Organizational Changes to Support Healthcare Workforce to Work at Top Capacity

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AT A GLANCE

Canada is facing a health human resources (HHR) crisis characterized by widespread staffing shortages driven by high turnover, low recruitment rates, and suboptimal work conditions with high job demands(Health Canada 2022). Expecting healthcare workforce to cope with the current crisis through individual-level efforts alone, puts burden on the already-burdened individuals. To allow the health workforce to work at their top capacity, macro and meso-level support is needed.

Following are the key recommendations and actions at a glance identified through literature. While most of the reviewed literature, government reports and grey literature have very rigorously outlined priorities and proposed actions at a macro-level governance, clear pathways to implement the proposed actions within the constraints of local realities, budgets and time are lacking. Moreover, interventions targeting strengthening of existing foundations of trust with the policymakers through transparency, co-creation and stable reforms rather than continuous restructuring remains under-explored.

RECOMMENDATIONS	KEY ACTIONS
Recommendation 1: Create inclusive, compassionate and safe workplace environment	•Anti-violence, -harassment, -racism policies and accessible pathways for reporting •Training in communication skills, conflict resolution, creative problem solving, positive psychology, resilience, debrief sessions, peer support programs •Ergonomic physical infrastructure and mental-health and well-being supports •Protected nap times, CBT-Insomnia, light therapy, mind-body therapy, sleep education, shift-schedule modification, sleep disorders as invisible disability •Safe transportation options for night shift workers (prevent drowsy driving) •Increase representation of, and supportive measures for, equity deserving groups (Indigenous, Black, 2SLGBTQ+) •Provide nutritious hospital night meals, childcare support and disability accommodation •Health coverage benefits and support services recognizing additional risk to developing acute and long-term physical and mental illnesses with some long-lasting repercussions even beyond retirement
Recommendation 2: Establish transformative leadership	•Leadership training at all levels of action to implement F/P/T policies within the local realities and budget limitations •Incorporate staff appreciation and reward in leadership style •Pathways for leaders to connect with leaders (akin to exchange programs) from organizations where the

	implementation strategies have successfully achieved desired outcomes •Transparency in decision-making and co-create reforms with staff •Leader should encourage staff engagement in change initiatives and listen to their feedback on organizational activities and decision-making •Support staff's career growth and communicate growth opportunities, and relieve staff's time to participate in growth opportunities, do weekly check-ins or one-on-one meetings
Recommendation 3: Establish growth opportunities	•Establish mentorship, peer support program, residency, clinical ladder programs, and leadership training •Allocate protected time and financial reimbursement for professional development activities •Reduce skills gap for geriatric care and on end-of-life through training and simulation •Skills training program to gain clinical expertise to transition to another department, gain experience in domains of research, knowledge translation, and policy •Leadership should communicate these opportunities
Recommendation 4: Increase staffing to meet current and future needs	•Expand training seats to meet future needs •Non-traditional recruiting pools for long-term care •Recruit staff with flexible scheduling •Increase public awareness through culturally relevant media campaigns to beat stigma and promote rewarding aspects of the profession (even in post-secondary institutions) •Introduce early exposure programs starting from secondary schools to develop programs that expose students to healthcare careers, encourage them to pursue these careers •Make pathways to recruit foreign medical professionals easier while abiding to ethical principles
Recommendation 5: Establish periodic monitoring and learning systems to inform evidence-	•Workforce monitoring and evaluation using established standardized pan-Canadian assessment tools for mental health and well-being, and its determinants; current and future recruitment and retention needs and their determinants •Evaluate the effectiveness of implemented strategies and modify interventions with emerging needs

based action and planning at provider level	•Establish an interdisciplinary team trained to operationalize learning systems including HHR, caregivers, researchers, administrators, leaders •Needs assessments and HHR's voice while introducing new policies/ reforms/technology

Introduction

Canada is facing a health human resources (HHR) crisis characterized by widespread staffing shortages driven by high turnover, low recruitment rates, and suboptimal work conditions with high job demands(Health Canada 2022). This crisis leaves significant strain on the health labor force as well as healthcare systems leading to compromised patient care and population health. The HHR crisis was further exacerbated due to the COVID-19 pandemic and the increased needs of the growing aging population(Canadian Institute for Health Information 2024).

Health Canada hosted a symposium in 2022 to identify key priorities to address the HHR crisis. Participants identified opportunities for change across five key areas: 1) recruitment for future needs; 2) retention of HHR; 3) workforce mental health and well-being; 4) create and utilize data to inform effective workforce planning and management; and 5) productivity and models of care. These interdependent focus areas directly and indirectly influence HHR's ability to work at their full capacity(Health Canada 2022).

Improving HHR's experiences in the workplace is rooted in the principle that care for the patient requires care for the provider(Bodenheimer and Sinsky 2014). Supporting HHR, the fourth pillar of the Quadruple Aim framework of effective healthcare system is prerequisite to sustainably achieving other aims of the framework i.e. enhancing patient experience, population health, and care affordability(Bodenheimer and Sinsky 2014; Nundy et al. 2022).

Accordingly, the current policy report delineates organizational strategies targeting three focus areas - workforce mental health and well-being, retention of HHR and recruitment for future needs - which will support HHR to perform at top capacity and identifies policy recommendations at various levels of action planning. Models of care were considered outside the scope of this report and are not discussed. However, team-based care models, which distribute responsibilities across clinical staff, have shown the potential to reduce clinician burnout. Investment in and evaluation of such models of care are therefore recommended(Health Canada 2022).

In brief

HHR's ability to work at their top capacity is a result of complex interactions between job demands and job resources(Van der Heijden et al. 2019). Thus, organizations should intentionally strategize to both enhance job resources (supportive leadership, adequate staffing, autonomy, workplace safety, support for career development, opportunities, maintain health, availability of equipment) and mitigate job demands which require HHR's physical and psychological effort at a cost (high workload, staff shortage,

inflexible work schedule, time pressures, administrative burdens and unsafe workplace environment)(Belita et al. 2025).

