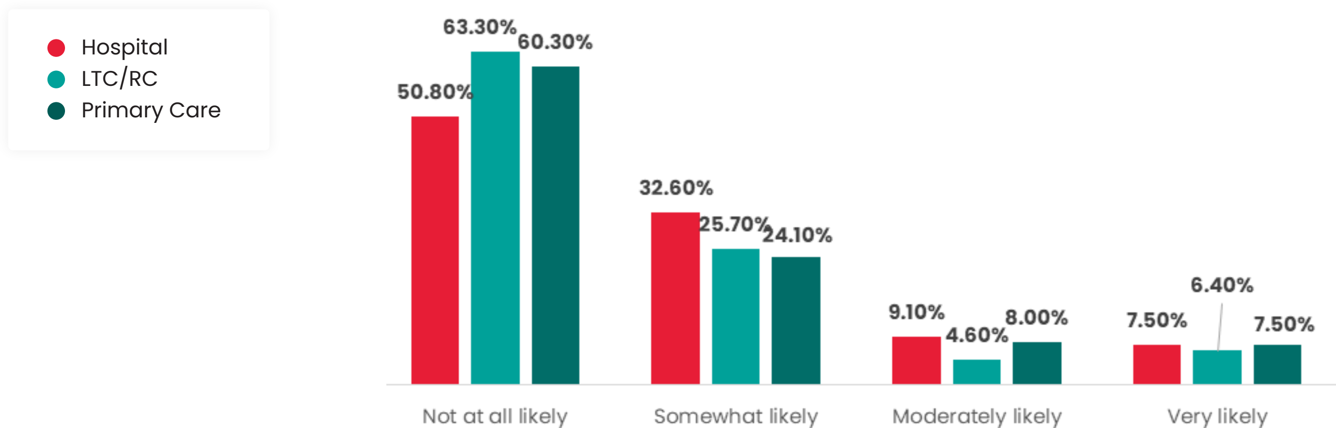
Leaving a position by sector

Do you plan to leave your current position?

A similar percentage of hospital nurses (29.6 per cent) and LTC/RC nurses (29.8 per cent) planned to leave their current position within the next 12 months, compared to primary care nurses (24.6 per cent). Similarly, a higher percentage of hospital nurses (42.7 per cent) planned to leave their current position within the next one to 5 years, compared to LTC/RC nurses (38.0 per cent) and primary care nurses (38.3 per cent).

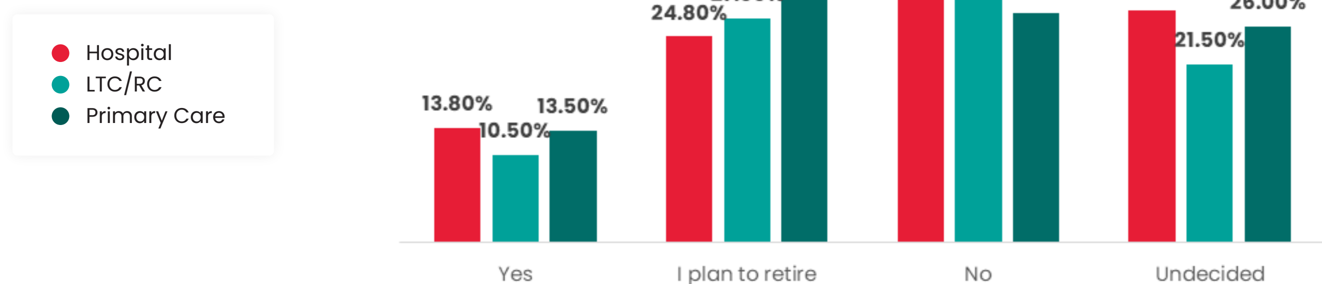
Leaving a profession by sector

How likely are you to leave nursing for a different occupation after the pandemic? *(Asked of those planning to leave their positions in one to five years)*



Of respondents planning to leave their positions within one to five years, a higher percentage of hospital nurses (49.2 per cent) were somewhat to very likely to “leave nursing for a different occupation” when compared to LTC/RC nurses (36.7 per cent) and primary care nurses (39.6 per cent). LTC/RC nurses had the highest percentage of nurses who were not at all likely to leave the profession (63.3 per cent) compared to hospital (50.8 per cent) and primary care nurses (60.3 per cent).

Do you plan to exit nursing to work in another field? *(Asked of those planning to leave their positions)*



Of those planning to leave their position, fewer LTC/RC nurses planned to pursue work in a different field (10.5 per cent) than either hospital nurses (13.8 per cent) or primary care nurses (13.5 per cent). A higher percentage of primary care nurses (32.9 per cent) planned to retire compared to the other sectors.

Conclusion: Comparison of sectors

Nurses in all sectors struggled significantly during the COVID-19 pandemic. Work demands were high across all sectors, and nurses reported impacts on their mental health outcomes including depression, anxiety, stress and burnout. Of those who planned to leave their positions, a significant percentage of nurses across sectors planned to leave the profession.

When comparing nursing sectors, hospital nurses' experiences of the pandemic were the most challenging. They had poorer mental health outcomes with higher levels of depression, anxiety, stress and burnout than nurses in the other two sectors. Even though work demands were high among all sectors, for hospital nurses the experience of high work demands were not mitigated by control or support. Hospital nurses were more likely to leave their position than LTC/RC nurses and primary care nurses. Of those leaving their position, hospital nurses were more likely to leave the profession altogether.

Of note, LTC/RC nurses were less likely to leave the nursing profession than nurses in the other sectors. Yet LTC/RC nurses reported high workplace demands and high levels of burnout, and a significant percentage also reported symptoms of anxiety, depression and stress. And, although LTC/RC and primary care nurses indicated they had similar work supports, LTC/RC nurses reported experiencing greater control in the workplace than their counterparts in the other sectors. It's possible that workplace control buffered the demands placed on LTC/RC nurses.

In all sectors, a significant minority of nurses reported they were "somewhat likely" to leave the profession or "undecided" about leaving. These nurses in particular may respond to retention programs and solutions.

Comparison of practice domains

The population

We collapsed all the nurse respondents into three domains under two broad categories.

1. Domain of nurses that **provides direct care**

Front-line nurses

Staff nurses, clinical nurse specialists and nurse practitioners domain

2. Domains of nurses that **do not provide direct care**

Management nurses

Management and nurse executives

Academic nurses

Research/teaching/education

Sector by age

A higher percentage of front-line nurses were younger on average (43.3 years of age) than nurses in the management domain (51.6 years of age) or academic domain (49.8 years of age).

Age group	Front lines	Management	Academic	Valid total
16 – 20	0.1%	0.0%	0.0%	0.7%
21 – 25	6.2%	0.0%	3.8%	7.5%
26 – 30	15.0%	1.8%	3.3%	12.3%
31 – 35	13.7%	5.7%	8.1%	11.7%
36 – 40	11.0%	8.0%	9.6%	9.6%
41 – 45	9.1%	10.8%	9.1%	8.5%
46 – 50	10.4%	17.2%	12.4%	10.9%
51 – 55	11.7%	15.4%	15.8%	11.4%
56 – 60	11.5%	19.8%	13.4%	12.5%
60+	11.2%	21.3%	24.4%	14.9%
Valid Total	100%	100%	100%	100%
Estimated mean age	43.3	51.6	49.8	44.5

Outcomes: Mental health

This section uses the Depression, Anxiety, Stress Scales – 21 (DASS-21) to examine the symptomatology of depression, anxiety and stress within the three domains of practice (see Appendix C). We examined levels of burnout across these domains.

DASS-21 scores

On average, DASS-21 scores were higher among front-line workers. However, mean scores were either normal or mild in all domains (see Appendix C).

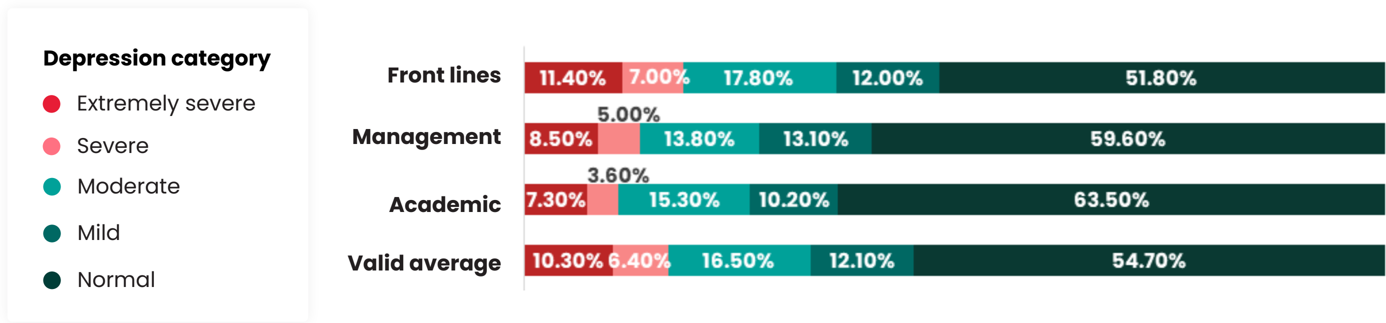
Mean DASS-21 Scores by Sector

Primary role	Depression	Anxiety	Stress
Front lines	Mild (11.51)	Mild (9.16)	Normal, approaching mild (14.71)
Management	Normal, approaching mild (9.40)	Normal (6.75)	Normal (12.66)
Academic	Normal (8.57)	Normal (5.81)	Normal (11.55)
Valid average	Mild (10.75)	Mild (8.49)	Normal (13.87)

Scores on each category of DASS-21 are interpreted differently; for example, a score of 8.9 on the anxiety scale is in the mild range, while a score of 13.6 on the stress scale is in the normal range (see Appendix C).

