

“WE ARE IN SURVIVAL MODE”

WHAT NURSES NEED YOU TO KNOW

2026

An in-depth academic study about Ontario hospital nurses’ lived experiences

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Forward

This qualitative study is a follow-up to the report published in 2025, *Why Ontario Needs Safe Nurse Staffing Levels* (Brophy & Keith, 2025).

It was undertaken in collaboration with the Ontario Council of Hospital Unions/ Canadian Union of Public Employees (OCHU/CUPE) in order to amplify the voices of nurses working under increasingly challenging conditions.

Everyone is aware of the escalating pressures plaguing Ontario's hospital system – the crowded emergency departments, scarcity of staffed beds, and agonising waits for care. While the crisis has created immeasurable anxiety and suffering for the public, few think about the impact it is having on the medical staff – including the nurses who must endure not only crushing workloads, but also the burden of their patients' distress. The status quo is not sustainable. But a resolution, at least in part, is attainable. The following report provides compelling evidence, based on nurses' experiential eye-witness testimonials, that makes an unequivocal case for the enhancement of nurse staffing levels through the implementation of legislated minimum nurse-to-patient ratios (mNPRs).

THIS IS THEIR STORY.

Executive summary





The healthcare system in Ontario faces a crisis of understaffing and inadequate resources, harming many overworked nurses and threatening the quality of care provided to patients.

This report highlights the concerns of a sample of Ontario hospital nurses who share their personal experiences with staffing shortages, lack of funding, and poor support. The nurses express fear for the future of health care, citing concerns about reduced quality of patient care.

Ontario's healthcare system is experiencing an accelerated move towards a two-tier model where those who can afford it receive more timely care while those who cannot are left to navigate a broken and underfunded system. This shift towards privatization will exacerbate existing inequalities, leaving vulnerable populations with even more limited access to quality care. It will also drain nurses from the already understaffed public system.

The root causes of this crisis are attributed to neoliberal reforms and business-style managerial approaches, which prioritize economic efficiencies over human needs. The provincial government's budget is below the needed allocation, leading to ineffectiveness, reduced care, and limited access to services. Moreover, the lack of recognition and support for nursing staff that is now contributing to burnout and decreased morale will be further exacerbated, leading to an escalation of the problem of staff retention.

To address these issues, nurse staffing within the public system must be prioritized. mNPRs are key to ensuring adequate staffing levels and improving patient outcomes.

Furthermore, a more empathetic and understanding approach to health care is needed -- one that puts patients ahead of cost and recognizes the inherent value of compassion and kindness as an integral and essential aspect of quality care.

Immediate action is required. This includes increasing funding, legislating safe nurse staffing levels, and recognizing nurses' rights and dignity. By prioritizing these essential components, we can ensure that our healthcare system provides high-quality care to patients and supports the well-being of nursing staff.



Introduction



As Canadians we enjoy an almost unique social benefit, a universal right, that distinguishes us from many other countries. Health care is, in theory, accessible to everyone, although there is more limited access in rural or remote areas and Indigenous communities (Burnett et al, 2020).

> *Rural and northern communities often face challenges disproportionate to their urban counterparts in accessing health care services... This situation is further complicated by social identities related to Indigeneity, race, gender, settler colonialism, age, ability, and sexual identity.*

The poor, unhoused, and those needing mental healthcare, among other marginalized populations, need to be better served.

Despite its shortcomings, however, the system is well worth salvaging and improving upon. It employs sophisticated medical equipment, advanced techniques, and highly trained professionals. Attaining this treasure took generations of social engagement, advocacy, and political cooperation.

> *When universal health care was adopted in 1966 with the passage of the Medical Care Act, it signified a profound moment in Canadian political history. Rarely before had an alliance of ideologically opposed figures... delivered legislation that would enshrine in collective consciousness the universal values of health and dignity; touchstones that still define this country and its society today. Indeed, medicare is a fundamental pillar of Canadian identity. It projects our national values onto the world stage, delivers positive outcomes to patients, and supports a vast infrastructure of globally recognized caregivers, physicians, researchers, and front-line workers (Samphir, 2015).*

Today, this precious, hard-won social right is under serious threat. While there are significant shortages of doctors and other healthcare professionals, nurse understaffing is a critical systemic issue that undermines the very foundations of Ontario's healthcare system. It is spawned by so-called efficiency measures – that result from years of austerity-driven budget cuts. On the surface, "efficient care" may sound like a good thing.



It implies that hospitals are providing high-quality care while minimizing waste, but often means prioritizing cost-cutting measures over patient needs.

John Ralston Saul (1999), a well-respected, internationally recognized Canadian philosopher and social critic, gave a prophetic presentation in 1999 critiquing Canada's slow drift into a two-tier healthcare system. He said, "The promotion of efficiency to the senior level of policy making has been one of the most disastrous innovations of our administratively led medicare system. The more 'efficient' you make a medicare system, the less well -- the less effectively -- it will work."

The term efficiency, in this context, is really a euphemism for underfunding. The reality is that the pursuit of cost savings in health care can be dangerous -- even heartless. Its consequences are stark: overworked healthcare personnel, compromised care, and increased rates of medical errors and human suffering.

To better grasp how understaffing can affect patient care and impact nurses' own well-being, consider Jane's hair-raising recounting of a particularly difficult shift in which she, as a medical-surgical nurse, was assigned five high acuity patients. (Note: Jane is a pseudonym for one of the nurses who was interviewed for the research included in this report.)

"I had a palliative patient. I had an acute patient who was an IV drug user and he was constantly in and out. I had a patient who was awaiting long-term care and I had another very confused person on isolation in restraints with a catheter. And I was down two different hallways, and I remember the student who was there that day obviously needed to take his break and so I sent him along for his break, and I was trying to shower my long-term care patient because it was her birthday and her family was coming. I thought to myself that it's fine, everybody is okay at the moment, they should be good during the time I am trying to get this patient washed and feeling good on her birthday before her family gets there. Then I hear the bells going off in my confused patient's room. She was on the floor with her catheter hanging. It was the only reason she didn't crawl out to the hallway naked. And then the same time I have a palliative patient who is now rapidly declining and I have my IV drug user patient who was having chest pain. So, during all of that, I'm wondering, 'Am I going to make the palliative patient comfortable? Am I going to try to save the drug user? Or am I going to get the naked and confused woman off the floor? What am I going to do?' And, of course, I also have a patient in the shower sitting naked. I asked for help but everybody else was very overwhelmed with their own patients. I couldn't get any more help. I had to do the assessments. I had to be the one administering the narcotics for the palliative patient. I had to be the primary at the bedside while we were tending to the patient with chest pain. And then I'm also needing to help my patient who had fallen and do a fall precaution protocol. Then there was my patient whose family showed up for her birthday celebration. I remember standing in the hallway, sobbing to

this family saying, 'I'm so sorry, she's in there. Can you go look after her? Because I need to go deal with other patients and I need to figure out how to prioritize all this right now.' … Oh, and in the midst of it all, my palliative patient passed away. I was asked 'Can you please get her down to the morgue because emerge is calling and they need this bed.' I absolutely lost my cool with my charge nurse and said to her, 'I can't believe you're expecting me to do this right now.' I still had to deal with all the ECGs and the blood work and what might be going on with this coding patient. I had the confused lady who's now up and having to go to CT and then I had family yelling at me because I'm not taking care of their family member properly. And I get that, but I'm the one who has to take the brunt of it. I'm the one who's getting yelled at. Then I'm the one who has to spend the next six hours of my shift constantly thinking about how I was a bad person because I couldn't provide the appropriate care. I kept thinking, 'What am I even doing? I'm not good enough. I can't provide care for these people. I don't even think I can take care of myself anymore because I'm literally left here prioritizing. Is it my life? Is it my license? Am I actually going to be conscious of someone's last breath or will I be sued because I had to leave a patient unattended in the washroom? What was more important? The safety or the shower? The last breath or the code? What am I expected to do? Where am I going wrong?' Because I know I'm wrong. Tell me why. And then what is going to be the resolution?' Well, there wasn't a resolution because, well, that's what work is. This is what it is to be a nurse."



Why this research was needed



Ontario's healthcare system is under significant strain due to chronic underfunding, understaffing, and rising patient acuity, resulting in high nurse burnout (Govasli & Solvoll, 2020; Suran, 2023; Duong & Vogel, 2023; Brophy et al., 2024). There are multiple causes for nurse burnout, including heavy workloads, hectic pace of work and long hours, moral distress, physical injuries, workplace violence, demoralization, and now a sense they are being unfairly evaluated based on computer-monitored task completion which, in essence, is a form of electronic surveillance. The crisis is a result of political and economic decisions that have been made by successive governments over recent decades.

The erosion of Ontario's public healthcare system can be understood as a causal chain beginning with the introduction of *neoliberalism* under which health care is treated as a market commodity. It emphasizes *austerity*, in other words, decreased government expenditures, which has resulted in reduced staffing, erosion of wages, and cuts to public funding for services. Government *bureaucracy* has since funneled billions of dollars into private for-profit agencies. The practice of *managerialism* has been introduced to carry out what are essentially the principles of "lean" manufacturing. Digital auditing of work activities and expenditures has proliferated. As a result of reduced funding, exhausted, overworked nurses are suffering *burnout*, moral distress, and surveillance anxiety. Patients are suffering from extensive *wait times* caused by bed gridlock within the overloaded, under-resourced system and they arguably receive less than ideal care. This *manufactured collapse* of the public system, regardless of the rationale behind it, then becomes a justification for private clinics, services, and even hospitals. (See *Figure 1: Causal chain*)





FIGURE 1: CAUSAL CHAIN



Nurses also suffer the inherent challenges of gender and racial hierarchies. In a 2024 report by the College of Nurses of Ontario, 90.8 percent of nurses identified as women and 32.3 percent as First Nations, Inuk/Inuit, Métis, or racialized.

In an atmosphere where nurses feel their voices and concerns are not being heard or addressed, it follows that many are leaving their profession (Statistics Canada, 2023; Ménard et al., 2022).

While Canadian jurisdictions such as British Columbia, Nova Scotia and, more recently, Manitoba have implemented minimum nurse staffing levels, Ontario does not mandate levels across hospital units. Professional associations, unions, and nurses themselves have repeatedly raised concerns regarding inadequate and unsafe staffing and its effects on moral distress, workforce retention, and patient safety (Brophy & Keith, 2025).

There is a sizeable and persuasive body of research literature describing the need for mNPRs and, where applied, their efficacy has been well established (McTavish & Blain, 2024).

Researchers who have been studying the issue of nurse staffing levels, along with unions, the public, and government representatives have made it clear that mNPRs are needed to begin to deal with the widespread hospital nurse staffing crisis in Ontario.