Common strategies across all focus areas discussed in this report include **leadership** skills training at all levels of action planning; enhancing **transparency in decision-making**; **co-creating** policies and digital tools with HHR; **establishing communication pathways** to receive HHR's feedback; fostering inclusive and compassionate **workplaces**; expanding **mentorship and career development opportunities** at all career stages; **reducing administrative burden**; and establishing a **continuous learning systems** to align policy implementation with identified needs and evidence of what works in the specific context.

Finally, while a majority of the reviewed government reports and grey literature have rigorously outlined priorities and proposed actions at a macro-level governance, there is a notable lack of sufficient evidence, clear implementation strategies, and promotion of learning health systems tailored to local contexts and provider needs(Dube et al. 2025). To effectively translate the macro-level investments to individual HHRs, it is imperative to understand the needs of service providers who work within the constraints of local realities, budgets and time. Strategic efforts should focus on strengthening existing foundations of trust with the policymakers through transparency, co-creation and stable reforms rather than continuous restructuring. Failure to do so can lead to HHR's distrust and frustration with the governments(Dube et al. 2025).

> "The decision-making process often seems far and disconnected from the people directly involved, making it difficult to access information. It's also difficult to get information up to the upper management level. Everything is managed by the specialty sector rather than locally or by the health region, which represents a major challenge. However, I'm not saying that these are all drawbacks; there are advantages to this structure. It's a question of improving it. I believe that work is underway at the regional level to solve these problems, but it remains a challenge and a source of frustration for many people, because many people come to see me about this. "
>
> (Dube et al. 2025)

The report

This report introduces priorities relevant to HHR's ability to work at their top capacity spanning from acute care to long term care in rural/remote and urban locations at various levels of governance ranging from individual service providers to governments and across sectors. Since nurses are the largest group of regulated health professionals in Canada, a majority of the literature on organizational supports focuses on nurses. Although some studies exist that focus on other healthcare workers such as new medical graduates, medical university students, physicians, and personal support workers, the strategies and recommendations summarized in this report should be applied cautiously to the non-nurse healthcare workforce. That said, a thorough needs assessment and targeted strategies specific to different health workforces is warranted.

Each priority has following sections: i) determinants; ii) implementable strategies from the literature; iii) policy recommendations at different levels of change and iv) author's notes. This report identified priority areas through a scoping review of systematic reviews and/or meta-analyses published between January 2021 – October 2025. Boxed sections include HHR quotations from qualitative studies in literature and from the Share Your Sleep Story initiative, as lived experiences provide important contextual insights into the proposed solutions(Share Your Sleep Story 2025c).

The report discusses individual- and organizational determinants for each focus area as they provide the theoretical basis for developing targeted strategies. Author's notes include recommendations and ideas which may not have been tested widely but are based on the author's experience in her field of study, recurrent informal discussions with clinicians about their needs and discussions with healthcare shift workers sharing their sleep stories with Share Your Sleep Story, an initiative founded by the author. Note that the author is *not* a healthcare worker but a neuroscience researcher. The author's research investigates effective ways of coping with sleep loss and identifies barriers to implementing sleep research in clinical settings. The author is also involved in knowledge translation projects related to sleep disorders.

Focus Area 1: Workforce Health and Well-Being

Maintaining the health of the healthcare labour workforce is important, as health is a fundamental human right and is essential for HHR to work at their full capacity and deliver high-quality patient care.

HHR do not work in isolation. Their physical and mental health and quality of life are influenced by individual factors, teams they work in, organizations they work for and provinces they practice in. This creates an opportunity to intervene at multiple levels to proactively support HHR's health and well-being through both preventive and coping strategies. The most studied outcomes of HHR's health and well-being are quality of life, burnout, physical and mental health well-being, mental health issues, second victim syndrome and compassion fatigue.

Determinants

Common contributors to the toll on HHR's health and well-being include work-related stress, high emotional demands, compassion fatigue, second victim syndrome, workplace mental and physical violence, racism, patient mortality rates in the unit, long work hours, overwork, lack of recognition and rewards, shift work, inadequate staffing and administrative burdens(Membrive-Jiménez et al. 2022; Mundey et al. 2023; Ajuwa et al. 2024; Anger et al. 2024; Araújo et al. 2024; Canadian Medical Association (CMA) 2024; Abdulwehab and Kedir 2025; Amberson and Quarry 2025; Bafna et al. 2025; Deriglazov et al. 2025; Okeahialam et al. 2025; Ong et al. 2025).

Moreover, insomnia, sleep disturbances and circadian rhythm misalignment are common amongst HRR, especially amongst shift workers. These issues increase the risk of fatigue, immune system dysfunction, and cardiovascular and other chronic conditions. Insufficient sleep impairs work performance, increases absenteeism and poses a workplace safety risk(Hafner et al. 2017). HHR with sleep issues and chronic fatigue tend to cope through excessive intake of caffeine and benzodiazepines, with nurses often compromising their social and family time because they need their days off and free time to recover from lost sleep (Ballesio et al. 2021; Membrive-Jiménez et al. 2022). Additionally, chronic fatigue and sleep issues also increase the risk of drowsy driving and near-crash incidents outside work hours(Smith et al. 2021).

Conversely, factors protecting HHR's health and well-being include supportive leadership and teams, open communication, access to dedicated wellness policies and resources, professional competence, appreciation, individual resilience and personal coping strategies, compassion towards patients, co-workers and patient families and autonomy over work and life.