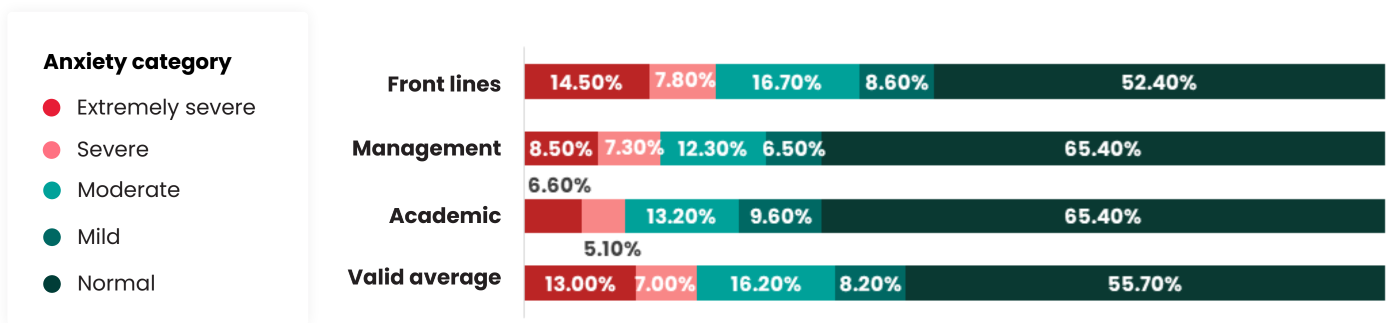
The distribution of DASS-21 scores for each of the three scales shows that despite the rather low mean scores, a significant minority of respondents in all domains experienced moderate to extremely severe symptoms of depression, anxiety and stress.

Distribution of DASS-21 depression scores by domain



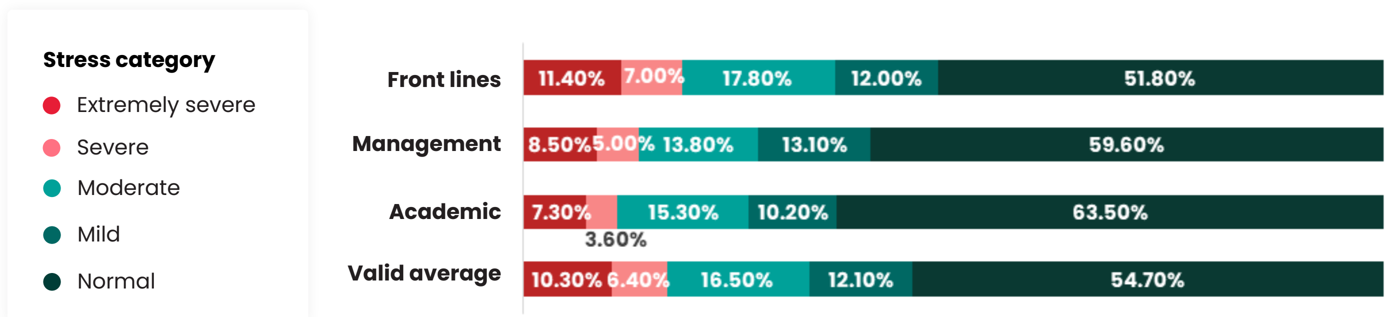
A higher percentage of front-line nurses (36.2 per cent) reported moderate to extremely severe depression, compared to nurses in the management domain (27.3 per cent) and academic domain (26.2 per cent).

Distribution of DASS-21 anxiety scores by domain



A higher percentage of front-line nurses (39.0 per cent) reported moderate to extremely severe anxiety, compared to nurses in the management domain (28.1 per cent) and academic domain (24.9 per cent).

Distribution of DASS-21 stress scores by domain



A higher percentage of front-line nurses (36.2 per cent) reported moderate to extremely severe stress, compared to nurses in the management domain (27.3 per cent) and academic domain (26.2 per cent).

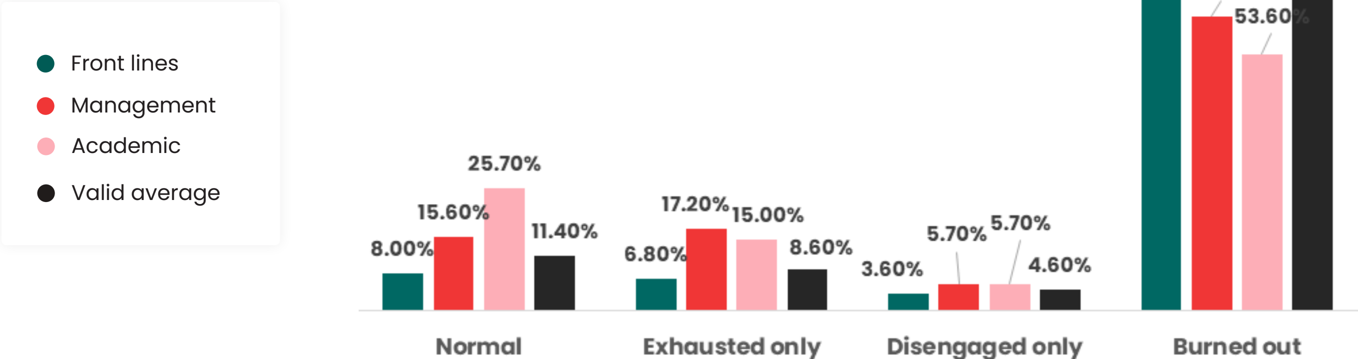
Oldenburg Burnout Inventory (OLBI) scores

Mean burnout scores by domain

We measured burnout using the Oldenburg Burnout Inventory (OLBI) to assess exhaustion and disengagement (see Appendix C). Suggested clinical cut-off scores are 2.25 for exhaustion and 2.1 for disengagement. Mean scores for exhaustion and disengagement were both above the suggested clinical cut-offs in all domains, implying widespread burnout. Burnout scores were highest among front-line nurses and lowest among academics.

OLBI attribute	Front lines	Management	Academic	Valid average
Disengagement	2.58	2.35	2.23	2.39
Exhaustion	2.84	2.67	2.49	2.67

Burnout by percentage of respondents in each domain



A large majority of nurses (75.3 per cent) gave responses that indicated they were burnt out (that is, exhausted and disengaged). A higher percentage of front-line nurses were burnt out (81.5 per cent), compared to those working in management (61.5 per cent) or academia (53.6 per cent).

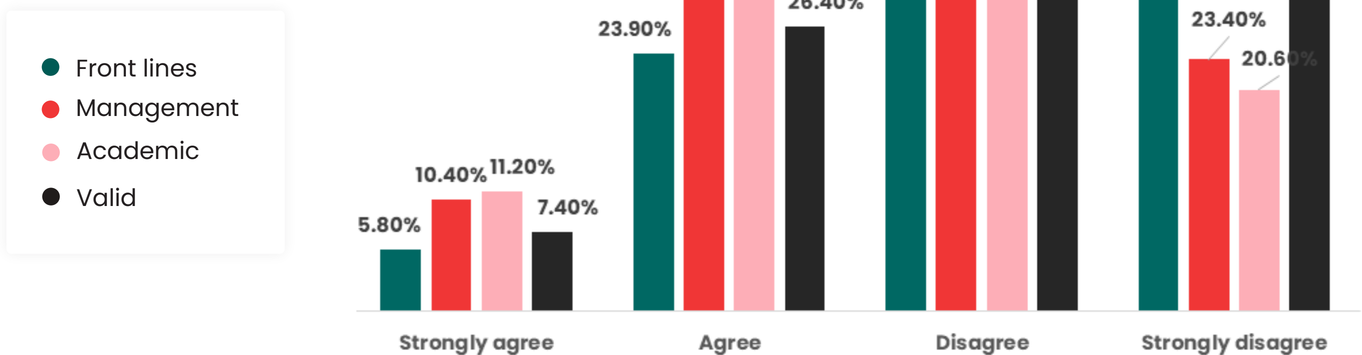
Demands, control and support

Demands

Demands within the workplace were similar among hospital and LTC/RC nurses, and lower among primary care nurses. Demands outside the workplace were similar in all sectors.

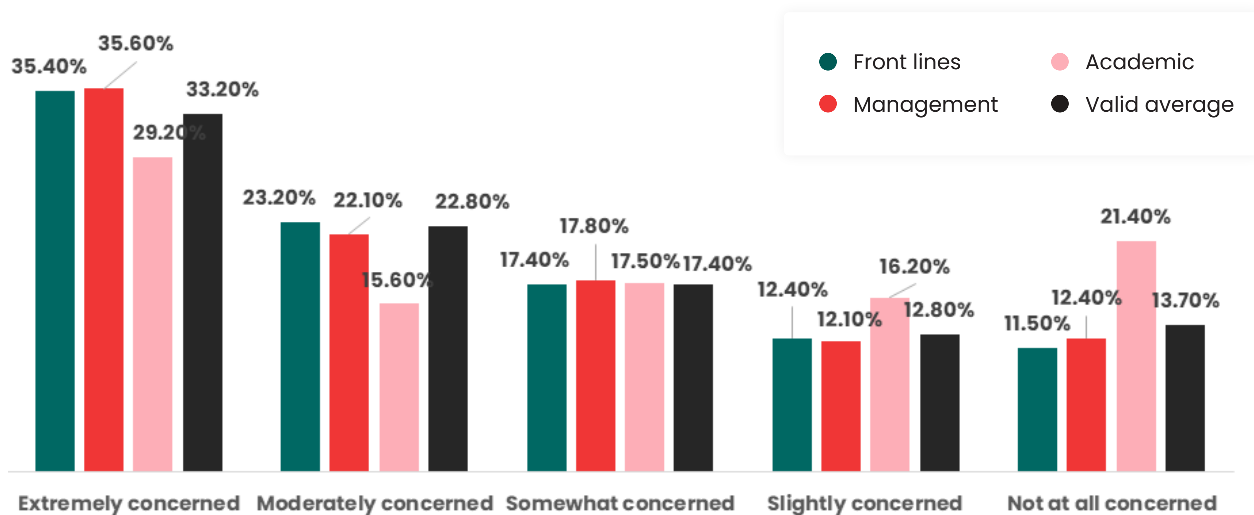
Demands within the workplace

Enough staff to get the work done



The majority of nurses in all domains disagreed or strongly disagreed with the statement that they had "enough staff to get their work done". A higher percentage of front-line nurses (70.3 per cent) reported lack of adequate staffing, compared to nurses working in the management domain (58.3 per cent) and in the academic domain (56. 1 per cent).