Evidence continues to grow that better hospital nurse staffing is associated with improved patient outcomes, including fewer hospital-acquired infections, shorter length of stay (LOS), fewer readmissions, higher patient satisfaction, and lower nurse burnout (Lasater et al., 2021; McHugh et al., 2021; Schlak et al., 2021). In California, for example, where mNPRs have been in place for a significant length of time, “Having fewer patients per nurse was associated with significantly lower patient mortality and nurse emotional exhaustion and job dissatisfaction, as well as better nurse-reported quality of care” (McHugh et al., 2020).

METHODS

Despite extensive quantitative data on the benefits of safe staffing ratios, less attention has been paid to the lived experience and observations of nurses working in understaffed environments. This research sought to address that gap. It was sponsored by the Ontario Council of Hospital Unions/ Canadian Union of Public Employees (OCHU/CUPE) and employed qualitative methods. The study protocol received clearance from the University of Windsor Research Ethics Board.

The research used *Storytelling* -- essentially individuals describing their experiences -- as its approach, which has been shown to reveal otherwise hidden realities (Ganz, 2011). It enables nurses themselves to provide insights that cannot be understood through statistics or patients’ experiences. Nurses’ own stories paint a vivid picture of what it is like to be working understaffed and why we so urgently need legislated mNPRs in Ontario. They highlight the gap between policy and reality. While empirical evidence shows statistically the benefits of staffing ratios, personal stories reveal just how current conditions are harming nurses and patients right now. They connect the facts to human experience. Nurses are often seen as endlessly resilient, but their stories help us recognize them as humans with limits -- not infinite resources -- thereby establishing the urgent need for safe staffing.

The research also included a review of relevant literature, studies, survey results, and media reports.

The nurse interviewees

Fourteen nurses from various regions of Ontario with a wide range of work histories spoke on the condition of confidentiality. Participant recruitment and scheduling were undertaken

by staff in the OCHU/CUPE provincial office. Thirteen women and one man provided their insights. They range in age from late-twenties to mid-sixties. Three identified as racialized. The hospitals where they work range from urban to rural and are of various sizes. Some of the nurses have worked in a diversity of departments. They are currently working in the following: emergency department, medicine-stroke, palliative, mental health, postpartum, musculoskeletal rehabilitation, medical-surgical, and day surgery; and also includes a float nurse and resource nurse, who are regularly assigned to a variety of units. The respondents are registered practical nurses (RPNs), one is also a registered nurse (RN), and two others have been enrolled in the program to bridge to RN.

Interviews were done remotely via secure video conferencing software from a location convenient to the participant. Each took, on average, approximately one hour. They were recorded and transcribed.

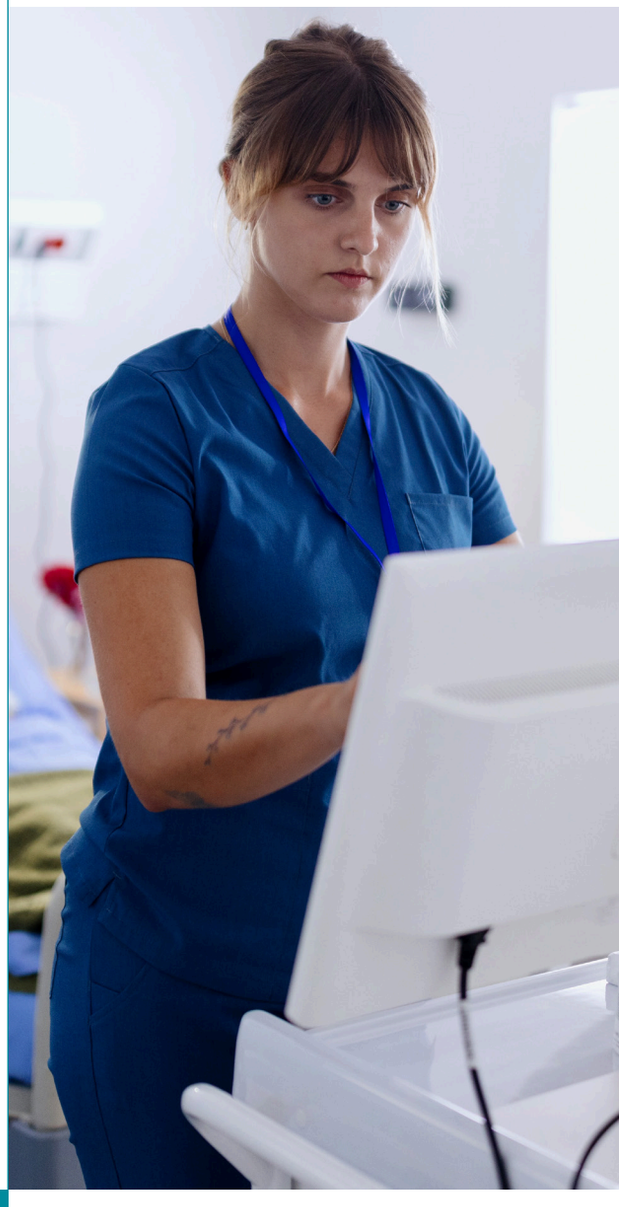
ANALYSIS

Thematic analysis (Braun & Clarke, 2006) was used to explore the responses provided by the nurses to the semi-structured interview questions. Interview data were coded and patterns were identified, providing insight into individual experiences and the contextual environment.

The excerpts included in this report have been marginally edited for clarity, brevity, or anonymization, but no changes have been made to the underlying message or content. Due to concerns about possible reprisal, pseudonyms are used for each of the interviewees.

Interview excerpts, i.e. the nurses' voices, are amply included to better meet the aims of the research, which are to reflect the present-day realities of working in Ontario's hospitals. However, what is impossible to capture in words is the sound of the nurses' voices as they were expressing sadness, frustration, anger, and even grief about their own working conditions, as well as the compromised care their patients often receive.

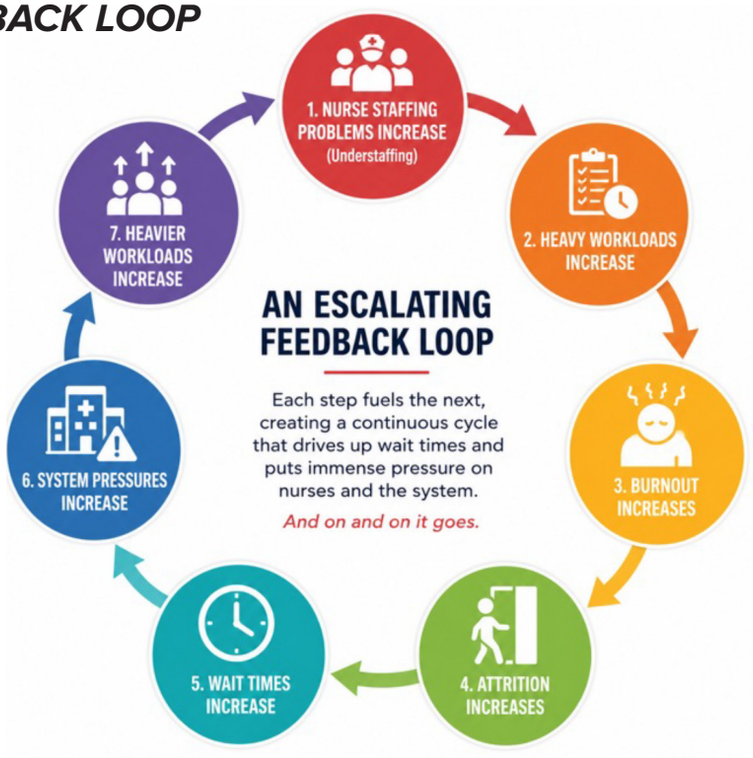




FINDINGS

The results of the literature review and the interviews indicate that the problems in Ontario's healthcare system can be viewed as an escalating feedback loop. As nurse staffing problems increase, wait times increase. These problems are deeply interconnected. Understaffing leads to heavy workloads, which then lead to nurse burnout, which then leads to attrition, which then leads to longer wait times, which then lead to high system pressures and missed care, which then lead again to heavier workloads, which then lead to burnout and attrition – and on and on it goes. (See *Figure 2: Feedback loop*)

FIGURE 2: FEEDBACK LOOP



This cycle creates systemic instability. As wait times grow, public dissatisfaction increases, and healthcare professionals experience rising stress and declining morale. Over time, nurse recruitment becomes more challenging and retention worsens.

THE DEVOLUTION OF ONTARIO'S PUBLIC HEALTHCARE SYSTEM

Health care in Ontario has changed dramatically over time. Forty years ago, if you were to walk into a hospital unit, you would likely witness nurses relating to patients and providing relatively unhurried care with comfort and compassion. Today, as you look around, you would probably notice a very different kind of environment -- one dominated by harried, exhausted nurses, call bells ringing, people shouting, and patients languishing in emergency department waiting room chairs or hallway beds. The need for increased staffing -- mNPRs -- is clearly evident.

A 2026 survey by the Registered Practical Nurses Association of Ontario (WeRPN) found:

> *Workload, staffing shortages, and the resulting impact on care remain among the most urgent concerns. Most nurses reported that their workload increased over the past year, with many continuing to take on extra shifts, overtime, and additional hours to compensate for staffing gaps. Nearly all respondents said patient care had either worsened or failed to improve over the past year, while most also reported that staffing shortages are directly affecting care delivery. These findings reinforce that workforce challenges are not isolated staffing issues; they are system pressures with direct implications for the quality, safety, and consistency of care Ontarians receive.*
>
> *These findings were reflected in the interviews conducted for this report.*

Lena has worked in palliative care for a decade and a half -- caring for patients in the final days and weeks of their life. She chose nursing because she believed she could help people through one of life's most difficult moments. *"I've always felt that people deserve dignity at the end of life," she said. "It's an honour to help them through that journey."* She went on the say that, unfortunately, being able to help in the manner she feels compelled to do is no longer always possible.

"When I first became a nurse, I was very, very proud of all the care that I could give. I could take the time to do a patient's hair and sit with them when they were afraid. And that was important because sometimes medications can't just be all that helps the patient. Their emotional well-being matters too. I would feel good going home having provided that care. And I used to have maybe four patients. We weren't ever short-staffed and work felt good. And then it seems like in the years just before COVID -- and then during COVID -- there were no standards. And we had to start accepting all kinds of patients and then principles didn't matter anymore. Didn't matter if men and women shared the same room... now we share their spaces in a ward room -- as long as we fill the bed. And I don't have time to sit and help people and calm their fears."