> "I wasn't feeling well but [if I] go home and just leave them short, I knew nobody's going to come in. So, I felt bad leaving them short. And it was like a Saturday, and it was very busy. So, I had to stay."
>
> "Working shiftwork is a risk factor for nurses... you have to take into consideration that amount of stress, you're not at your peak when you're working nightshifts, so you know you're putting yourself in jeopardy and you're doing it for patients, of course that they're cared for, but you know it, has an impact on your health from switching back and forth."
> (Gohar et al. 2020)

Strategies

While combined strategies are more effective, there are several practical strategies to better HHR's health and well-being that organizations can adapt based on their needs and feasibility (Wiisak et al. 2025). Importantly, staff education about preventive and coping strategies alone is not enough to drive their participation in these interventions(Ross et al. 2017). It may raise motivation to implement those strategies, but organizations play a crucial role in enabling and sustaining participation. Accordingly, strong leadership and management endorsement and active involvement are required to realize the benefits of these strategies(Guibert-Lacasa and Vázquez-Calatayud 2022; Niinihuhta and Häggman-Laitila 2022; Chaudry et al. 2024).

1. **Yoga, mindfulness and relaxation techniques**:
   These strategies implemented in the workplace or at home, are widely studied in the literature for managing work-related stress and promoting health. Integrating these techniques into the workplace (online or in person) was found to be beneficial when administered through various formats: education and training at the beginning of the program, followed by practicing at home or practicing them in person in the workplace, weekly or everyday sessions. **Mindfulness** training may include teaching HHR to observe thoughts, sensations and feelings in a non-judgmental manner as well as movement-based practices such as performing Tai Chi (e.g. 45 minutes weekly). **Yoga and massage therapy** were found highly effective at reducing occupational stress. Practical options include workplace yoga sessions weekly for an hour, laughter yoga for 30 - 60 minutes (laughter yoga is an intentional laughter exercise combined with breathing exercises (Pranayama) and relaxation), light stretching for 40 minutes, 3 times per week, progressive muscle relaxation and posture-focused exercises. Swedish massage, weekly for 15-25 minutes, 10 minutes chair massage, or aromatherapy massage for 90 minutes weekly were some options which were discussed in the literature(M. Zhang et al. 2021; Erkin and Kocaçal 2024; Eva et al. 2024; Musker and Othman 2024; Esplin et al. 2025; Wei et al. 2025; Yee and Kauric-Klein 2025).

2. **Training in improving workplace culture**: Training in communication skills, conflict resolution, creative problem solving, bioethics time management, and positive psychology (e.g. writing three good things) were found beneficial for HHR's morale and mental health. Availability of social support groups, access to cognitive behavioral therapy, consultations with bioethics experts, debrief sessions and access to information regarding self-care during onboarding, were also found effective in enhancing resilience, reducing stress and dealing with moral distress(Colleen Grady 2022; Heijkants et al. 2023; Herz et al. 2024; Badriyah et al. 2025; Janitra et al. 2025; Nielsen et al. 2025; Yee and Kauric-Klein 2025).

> "Don't make people feel guilty when they're sick. I have huge moral distress if I have to call in sick, huge moral distress because I know that my next available clinic day is four weeks out and these people have already been waiting four weeks. So, it's eight weeks for primary care … So, I never want to call in sick. So, I had COVID last week and what did I do? Work from home."
> (Spencer et al. 2025)

3. **Moral distress:**
   Education on strategies to avoid emotional attachments to patients and their families, practicing self-awareness, reflection and reframing, learning to accept the limitations of medicine, rationalizing and philosophizing about the nature of their work were shown to help HHR cope with moral distress(Prudenzi et al. 2021; Colleen Grady 2022).

4. **Compassion-based interventions:**
   Compassion is a response to one's own or others' suffering, coupled with a strong desire and action to help alleviate that distress or suffering(Malenfant et al. 2022). Compassion based interventions focus on cultivating a caring mind, promoting team building, fostering a nurturing organizational culture and relationships with peers and creating a psychologically safe space for sharing to increase interconnectedness between staff and patients. Programs may include facilitated 60-minute sessions weekly or monthly where staff describe their role, discuss patient adverse events, issues and emotions that arose due to the issues, and their coping strategies, followed by a discussion between staff members, reflecting on what was shared and inviting them to share their experiences, thoughts, and feelings on the topics discussed(Nielsen et al. 2025; Ong et al. 2025; H. Zhang et al. 2025). These exercises were helpful for staff members to feel connected with peers and understand others' perspectives.

5. **Supportive leadership:**
   Developing training programs for leaders and managers about how to design, communicate, and support wellness initiatives, and actively encouraging staff participation in training programs, have been found to be important for the health and well-being of HHR (Guibert-Lacasa and Vázquez-Calatayud 2022).

6. **Animal-assisted interventions:**
   Some studies showed acceptance, feasibility and effectiveness of animal-assisted interventions on job satisfaction and well-being. This could include an active 20-minute dog visit during work shifts in a room separate from clinical care, where staff can feed, pet or play with the dog, or sit next to the dog. Implementation requires caution regarding allergies, hygiene, staff and patient safety and potential fights between pets(Acquadro Maran et al. 2022).

7. **Peer support programs**:
   Peer support programs which can be implemented virtually or in-person have been found helpful for maintaining HHR's well-being. These programs aim to connect new HHR with their peers who are experiencing similar challenges, create a supportive network and enable sharing new HHR's challenges and concerns and exchanging effective strategies. Evidence indicates that such programs reduce feelings of loneliness, isolation, and emotional distress amongst new graduates(Ong et al. 2025; Raqueno et al. 2025; H. Zhang et al. 2025).

8. **Sleep-related interventions:**
   These interventions have shown positive impacts on shift-work disorder, various aspects of sleep health, including reduced sleepiness at work, improved sleep efficiency, and enhanced sleep satisfaction, thus contributing to the overall well-being of shift-working nurses (Wickwire et al. 2017; Qtait et al. 2025).
   a. For shift-workers, implementing protected nap times with sufficient replacement staff and building quiet, dedicated nap rooms at work are important organizational measures which benefit from leadership and management support (Dore et al. 2021; Ko et al. 2025)

b. Beyond nap facilities, interventions shown to manage sleep disorders and improve sleep outcomes among nurses include cognitive behavioral therapy, light therapy, mind-body therapy, sleep education, exercise, shift-schedule modification. Combined interventions can include light therapy delivered through light boxes (1,500–10,000 lx bright light for durations ranging from 15 minutes to the entire night shift) and sunglasses (to limit light exposure during the commute home) or increasing the ambient brightness of the ward during the night(Dou et al. 2025; Ko et al. 2025). ***Caution***: For effectiveness, light blocking glasses and lamps should be purchased from a trusted evidence-based source. Care should be taken so that they do not increase the risk of drowsy driving while returning from shift work.

c. Sleep health promotion interventions for HHR which include education on the role of sleep in physical and mental well-being, shift work disorder, sleep hygiene practices, and both pharmacological and non-pharmacological coping strategies have shown to be effective (Dou et al. 2025; Ko et al. 2025). (**Author's note**: These educational components and resources can be integrated into onboarding programs and reinforced through ongoing, recurrent messaging.)