Managing my workload

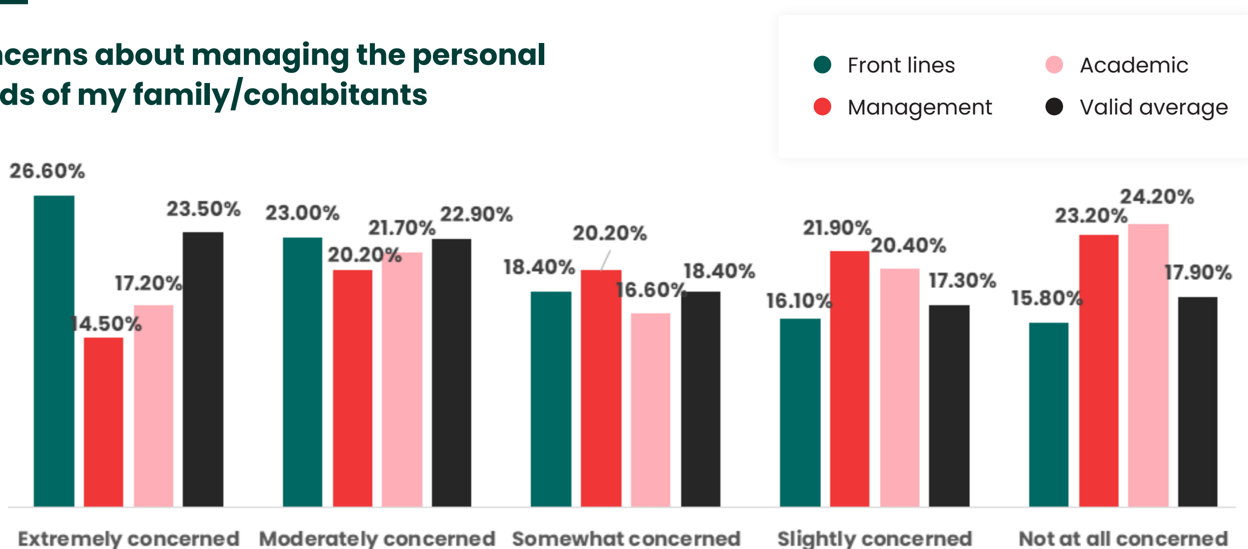


In all domains, a significant per cent of nurses were moderately or extremely concerned about managing their workload. A similar percentage of nurses working on the front lines (58.6 per cent) and in management positions (57.7 per cent) expressed moderate or extreme concern, compared to nurses working in academic or teaching positions (44.8 per cent).

Demands outside the workplace

A significant minority of nurses in all domains reported they had caregiving responsibilities outside the workplace during the pandemic.

Concerns about managing the personal needs of my family/cohabitants

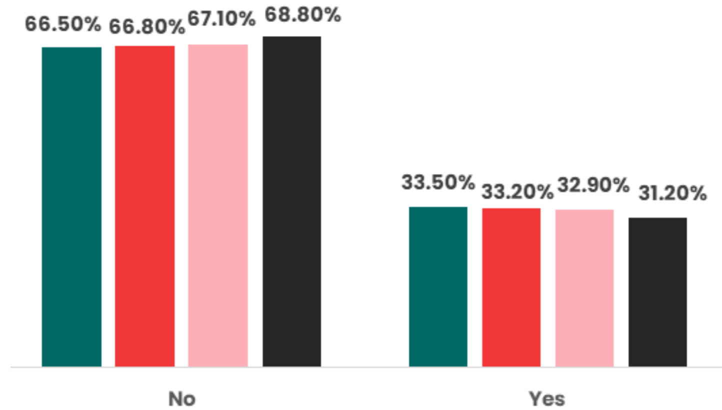


A large minority of nurses in all domains were moderately or extremely concerned about managing the personal needs of their family or other people living with them: 49.6 per cent among front-line workers, 34.7 per cent in management, and 38.9 per cent among those in academia or teaching.

Child care responsibilities at home

Front lines
Academic
Management
Valid average

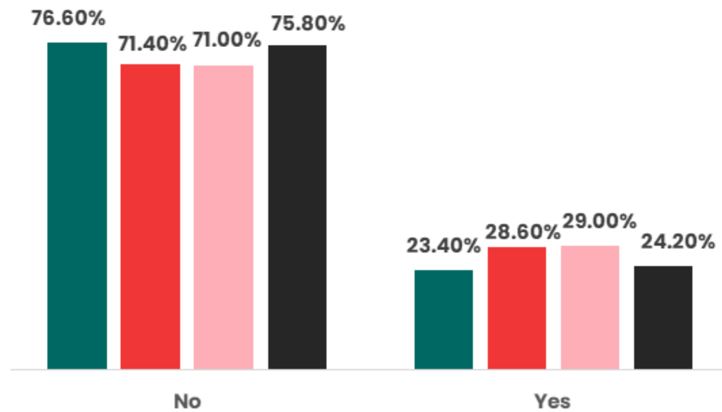
A significant minority of nurses in all domains reported that they had child care responsibilities at home. These results were very similar across all domains.



Other caregiver responsibilities (excluding caregiver for children)

Front lines
Academic
Management
Valid average

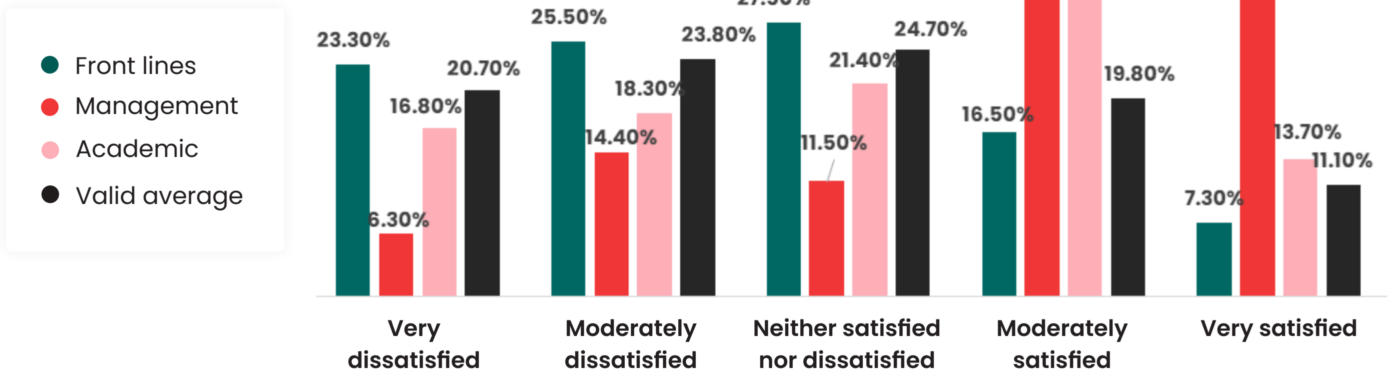
A significant minority of nurses in all domains reported having caregiver responsibilities at home.



Control

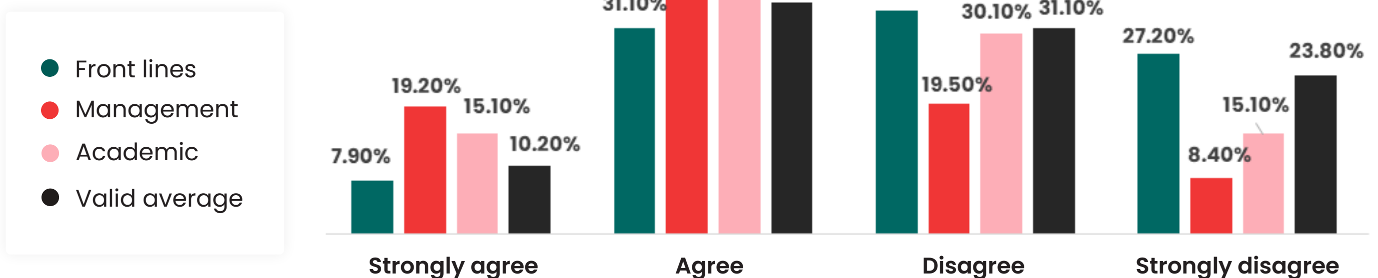
Lower percentages of front-line nurses reported experiencing control in the workplace.

Your participation in organizational decision making



A significant percentage of nurses across all domains were dissatisfied with their level of participation in organizational decision making. Only 23.8 per cent of front-line nurses were moderately satisfied or very satisfied with their participation in organizational decision making, compared to nurses working in the management domain (67.8 per cent) and the academic domain (43.5 per cent).

Staff nurses are involved in the internal governance of the health service (for example, practice and policy committees)

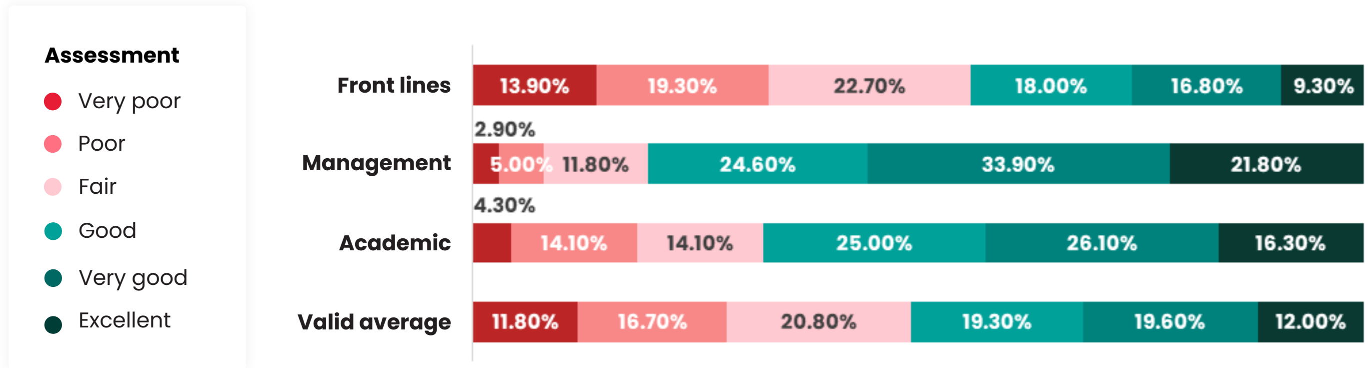


A significant percentage of nurses across all domains “disagreed or strongly disagreed” with the statement “staff nurses are involved in the internal governance of the health service”. A higher percentage of front-line workers (60.9 per cent) “disagreed or strongly disagreed” to the statement, compared to 27.9 per cent of management nurses. The difference in perception between these two domains is striking.