Claudette has worked as a float nurse for over a decade. Her work takes her across hospital units -- emergency departments and surgical, mental health, cardiac and palliative units. Her journey into nursing was motivated by her desire to help others and make a positive impact on people's lives. When she began her career, she said, *"Nursing was one of the fields that connected being people-oriented along with my interest in anatomy and physiology -- and I wanted a way of helping others."* She began to experience an increase in patient load about ten or so years ago. She observed that staffing levels were becoming increasingly strained. Prior to this period, she said workload was more manageable, with a maximum of four patients per nurse. However, Claudette saw that the numbers began to change in favor of adding more patients to a nurse's workload. *"But you still need to make sure you assess everything and the numbers are a huge driver because, just mathematically, the more patients you have, the more work you're going to have to do."* She also recalled that when she first started, she wasn't required to perform blood transfusions, but now such tasks have become a part of her daily routine. She said, *"All these different skill sets started getting added. And then, maybe they wouldn't cover a sick call and now because, that nurse isn't there, I might have seven patients."*

Kim is a resource nurse in her early forties, with a wide range of nursing experience. She said, *"I always felt the need to care. I feel nursing is a high calling and I'm very proud to be a nurse. It's such a privilege and a joy to look after people in their darkest hours and their moments of joy."* But she is dismayed by the changes she has seen since she began her career.

"It's gotten really bad. I find a difference over the last ten years -- I would say it's been really, really going downhill... Early in my career, I was working on a complex continuing care unit. We had a man who was dying and he had young children and a young wife. It's hard to say those final words, something that the family can cherish and carry with them. Over the course of a few days, I worked with him and helped him prepare. But conditions now have changed dramatically. I feel like care and compassion have left the bedside, which pains me to say. And if those things happen -- giving that extra care and compassion -- it is on my own time; it is on my mealtime; it is on my break time. I have stayed after hours with patients because they were alone and they got terrible news that they had three days left to live and nobody was with



them, so I stayed after my shift because I felt in my heart it was the right thing to do."

Katherine already knew as a young girl what she wanted to do for a living. *"I wanted to be a nurse and look after people,"* she said. Caring for others had always been part of her life. As a teenager, she helped care for family members with chronic health problems. Nursing felt like a natural path. She said it was an easy transition --one rooted in compassion, patience, and the belief that health care is about human connection. Now a palliative care nurse, she explained, "People require dignity at the end of their life, it's a special time, so it's an honour for me to help them." It breaks her heart not to be able to give her patients more of herself. With decades of experience, she has seen dramatic changes in the way care is given. Katherine said, *"The government is choked for money. Our managers are all about the budget, nothing about the patients. Our hospitals are crumbling."* That may well be the case. Unfortunately, in order to keep the books balanced, hospital boards, executives, and managers are finding more and more ways to reduce expenditures.



MANAGERIALISM

Managerialism is the dominant ideology behind present-day healthcare funding and the organization of its delivery in Ontario. It represents a fundamental shift in how hospitals operate and has brought business-style management practices into our publicly funded healthcare system. It is characterized by administrative managerial layers and an emphasis on throughput and productivity. Simply put, it is more about numbers, cost, and productivity than compassionate patient-centred care (Zelnick & Abramovitz, 2020). The focus is on saving costs and prioritization of key performance indicators and rigid targets. Managers now control resource allotment, patient flow, scheduling, and budgeting and they themselves are pressured to get fewer staff to work harder to meet targets. This practice isn't just a reflection of changing population demands or economic pressures, it is the result of decades of austerity that views health care as a system that needs to be managed more efficiently, rather than an essential social programme and a basic human right.

A collection of the presentations given in 1999 about Canada's healthcare system, one of which was delivered by John Ralston Saul, was published as a book entitled *Do We Care? Renewing Canada's Commitment to Health*. A book review included some noteworthy arguments made by Saul (Glouberman, 2001).

> *... the abstract control-oriented approach typical of a management-dominated corporatist system leads to the simple denial of such obvious problems as the shortage of nurses and the destructive delisting of certain services. Saul argues that the concern of medicare has shifted from truly caring for patients to a concern for the bottom line. At the same time, there is a continuing denial that the primacy of this concern for efficiency and more bang for the buck has harmed medicare.*

Saul (1999) expressed concern that no public debate or publicly agreed upon policy determines the direction or priority issues for our system.

> *Management only works effectively as a function or servant of policy. How did management come to be given so much importance? We have never had so many managers. Hospitals and other institutions are more and more dominated by a*

managerial approach… This is not an attack on managers, but an attack on the role we have given to management.

Katherine described what the prioritizing of efficient patient flow looks like. She said, *"Along with the acuity of the patients, there is the rush to get people out of their beds and out the door to fill them again."*

Guytano Virdo (2025) has explored the issue of how managerialism is impacting the way hospitals are being run. He explains:

In the context of neoliberalism and managerialism, care workers must contend with care being treated increasingly as a commodity whereby workers are objects of control rather than important members of a health care team, and quality is viewed in the context of market competition instead of what providers and receivers of health care require.

He argues that, in practical terms, managerialism has changed the priorities of hospital-based care and is altering the management structures. "Decision-making authority is moving away from frontline medical staff and towards administrators and executives who rely on data-driven oversight. This can create tensions between clinical judgment and managerial priorities, leading to feelings of frustration among healthcare workers."

In Ontario, hospitals are regulated by the government, but they are subject to the same cost-cutting measures and managerial reforms as private, for-profit hospitals, which are dominated by numbers -- metrics -- that measure everything from patient throughput to staff productivity.

Andy made the decision to become a nurse after he was given the opportunity to work as a patient watcher. That experience changed everything. *"Just being at the bedside and having that rapport with patients,"* he said, *"that's what made me realize I needed to become a nurse."* He went back to school and eventually began working as a full-time nurse in a medicine and stroke unit. Now in his thirties, he has spent nearly a decade caring for patients who often arrive at the hospital at the most vulnerable moment of their life and who need more hands-on care than he can readily give. He is outspoken about the need for better staffing for the sake of his patients and for the nurses. He said he is frustrated because he sees the hospital investing a significant amount of money into infrastructure without contributing to direct patient care while simultaneously laying off frontline staff and expanding the control of the managerial staff. *"They laid off a bunch of our staff and now we're getting all these new investments coming into the hospital and you don't see it put into the bedside patient care or into staffing our ORs. And then I'm seeing my CEO getting a six-figure salary increase and my strategic executive getting a big increase. And I'm just confused; we're getting more managers than I've ever seen before."* He said that hospitals can't just dismiss the dedicated staff who have been working tirelessly to provide quality care. It feels to him like a serious disconnect between the leadership and the actual work happening on the ground.

Lena described how managerialism plays out in her hospital setting. She said that for much of her early career, she felt proud of the care she provided. Unlike the present day, nurses had time, not only to give medications and perform treatments, but also to sit with patients who were afraid,

comfort families, and provide the emotional care that dying patients needed. She describes the current, top-heavy system as *"broken."*

"The frontline staff we work with are great. All the interdisciplinary team members are angels, but it's a system that is broken. It's the mandates above our manager that are always focusing on the money and filling the beds. They are saying these hospital-mandated systems are designed to help the patients' experience. But they actually take away time from bedside patient care. We're already stretched and then the hospital wants us to do all these extra things, all these 'care initiatives' and 'care rounding' and 'continuous quality improvement'. But that takes a lot of our time. And I just feel, and other nurses feel, like it's just being done to cover hospital's liabilities and to further put more responsibility on the nurses. And it doesn't feel like we're supported. We're working short-staffed and they're not seeing that. We're working with less, doing more now. And it's burning us out."

Sumaia is a postpartum nurse in her mid-thirties. She said she has always wanted to work with new mothers and their babies. *"I remember watching the documentary A Baby Story when it came out. Being a nurse is always what I wanted to do. From the time I was a kid all through high school, I knew I wanted to be a nurse."* Now, in light of serious understaffing, she is losing her love for the profession. And she is exasperated by the unwillingness of her management to address the nurses' declining morale, instead it is making even further, unfair demands. She said, instead of hiring additional nursing staff, the hospital brought in a new manager who sent them email reminders for required online education updates. But finding the time to complete the work is very difficult. *"We don't get paid for doing it at home. And I'm not doing it at work either; when I come to work, my time is valuable and we're always short-staffed. So, you're paying a manager's salary to tell me that my education is due when really, you could hire two nurses for her salary. I just can't believe it."* Sumaia also talked about all the unpaid overtime she is expected to put in as a postpartum nurse.

"I start at 7 p.m. but we're expected to be there at 6:45 p.m. -- unpaid. So, we're expected to be there 15 minutes early and 15 minutes after our



shift, 30 minutes, unpaid to do reports, which has always bothered me because, working full-time, that's two hours out of a full-timer's week. And if you try to put in for overtime, they'll just deny it, which just seems so wrong to me."

Lack of, not only staff but also resources, impacts nurses' ability to provide care. Lena described how it affects them.

"If we lose a patient during a shift, they'll try to fill that bed as soon as possible...And a lot of times our equipment doesn't work for us, so we show up to work, and we don't have the tools to do our job properly... our computers are broken down; they're not functioning properly, so then we have to share a computer. That's added stress; it just takes more time to start our day. These are everyday occurrences -- things not working properly, linen shortages... Nurses improvise all the time... We work short. We work under stress. A lot of times we work with no clerks, so we're left answering phones; we're left wearing many hats, and that's leading to burnout. Oftentimes they admit on the weekends when there is no extra interdisciplinary team. There are no social workers. There is no chaplain. There is no dietitian... nurses are left to make a lot of decisions, have a lot of responsibilities with less staff to help them, but no one sees that. It's a lot of strain."

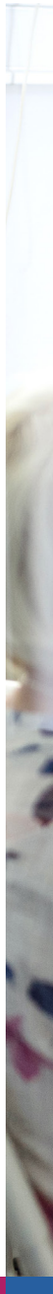
Several nurses said that when asked why the hospital isn't putting more money into staffing or even equipment, managers will consistently say they just don't have the funding for it.

Erin, now in her fifties, has been a nurse for over thirty years. She says nursing has been a good fit for her. *"I couldn't see myself doing anything else. I'm not a sit-at-the-desk kind of girl... I've worked in complex care, dialysis, on oncology, and now I am on a medical floor... I've learned over the years working with different people, looking at the people in my care, if that was me, or my family member, how would I want to be treated? That's been my philosophy through my whole career."* She said there are not enough hours in a shift to complete their required work, but additional staffing, which would make their workload more manageable, is not provided.

"They don't want to pay overtime. It's too expensive. But they don't have the nurses, so they have to pay overtime. But they'll have us work one short before they'll upstaff you. Even if our support staff or personal support workers were full-time, but they don't want to give them full-time because then that increases the benefits they have to pay and if they take sick time that'll cost. But they don't cut from the top. They have managers on top of managers. They don't get rid of them. They just redirect and give them a different title."