Policy Recommendations

The effectiveness of the above-mentioned strategies may be limited without systemic and organizational support. HHR are already overworked(Canadian Institute for Health Information 2024). Thus, relying only on individual-level interventions in achieving work-life balance can be a barrier. Implementing organization-wide and nation-wide interventions to support HHR's health and well-being now will reap long-term benefits for the health systems.

> "They're medicating with things [such as] caffeine. They can go to work and they're drinking 10 cups of coffee a day because that's what keeps them alert. It's hard to flip the body when you you're supposed to be awake, and you're supposed to be sleeping. So, sometimes you have to take a sleep aid to get good sleep. So, you can get up for your nightshift."
>
> "Shift work is hell on the ability to sleep and if you don't sleep you don't heal, and if you don't heal, then that MSD [musculoskeletal disorders] injury is much more likely to happen."
> (Gohar et al. 2020)

1. **Periodic monitoring and learning**:
   a. Regional health authorities and local service providers should periodically monitor healthcare workers' physical and mental well-being, and its determinants, using standardized pan-Canadian assessment tools.
   b. Organizations should conduct needs assessment and consult staff in setting health and wellness policies and adapt the strategies to their changing needs.
   c. Regularly evaluate the effectiveness of implemented strategies and modify interventions in response to emerging needs.
   d. Investments are needed to train and build leaders within each local service provider organization who can optimize HHR performance in high-stress environments, develop sustainable wellness programs, establish and communicate well-being policies with staff, promote staff

engagement with these initiatives, and implement meaningful systems of staff appreciation.

2. **Improve access to organizational initiatives:**
   a. Organizations should strive to provide staff with sufficient flexibility to participate in workplace health and well-being activities, programs, and services (e.g., CBT services, debriefing sessions, educational sessions, and group counseling) by offering them at times that are accessible to staff (i.e. the initiatives should not require extra time beyond their regular work hours).
   b. Allocate protected time for enabling HHR's participation in these initiatives.
   c. Ensure no cost for individuals participating in organizational wellness initiatives.
   d. Provide staff with easy access to information about wellness programs and internal or external mental health resources through clear communication channels.
   e. Establish ongoing monitoring processes to evaluate the accessibility of interventions, identify barriers to access, and implement evidence-informed mitigation strategies.

3. **Organizational efforts:**
   a. Organizations should secure protected budget lines and invest in creating physical and psychological health and safety activities in the workplace. While organizational interventions are effective, they often face implementation barriers, due to limited financial resources or lack of sufficient legal support for development of interventions. Investments in studying and devising evidence-informed mitigation strategies should be made.
   b. Leaders at various levels within the organization should adopt creative approaches to recognizing staff achievements (e.g., annual recognition awards, service-length recognition, and personalized one-to-one feedback) to ensure staff feel genuinely valued in the workplace.
   c. Regional health authorities should implement frameworks to hold organizations accountable to create physically and psychologically safe workplaces (e.g.: anti-harassment and anti-violence policies).
   d. Organizations must invest in sleep health of HHR especially for shift workers by promoting above-mentioned strategies like sleep education, access to an on-site or online psychologist for CBT for insomnia (and insurance coverage for services), light blocking sunglasses and light boxes.
   e. Investments should be made to create ergonomic physical infrastructure. For example, building bedside support equipment, or ceiling lifts, especially for long term care workers where musculoskeletal injuries are common from repeatedly performing resident transfers without proper equipment.
   f. In collaboration with educational institutions and professional regulatory bodies, organizations should expand and invest beyond traditional staff competencies by incorporating resilience- and compassion-based training for both leadership and staff, embedded within mentorship programs.
   g. Organizations should recognize the need for and streamline the process of flexible scheduling and workplace accommodation for visible and invisible HHR disabilities and streamline processes for accessing these supports.
   h. Providing comprehensive health coverage benefits and support services for HHR recognizing the stressful nature of HHR's occupation, which poses additional risk to developing acute and long-term physical and mental illnesses with some long-lasting repercussions even **beyond retirement**.

i. Increase representation of, and supportive measures for, equity deserving groups (Indigenous, Black, 2SLGBTQ+) in health workforce initiatives(Health Canada 2022).

> "We expect night shift workers to continue to be fathers, mothers, daughters, wives and, sometimes, come home and take care of their older or sick parents and still perform their 105% without sleep."
> (Share Your Sleep Story 2025b)

Author's Note

1. Organizations should recognize sleep disorders (e.g.: narcolepsy, sleep apnea, delayed sleep-wake phase disorder etc.) as invisible disabilities. Proactive efforts to accommodate staff with these issues are imperative for individual well-being and optimal work performance.
2. Organizations should promote road safety for shift workers by providing taxi vouchers, independent bus service or by partnering with organizations that offer transportation services (e.g., Operation Red Nose).
3. Sleep health interventions were amongst less studied HHR health variables while sleep's implications on physical, and mental well-being, quality of life and productivity are widely known(Hafner et al. 2017). If chronic sleep issues persist, HHRs should have access to sleep disorder screening tools, resources, and guidance for managing sleep issues.

Focus Area 2: Retention

Determinants

Recruiting HHR into a system that has challenges with retaining them can prove costly due to high turnover(Canadian Medical Association (CMA) 2024). Effective retention strategies should be developed by targeting the determinants of HHR's intention to leave, which is influenced by multiple individual and organizational factors.