Supports in the workplace

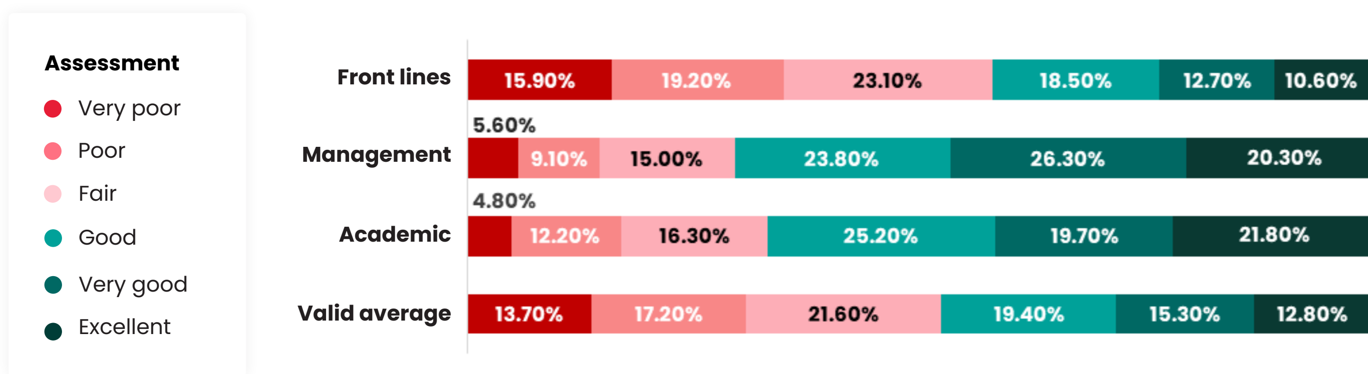
A lower percentage of front-line nurses reported being supported or having support in the workplace compared to nurses working in the other two domains.

Support for new graduates or inexperienced staff



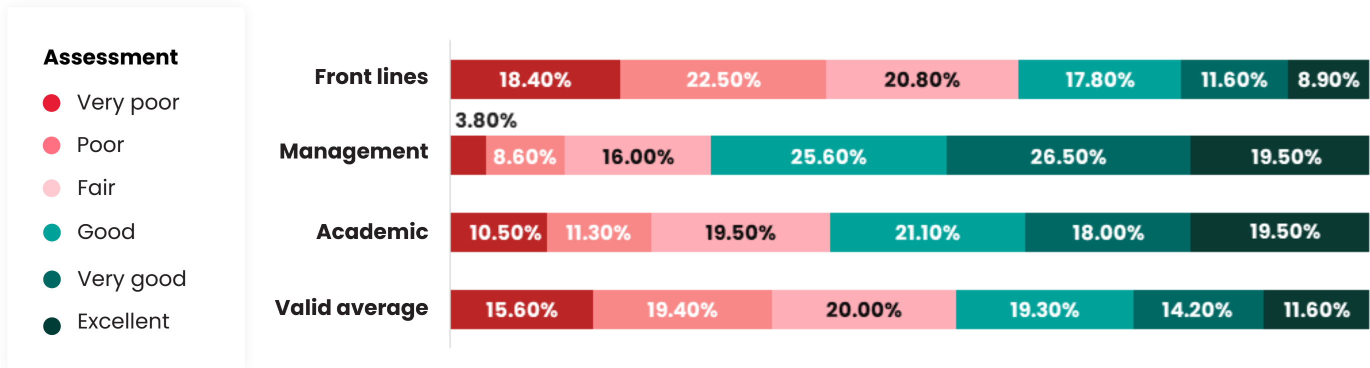
A higher percentage of front-line workers (33.2 per cent) reported "support for new graduate nurses or inexperienced staff" as poor or very poor, compared to nurses working in management (7.9 per cent) or academia and teaching (18.4 per cent). Again, the difference between the perception of support among front-line workers and their counterparts in nursing management was notable.

Access to workplace psychological or mental health support



Significant numbers of nurses in all sectors noted "lack of access to psychological or mental health support". A lower percentage of front-line workers (23.3 per cent) reported very good or excellent support, compared to 46.6 per cent of nurses working in management positions, and 41.5 per cent in the academic domain.

Preventing abuse of staff (for example, physical or verbal harassment)



Preventing abuse among or of staff was inadequate in all domains, with only a minority of nurses in each domain reporting very good to excellent prevention of abuse at their sites. A higher percentage of front-line respondents (40.9 per cent) reported that prevention of abuse was in the poor or very poor range, compared to nurses in the management domain (12.4 per cent) and the academic domain (21.8 per cent).

Conclusion

In all domains, a significant minority of nurse respondents reported moderately severe or greater, symptoms of depression, anxiety, and stress. A higher percentage of front-line nurses reported these symptoms, compared to nurses working in the other domains. Burnout was prevalent in all domains, with the highest mean scores and the highest incidence of burnout among front-line workers.

Although a significant percentage of nurses working in all domains of practice reported high workplace demands, fewer front-line nurses reported having adequate workplace control and supports. Higher workplace demands, lower control and support helps to explain the higher percentage of front-line nurses that reported significant levels of depression, anxiety, stress and burnout.

We also noted stark differences in perception between front-line nurses and their counterparts in management roles on items such as support for new graduates or inexperienced staff and involvement of staff nurses in the internal governance of the health service. This suggests that nurse leaders do not always understand the needs of front-line nurses.

Outcomes: potential departures

A high percentage of respondents across domains of practice planned to leave their positions within the next five years. Of those who planned to leave their positions, a significant percentage of respondents also planned to leave the profession. A higher percentage of front-line nurses were more likely to leave the profession.

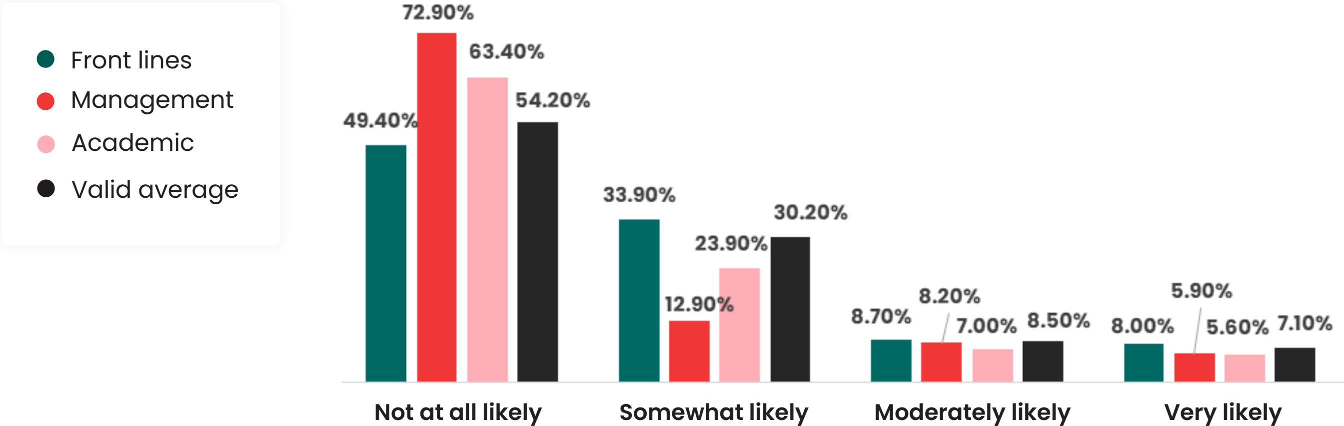
Leaving a position by domain

Do you plan to leave your current position?

Similar percentages of respondents from the front-line domain (68.6 per cent), management domain (67.6 per cent) and academic domain (60.6 per cent) indicated that they planned to leave their positions within the next five years, meaning we expect high levels of departure across all domains.

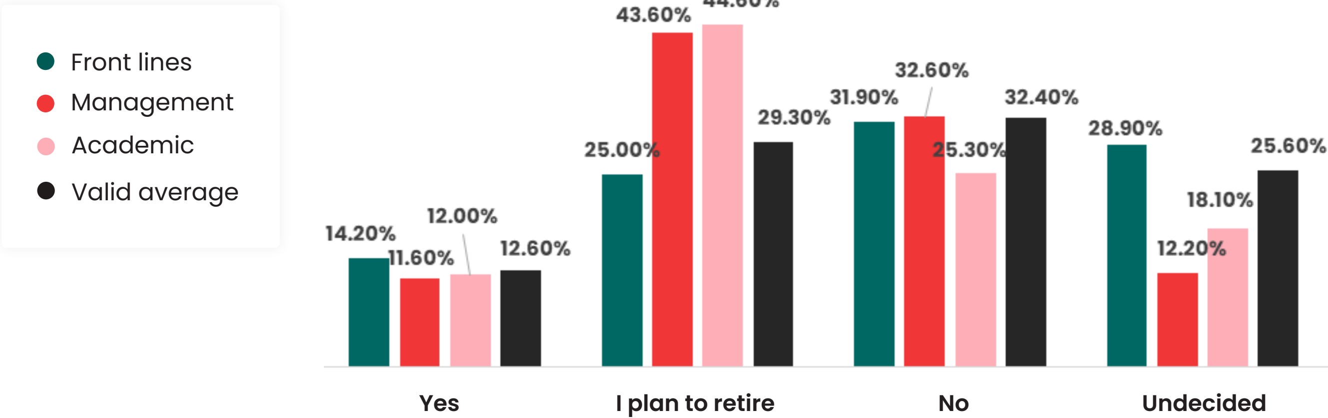
Leaving the profession by domain

How likely are you to leave nursing for a different occupation after the pandemic?



Of respondents planning to leave their positions in one to five years, a significant per cent of nurses in all domains were likely to leave the profession. A higher per cent of front-line nurses (50.6 per cent) were somewhat to very likely to "leave nursing for a different occupation" when compared to nurses working in the domains of Mgmt./Nurse Exec (27.0 per cent) and Research/Teach/Ed (36.5 per cent).

Do you plan to exit nursing to work in another field?