Erin explained how there used to be communication about patients and bed availability and so on that was conducted by the health professionals who knew the patients' needs, what department they should be in and resources they would need. Now its managed by clinical operations.

"Now they have clinical ops. They don't know what they're doing. They cost a lot of money. And they're telling you to admit patients to the hallways or to our overflow areas. And the nurses are looking at the patient and saying we can't take that patient; they are not acceptable for this area. And they push and they push and they push and they browbeat you and tell you to take this patient. Then when the patient gets there, you find out they're cognitively not appropriate or their microbiology is not right, they've done tests on them, but they shouldn't be in the confined



areas or communal areas. I've had great managers and I've had awful managers but most of the managers have to answer to somebody above them who has to answer to somebody else. We are told we can't buy this equipment because there's no money; there's a hiring freeze. But how can you freeze hiring when there's so many vacancies?"

Zahra is a postpartum nurse in her forties who began her career in a retirement home. She said, *"I felt so proud. I took care of the residents and they were really appreciative because they felt someone was helping them, someone was there all the time to support them."* She is dismayed that, despite their need for more nursing staff, management instead has added supervisory personnel.

"Our budget was cut. And right away they cut the nurses, but not anyone on the management level. Now we have three nurses on the floor, but we have a clinical lead, an educator, and we have a charge nurse -- all people who are not handling patient care. They are there to supervise us, to guide us to do our work."



As Virdo (2025) points out, nursing is primarily viewed as a large "budget cost" and one that is a prime target for cuts.

Erin said she finds the fast task driven pace at which she has to work today is not only tiring, but emotionally paralyzing.

"You're just numb… They run a hospital like it's a business… And it's not for the benefit of their workers. They don't care if you have a work-family balance. They don't care if your schedule is what you want. It has to be what works for them… I think the writing has been on the wall for a while. It's about money… They want to give us less all the time. Fewer nurses."



Restructuring

The origins of Ontario's restructuring of health care can be traced back to 1995 when Premier Mike Harris and his government launched what they called *The Common Sense Revolution* (Keith & Brophy, 2022).

They employed neoliberal austerity policies, which were guided by the interests of the profit-driven private sector and which would substantially reduce public spending. They opened up avenues for corporate involvement in the healthcare system by launching public-private partnerships (P3s) to build and manage health facilities.

In keeping with their adoption of efficiency-driven *Total Quality Management* (TQM) principles, the Harris Conservatives dramatically reduced healthcare services by eliminating over 11,400 hospital beds, closing or amalgamating dozens of hospitals, and reducing hospital and long-term care staff by nearly 25,000. As a consequence, the twin problems of underfunding and understaffing deepened, which, in turn, eroded care. Subsequent governments, including the Liberal governments of Dalton McGuinty and Kathleen Wynne, continued to employ neoliberal policies by implementing budgetary constraints and further privatizing services previously covered under the Ontario Health Insurance Plan (OHIP). Hospital spending in Ontario started to fall below that of other provinces and frontline staff were seriously reduced, leading to the decline of Ontario's healthcare system and to a chaotic and unsustainable situation.

The decline is being further exacerbated under Premier Doug Ford and his Conservative government. In Canada, "Despite growth in the number of nurses and the nurse-to-¬population ratio, rising job vacancies, overtime hours, and cost suggest persistent supply-¬demand imbalances" (Wu et al., 2025). And further, Ontario, along with several other



provinces, fared more poorly than the rest of the country as the nurse-to-population ratio for each has actually decreased. And it may decrease further.

Although the provincial government has announced "a $1.1 billion funding boost this year, the Ontario Hospital Association has said the need was more than double that. More than 70 per cent of hospitals are forecasting deficits and some are using their reserves to fund operating expenses." Furthermore, there are many job cuts planned in order for hospitals to decrease their deficits. Erin Ariss, president of the Ontario Nurses Association (ONA), said she expects nurses will be hard hit by cuts. "When (hospitals) are looking for further efficiencies, they will look to nurses to eliminate a liability, that's what they feel it is" (Jones, 2026).

According to the Financial Accountability Office (FAO) of Ontario (2025), the province has a lower average number of hospital beds than other provinces with 230 per 100,000 population compared to the national average of 249 per 100,000 and had the lowest per capita hospital spending in all of Canada.

> *Based on the 2025 budget health sector spending plan, the FAO projects that there would be sufficient funding for 143,726 provincially funded nurses in 2027-28, a decrease of 7,263 provincially funded nurses from 2024-25 levels. On a per-capita basis, this represents a decline from 936 provincially funded nurses per 100,000 Ontarians in 2024-25 to 883 provincially funded nurses per 100,000 Ontarians in 2027-28.*

It is not about to get better anytime soon. According to Andrew Longhurst, senior researcher for the Canadian Centre for Policy Alternatives (CCPA) (2026):

> *There's little relief in sight for Ontario's public health care system. Ontario's 2026-27 budget delivers austerity for the province's under-resourced health care system. Ontario funds hospitals at the lowest per person rate in the country, at $1,805 per person, below the national average of $1,949 per person (based on 2022 data), and the province had the second lowest per person funding rate for the entire health care sector, at $5,268 per person, below the national average of $5,562 per person. This translates into a provincial health care system that is under such strain that it can no longer meet the needs of the population. Overcrowded hospitals and hallway medicine are the norm.*

Doug Allan (2026), senior researcher at CUPE, said Ontario "needs 48,000 more full-time staff [which includes nurses] just to meet the staffing levels of the other provinces. We need additional funding to offset healthcare inflation (which is considerable), population aging, population growth, increased utilization, people getting sick at a younger age, and people living longer with chronic conditions."

This erosion of resources has affected quality care and increased wait times for specialist consultations, surgeries, and emergency department care. There is also an increase in the dreaded hallway medicine. Data from January 2024 show 1,860 patients per day waiting or being treated in beds in hallways or other unconventional spaces – up from 826 per day in June 2018 when the current administration came into office (Chamandy, 2024). Unfortunately, the provincial government has made the decision to stop tracking and reporting hallway medicine incidents, ending fundamental public transparency. Dr. Raghu Venugopal, an emergency physician in Toronto, is quoted as saying, "The only reason you wouldn't share data is shame...

[but] it's not one person that did this, it's decades that did this, multiple administrations… it's like an abscess, just say it's there and open it and deal with it." He said that the experience for patients is "brutal" and an "affront to human dignity, a patient safety issue, and just terrible medicine." He added "that patients are having their undergarments changed or sensitive exams done in hospital hallways because of a lack of available beds" (Duggal, 2026).

Lena said she feels the direction health care has been going is seriously misdirected.

"It's sad. I love nursing and I love my job and I love helping people. That's why I am passionate about this, because it's so unfair. And something needs to be done. We're understaffed. We're not valued. We're underpaid. We're doing more with less. We have no PSWs [personal support workers] and we're more and more instructed to participate in hospital mandated, corporate-wide initiatives that are made to look like they are designed to help the nurses and the system but, all the while, are further taking away time from our bedside care."

Performance metrics

Hospital care in Ontario is characterized by work streaming, task fragmentation, time pressures, and demands for cost-driven efficiencies. One of the key demands of managerialism is gathering data to document productivity and cost-rationalization. Nurses are being required to take on detailed computer-based record-keeping. Patient charting systems are being used for performance metrics, time management, and benchmarking tools. As frontline caregivers, nurses now must navigate a complex system that is increasingly focused on efficiency and productivity, rather than patient-centered care (Virdo, 2025). In addition to taking care of patients -- often at a breakneck pace -- they must also provide the documentation their employers use to show they are managing effectively.

Mary is in her fifties. She has been a nurse for over thirty years. In the last two decades, she has worked in an emergency department. *"I've seen lots of changes, that's for sure."* While she still derives satisfaction from the grateful patients she cares for, she says the pace at which she and her co-workers have to work is debilitating. *"I'm exhausted now."* She described how performance metrics impact care.

"The change that I've really noticed over the years is when they started talking about this paid for performance. They get more from the government when our numbers are better, when we get them in, get them seen, get them out. That's when things really started changing. Now they push us so hard."

Lisa described the additional work but also the stress created by the demands of computer-based charting.

"When we started our new charting system online, our whole care plan had everything you have to do in the day, all your tasks…you're always meeting the clock on the computer… So, you're spending more time worrying about your clocks than what you're actually doing… I have to do this, this, this for this clock. Patient care is not like that. You never know what you're going to have to do when you walk into a room."

Nurses are having to record and justify every task they accomplish but say that it does not come close to accounting for many of the patient interactions they have or additional time they must spend because a task does not go according to plan.

They also feel they are being judged according to what they enter.

Andy explained that nurses are forced to do extensive charting to protect themselves – even if it is at the expense of patient care.

"The workloads are heavy. The majority of the time on nights I'm one to eight, and on days, I would say one to five. And we've got a lot of unsafe work going on there that's not really addressed... and the blame is going to be put on you... I always tell my colleagues, you have to look after yourselves and your license and these are your patients. At the end of the day, no matter what happens, we have to remember that. Charting is so important in our career even if we can't get to all of our work. There's paperwork that we need to do to protect ourselves."

Sumaia explained how charting seriously under-represents the actual workload in the postpartum unit.

"When we chart things, our system captures times. So then, based on the recorded time spent, that's how they decide how much staff we need. But even though I chart vital signs, for example, it doesn't mean I was only in a room for ten minutes putting a blood pressure cuff on someone. I'm relating to a patient, having a conversation. I could have a mom with a learning disability. I could have a mom with a language barrier. This is why I say the humanity has been taken out, because they see what the computer system says. It's saying, 'Oh, you only did eight hours of work in your twelve-hour shift.' But, for breastfeeding for example, we're in there for a half hour to 45 minutes helping these moms. We're encouraging them, teaching them. We also multitask a lot, so as we're teaching breastfeeding, we're also teaching lots of other things about becoming a parent. And we get reprimanded. They go through our charting all the time. They're asking things like, 'Oh, why didn't you do this on this shift?' But just because I didn't chart my half hour long conversation doesn't mean it didn't happen. There's so much more to nursing than just the tasks that these computer programs measure for management."

Canadian researchers, Pat and Hugh Armstrong, warned of the implications of such management techniques a decade and a half ago. In a 2010 article, they wrote about how hospital managers sought to increase control over nursing work and speed it up by using Taylorist techniques, which are essentially those used to organize work on industrial assembly lines. Management analyzed individual tasks, timed and recorded them, and reorganized the work to fit a predetermined model.