Frequently reported determinants of intention to stay and leave are summarized here. **a) Personal characteristics**: These include age, gender, physical and mental health, passion for work, resilience, coping mechanisms, lifestyle factors, and disillusionment with profession. **b) Job demands and resources**: These encompass job satisfaction, job-related emotional burden, excessive workload, lack of challenges and career development opportunities, skills gaps due to disparity between training and job expectations, administrative burden and working on these tasks during personal time, inadequate time for patient interaction and health and well-being related determinants as outlined above. **c) Employment terms**: Key determinants include competitive salary, adequate social benefits, health coverage, effort-reward balance, autonomy in scheduling and irregular work hours, support for workplace policies for physical and psychological safety, anti-harassment and anti-racism policies. **d) Working conditions:** This consists of workplace infrastructure, hospital location (rural, urban), patient satisfaction, adequate staffing, work autonomy, social support, organizational involvement in staff's health and well-being. **e) Work relationships and organizational culture:** These include appreciation from leadership, mutual respect amongst staff, open communication, peer support, horizontal violence, and quality of leadership. For HHR working in long-term care, there are added challenges such as more physically strenuous tasks which increase the risk of injury, such as lifting or moving patients and serving many patients under time pressure each day(Van der Heijden et al. 2019; Russell et al. 2021; de Vries et al. 2023a; De Vries et al. 2023b; Heijkants et al. 2023; Zhu et al. 2023; Berthelsen and Hansen 2025; Kiptulon et al. 2025).

Given that many determinants of HHR retention are beyond an individual's control, implementing evidence-based strategies at both individual and systems level can meaningfully improve HHR retention.

Strategies

The Health Canada *Nursing Retention Toolkit* has thoroughly reviewed and recommended practical strategies and tools for healthcare organizations to improve nurse retention. In this section, common strategies emerging from literature and the *Nursing Retention Toolkit* are summarized(Health Canada 2024a). These include strengthening transformational leadership, improving onboarding for new graduates, mentorship programs, reducing administrative burden, facilitating transitions between units, promoting career growth, and leveraging technological innovations to improve work environments. Stress coping strategies are discussed above in the "workforce health and wellbeing" section.

1. **Leadership training:**
   Leadership within healthcare can extend across all levels of governance, from HHR leaders involved in individual departments, hospital units and clinics to the office of the federal health minister(Health Canada 2022; de Vries et al. 2023a; Health Canada 2024a; Kiptulon et al. 2025). Leaders are uniquely positioned to create a conducive environment for HHR's retention by influencing patient outcomes, inspiring staff, fostering staff's

professional growth, ensuring a thriving work environment, identifying gaps and inefficiencies in organizational structures, and leading change initiatives to solve challenges of everyday clinical practice (Guibert-Lacasa and Vázquez-Calatayud 2022). Interventions promoting clinical leadership training have shown to increase nurses' retention and lower turnover. These interventions included in-person or online training programs ranging from 6 months to 2 years for multi-hour and multi-day sessions through various formats like educational, didactic, interactive and hands-on learning activities such as change projects in hospitals. Recommended leadership training competencies involve: (1) cognitive competencies (practical problem-solving skills, decision-making, change management, ability to regulate behavior), (2) inter-personal competencies (social skills to establish effective relationships and communication with staff, patients and families) and (3) intrinsic competencies (one's own values and skills to manage conflict (psychological empowerment, emotional intelligence and critical reflexivity))(Guibert-Lacasa and Vázquez-Calatayud 2022; Health Canada 2024a).

2. **Reduce administrative burden**:
   Various interventions to reduce the non-clinical and administrative tasks have been studied as ways to maximize HHR's time for clinical practice. Example interventions include:
   a. Utilizing paid student roles to help with administrative tasks while offering simultaneous clinical exposure and learning opportunities (Health Canada 2024a).
   b. Identifying and implementing effective technologies and digital tools aimed at reducing administrative burden (Sarraf and Ghasempour 2025). Technological tools have been found to be effective when they are tailored to the needs and challenges of specific departments and co-created with staff input. Studies have found that HHR are more likely to adopt these tools when the relevance and rationale of their use are well-communicated, the tools are easy to use, adequate training is provided and staff is prepared for digital transformation (Jedwab et al. 2023). Otherwise, these tools can add to the existing burdens and prove ineffective. AI scribe technologies emerged as a promising approach to alleviate EHR documentation burden(Jedwab et al. 2023; Al Khatib and Ndiaye 2025; Sarraf and Ghasempour 2025).

> "The joy of practicing medicine is gone."
>
> "I hate being a doctor…I can't wait to get out."
>
> "I can't tell you how defeated I feel…The feeling of being punished for delivering good care is nerve-racking." "I am no longer a physician but the data manager, data entry clerk and steno girl… I became a doctor to take care of patients. I have become the typist."
> (Bodenheimer and Sinsky 2014)

3. **Early-career onboarding mentorship and transition programs:**
   Early-career stage was identified as a high-risk period in a nurse's career during which they may face disillusionment with the profession which influences intention to leave. This period thus presents a critical opportunity to intervene. Widely discussed interventions aim to prevent "transition

shock" through various programs like externships, internships, extended orientation, transition-to-practice programs, nursing residencies, preceptorship, mentorship, and clinical ladder programs, which can be incorporated at the last stage of university training(Berthelsen and Hansen 2025). The components of these early-career programs are built to expose and prepare new graduates to the demands of fast-paced clinical practice, like time and stress management, required leadership and communication skills, working in compassion-based care, and in emergency or end-of-life settings(Brook et al. 2024; Mohamed and Al-Hmaimat 2024; Berthelsen and Hansen 2025).