Of those planning to leave their position, a significant percentage of nurses indicated that they planned to exit nursing to pursue work in a different field. A greater percentage of front-line workers planned to exit nursing (14.2 per cent), compared to nurses working in the management domain (11.6 per cent) and the academic domain (12.0 per cent). But there were nurses who were undecided about leaving the profession across all domains of practice.

Conclusion: Comparison of domains of practice

Nurses in all domains of practice struggled significantly during the COVID-19 pandemic. Work demands were high across all domains, and nurses reported impact on their mental health outcomes including depression, anxiety, stress and burnout. Of those who planned to leave their positions, a significant percentage of nurses across domains planned to leave the nursing profession.

When comparing nursing domains, experiences of the pandemic were the most challenging among nurses working on the front lines. These nurses had poorer mental health outcomes with higher levels of depression, anxiety, stress and burnout than nurses in the other two domains. Even though work demands were high across all domains, the experiences of front-line nurses were not mitigated by control over their work or support in the workplace. Front-line nurses were also more likely to leave their position than nurses working in the other domains. And, the front-line nurses who indicated they were planning to leave their position within one to five years were also more likely to leave the profession altogether.

In all domains, a significant minority of nurses reported they were "somewhat likely" to leave the profession or "undecided" about leaving. These nurses in particular may respond to retention programs and solutions. Similarly, differences of perception between front-line nurses and their management counterparts regarding control and support in the workplace suggest the need for leadership programs that enable management to better understand the needs of front-line nurses, perhaps leading to greater retention.

PART 2

Conclusions and commitments

The survey results show that a significant minority of respondents in all sectors and domains of nursing experienced moderate to extremely severe symptoms of depression, anxiety and stress, with hospital nurses and front-line nurses reporting the highest levels for all three outcomes. Widespread burnout was noted among nurses working in all sectors, with the highest burnout scores evident among hospital and front-line nurses. Overall, we noted that job demands were high for nurses across each of the sectors and domains.

In the wake of a global pandemic, coupled with a historic but growing RN shortage in Canada, it is no surprise that RNs across all sectors and domains have been confronted with excessive job demands. These intense job demands must be addressed with immediate public policy changes aimed at improving staffing levels and alleviating workloads of RNs, as recommended in part 1 of this report. These policy changes are crucial for the effective retention and recruitment of nurses.

We expect that job demands for RNs will remain high for the foreseeable future due to pre-pandemic understaffing compounded by pandemic-related workloads, staffing losses and care backlogs such as procedures and surgeries. It is crucial that additional retention measures be implemented at the meso and micro levels to mitigate job strain by providing nurses with strong workplace supports and a greater sense of job control.

RNAO is urging health-care employers to identify and implement strategies to better support their nursing workforce and provide nurses with more control over their working lives. For example, employers must consider things that they can do to accommodate or relieve the burden of work-life balance issues identified by nurses in the surveys. In part 1 of the report, we identified the critical retention factors which employers must address: better workplace supports; reduced workloads and limits on overtime; ability to adjust work schedules and access to full-time employment; better career development opportunities; career laddering/progression to management opportunities; better access to mentoring/more opportunities to mentor other nurses; and increased access to childcare.

RNs are central to Ontario's quality health system in all sectors and settings. The urgent need to increase the RN workforce is recognized by credible organizations and entities who themselves have called for more RNs and raised concerns about the shortage. For example, Ontario's Long-Term Care COVID-19 Commission, led by Justice Frank Marrocco, recommended a skills mix requiring substantially more RNs in its final report. The Ontario Hospital Association also identified the need for 10,000 additional RNs over the next five years in its 2022 budget request. Further, Colleges Ontario and the Council of Ontario Universities, key partners to addressing the need for more RNs, are eager to contribute to rebuilding the nursing workforce to quickly resolve the nursing crisis by substantially increasing enrollment of qualified applicants to BScN programs (see Appendix E).

Nurses, however, must also help other nurses. In light of the long-term nursing shortage, which has led to excessive demands on nurses in all domains and across all sectors, RNAO is committed to the development of micro-level leadership and mentorship programming by nurses for nurses.

RNAO commitments

In 2022, RNAO will launch a series of nursing leadership programs intended to provide the skills needed to lead in the context of nursing human resource constraints. These programs will address the following issues:

1. **RNAO's programming will encourage nurse managers to foster more opportunities for all nurses to:**

    a. **participate in organizational decision making. This is especially important for nurses working in hospital environments and nurses across all sectors working in direct care positions.**

    b. **become involved in the internal governance of their organization. This is especially important for front-line nurses and for nurses who work in hospital settings.**

Nurse engagement in organizational decision-making and internal governance can help nurses gain a sense of control over their work and working lives. Many survey respondents were dissatisfied with their involvement in decision-making and governance, which could translate to a lower sense of job control. According to survey findings, front-line nurses and hospital nurses were especially dissatisfied with their ability to engage in organizational decision-making and internal governance, suggesting they are particularly at risk of low job control. Interestingly, many nurse managers perceived staff nurses as being involved in the internal governance of the organization. This finding showed a sharp contrast with the perceptions of front-line nurses, suggesting that nurse managers must enhance measures to understand and improve front-line nurses' experiences of job control.

2. **RNAO's programming will help nurse managers support front-line nursing staff by:**

    a. **promoting and fostering opportunities for staff to easily access psychological or mental health supports. These supports are especially important for front-line nurses.**

    b. **ensuring that all types of abuse of nursing staff are addressed and prevented.**

Front-line nurses had the worst mental health outcomes out of all nursing domains – they were more likely to experience depression, anxiety and stress. A significant number of nurses in all sectors noted a lack of access to psychological or mental health supports, with front-line workers facing the greatest challenges with this. Front-line respondents rated the prevention of abuse most poorly, showing a disconnect with managers' positive perceptions of abuse prevention in their organizations. This suggests that all nurse managers must engage in processes to support their teams, including identifying the need for support, being able to provide support and facilitating access to professional supports. Nurses across all sectors and domains, whether on the front lines, in management or in academia, need this level of support from their managers and employers.

3

RNAO's programming will help nurse managers across sectors to:

a. **be highly visible and accessible in their facility.**

b. **continuously develop skills necessary for leader-managers in a high job demand environment.**

Nurses must learn to lead for nurses and to make sure that all are provided with workplace supports and opportunities for job control. Many nurses, particularly in the hospital sector, did not feel that their leader was highly visible or accessible. Moreover, a significant minority of nurses all sectors indicated a poor level of support from nurse managers and supervisory staff. In the context of ongoing nursing human resources shortages and resulting high workplace demands and work-life imbalance, all nurses must learn leadership skills. More importantly, nurse managers must develop their own leadership skills to ensure the retention of early career nurses.

4

RNAO's programming will make mentorship opportunities available to all nurses as they progress through their careers to ensure supportive experiences.

All nurses need support – especially when transitioning into practice or into new roles. Mentorship is particularly crucial to retention of new and/or inexperienced nurses and front-line nurses who provide direct care, especially in hospital settings. Mentorship is an excellent way to provide nurses with the support that they need, and can also reduce experiences of job strain. Front-line nurses, especially those working in hospitals, reported lower levels of support than nurses in other domains of practice. While the hospital sector should be a priority for establishing and improving mentorship programs, all nurses can benefit from mentorship throughout their careers.

Nursing programs

Advanced Clinical Practice Fellowship program

Program target group:

The Advanced Clinical Practice Fellowship program (ACPF) provides registered nurses (RN) and nurse practitioners (NP) the opportunity to have a focused self-directed learning experience to develop clinical, leadership or best practice guideline implementation knowledge and skills, with support from a mentor(s), in the organization where the RN/NP is employed and RNAO.

Program objective:

This program is aimed at developing and promoting nursing knowledge and expertise, and improving client care and health outcomes in Ontario. Clients are defined as individuals, families, groups or communities.

Brief description:

The ACPF program, originally launched in 2003, provides the opportunity for registered nurses (RN) or nurse practitioners (NP) to develop their skills, knowledge, and expertise while advancing a project that will meet a need or gap in service within their organizations, with the ultimate goal of improving patient outcomes in their practice setting. The length of the program is 12 weeks (full-time) or 20 weeks (part-time) for a total of 450 hours, and is funded through the Ministry of Health. In collaboration with their sponsoring organization (employer) and mentor/mentoring team, applicants will identify a personal learning goal and develop a plan for achieving that goal through work on a specific project.

New in May 2022:

All ACPF streams are aimed at developing and promoting nursing knowledge and expertise while enhancing compassionate, person-centred care and promoting positive health outcomes. Applicants are required to select one of the following four skill development streams in which to focus their learning: 1. Leading change in evidence-based practice (includes the original three sub-streams of clinical practice, leadership and guideline implementation), 2. Equity in nursing and health, 3. Health and wellbeing, or 4. Long-term care. The proposed project must meet a need or address a gap in service at the sponsor organization, and provide opportunity for the applicant to directly meet his/her learning objectives through the application of a range of learning activities.

This mentorship program provides career development opportunities beyond the Fellowship experience, as Fellowships address an area of practice that both the Fellow and their employer have identified as a gap in service. This provides the Fellow with organizational commitment and workplace supports to ensure a successful Fellowship and long-term sustainability of Fellowship outcomes. Promoting new learning experiences and engagement in the profession, on a topic of passion for the Fellow, enhances retention within the profession, as well as opening new doors for lifelong learning and career advancement.

Leadership and Management for Nurses program

Program target group:

This professional development program offering is designed for nurse managerial leaders across all sectors to enhance key knowledge and skills necessary for their success in enabling goal achievement and powering staff teams. Program participants have the support of their health care organizations through their direct supervisor and are provided with two full days a month release time over the four-month period of the course to:

- attend sessions
- prepare for monthly sessions by completing pre-working reading and activities
- complete self-reflection exercises on content learned, and post-session exercises
- apply content in the workplace in the context of their leadership role

Program objective:

The overall aim of the Leadership and Management for Nurses program is to enhance competence, confidence and effectiveness of nurses in health care managerial roles through building leadership and managerial knowledge and skills. Effective nurse leader-managers power staff to achieve personal and professional goals, promote and enable shared decision making and create healthy work environments and team functioning.