> *It quickly became obvious, however, that the purpose was to speed up the work and reduce staff. Even when the figures showed that more staff were needed, nurses found the numbers were simply recalculated to show that what initially took 120 per cent of their time now took only 80 per cent. These task measurement techniques were combined with computerised patient classification and patient information systems. These systems, like the work measurement ones, were sold as ways of improving patient care... [but] were in effect indirect forms of control over nursing work.*

Sumaia also expressed frustration with the way documentation is used to track and control activities of nurses and its inability to capture the complexities of actual care. She said this approach overlooks the nuances of patient interactions and relationships. Sumaia pointed out that many aspects of nursing care are not captured by the system. *"We're not just doing tasks,"* she said. *"We're relating to patients, having conversations, and making a significant impact on their lives."* She is saddened to see that relational patient care is often overlooked in favour of metrics that prioritize task completion over patient relationships and experiences. "The humanity has been taken out because they only see what the computer system says." She recalled an incident that occurred about ten years ago, in which having the time for care and compassion resulted in a mother being able to leave a violence domestic situation.

"I had walked into her room and I just noticed she was a little bit sniffly and I asked, 'Are you okay?' and she just had a breakdown and told me everything. Could you imagine if I hadn't asked? She would have gone home and who knows what would have happened to her and her baby. Luckily it wasn't a busy shift, but if it was, I probably wouldn't even have asked because, in the back of my head, I'd be thinking about the twenty other things that I had to do. We ended up getting social work involved and she left with a family member. Police were involved too. She continues to go see the same obstetrician who I also still work with and she's remarried and has had other children and is living a very healthy life."

Sumaia went on to say that since nursing has seemingly become *"more about numbers and logistics,"* she cannot provide the care she was trained to give. And she finds it upsetting.

"You are supposed to have vital signs done and charted in fifteen minutes and that's it. If I go into a mom's room at 4 a.m. and she's crying because she has all these issues with her baby, I don't have time for that now. And that's the part that I'm struggling with. I became a nurse to help people and I don't have the time to help people anymore... I can't do that when I'm taking care of five dyads [mother-baby pairs]."

Privatization

Ontario has been progressively privatizing services, such as medical labs, laundry, dietary services, diagnostic imaging, and so on. And more private facilities are springing up, signaling concerns about two-tier drift. The Ontario Health Coalition (OHC) (2022) explains the implications of increasing privatization, which they claim threatens the "foundational principles of our public health care system." The OHC has identified five facts about two-tier medicine: private clinics increase wait times for the 99 per cent; private clinics provide an inferior quality of care; private hospitals are less efficient; public-private-partnerships cost more, deliver less; and patients are subject to pay more through taxes and out-of-pocket. The OHC said, "It is a system for the rich. It widens the gap between the 1% and 99%. People who can afford to, pay to jump the queue, even when they have less need or no medical need and are buying unnecessary care, pushing back others with greater need."

The current system clearly is not providing the care Ontarians need. But there has been no public debate about whether we still value a universal public system and would be willing to work to make the changes





needed to repair it or whether we are happy to see a two-tier system put in place where the better and more timely care goes to those who can afford it. John Ralston Saul (1999) suggests that the public system has been deliberately underfunded and restructured in such a way that it no longer meets our needs. "Medicare's current difficulties derive in part from people telling us that the system does not work, then taking actions to make sure that it will not work, then telling us again 'See, we told you it didn't work.'" In other words, the public has been led to believe it isn't workable or repairable and that a new system -- such as a two-tier one -- is needed. Out of naivety, blind trust, frustration, or desperation, many might accept or even embrace that arrangement.

Mary said that she sees the system *"pushing, pushing, pushing for privatization... You know you hear what's happened out in Alberta now and I can't understand how people are not opening their eyes... I can see [the provincial government] pushing more and more for the privatization of services."*

Ellen, a musculoskeletal rehabilitation (MSK rehab) nurse who has been nursing for over thirty years, said she started working in finance but redirected when her aunt said she was a very good problem-solver and should seek a career needing more of that skill. *"That's when I chose nursing... I love nursing. I found that helping people gives me a sense of peace and belonging. It's that need to help another human being that gives me satisfaction."* But she is alarmed by the threats to the public system and agrees that privatization is not equitable. *"The rich, who are able to afford a private system, are going to get what they need more than somebody who cannot afford it and who have to go and sit in emerge or in an urgent care clinic and wait for hours until somebody is able to care for them. The wealthy can just pull out their Visa and say, 'I need my care right now.'"*

Several of the nurses who were interviewed implied that the financial crunch in the public system is not just a matter of circumstance, but rather a result of intentional design or policy decisions.



Jane

"And then the same time I have a palliative patient who is now rapidly declining and I have my IV drug user patient who was having chest pain. So, during all of that, I'm wondering, 'Am I going to make the palliative patient comfortable? Am I going to try to save the drug user? Or am I going to get the naked and confused woman off the floor? What am I going to do?'"

"I asked for help but everybody else was very overwhelmed with their own patients. I couldn't get any more help."

Kim said, *"It's wonderful to see babies being born and to do maternal teaching with new parents. That's an exciting time. And I've been with people when the trajectory of their life changes dramatically in an instant and it's devastating."* She said she loves nursing but is increasingly disturbed by what she sees and the creeping privatization that is threatening public health care.

"They are intentionally underfunding to push an agenda of privatization. They are not investing in public health care. And they are using tax dollars for private clinics... who then in turn are charging either someone's insurance or charging the patient additionally... We are coming to a time where the baby boomers are going to create a surge in hospital admissions because our population is aging. These are just the facts. So, there's going to be a larger demand on our public healthcare system with intentional underfunding right at a time of crisis... I have a child with a very complex medical condition. So, we are accustomed to health care and surgeries and being in hospital and being a patient and a mom of a child who had surgery. Privatization is terrifying for me. If I were in the States, my child would be considered a golden ticket or a million-dollar baby. We would probably have lost our home to try to pay co-pays. It's going to be lifelong management for my son. That is definitely a concern because, what if he's not able to work because of his condition or what if he gets a job and doesn't qualify for insurance because he has a pre-existing condition? We need quality public health care. I think health care for everyone is important. And privatization? People can't even afford groceries now. What's going to happen? We have elderly people who are stretching out their medication because they can't afford the marginal co-pays that they're facing now, coupled with the cost of living and rent and all these other things. The decision makers are not thinking of others, really. The people who are disadvantaged, people who are on ODSP [Ontario Disability Support Program]. People are struggling for basic necessities. Privatization is just for the elite and for the wealthy, and it really leaves everyone else disadvantaged."

Andy said it breaks his heart to see privatization seeping in and is apprehensive about its negative impact on public health care. *"At the end of the day, I know we all need our public system. We all need access to it. We're barely affording life as it is."* He said he firmly believes privatization is behind the decision to underfund public care.

"Privatization is a huge factor because we are taking money directly out of our public system and putting it into investors' pockets and into private clinics that are giving us the window dressing for people who think they're going to get their surgeries right away -- which they will if they can pay out of pocket... If you come to the ER and you need surgery done, you should not have to pay for it and you shouldn't have to wait six months. The funding needs to be put back into our public system and privatization needs to be stopped. It's going to separate everyone in our society. You're going to let high income people get decent health care -- they're the government's priority now -- and your low-income people can go to the public system, which is already overwhelmed and underfunded."

CCPA researcher, Andrew Longhurst (2026), echoes the view of the nurses who suspect that the underfunding of public health care is a strategy designed to introduce more privatization with less resistance. He says "there is a deepening public health care funding crisis in Ontario. The new provincial budget encourages greater privatization --both out-of-pocket payments

for health care services and outsourcing to investor-owned corporations." While stating that accurate information about private healthcare spending is not publicly available, he outlines the expenditures that we do know about. "While the public hospital sector is being downsized through reduced provincial funding, Ontario is expanding outsourcing contracts with for-profit surgical facilities. In December, the Ontario government announced four new private orthopedic surgery facilities as part of a $125 million scheme to increase for-profit involvement."

Jane, a medical-surgical nurse, said her interest in nursing began at a young age, sparked by her grandfather's illness. He had cancer and was cared for by a nurse who would visit him regularly at home when she was a child. This experience left an impression. She felt a sense of purpose and fulfillment as she began her career. She said, *"My own moral compass led me to want to help people because I could understand how vulnerable they were and that they need good nurses. I just threw myself wholeheartedly headfirst into nursing. I found my spark."* Now she finds the care she can provide to be wanting and the effects on her well-being a challenge. She believes the privatization of many services has added to her strain and she passionately wishes that the funding for health care be returned to the public system.

"They're downsizing hospitals. They're downsizing long-term care homes. Building all these private facilities, these private hospitals, these private long-term care facilities that people cannot afford. People can barely get over the poverty level at this point and they're working a full-time job. I can barely make ends meet myself. And it's hard because I value my job; it's a very rewarding job. At the end of the day, I go home knowing that I provided the best care that I could for somebody. But I also look at the fact that I have a young family. I still don't own a home. I still owe money on my vehicle. I have debt up to my ears. But I love my job and that's what I take away from it. But that can't be for everybody. You know, people who are coming into nursing or those coming in as a healthcare provider may not have things accessible to them like affordable housing, affordable living costs. Some healthcare workers are making just above minimum wage. I don't know how they do it and it's so disheartening because I hear some of my co-workers who have to go to the food bank now. They're standing in line next to the patients that they're providing care for at the food bank because neither one of them can make ends meet. And you turn around and you look at the government and ask, you took how much money out of the public sector to make a private facility... and then you see your public hospitals struggling, bursting at the seams, patients lying on stretchers in the hallways -- in order to have less of a deficit? That's what the problem is. It's just not the proper allotment of money. They talk about giving all this money to the public hospitals. Okay, come lie in this hallway. You come here and you tell me how this is okay... I think that if we were to stop building these private facilities and putting it back into the public sector, the public hospitals, the public system, then we would have the appropriate funding and resources to ensure that nurses can practice safely. It's bringing the money back to where it should already be."

Lena is also upset about what she perceives to be the government's misdirected priorities.

"I think the provincial government needs to take a look at the bigger picture. So many of the baby boomers and the seniors are now landing in our healthcare system. They have worked all their lives and deserve dignified care. They don't deserve to be put at the wayside because of government priorities. I think that we all deserve public health care in Ontario and privatization is the end if we go that route. We need to fight for our public system. We need more beds. We don't need beds taken away. We need to support our nurses, not beat them down. I think it's the government's agenda to try to force nurses out to private clinics -- it's just going to further affect our broken system. We need help. We need more funding -- we don't need funding taken away. This is a crisis."

Claudette, too, is very concerned about the impact privatization will have on Ontarians who cannot afford out-of-pocket healthcare expenses.

"Healthcare access is a huge thing. Privatizing is going to impact those who do not financially have the ability to go and pay for that care. It will take staff away from the public system. And then you'll have even a further reduced nursing staff available to care for patients in our hospitals. And wait times will be longer, especially for people who go to emergency."