4. **Addressing skills gap:**
   HHR staff in long-term care often experience skills gaps in meeting the demands of geriatric care(Ontario Minstry of Long-Term Care 2020; Marsh McLennan 2021; Boamah et al. 2023; Heijkants et al. 2023). Training to meet skills gaps at various stages of school or after graduation can include:
   a. Onboarding and mentorship programs (e.g. pairing student or new graduates with mentors while also incentivizing mentorship as it could add to existing burdens of the mentor).
   b. Specific training modules on end-of-life and geriatric care (e.g. communication with individuals living with dementia, caregiver education programs).
   c. Simulation programs in which staff can experience challenges of someone living with degenerating physical functioning (e.g. special glasses to simulate poor eyesight or frailty).

5. **Improving job environment:**
   A respectful work environment and a sense of belonging among HHR have been associated with reduced intention to leave(de Vries et al. 2023a; Zhu et al. 2023; Health Canada 2024a; Kiptulon et al. 2025).
   a. Workshops and programs have been tested as ways to create respectful job environments. Components of these programs may include training on interpersonal relationship development, nonviolent communication, conflict resolution, respecting privacy, inclusivity, anti-racism, and addressing aggression.
   b. Leadership has been examined as a way to periodically communicate the available pathways to report violence, aggression, and racism. The studies suggest that these pathways can be effective if they are easily accessible(Aljohani et al. 2021; Bekelepi and Martin 2022; Ajuwa et al. 2024).
   c. Weekly check-ins or one-on-one meetings have been found to foster relationships between leadership and HHR(Colleen Grady 2022).
   d. Encouraging staff engagement and listening to their feedback on organizational activities and decision-making has been found to create an environment in which HHR feels seen and valued.

> "In practice, you have to perform every role; you're a phone operator and you have to make the beds, and you have to help patients go to the toilet, and yes, just a lot of minor tasks. That was ultimately not my ambition. […] At one point I thought, it feels a bit like a dead end, and then what? Being a nurse, OK, and that's it. Yes, I think that is in fact the difference between what you are trained for and what you really do in practice."
> (Lessi et al. 2025)

e. Animal-assisted interventions mentioned in the "Workforce Health and Well-Being" section have been associated with decreased turnover intention.

6. **Self-scheduling**:
   Self-scheduling has been shown to increase HHR's autonomy and potentially improves work-life balance, and work satisfaction. However, literature shows mixed results(Wynendaele et al. 2021). Self-scheduling was associated with more requests for short notice shift changes and fixed scheduling was associated with less overtime. Some studies indicate that self-scheduling may result in low to moderate staff turnover compared to fixed scheduling (Wynendaele et al. 2021; Bae 2024; Health Canada 2024a; O'Connell et al. 2024). Policies such as Ontario's "70% full-time commitment," aimed at retaining part-time and casual nurses, were found to be ineffective(Frieda Daniels 2012; Health Canada 2024a).

> "I expected that my department or hospital would appreciate my efforts. However, this was merely wishful thinking. I was not as important as I thought I was. I did not feel that my department or the hospital treasured me as an effective staff member. I realised that what I had done was so meaningless. My intention to leave the profession was ignited at that moment."
> (Lessi et al. 2025)

7. **Growth opportunities:**
   Clinical ladder programs incorporated into workplaces are shown to support staff career growth and skill development(Berthelsen and Hansen 2025). The staff can utilize these programs if they have the option to claim protected time up to a specified percentage of their work hours for professional development activities, such as gaining clinical expertise to transition to another department, participating in leadership programs, or gaining experience in domains of research, knowledge translation, and policy(Alger et al. 2012; Ontario Minstry of Long-Term Care 2020; Marsh McLennan 2021; de Vries et al. 2023a; Brook et al. 2024; Health Canada 2024a; Kiptulon et al. 2025).

Policy Recommendations

1. **Government investment:**
   a. Government and organizational commitment, reflected through sustained investments, is required to implement the abovementioned strategies, including early and holistic onboarding and mentorship programs that adapt to evolving workforce challenges, narrow skills gaps particularly for HHR working with older individuals, promote transformative leadership styles, and reduce administrative burden (Kiptulon et al. 2025).
   b. Deliberate governmental and organizational efforts are needed to implement and enhance access to existing HHR health and well-being programs within healthcare settings (see "Workforce Health and Well-Being" section).
   c. Sustained government investment in scaling effective HHR retention practices is essential.
   d. To promote implementation of above-mentioned strategies, health authorities can incentivize organizations for their implementation efforts.
   e. Governments should consult relevant stakeholders to develop a comprehensive, nationwide retention toolkit for different healthcare workforce groups.

f. Organizations and leadership should have access to information on evidence-based strategies and best practices that have been effectively implemented across Canada, which can be adapted to their own settings (examples of such initiatives are outlined in the Nursing Retention Toolkit(Health Canada 2024a)).

2. **Leadership development:** Leaders should have opportunities to connect with and learn from leaders of other organizations (akin to exchange programs) where the implementation of specific strategies, reforms, and policies has successfully achieved desired outcomes.

3. **Workplace resources and amenities:** Availability of workplace benefits and amenities such as childcare support, accessible and convenient transit options (particularly for night-shift workers), nap and rest rooms, nutritious hospital meals at night for night workers, and ergonomic physical infrastructure are some organizational strategies that contribute to a supportive work environment. Organizations should equip HHR with appropriate ergonomic workstations and patient handling and transfer aids to prevent musculoskeletal injuries.

> "It happened to me five times in the last year that I had to stop driving to sleep. Once I was just two minutes away by drive from my house – so close – but I refused to continue driving. So, I left the car and walked home. I didn't want something bad to happen to me or others on the road" - a night shift nurse (Share Your Sleep Story 2025b)

4. **Stay and exit interviews:** HR teams and managers should conduct exit interviews to identify organization-specific determinants of turnover to enable developing interventions targeting these determinants. In addition, stay interviews should be conducted to proactively identify individual-level facilitators and barriers, enabling HHR to work at their full capacity and allowing organizations to adapt early strategies accordingly.

5. **Protected time to participate in programs**: HHR should be granted protected time to engage in professional development, well-being activities, and skills training, as excessive workloads without such provisions can limit participation and reduce the effectiveness of retention strategies. Efforts made by staff in engaging in these activities should be formally recognized and rewarded.