Brief description:

The Leadership and Management for Nurses program is an interactive modular education offering that extends over four months. Content is guided by RNAO's Developing and Sustaining Leadership Framework, and highlights:

- key leadership behaviours
- transitioning to a leader-manager
- the context of leadership
- day to day management skills
- personal supports critical to becoming an effective leader-manager

The program includes evidence-based theory, application using case studies, working with peer leaders, and transferring theory to practice supported by a skilled mentor. The content sessions and case studies for each of the program themes are three hours in length, and provide opportunities for developing peer networks. All participants are paired with a leader-manager mentor to guide clinical application. In addition, the course includes a program workbook to guide the participants in preparatory reading and work and follow up activities in their workplaces and with their peers.

This professional development offering commences September 2022, specifically targeted to nurse-managers/administrators in long-term care and in hospital sectors (including acute and community hospitals, rehabilitation centres and complex continuing care). The second offering commencing in January 2023 is for nurse managers in home and community care and primary care.

Mentorship for Nurses program

Program target group:

The Mentorship for Nurses program is designed for those looking for a mentor to support their professional career development. This includes RNAO members and non-members: nursing students, registered practical nurses, registered nurses and nurse practitioners.

Program objective:

The Mentorship for Nurses program supports the retention, engagement and the professional career development of members of the nursing profession.

Brief description:

Mentorship is a voluntary, mutually beneficial relationship between two people where the individual with more experience, knowledge and connections (mentor) is able to pass along what they have learned to a more junior individual (mentee) within a certain field. The mentor benefits because they are able to lead the future generation in an area they care about and ensure the best practices are passed along; meanwhile, the mentee benefits because they have demonstrated that they are ready to take the next step in their career and can receive the support needed to make that advancement. Mentors will be RNAO members and will be recruited from RNAO's extensive membership and may be members of one or more RNAO interest groups. Participants will complete an online intake form to support matching mentors with a mentee that will benefit from their specific skills and experience.

The Mentorship for Nurses program is important given the demographic shift in nursing. Providing additional supports and guidance for not only early career nurses, but also nurses across all demographics, to engage in career development is essential to retaining nurses within the profession. Mentorship supports nurses new to the profession, and experienced nurses who are considering or have made a change in career path. Providing formal mentorship opportunities supports the retention, engagement and professional development of both mentees and mentors. Mentees receive the support they have identified a need for and sought out, and mentors experience enhanced professional satisfaction and commitment to the success of others.

Nursing Student and Preceptor Long-Term Care program

Program target group:

This program is targeted to nursing students (RN and RPN students) completing or contemplating clinical placements in long-term care settings, and preceptors in long-term care (LTC) settings who will be guiding students through their learning journey.

Program objective:

The overall aim of the Nursing Student and Preceptor Long-Term Care program is to provide support and resources to students and preceptors in long-term care, to develop positive student learning experiences, and promote the leadership role of preceptors as knowledge brokers in long-term care.

Brief description:

This program consists of a variety of web-based and other resources to support students and preceptors including:

1. **Student videos:** Four-part video series developed to assist nursing students in understanding their role, the role of the preceptor and preparing them to get the most of their LTC placement.

2. **Preceptor videos:** Five-part video series will provide an introduction to the role of the preceptor, key attributes and learning approaches preceptors can use with new students

3. **Long-Term Care Best Practices Program and LTC Coordinators:** The LTC Coordinators are a great resource to support students and preceptors during clinical placements.

4. **LTC Best Practices Toolkit:** The LTC Best Practices Program maintains an online toolkit designed to offer students, point-of-care staff, nurses, educators and leaders with access to the best available evidence-based resources and tools.

The Nursing Student and Preceptor Long-Term Care program resources are freely available on the RNAO website for students, preceptors, LTC homes, and academic institutions to access and use.
The program supports the development of positive student learning experiences in LTC encouraging recruitment of new nurses into this setting. It also supports enhancing knowledge and skills of preceptors to facilitate positive learning experiences for students while enabling their own leadership professional development.

Appendices

Appendix A Demographics

Respondents by nursing classification

The Canadian nursing survey was targeted at nurses of all classes. However, respondents were overwhelmingly registered nurses (RN). The Work and Wellbeing survey was targeted at nurse classes within RNAO's membership – RNs, nurse practitioners (NP) and nursing students. In addition to RNs, NPs and nursing students, the Australian survey was targeted at enrolled nurses (18–24-month education program), midwives (RM) and personal care workers (PCW). The HPWP survey reached seven different professions, including 1,013 nurses. The HPWP working group also interviewed 54 nurses.

	Canadian survey	Work and Wellbeing survey	Australian survey	International survey	HPWP survey
Respondents	**5,200**	**2,102**	**11,461**	**1,335**	**1,013 nurses**
Survey period	**May 21–July 31, 2021.** Third Canadian wave.	**Jan. 29–Feb. 22, 2021**. Second Canadian wave.	**Aug. 12–Oct. 21, 2020**. Second Australian wave.	**March 20–April 30, 2021**. Second International wave.	**End of Nov. 2020–early May 2021.** Second and third Canadian waves.

	Canadian survey	Work and Wellbeing survey	Australian survey	International survey	HPWP survey
Classification	**4,213 RNs** (87.9%) **183 NPs** (3.8%) **241 RPNs/LPNs** (5%) **26 RPsychNs** (0.5%) **37 temporary** (0.8%) **95 non-practicing** (2%)	**1,910 RNs** (91%) **93 NPs** (4.4%) **96 nursing students** (4.6%)	**7,682 RNs** (68.6%) **99 NPs** (0.9%) **194 dual RNs/RMs working as RNs** (1.7%) **48 students** (0.4%) **336 RMs** (2.9%) **480 dual RMs/RNs working as RMs** (4.2%) **1679 ENs (18-24 month program** (14.6%) **763 PCWs** (6.7%)	**985 RNs** (78.2%) **90 RPNs/LPNs** (7.1%) **65 RNs/RMs** (5.2%) **59 NPs** (4.7%) **35 RPsychNs/MHNs** (2.8%) **8 ENs** (0.6%) **5 CNAs** (0.4%) **4 RMs** (0.3%) **4 assistants in nursing** (0.3%) **4 nursing or midwifery students** (0.3%) **76 No response**	**1,013 nurses** (classes not available at time of writing) **54 nurses also interviewed** (36 RN, 1 RPN, 6 LPN/RPN, 7 NP, 4 unspecified)

Acronyms used in above table:

CNA=certified nursing assistant
EN=enrolled nurse
MHN=mental health nurse
NP=nurse practitioner
PCW=personal care worker
RM=registered midwife
RN=registered nurse
RPN or LPN=licensed practical nurse, also called a registered practical nurse in Ontario
RPsychN=registered psychiatric nurse

Jurisdiction of respondents' employment or location

While respondents to the Canadian survey represented all provinces and territories, representation was overwhelming tilted to Ontario. Manitoba, the next most heavily represented province, accounted for only 2.1 per cent of survey responses.

The HPWP survey had a more even geographical distribution of respondents across Canada. The Workplace and Wellbeing survey had only Ontario-based respondents; the Australian survey, only Australian respondents.

The International survey, which asked respondents to identify their "country of birth", was heavily represented by North America (including Canada) and by Europe.

	Canadian survey	Work and Wellbeing survey	Australian survey	International survey	HPWP survey
Repondents	Alta. **18 (0.4%)** B.C. **45 (0.9%)** Man. **109 (2.1%)** N.B. **5 (0.1%)** N.L. **37 (0.7%)** N.W.T. **8 (0.2%)** N.S. **74 (1.5%)** Nvt. **2 (0.0%)** Ont. **4,719 (92.7%)** P.E.I. **2 (0.0%)** Que. **16 (0.3%)** Sask. **9 (0.2%)** Yukon **1 (0.0%)** More than one: **29 (0.6%)** Other **17 (0.3%)**	Ontario **2,102**	Australia **11,461**	North America **569 (44.1%)** Europe **404 (31.3%)** Asia **114 (8.8%)** South America **78 (6.1%)** Africa **70 (5.4%)** Central America **42 (3.2%)** Oceania **12 (0.9%)**	Alta. **91 (10.3%)** B.C. **77 (8.7%)** Man. **37 (4.2%)** N.B. **106 (12%)** N.L. **20 (2.3%)** N.W.T. **0 (0%)** N.S. **108 (12.2%)** Nvt. **0 (0%)** Ont. **185 (18.4%)** P.E.I. **12 (1.2%)** Que. **210 (23.6%)** Sask. **40 (4.5%)** Yukon **0 (0%)**

Age, gender, relationship status and employment status

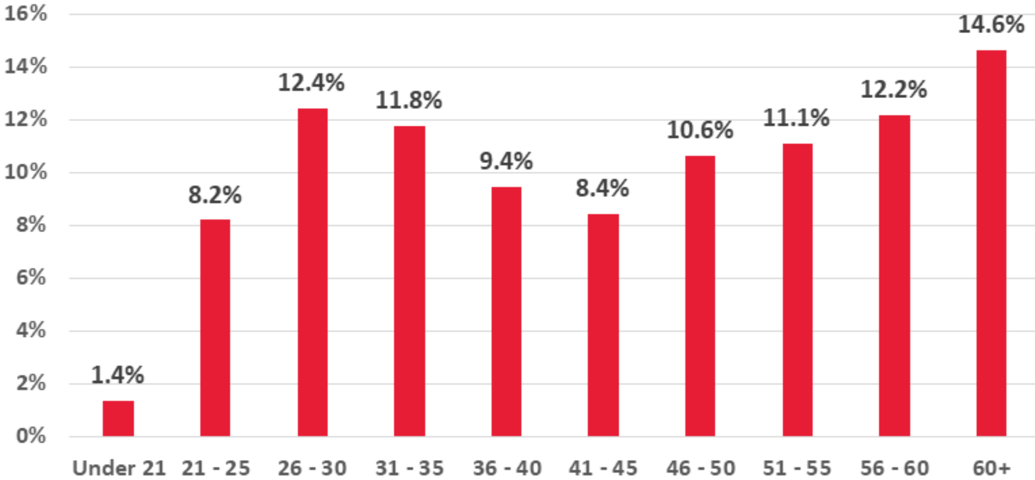
Responses to the Australian, Canadian and International surveys confirm the gendered nature of nursing around the globe. Canadian respondents were only slightly less likely to be male and were least likely to be in a relationship. Australian respondents were slightly older. International respondents were most likely to have full-time employment while Australian nurses were least likely to have full-time employment. Almost 70 per cent of Ontario nurses reported working full-time – approximating the 71.6 per cent average reported by CNO in 2021. Ontario nurses are more likely to work full-time than nurses in the rest of Canada. Australian respondents had a very low full-time share while the international share was high, at over 80 per cent.