Erin understands why, regrettably, some nurses feel they have to leave the public system. *"Nurses will want to go to private nursing jobs because they'll get paid more or they'll maybe have a better work-life balance. And then it affects us all financially. We're going to lose out because our nurses are going to go to private clinics and it's going to cost us."*

Andy also sees nurses leaving the public system and places the blame squarely on the provincial government.

"It's coming from the premier's office... I don't know how many studies have been put out there and how many times they have been told we need more money in Ontario just to be stabilized -- everyone is in a deficit right now. How do you run a public system and public hospitals on a deficit?... I honestly don't see our healthcare system in a good light right now. So many nurses want to leave their career or want to go to the private sector. Everything's so expensive, so they are going to go to the job that's making the most money. I've thought of that myself to keep my family financially stable. But I can't forget about the public system and where I come from and my community at the end of the day, because I have loved ones out here that need to use the public system – most of us do. I'm afraid we're going to lose our public hospitals and we're going to lose our public system here. And it's very scary. I hate to say it, but that's where we're going right now."



Understaffing and workload

Despite the undeniable evidence that more nurses are needed, hospitals continue to struggle with staffing shortages -- in some cases even laying off nurses -- leaving those remaining to manage exhausting workloads and increasingly complex cases without adequate support. As the burden on nurses grows, so too does the risk of burnout, turnover, and decreased job satisfaction.

The most recent survey by the Registered Practical Nurses Association of Ontario (WeRPN, 2026) found that "Seventy-two per cent of nurses surveyed say their workload has increased this year. On an average shift, just over half (51 per cent) of nurses surveyed say that they are working more time than they are scheduled."

Erin, a medical-surgical nurse, described a day in her life as a nurse in an understaffed medical-surgical unit.

"I work 12-hour shifts. I'll come on, get my assignment. I work on a busy medical floor, so I will have different patients varying in acuity throughout the day. And, of course, that changes with admissions and discharges. I'll start with introducing myself, getting vitals, doing my assessments, and trying to adjust my day. Sometimes it takes me up to three hours to do my medication pass, which is, according to the College of Nurses of Ontario, not in the best practice. But sometimes you can't help that. Your situation changes daily, hourly, by the minute. I have to deal with that. I may have a co-worker that's struggling. Who's going to support them? It has to be me. I'm the senior nurse on the floor. We have a lot of new staff. I can be a contact, moral support, confidant, go-to for my grouping... I don't have all the answers, but I truly do my best for sure. Allied health needs help. Transferring, moving, questions about my patient. We're getting phone calls starting at 8 o'clock in the morning from families. 'What's going on? How is the patient? What can you tell me?' I might have just introduced myself to five people I've never met before. I'm just learning about them. So, 'Can you call me back in an hour?' So, you're expected to take a break time between 9:00, 9:30, 10:00 o'clock, and lunchtime. I might get a break by one o'clock, sit down, eat something, but there's often something going on that is more pressing... I feel overwhelmed but carry on and hopefully I can leave on time. But sometimes my work's not done. I have my charting to finish. I have to sign off. So, often enough, my shift runs a good 15 to 30 minutes past. We had terrible weather last week and people couldn't easily travel... But we had to get to work. There was no way we could not. There were cars blocking the intersections. It was wild. But in my unit, night shifts stayed on almost four to five hours. We had nurses on units that worked over 22 hours. We had an isolated unit that was working with only four nurses in the whole unit. We had two dietary people show up, one cleaner."

Andy said he is feeling distress over his and his co-workers' limitations when trying to influence needed changes. He said it seems he is not being taken seriously when expressing his ideas for improving staffing in order to better serve patients.

"It can be overwhelming for me as a nurse to witness this and not know how to best support patients... Recently, I've been sharing my concerns with my manager, who has acknowledged the importance of discussing our feelings as part of their programs. As someone who expresses my emotions daily, I'm heartened to know that my concerns are being heard. However, when they ask me what we can do, I respond by



saying, 'You're running short on nursing staff. In reality, we need more hands-on deck and float pools to provide better care.' Our employer doesn't want to look at any type of other staffing models than they have right now. We had PSWs during the pandemic, which we never had before. That helped my workload. I was able to breathe during that time and I was able to get to my patients and do what I had to do. Even if we were short-staffed, I still felt the support there and I could get to patients. Now my employer is starting to lay off PSWs. Unfortunately, they aren't part of the current program and I suspect that's due to other priorities at play. I feel the workload coming back and I feel the burnout again. I firmly believe that patient-centered care should be our top priority. It's a systemic issue that extends beyond our workplace."



Kim explained that the demographics and acuity of today's patients have added to nurses' workload and that tasks are much more demanding than they once were.

"We have people that are living longer with more complex diseases needing more complex treatment. Once upon a time, if they were being treated, they might be in the ICU department where there might be one to one or two to one. But now we're doing more complex treatment on inpatient units with full assignments... I work through my breaks often because I don't want to sacrifice the quality of care that I am trained to give. When I went to school, I learned about proper standards of care and that they are really important. And that's something that I pride myself on and that I want to be able to deliver to my patients. And if I go and take my half-hour break, they might be delayed with a treatment or they might need pain medication, they might need this antibiotic or whatever. And I don't want to put my patient at risk. Many of us work through our breaks. We'll sometimes work an entire shift with no breaks because you're so short-staffed and you don't want to leave your co-workers even shorter because you care about them. So, sadly, this is the reality sometimes. And you're thirsty. Sometimes

it's like, oh my gosh, I'm going to choke on my own throat, I'm so thirsty."

With hospitals facing unprecedented capacity demands, staffing shortages have become a pressing concern. **Zahra** said that now, working, understaffed, with new mothers and their babies, the workload is so heavy she doesn't feel it's safe for herself, her co-workers, or her patients. *"To be honest, it's becoming unsustainable. And there's no support staff available to help, such as answering a call bell. And 90 per cent of the time, our staffing levels are stretched to the limit... And there's no way we can get even an occupational therapist on board."* She said she frequently has to juggle multiple tasks at once, leaving her with little time to take care of even her basic needs. She often finds herself with limited opportunities to use the bathroom during her shift and she said, *"Sometimes you don't even have time to drink because the water station is so far away."*

Sumaia experiences similar demands in her role as a postpartum nurse.

"A lot of these moms are first time moms who have never breastfed a baby and it's difficult to get started. I remember one night in particular; I had five dyads – five moms plus their babies. One of my moms had twins who she was trying to feed. It takes about 30 minutes to breastfeed a baby. She has two. And when you're a first-time mom, you can't necessarily do both at the same time. So that's an hour I'm spending in the room. A baby is expected to breastfeed every three hours. There's not enough time in a day when I have four other moms and babies to care for at the same time... Nurses, in general, I think are such caring people, which is why I think we just deal with it. At the start of the shift, we get reports; I'll get the report from my patient load, and then I go around and do everyone's vitals, check in on everyone, kind of explain to them what I'll be doing throughout the night because it is also important for parents to sleep. I tell them to call me with feedings. Every day looks a little bit different, depending on when deliveries happen, because you never know what that can be. Giving out medications, a lot of health teaching for postpartum, a lot of helping babies feed. Babies wake up at about 11 p.m. and like to stay awake until about 5 a.m. They feed mostly at nighttime. I'm helping a lot with moms who are exhausted because they've had visitors all day. We could have a mom, you get her up to the washroom the first time and she faints. That happens quite often. Not all the time, but it does happen. We have moms who have postpartum haemorrhages who we might need to hang blood for. It involves quite a lot of people depending on how serious it can be. You could have a baby that turns blue all of a sudden and now you're in a critical situation. Again, you are calling a lot of people for assistance. There are many scenarios that could happen through a shift... We very often have patients say, 'I called you 10 minutes ago' or 'I called you half an hour ago.' I explain to them, 'Unfortunately, I'm caring for four other moms or three other moms.'"

Laura is relatively new to nursing and is working in an emergency department. She said she didn't start out in nursing; this is her second career. She explained, *"My father-in-law got sick and I helped care for him. A lot of the family members told me that I missed my calling and told me that I should have been a nurse. So, I applied for nursing school and didn't tell anybody until I was accepted."* Laura says she started just before the pandemic and has seen dramatic changes. *"Everything was beautiful before COVID and then health care exploded."* She described the challenges facing healthcare workers and

the public. She talked about how frenzied her work often is, but also how she does her best to be a compassionate nurse to the troubled patients in her care as well as their family members.

"My work in emerge is chaotic for the most part. It is ever-changing. You never know what is going to walk in the door. Your assignment changes from hour to hour. Sometimes I have nine patients I'll see in a day and sometimes I'll have twenty-two... If I'm caring for a child, it's also very hard for the parents, so I care for them too even though they don't have the wristband on. It's important for me to look at the whole picture. And when you get a good thank you and a hug from a parent who's been distressed, and they say I helped them, that makes me feel good inside. When you have patients with dementia who are climbing out of bed or not really participating in their care, not because they don't want to but because they're scared, you kind of put yourself in their shoes. You try to figure out how to speak to them a bit differently in order to get them to let you go ahead with certain procedures."

Erin talked about how she experienced nursing, even a few years ago, prior to the pandemic. She said, *"When I was working on medicine, we had four patients. If there was a sick call, we had five patients. But now you're having two or three sick calls and people aren't coming in because they know what the floor is like."* Erin also pointed out that it's not only the nurses that need to be better staffed. *"We have less support. Even our support staff, our environmental services, and our porters, are overwhelmed because they're working two jobs. They combine them. How do you combine two jobs? You can't."*

Ellen described what happens when one of her patients falls and requires immediate attention and she must perform multiple tasks in response, including assessing the fall, conducting risk assessment, checking for potential skin tears, and verifying medication. Despite having four other patients to care for, she is required to prioritize these unexpected tasks. But when she can't complete her duties within her scheduled working hours, she is told that any overtime worked without approval will not be paid. This creates a situation where she has to stay on to complete the necessary tasks. *"Management expect you to accomplish two hours work in ten minutes, but you can't -- you're a human being. The only way you can accomplish it is by using your own personal time."* She said such demands and extended work hours happen almost daily and explained that the workload has intensified to the point that many nurses are experiencing exhaustion. That, in turn, has manifested itself in increased absenteeism, where employees call in sick due to exhaustion. In response, the hospital implemented an attendance management system, which resulted in employees receiving letters of warning. *"So now the person has a double whammy, where management is monitoring you because you are so tired you have to call in sick. There's a limit your body can handle and if you go into work, you are no good to your co-workers and you are actually no good to the patients."* She went on to explain that the hospital is deciding to focus on managing the staff they have instead of increasing the size of the staff. *"But the staff are suffering and people are going to find ways to survive. Humans did not evolve by not figuring out how to survive. You cannot tolerate the exhaustion and stress. So, you're going to look for a way to fix it. And if you look for a way to fix it, then the hospital will look for ways to punish you for finding a way to survive."*



Claudette

"There are a lot more sick calls now. There's a lot more stress. There's a lot more tension among us. We are in survival mode at this point. Before, there used to be a level of collegiality because you had the time to support someone else, but with the workload, it's so hard now."