6. **Co-creating reforms and policies**: Retention programs and reforms should be developed by consulting staff. Staff engagement can be incentivized if necessary. Formal and sustained communication mechanisms should be established for HHR to share concerns regarding reforms, policy feedback, and ideas for change, with transparent communication on how their input is acted upon(De Vries et al. 2023b).

7. **Technology adoption:**
   a. Investments should be made to adopt effective AI based technologies to reduce administrative and documentation burden and inbox management.
   b. Barriers to technology adoption and implementation barriers should be mitigated by increasing HHR's technological literacy and trust, clear communication of the rationale for adopting new technology and challenges regarding liability, privacy, and compliance

should be identified and tackled. The accuracy, completeness, and clinical appropriateness of AI-generated output should be validated.

c. Impact of technological adoption on desired outcomes should be evaluated quantitatively and qualitatively through staff interviews.

d. Multistakeholder collaboration should be fostered to design AI tools that are widely accepted and equitably accessible.

> "…people will do the training and then they've got loads of other things to do. They'll forget about it. So, at the point (…) I'm thinking this client could maybe do digital, but I can't remember how to log on."
> (Turnbull et al. 2024)

8. **Support for growth opportunities:**
   a. Through multi-stakeholder collaborations, governments should develop opportunities, and training courses for HHR career growth. Leadership should communicate these opportunities with staff.
   b. Implement specialized programs with equal access, by offering financial reimbursement, reduced work arrangements, temporary leave, and protected time for professional growth, while ensuring continuity and quality of care.
   c. Provide incentives for experienced staff to mentor new graduates, senior-stage students, and less experienced team members.

9. **Retention of internationally educated healthcare professionals (IEHPs):** IEHPs face unique challenges as they integrate into the Canadian healthcare system (covered in the "Recruitment" section). Targeted investments are needed to support the implementation of IEHP-specific retention strategies.

10. **HHR retention in rural and remote areas**: Interventions that recruit students from rural or remote backgrounds, train them within those settings, and prepare them for practice in those contexts have been shown to support long-term rural workforce retention. Strategies must also address barriers to professional growth and personal well-being faced by HHR working in rural and remote areas. Coercive return-of-service programs should be applied cautiously, as their effectiveness in improving long-term rural retention could be limited(Russell et al. 2021).

Author's Note

1. Investments should be made to establish learning health systems enabling continuous learning through data collection, evaluation, adaptation and implementation of retention interventions based on evidence specific to an organization(Foy et al. 2025).
2. Each organization should establish a dedicated, multidisciplinary, and diverse task force, comprised of researchers, HHR representatives, administrators, and leadership, to develop and evaluate the implementation of evidence-based retention strategies. Appropriate incentives and protected time should be provided to task force members, recognizing that participation adds to existing workloads and responsibilities.
3. Beyond policy development and reform, governments should invest in the development of a clear implementation framework for change initiatives. These

frameworks should be disseminated by regional health authorities with service providers along with education and training on ways to adopt those strategies within the budget and time constraints.

4. Transparency regarding change of policies and regarding rationale behind decision making at all levels of governance will help regain trust of the end-users in the system and feel valued.
5. Create standardized measures and indicators of intention to leave/ stay and create standardized surveys which can be used across provinces.

> "Some of them discussed going to another area of nursing like public health that could allow them to have more work-life balance and better sleep. But some stay for financing reasons or because they always wanted to be nurses. For new graduates, it's a shock because they don't teach you this [in school]"
> (Share Your Sleep Story 2025a).

Focus Area 3: Recruitment

Determinants

Many factors influencing recruitment overlap with the factors influencing HHR's retention and health and well-being such as workplace culture, professional development opportunities, compensation and benefits, work-life balance in the profession role, attachment to a particular geographical location, availability of technology and equipment to support work.

Additionally, recruitment is influenced by group-specific factors, with distinct challenges for HHR working in long-term care (LTC), nursing, rural and remote settings, and for internationally educated health professionals (IEHPs)(Ontario Minstry of Long-Term Care 2020; Marsh McLennan 2021; Beduchaud et al. 2024; Ben Natan and Hazanov 2025).

LTC is often perceived as a less desirable career path than acute care, as it is commonly viewed as lower-paid, undervalued, mentally and physically demanding, and lacking benefits, career advancement, or rewards(Ontario Minstry of Long-Term Care 2020).

> "For some PSWs, it's a second or may be third career. So they're already older when coming into the position and they're new... There is also the fact that the older you get, the less able you are to heal. So, they may have a smaller injury, that's not necessarily at the beginning worthy of note, but [then] it aggravates [and] gets worse over time." (Gohar et al. 2020)

Nursing recruitment is influenced by financial barriers such as high tuition costs and student loans, and societal stigma, gender roles and the misconception that the profession is associated with femininity.

Practice in rural and remote areas is influenced by availability of economic opportunities, work conditions, career development opportunities, access to new research, technologies and local amenities, job availability for family members, and preparation to live a rural lifestyle(Ben Natan and Hazanov 2025). IEHPs are viewed as a solution to medical shortages in rural areas, but they face multiple barriers to recruitment. These include lengthy, costly, unclear or inconsistent licensure processes, time delays, changing immigration regulations, and language and cultural barriers(Beduchaud et al. 2024; Healthcare Excellence Canada (HEC) 2024).

Strategies

Since many determinants of recruitment overlap with those of retention, strategies targeting these issues are also shared namely those targeting availability of growth opportunities, supportive leadership, self-scheduling, onboarding and mentorship programs, workplace resources and amenities, and support for staff mental health and well-being. Therefore, these strategies are not repeated in this section.

Under policy recommendations, evidence-based strategies specific to recruitment issues are clearly stated. However, the literature on recruitment strategies for LTC and IEHPs is limited. Consequently, several policy recommendations were informed by grey literature, including executive reports, government and organizational reports.