	Canadian survey	Work and Wellbeing survey	Ontario RNs (CNO data)*	Australian survey	International survey
Mean age	**44.5 (SD =21.9)**	**N/a**	**N/a**	**48.2 (SD=12.3)**	**44.5 (SD=12.0)**
Gender	**92.8%** Female **5.9%** Male **0.5%** Non-binary **0.8%** Prefer not to say	**N/a**	**N/a**	**91.5%** Female **8.0%** Male **0.2%** Non-binary **0.4%** Prefer not to say	**87.6%** Female **11,8%** Male **0.2%** Non-binary **0%** Prefer not to say
Work status	**65.9%** Full-time **28%** Part-time **6.1%** Casual	**69.5%** Full-time **23.1%** Part-time **7.4%** Casual	**71.6%** Full-time **24.6%** Part-time **6.3%** Casual	**30.1%** Full-time **60.2%** Part-time **9.7%** Casual	**80.9%** Full-time **14.9%** Part-time **4.2%** Casual

* these membership statistics provided by the College of Nurses of Ontario are available here: https://www.cno.org/globalassets/2-howweprotectthepublic/statistical-reports/membership-statistics-report-2021-final.html

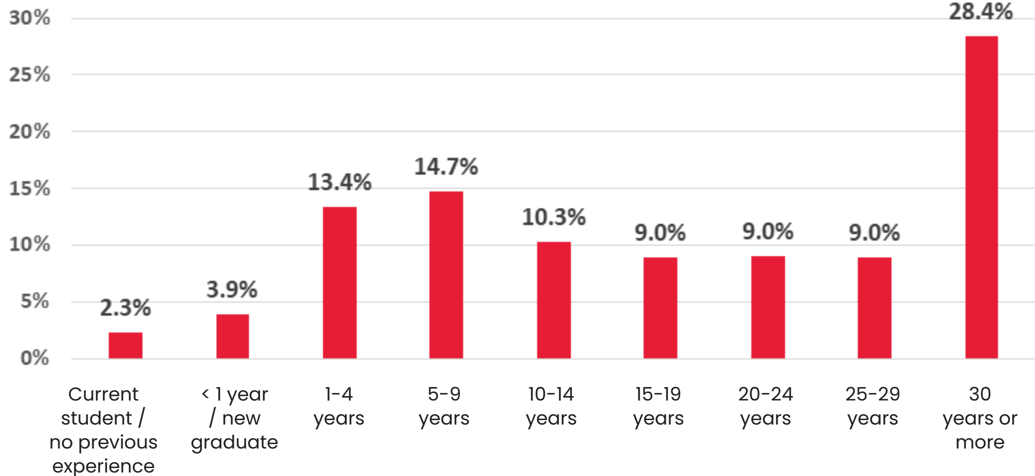
Age and experience of Canadian respondents

Percentage (%) age distribution in Canadian survey



The Canadian age distribution of respondents dipped somewhat for mid-career nurses, in line with a similar dip in the age distribution in the Ontario nursing population.

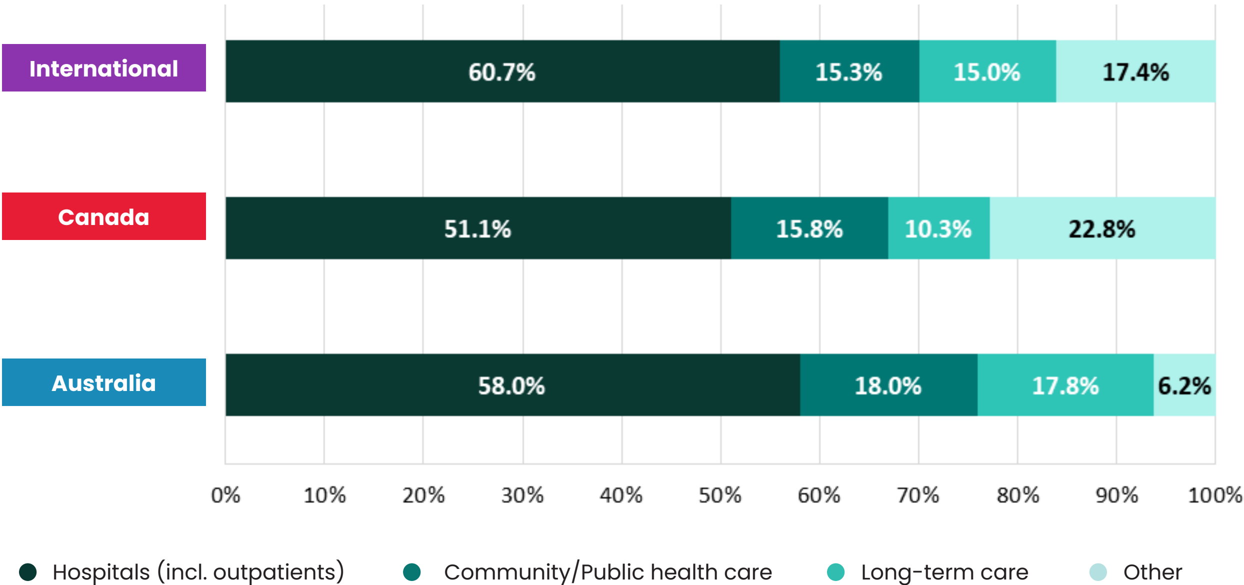
Years of nursing experience: Valid percentage (%) in Canadian survey



As one would expect given the age distribution, the respondents were highly experienced health-care professionals. Well over half (55.4 per cent) had experience of 15 years or more working in health care. Approximately one in five had less than five years of experience.

Employment sector across the surveys

A slight majority of Canadian survey respondents work in hospitals, reflecting the overall Canadian nursing population. Australian and International survey respondents were more likely to work in hospitals. Canadian survey respondents were more likely than their counterparts to work in sectors other than hospitals, community and long-term care.



Membership in associations

Canadian survey respondents belonged to a wide range of nursing associations. However, RNAO had by far the largest membership among respondents, followed by the College of Nurses of Ontario (CNO) - the regulatory body, with which all nurses working in nursing in Ontario must register. Given that 92.7 per cent of respondents worked in Ontario, and that RNAO was involved in the survey, it is not surprising that RNAO and CNO membership had larger counts in the survey results.

Association	Number of member respondents
RNAO	4,102
CNO (College of Nurses of Ontario)	2,682
CNA (Canadian Nurses Association)	1,027
WeRPN (Registered Practical Nurses Association of Ontario)	132
NPAO (Nurse Practitioners Association of Ontario)	97
BCCNM (British Columbia College of Nurses and Midwives)	48
NNPBC (Nurses and Nurse Practitioners of British Columbia)	26
CARNA (College of Registered Nurses of Alberta)	10
SRNA (College of Registered Nurses of Saskatchewan)	81
CRNM (College of Registered Nurses of Manitoba)	81
ARNM (Association of Regulated Nurses of Manitoba)	50
OIIQ (Ordre des infirmières et infirmiers du Québec)	18
NANB (Nurses Association of New Brunswick)	5
NSCN (Nova Scotia College of Nurses)	65
CRNNL (College of Registered Nurses Newfoundland Labrador)	31
RNANTN (Registered Nurses of the Northwest Territories and Nunavut)	14
YRNA (Yukon Registered Nurses Association)	3
Other	175

Membership in unions

The predominance of the Ontario Nurses' Association (ONA) in union affiliation is consistent with the bulk of respondents working in Ontario, and with ONA representing more nurses than any other union in Ontario.

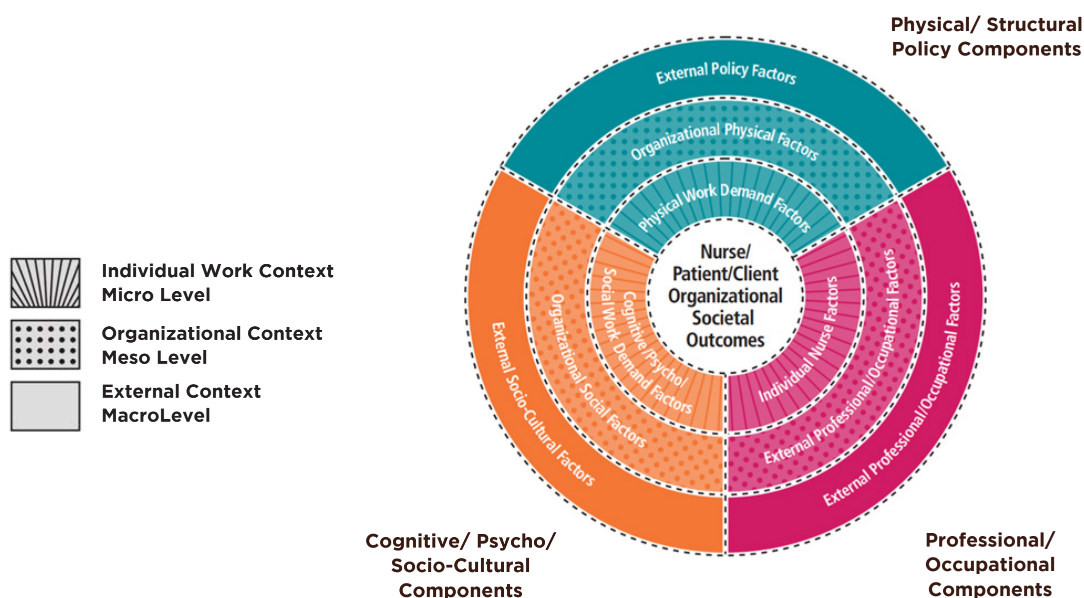
Canada	Australia
3,063 Yes (63.8%)	**11,192 Yes (98.2%)**
ONA (Ontario Nurses' Association) **2,276** **BCNU** (BC Nurses' Union) **48** **FIQ** (Fédération Interprofessionnelle de la santé du Québec) **3** **MNU** (Manitoba Nurses Union) **103** **NBNU** (New Brunswick Nurses Union) **5** **NSNU** (Nova Scotia Nurses' Union) **45** **PEINU** (Prince Edward Island Nurses Union) **1** **RNUNL** (Registered Nurses' Union Newfoundland Labrador) **29** **SUN** (Saskatchewan Union of Nurses) **4** **UNA** (United Nurses of Alberta) **11** **SEIU Healthcare 59** **Unifor 28** **USW** (Unity and Strength for Workers) **7** **CUPE** (Canadian Union of Public Employees) **223** **OPSEU** (Ontario Public Service Employees Union) **123** **Other 195**	**ANMF** (Australian Nursing & Midwifery Federation) **11,192**