Claudette concurs that the stress the heavy workload generates has increased exhaustion-related absences. It has also affected nurses' ability to support one another.

"There are a lot more sick calls now. There's a lot more stress. There's a lot more tension among us. We are in survival mode at this point. Before, there used to be a level of collegiality because you had the time to support someone else, but with the workload, it's so hard now. Sometimes you're having to go out of your way to help a co-worker, but it puts you in a situation where you're under more pressure and you can't get your work done either. Sometimes they may need some type of assistance and you can't get to them. So, it just creates this tension between everyone... Sometimes a family may want to talk with me. And it makes sense, right? There are things they need to make decisions about, but I can't even spend the time to talk with them because I have too many patients and I have to prioritize what tasks to do in that moment. If there were more staff and the assignments were allocated properly, I could attend to those other things that I should be doing. In medical units, I see it more because there's such a high level of acuity."

Mary, an emergency department nurse, provided a chilling and detailed description of a typical shift for her.

"When I pull into the parking lot at 6:45 in the morning and it's full, I know it's going to be a bad day... Nine times out of ten, if I'm assigned to rapid access, I'll walk into the department, and the beds are already full. That means that probably three or four people that are there holding a bed are waiting for ultrasounds or CT scans, waiting for results, have IV fluids going because maybe they just need to be rehydrated through the night — because the other areas which is your trauma area, your



admitted patients and then your acute is full and literally the halls are full. You have nowhere to put them so I have to be the bad guy at seven o'clock in the morning and say, 'Okay, Mr. Smith, you're now getting out of your bed where you lay for the night because you're waiting for an ultrasound and they don't start till 8 or 8:30 in the morning and I need you to move over to that room and sit in a chair and it doesn't matter that you might be uncomfortable; you've got to go over there so that I can start bringing other people from the waiting room.' And I have to do that to every room... and you've got all these new people coming through. You're assessing them; you're doing all the blood work; a gentleman comes in with urinary retention and I know I'm going to do everything I can to get back to him because he is in dire straits and then I have to do a bladder scan on him. Okay, then he's shown that he's retaining 600 ml of urine in his bladder and I've got to go tell the doctor. Okay, I'm throwing a catheter in this guy and I've got to send urine to the lab. I've got to do blood work — and that's just one patient. I've got two or three little sick kids coughing, you know, snot running everywhere. I'm told, 'Well make sure you isolate them.' 'Where would you like me to isolate these people? Behind that blue curtain does not stop everything and I can't isolate everybody.' So that to me is a complete joke because we're not set up for that kind of thing. And it just progresses on and on and on. Oh wait, now we've got someone that's come in with chest pain. So, when they're triaging them, if they have time, they try to do blood work and an ECG, but if they don't, then I'm bringing them back to my area too and we're working them up. So that's at least 15 to 20 minutes for every workup because you have to enter the orders, you have to complete the orders, you have to do an ECG, you usually start in a line on them just to make sure that you're set and ready if something goes down the tube. Oh, wait, now we need them on the heart monitor because their ECG showed something funny so then we have to go get a portable telemetry monitor. Wait, we've got to go back to the main desk, hook that up, put all their information in so that the team leader can watch that monitor because I'm across behind a wall, so if this little box is sitting on their chest, I don't see what's going on with them. So then, the doctors are coming through — and the doctors are supposed to be there — dedicated, quote unquote, dedicated to that area to get people in and out. So, they come in and they start seeing everything, and then we are hit with all of the orders. Okay, do this, do this, send them here, bring them back, oh wait, they've got to come back to that room because I want to see them in that room. Okay, well now you've just screwed up my whole flow there because I needed that room. That next patient sitting in the chair is waiting. And that literally happens for probably sixteen hours a day. Sometimes, through the night, it will be slow in that area, but typically it goes right till 11 o'clock, midnight, and I know when I've come in at 7 o'clock in the morning to start my shift people are waiting six, seven, eight hours to be seen and they are frustrated and they're angry and then that's what starts your day... then you've got all the ambulances coming in and they're like, 'Just wait a minute, we have an offload'. You need to find a spot for this offload and it's like 'you're kidding me' and I say 'okay'. So, then we've got to move someone else to get that offloaded patient and forbid they need a stretcher because typically you get your offloads from a nursing home. A lot of these are frail elderly people. You can't expect them to sit up in a wheelchair or on a hard back chair. They come in with hip pain or knee pain from a fall or a laceration of their head from a fall out of bed. Well, they're taking up a bed for two to three hours minimum, and

then we'll take that bed out of the room and we'll put it right in the middle of our little area where we work so we can keep an eye on them, but then we put a clean bed into the next room so that we can get more people seen… Then, if you're over in the acute area, you have four to five patients because we always have a hallway stretcher in the acute area. So, we are assigned five rooms, and I would work with typically two RNs. All the monitors are over there for the telemetry to watch the hearts and everything. You have full emerge patients; they come in through the door, get them in, you get reports from EMS, and you start working on them. You basically try and have them completely worked up before the doctor gets there. So, you'll do blood work, ECGs, catheters if they need it. You'll start an IV. Lots of times if they're septic, you'll start that whole protocol, and you have to follow up with a medical directive. We all have training on doing a medical directive, so if it's a septic patient, we do all their blood work, ECGs, start an IV fluid because typically they'll be feverish or whatever. We just kind of get with it and figure out what needs to be done before the doctor gets there."

Karla, a mental health nurse in her late twenties, took an indirect path to her career. She felt uncertain after pursuing another course of study. She applied to nursing school after being inspired by her friend's plans to become a doctor. She said, *"I actually enjoy working with families of patients, which can be difficult, but I find there can be a lot of reward in being supportive. I am very honest with the patient and their family about what's going on, what recovery is going to potentially look like — the good, the bad. And I think I do that fairly well."* Her strengths are being tested under the difficult working conditions she faces. She attributes, in part, the workload in her understaffed mental health unit to the aging population, but also to the high prevalence of substance use disorders among patients, who often present with multiple diagnoses. She explained that there is a high level of complexity and comorbidity among such patients. *"You've got withdrawal risks that you're trying to treat, kidney issues, liver issues, pancreatitis; often mental health comes into that too."* She noted that these patients can be challenging to manage due to their unpredictable behaviour, emotional instability, and sometimes hostile demeanor. She said that her empathetic nature makes it difficult for her to navigate these complex situations. *"When you're caring for people who might be withdrawing or on substances and have mental health issues, they're also not always the most pleasant patients to work with. And they take up so much time — it can be tiring."* She explained that understaffing is a key reason for the nurses exhausting workload. *"It's a lot easier when you can team up and do what they used to call team nursing. I don't even know what team nursing is. I've never really seen it because it doesn't seem to exist anymore. You're on your own and you try to find help in the moment, but it would be better if it wasn't every person for themselves… It's frustrating when you're all running around dealing with the same thing and you can't help each other — there's really no team support or support from your managers these days. They're absent in the majority of the units in my hospital."*

Claudette, a float nurse, recalled a frightening experience working without an adequate number of staff on a surgical unit.

"I had a patient who was post-op coming back with a patient-controlled analgesic pump that requires a lot of monitoring. I had somebody who had a trach tube that required suctioning quite often. I had another person who was being prepped to go to surgery. And then I had someone that had a chest tube to be tended to. Those were high acuity responsibilities. And we were short on that unit. And then I'm being asked to cover the other nurse that's going on break. So now I'm at eight now with my already overwhelming assignment. And it was horrible. I felt a huge level of anxiety. I remember just feeling overwhelmed because I was afraid about the safety of the patients given their acuity, especially the one that may have needed suctioning. You don't want someone to not be able to breathe and you can't get to them right away. I found myself working harder and running a lot more. One person cannot do all these things. I was fearful that a patient was going to be hurt because I just can't get this all done — I'm in this position of being forced to do something I physically can't do. And I was also afraid that if something happens it's going to be my license and my career... They're acute situations



and everyone has different care needs. And some of them are a fall risk. Then you add that they may have dementia or something that requires additional levels of monitoring where you need more than one person on this assignment — because you can't possibly be in another room when someone who's on a fall risk status is able to get out of bed. You may have five or six patients and you're expected to be watching them every 15 minutes, but now you're in a room, having to troubleshoot an IV or something.

The staffing just doesn't align with what we're being asked to do. And I am always leaving an hour late because a priority task couldn't get done. I have to make sure these immediate needs are done. And I have to stay after my shift to document. I never leave on time, or sometimes I'm coming back because we have a grace period to document, but then we get pushback for working overtime."


HEALTH CENTER

Wait times

Wait times are not just an inconvenience. They can be very detrimental to patients' health. They can delay diagnoses and treatment, increasing the risk of more serious morbidity or even death. Researchers Hajizadeh & Jalili (2025) investigated the impact of wait times in Canadian health care and reported that, "Prolonged delays lead to adverse physical and mental health outcomes, higher treatment costs, and economic burdens for patients and families."

Depending on the location, Ontario patients visiting an emergency department, for example, typically have very long waits. The first assessment takes, on average, three hours. And even worse, according to the Ontario Health website (2026), patients in Ontario who were being admitted spent, on average, 17.1 hours in the emergency department waiting for a bed; only 30 per cent of patients met the provincial target time of 8 hours. It is often much worse, depending on the location. The Financial Accountability Office of Ontario (2023) places at least a portion of the blame on insufficient nurse staffing levels: "Ontario hospitals have identified a lack of available staff, including nurses and physicians, as the key issue causing longer emergency department wait times and closures."

An increased number of patients now leave the emergency department without even being seen by a doctor (LWBS). A study carried out in Ontario (McNaughton et al, 2024) reported:

> *Our findings are an important signal of possible deterioration in overall quality of care within a large universal healthcare system, with the potential for severe consequences for patients. Recent LWBS ED visits in 2022-2023 were associated with higher risk of 7-day and 30-day all-cause death or hospitalization compared to a pre-pandemic baseline period.*

The lead author, Dr. Candace McNaughton, an emergency medicine physician in Toronto, said, "There are many reasons why people choose to leave the emergency department, but it's usually about wait times… There's an assumption made that if people leave the ED before being seen, they're well enough to go and they will probably be fine. But our findings paint a different picture" (ICES, 2024). The researchers call for urgent intervention, including increasing personnel, such as physicians and nurses.

According to Renaud Brossard, MEI, almost 300,000 Ontarians left the ER room without treatment in 2025. He said that "Thousands of Ontarians are being denied access to care each year" and emphasized that "patients forced to delay or forgo care often end up suffering from worsening conditions, which lead to more complex cases" (*Hospital News*, 2025).