Policy Recommendations

1. Collect pan-Canadian healthcare needs-based data (i.e., current and projected health care

needs) to inform future recruitment needs(Health Canada 2022). According to what's needed the most, federal/ provincial/ territorial governments in collaboration with regulatory bodies, and educators can develop or expand educational and training programs for existing and next generation specifically and plan targeted recruitment to meet health systems' needs(Health Canada 2022; Canadian Medical Association (CMA) 2024).

2. Expand labor pool:

a. Recruit staff with flexible scheduling such as weekend workers (individuals can work exclusively or primarily on weekends), casual positions (as-needed basis to cover shifts when regular staff members are unavailable.), float pool (nurses are hired on a temporary basis to work at various health care facilities and who could work in any department, where there is a need(Ontario Minstry of Long-Term Care 2020; Health Canada 2024a).

b. Tap into non-traditional recruiting pools for LTC should be explored such as parents and family caregivers looking to re-enter the job market, foreign-educated allied health professionals, volunteers, and social assistance recipients looking to re-entre workforce(Ontario Minstry of Long-Term Care 2020).

3. Increase staffing:

a. Early exposure programs:

i. Invest in nationwide early exposure programs and evaluate their eff-effectiveness for recruitment(Health Canada 2022).

ii. Foster collaboration of providers and LTC particularly in remote areas with secondary schools to develop programs that expose students early to healthcare careers, encourage them to pursue these, and help reshape some misperceptions about healthcare. For example, through co-operative (co-op) education programs for the LTC and other healthcare sectors where high school students could directly gain hands-on paid experience in the field and understand its demands(Ontario Minstry of Long-Term Care 2020; Ben Natan and Hazanov 2025).

b. Mentorship and leadership initiatives should actively promote representation of minority groups to increase visibility and encourage students from diverse backgrounds to enter the healthcare workforce(Ben Natan and Hazanov 2025).

4. Increase capacity:

a. Significant increases in training seats are required to meet the current and future demand HHR in Canada. Investment and partnerships with post-secondary education programs in medical universities with relevant ministries to increase training capacity should be prioritized(Health Canada 2022).

b. Financial incentives such as scholarships, paid tuition or loan forgiveness programs may help alleviate financial barriers to pursuit of healthcare jobs(Marsh McLennan 2021; Health Canada 2022; Ben Natan and Hazanov 2025).

5. Increase Public Awareness:

a. Invest in public awareness and media campaigns to reduce stigma and improve public perceptions of healthcare profession. These campaigns should also target post-secondary institutions and be culturally relevant(Ontario Minstry of Long-Term Care 2020; MacKay et al. 2021; Ben Natan and Hazanov 2025).

6. Recruitment to LTC:

a. Dedicate investments to attract and prepare new staff to work in long-term

care(Ontario Minstry of Long-Term Care 2020).

b. Targeted public campaigns to beat stigma and promote rewarding aspects of working in LTC homes may improve the likelihood of attracting people to LTC(Ontario Minstry of Long-Term Care 2020).
c. Concurrently, strategic investment in improving work conditions and infrastructure of LTC are important.

> "It's difficult because what nurses … need the most is [the] ability to take time off when they do need to recharge or refresh or do something for their family … You can't get time off because of the short staff. I have over 150 vacation hours from last year that I didn't get to take and I'll have that many again. It's hard to be willing to take [time off] when people are so desperate for care." (Spencer et al. 2025)

7. Recruitment of IEHP:

IEHPs are often seen as solution to staff shortage in remote areas while they face unique challenges as mentioned above. Evidence on utility of IEHPs in remote areas is non-conclusive due to high turnover (Beduchaud et al. 2024). However, the recommendations provided are focused on mitigating the barriers in recruiting IEHPs to grow Canada's healthcare capacity.

a. Develop immigration programs to attract foreign medical professionals by facilitating the recognition of foreign credentials through clear, transparent communication of procedures, reducing associated costs, easing visa restrictions and providing support to reduce transition stress and cultural shock(Health Canada 2024b; Healthcare Excellence Canada (HEC) 2024).
b. Develop onboarding and human resource support. These programs should include training about the Canadian healthcare system, information on workplace culture, role of different governing and regulatory bodies, the role of the federal and provincial governments(Canadian Medical Association (CMA) 2024; Health Canada 2024b).
c. Implement pre-arrival programs and orientation to support familiarity with Canadian culture before arrival to Canada. IEHPs should receive information on essential needs such as housing, childcare, schooling and transportation. (Author's note: Government could invest in providing housing for initial months for IEHPs until they find housing.)
d. Recruitment efforts of IEHPs should preclude unethical practices that deplete other countries of health care professionals. For more information, refer to the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010), which outlines ethical principles for the recruitment of IEHPs(Health Canada 2024b).
e. Importantly, along with IEHPs and nation-wide targeted efforts should be made to recruit national medical graduates from rural and healthcare shortage areas. This may include providing accessible training opportunities within local communities, implementing rural education programs, and supporting initiatives aimed at making these areas self-sufficient(Health Canada 2022; Beduchaud et al. 2024).

> "[The new project or policy] should be discussed with all stakeholders. It is not a good idea to introduce something that a group is critical towards from the beginning, as it often leads to adversity."
> (Dube et al. 2025)

Conclusion

Overall, this report outlines strategies and recommendations that can be implemented across micro-, meso-, and macro-levels of governance to support HHR in working at their full scope and capacity which can be achieved by addressing Canada's HHR crisis.

There is broad consensus that effectiveness of the strategies and reforms depends on coordinated, system-level actions rather than reliance only on individual-level action. This includes sustained investment in workplace conditions, leadership engagement, ethical recruitment of IEHPs, transparency in decision-making, co-development of policy reforms and new technology with HHR, and reduction of administrative burden.

Furthermore, clear implementation frameworks to support organizations are currently limited, resulting in variation in how macro-level policies are translated into practice across individual settings. Through development of continuous learning systems within organizations that integrate evidence, continuous evaluation of evidence and reforms, and adaptation, would support more consistent and effective policy translation aimed at ameliorating the HHR crisis.

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