Appendix B Conceptual models used in this research

In this appendix, we provide more information about the models used by RNAO in this research:

1. Healthy Work Environments Conceptual Model (RNAO, 2017)
2. Job Demand-Control-Support model (Karasek and Theorell, 1990)

1. Conceptual Model for Healthy Work Environments for Nurses - Components, Factors & Outcomes



RNAO's "Developing and Sustaining Safe, Effective Staffing and Workload Practices" Best Practice Guideline includes a conceptual model for healthy work environments. This model is centred on the notion that healthy work environments maximize the health and wellbeing of nurses. Healthy work environments have several components, including policy, physical demands and organizational design. The relationships among these components makes healthy work environments complex and multidimensional. At the centre of the model are those who benefit from healthy work environments – from nurses, patients and health-care organizations to the health-care system and society as a whole.

This model incorporates many factors at the micro, meso and macro levels that influence healthy work environments.

- **Micro (individual factors):** physical work demands, workload, changes to schedules and shifts, workplace exposures to hazards/infectious diseases, threats to personal safety, cognitive and psychosocial work demands, job security, team dynamics, emotional demands, role clarity and strain, personal attributes, knowledge and skills.

- **Meso (organizational factors):** staffing and scheduling practices, equipment availability, policies related to occupational health and safety, presence of security personnel, structures and practices for communication, labour relations, culture of learning and support, scope of practice, level of autonomy over practice, nature of interprofessional relationships and overall climate, culture, values and stability of the organization.

- **Macro (systemic factors):** health-care delivery model, funding, legislation, economics, policies, regulations, consumer trends, care preferences, family roles, diversity and changing demographics.

2. Job-Demand-Control-Support model

In this leading theoretical model (Karasek and Theorell, 1990), job demands are defined as factors that cause psychological stress in the workplace, such as workload, time pressures and role conflict (van Doorn et al., 2016). Job control relates to employees' level of control over their work activities, and autonomy to make decisions related to their job (Karasek 1979; van Doorn et al., 2016). Support is defined as the amount of helpful social interactions available to employees from coworkers and supervisors, which allow employees to feel valuable as team members (De Witte et al., 2007; Karasek 1979; van Doorn et al., 2016).

According to Shain et al., (2012), the mental health of employees is put at risk when:

- job demands continually exceed workers' skill levels, exploit workers beyond what is reasonably expected or require workers to perform an inequitable amount of work
- workers are deprived of control or discretion over their work, including the ability to freely express their feelings or views
- workers lack support in using any resources and information available to them within the organization

Job demands can cause high stress for employees. However, according to the job demand-control-support model, employees can better manage these stressors if they can gain control over their work and get support from colleagues and supervisors (Karasek and Theorell, 1990). Employees can gain control over their job by gaining autonomy in their job, decision-making latitude and freedom in making decisions with respect to ways to work.

Helpful social interactions with supervisors and coworkers also provide support to employees. Support from supervisors can buffer the impact of stress, can influence employees' attitudes towards their job, improve job satisfaction, and lessen turnover intention. It can also can act as a source of companionship and can foster positive teamwork. Moreover, workplaces that adopt a positive approach to workplace psychological health can increase their ability to recruit and retain talent, enhance employee engagement, improve productivity levels and reduce overall risks of conflict, turnover and absenteeism (Shain et al., 2012).

References:

De Witte, H., Verhofstadt, E. & Omey, E. (2007) Testing Karasek's learning and strain hypotheses on young workers in their first job. Work & Stress 21 (2), 131–141. https://biblio.ugent.be/publication/384495

Karasek, R.A. (1979) Job demand, job decision latitude, and mental strain: implications for job redesign. Administrative Science Quarterly 24 (2), 285–308. https://www.jstor.org/stable/2392498

Karasek, R., & Theorell, T. (1990). Healthy Work: Stress, Productivity, and the Reconstruction of Working Life. https://www.journals.uchicago.edu/doi/abs/10.1086/417423

Shain, M., Arnold, I., & GermAnn, K. (2012). The road to psychological safety: Legal, scientific, and social foundations for a canadian national standard on psychological safety in the workplace. Bulletin of Science, Technology & Society, 32(2), 142-162. https://journals.sagepub.com/doi/full/10.1177/0270467612455737

van Doorn, Y., van Ruysseveldt, J., van Dam, K., Mistiaen, W., & Nikolova, I. (2016). Understanding well-being and learning of nigerian nurses: A job demand control support model approach. Journal of Nursing Management, 24(7), 915-922. https://pubmed.ncbi.nlm.nih.gov/27237454

Appendix C

Measuring mental health and wellbeing in the workplace

Overview of the Depression Anxiety Stress Scale (DASS) and its uses

Depression, anxiety and stress are all negative feelings. The University of New South Wales in Australia developed a questionnaire to measure all three of these categories using one questionnaire, known as the Depression Anxiety Stress Scale (DASS).

The DASS is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. The DASS was constructed both as a set of scales to measure conventionally defined emotional states and to further the process of defining, understanding, and measuring the ubiquitous and clinically significant emotional states usually described as depression, anxiety and stress. It was designed to meet the requirements of both researchers and scientist-professional clinicians.

DASS severity labels are used to characterise the full range of scores in the population, so "mild" for example, means that the person is above the population mean, but still well below the typical severity of people seeking help. In the category of "moderate", symptoms are significant enough to cause problems at work and home. In the "severe" or "extremely severe" categories, symptoms are severe and often noticeable. Participants are asked to use four-point severity/frequency scales to rate the extent to which they have experienced each state over the past week. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

Each of the three DASS scales contains 14 items, divided into subscales of two to five items with similar content.

In addition to the basic 42-item questionnaire, a shorter version - the DASS-21, used in the survey, is available with seven items per scale. DASS-21 scores are multiplied by two so that you can compare the DASS-21 score with the normal DASS interpretation guide.

Interpretation of DASS scores

Meaning	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely severe	28+	20+	34+

References:

Psychology Foundation of Australia. Depression Anxiety Stress Scales (DASS). Version updated on July 26, 2018. http://www2.psy.unsw.edu.au/dass

PsyToolkit. Depression Anxiety Stress Scales (DASS). Version updated on Nov. 11, 2021. https://www.psytoolkit.org/survey-library/depression-anxiety-stress-dass.html#_introduction

Oldenburg Burnout Inventory (OLBI) explained

The OLBI was developed as a measure of workplace burnout, and has two subscales: exhaustion; and disengagement:

- **Exhaustion** is defined as a consequence of intense physical, affective, and cognitive strain.
- **Disengagement** is related to distancing oneself from one's work in general, work object, or work content. The disengagement items also measure the relationship between employees and their jobs, particularly concerning their identification with work and their willingness to continue in the same occupation.

The OLBI provides high scale reliability (Cronbach's alpha=0.63) as well as on its subscales, exhaustion (Cronbach's alpha=0.87) and disengagement (Cronbach's alpha=0.81)

The 16 items are divided between the two subscales, the items are also summed to form two sub-totals. Using a four-point Likert (closed choice) scale, the total score can range from 16 to 64. The higher the total score, the greater the level of burnout.

References:

Peterson, U., Demerouti, E., Bergström, G., Samuelsson, M., Asberg, M,. and Nygren, A. (2008). Burnout and physical and mental health among Swedish healthcare workers. *Journal of Advanced Nursing.* v.62(1): 84-95. https://pubmed.ncbi.nlm.nih.gov/18352967

Tipa, R.O., Tudose, C., Pucarea, V.L.. Measuring Burnout Among Psychiatric Residents Using the Oldenburg Burnout Inventory (OLBI) Instrument (2019). *Journal of Medicine and Life.* v.12(4): 354-360. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6993305

Appendix D Sectoral mapping

Workplace was also collapsed into four sectors: hospital (including rehabilitation services), primary care (including family practice and community health services), long-term and retirement home care, and other. We did not use the sector of other as it is comprised of many sub-sectors with small sizes.

1. Hospital	Hospital
2. Rehabilitation service	Hospital
3. Community health care service (excluding Indigenous)	Primary Care
4. Long-term care (profit)	LTC
5. Long-term care (not-for-profit)	LTC
6. Long-term care (unsure of status)	LTC
7. Retirement home (profit)	LTC
8. Retirement home (not-for-profit)	LTC
9. Retirement home (unsure of status)	LTC
10. Mental health services	Primary Care
11. Disability services	Primary Care
12. Indigenous health services	Primary Care
13. Correctional services	Other
14. Tertiary education facility	Other
15. Family practice	Primary Care
16. Public Health	Other
17. Agency	Other
18. Defence	Other
19. Other government department or agency	Other
20. Other private health service	Other
21. Other	Other

Appendix E

Support for increasing the number of RNs in Ontario

This list includes statements and reports by Ontario organizations and entities, which have called for more RNs and raised concerns about the shortage, including those eager to contribute to rebuilding the nursing workforce by substantially increasing enrollment of qualified applicants to BScN programs.

Colleges Ontario. (January 2015). Opening doors to Nursing Degrees: Time for Action. A proposal from Ontario's colleges. https://cdn.agilitycms.com/colleges-ontario/documents-library/document-files/2015%20Jan%20-%20Nursing%20Report.pdf

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RNAO is also grateful to the **Healthy Professional Worker Partnership (HPWP)** for permission to use data and graphics from its report Preliminary Comparative Findings. HPWP graphics appear on pages 32, 46, 47 and 51 in this report.

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses, nurse practitioners and nursing students in Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the health system and influenced decisions that affect nurses and the public we serve.

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May 2022