ER closures have also contributed substantially to patient wait times. There is an urban/rural divide in the likelihood of closure. "Smaller rural hospitals have been hit hardest by ER service disruptions. In 2024, Ontario saw a record number of ER closures – a CBC analysis found one in every five hospitals with an ER or urgent care had to temporarily shut down at least once that year, the vast majority of them in rural communities (County First, n.d.). The article indicated that the absence of even a single physician or nurse could lead to closure.

This is yet another argument for legislating mNPRs.

Laura said wait times can be gruelling for patients.

"People are upset with the wait times in emerge. We hear about that quite often that they're waiting too long but a

lot of the problem is that we become bed locked within the hospital. The medicine floors are full, their storage rooms, their hallways, they've converted break rooms into patient rooms that don't have adequate oxygen and air quality. That's where it's becoming scary... Our emerge wait time does depend on why you're there. It depends on what section you get put in. But our average wait time is anywhere between five hours and sometimes up to six, seven hours. I've seen it up to twelve."

Mary said that when the emergency department is busy, they work at a steady pace to keep patients in the flow, but it is often a losing battle. She has sympathy not only for her colleagues, but also for the patients who often experience uncomfortable waits.

"We are doing everything. We are doing full blood work, we're doing catheters, we're doing ECGs. And then if they're going to be very long, the hospital wants us to move them over to the acute area in the hall. So, they want us to see everybody, get everybody worked up, and then move them. It's crazy. Mondays are always a write-off. Sundays at church time is always a write-off. You can almost predict what days are going to be awful. And it is exhausting... You just do your best to keep going and if beds become available, you'll transfer some patients. Even in the acute area, when there are beds available and you get them in, they get admitted; the hospitalist does their work-up. They send pages of orders for us to cover everything. Then we have new patients coming in and we do this whole process all over again. It's like Groundhog Day for twelve hours or more. When the flow is good and the hospital has beds, it's manageable, but when the flow is bad and we have no beds — it's absolute hell. They're saying give me a report on this patient and we'll send them up to the hallway. It's degrading for patients to spend six, eight, ten hours lying on a stretcher in a hallway with people walking by with everyone gawking at them. Even mental health patients yelling, cursing, screaming beside other patients is horrible. I feel terrible for those hallway patients; I've been there before and know how it feels. We try to get little foldable curtains or dividers to separate the hallway from the rest of the hospital, but still, it's very degrading for patients to be treated like that."
She described the current layout of the emergency department as chaotic, with limited space and a high volume of patients. The hospital had implemented new protocols, such as moving patients from the waiting area to one of several designated rooms upon registration. These rooms were often overcrowded, with patients competing for limited space. Working space is a practical issue for the nurses.
"They have jammed another bed in there and honest to God you cannot even get an ECG machine up to the top of the bed. It literally holds one stretcher and one little wee chair for people to sit on... you're tripping over the wheels, you're tripping over the chairs, you're just fighting for space everywhere... You put them in a room, you do their blood work, they're assessed by the doctor, you pull them back out... it's just this ongoing circle and some days you have absolutely nowhere to move, like literally nowhere to move."

Erin tells us that wait times are almost aways bad where she works and *"can be worse depending on the weather."* She remembers taking her own sick child to the ER. He ended up on her lap for twelve hours.
"My legs were numb. And the things he saw! It was so full and some of the people were under the influence. You're scared to even use the bathrooms because you don't know what people are doing in there. It's like a war zone."

Assembly line care

According to Annette Bourgault (2023), a nurse researcher who has extensively studied modern-day nursing practices:

> *In today's work environment, it is increasingly difficult for nurses to find the time to perform non-task-related nursing care. Health care organizations that cut nurse staffing to minimal levels for monetary gain threaten to extinguish the caring part of nursing care by leaving nurses only enough time to complete the required tasks during a typical shift. To preserve the essential aspect of nursing care that focuses on relationship building and communication, nursing time and nursing care need to be valued.*

As **Lena** said, nurses are now required to *"do more with less."* The resulting conditions can lead not only to burnout, but to decreased job satisfaction and reduced morale among nursing staff, who feel overwhelmed, exhausted, and defeated.

As conditions deteriorate, **Karla** is questioning whether she will be able to stay in the profession she trained for just a few years ago. She has heard from her more senior nurse colleagues about how much more relational care they were able to give patients before the restructuring took hold.

"There just used to be a lot more quality engagement with the patients; they would get to know their patients, especially ones that were in the hospital for longer periods of time. They used to know the families; they used to know all the quirks."

Andy said the patients he cares for in his unit are usually older and he said they are often very discouraged, besides being unwell. He believes that *"health care is not just about giving drugs."* Spending time with vulnerable patients is important for their care and comfort.

"Many of my patients are at the end of their life and it's more about conversation and holistic care at the bedside. They are not just a part on the production line and we're just oiling it up and moving it along to the next thing. These are people and that's one thing that really upsets me. Sometimes our ratio is one nurse to six or one to eight and I don't know how we can properly care for these people — and do it safely — and look after ourselves at the same time."

Andy finds the new efficiency-oriented manner of operating hospitals to be dehumanizing. He also said it leads to more readmissions.

"When patients are readmitted, it's often because we're pushing them out of the hospital quickly so that we can accommodate other patients who are waiting in the ER. This creates a flow problem, where we have to move patients through the system as efficiently as possible. We use flow coordinators to manage this process, but they often struggle with how quickly we can discharge patients and start them on antibiotic treatment. The question is, are we prioritizing the right care for our patients? Are we just moving them along the production line so quickly that we're not providing the level of care they need? By doing so, are we setting ourselves up for more readmissions in the future? And what's the real cost of this approach? We're wasting public dollars on unnecessary treatments and procedures. This is a model of care where patients become just another cog in a production line."

Besides **Andy**, several nurses talked about the managerial strategy of moving patients through the system as if they were on an assembly line. This concept really captures the dehumanizing of efficiency-driven health care.

Kim said:

"It's just very in-out, here are your pills, peace out. I've got to fill out all these forms for funding. Patient care is just not prioritized and it should be... We are too stretched to have thoughtful communication and interaction with our patients to connect on a personal level. And because we are doing personal care, you need that connection with the patient. But it is very much assembly line care... My co-workers are upset. They said they did not go through nursing to provide this type of care. It's not the care that they are proud to deliver. We just keep filling out workloads to document the problems that we're having so we're doing all the right steps. We've had meetings with HR and management, and we've provided documentation of all the concerns; we have laid them out and said what we think would correct the issue. This is an ongoing problem, trying to achieve proper staffing ratios."

Lena said it is emotionally trying for nurses to have to move so swiftly from one patient to the next on the palliative care unit, especially when there is a death.

"When I have a death, which happens almost daily — we have over 500 deaths a year on our unit — we don't have time to debrief. We have to tuck that away, put on another hat

Kim

"It's just very in-out, here are your pills, peace out. I've got to fill out all these forms for funding. Patient care is just not prioritized and it should be... We are too stretched to have thoughtful communication and interaction with our patients to connect on a personal level."

"But it is very much assembly line care... My co-workers are upset. They said they did not go through nursing to provide this type of care. It's not the care that they are proud to deliver."



and get another admission, go see our next patient, because often we're short-staffed and we just don't have the time to deal with our feelings. That would be considered not professional and it's looked down upon. You have to be strong, so you just have to carry on and push forward."

Laura said that in the emergency department, the demands on her are so heavy, she is often unable to provide the compassion she believes patients need.

"My nurse's training was highly focused on helping people in their time of need and to comfort them and hold their hand and give them back rubs and foot rubs. Now, there have been many times where I want to be able to sit down with a patient and just comfort them but unfortunately meds have to be given, orders need to be processed, and I have so many things to do. So, I have to just kind of pat them on the back now and give them what little bit of myself that I can give them in that moment."

Mary, also an emergency department nurse, said "*It's not a car assembly line but it's still an assembly line… they come in, they get seen, and by God I hope we can get them back out the door because that will save us some money."* She said that having adequate nurse staffing would help with both *"workload and patient care… it would be so much more manageable."*

Sumaia said she is experiencing similar challenges. She said her work in the postpartum unit with mothers and babies is *"almost like it's an assembly line now. We're expected to just task, task, task. I feel like I can't connect with patients the same as I used to."*

Ontario hospitals are using the just-in-time "Lean Production" system, which was originally designed to cut costs in manufacturing plants like Toyota. It has resulted in an ongoing problem related to the organization of work. "Since early 2020, Ontario's hospitals have lurched from crisis to crisis. Emergency departments have been overwhelmed, nurse-patient-ratios have risen to a shocking 1:8, nurses and physicians have burned out, and whole wards have had to close" (Thompson, 2023).

Research published in the *International Journal for Quality in Health Care* studied the effects of the Lean approach on "worker and patient satisfaction, health and process outcomes, and financial costs." The researchers concluded: "While some may strongly believe that Lean interventions lead to



quality improvements in health care, the evidence to date simply does not support this claim" (Moraros et al., 2016).

Katherine, a more senior palliative care nurse, feels it is important for her to be supportive to the newer nurses who are having a difficult time adjusting to the work environment as it has become. She said a young nurse on her unit was working intensely for about two hours with a critically ill patient when the patient passed away. It left her colleague emotionally drained. *"She hadn't had a break yet at all but sat down to chart for that patient. Just then one of the case managers came around the corner and said to her, 'Can you get her finished up; we need that room cleaned by within the hour.' She started to cry and I went and gave her a hug. This is what it's always like. It's terrible."*

NURSES' WELL-BEING

Researchers Coderre-Ball et al. (2022) conducted research in collaboration with the Mental Health Commission of Canada. They concluded:

> *Every day it seems the Canadian health-care staffing crisis worsens…At the core are health-care workers who are physically and mentally burnt out from the unsafe work environments they've been asked to work in for years, which were made remarkably worse during COVID-19…Even before the COVID-19 pandemic, Canadian health-care workers were experiencing burnout and depression.*

The harsh reality is that nurses are being negatively affected on a broad scale by their working conditions. They are being harmed physically and emotionally by exhausting workloads and stress. Many experience violence and trauma, with many suffering verbal and physical abuse, while others bear the emotional toll of witnessing such incidents. They feel they don't get enough respect for their skills and the work they do. And many find their spirit is being crushed.

As **Lena** said, her responsibilities are not always acknowledged and she finds that hard to accept. *"Nurses make a difference every day. I just wish we could be more respected and supported. It's a very sore spot for me."*

Moral distress

For many nurses, their inability to provide the care they believe is needed can cause moral distress. It can affect them when they "know what needs to be done but feel prevented from doing what [they] think is right because of complex healthcare limitations such as understaffing, time constraints or a lack of resources" (Fortier, 2019).

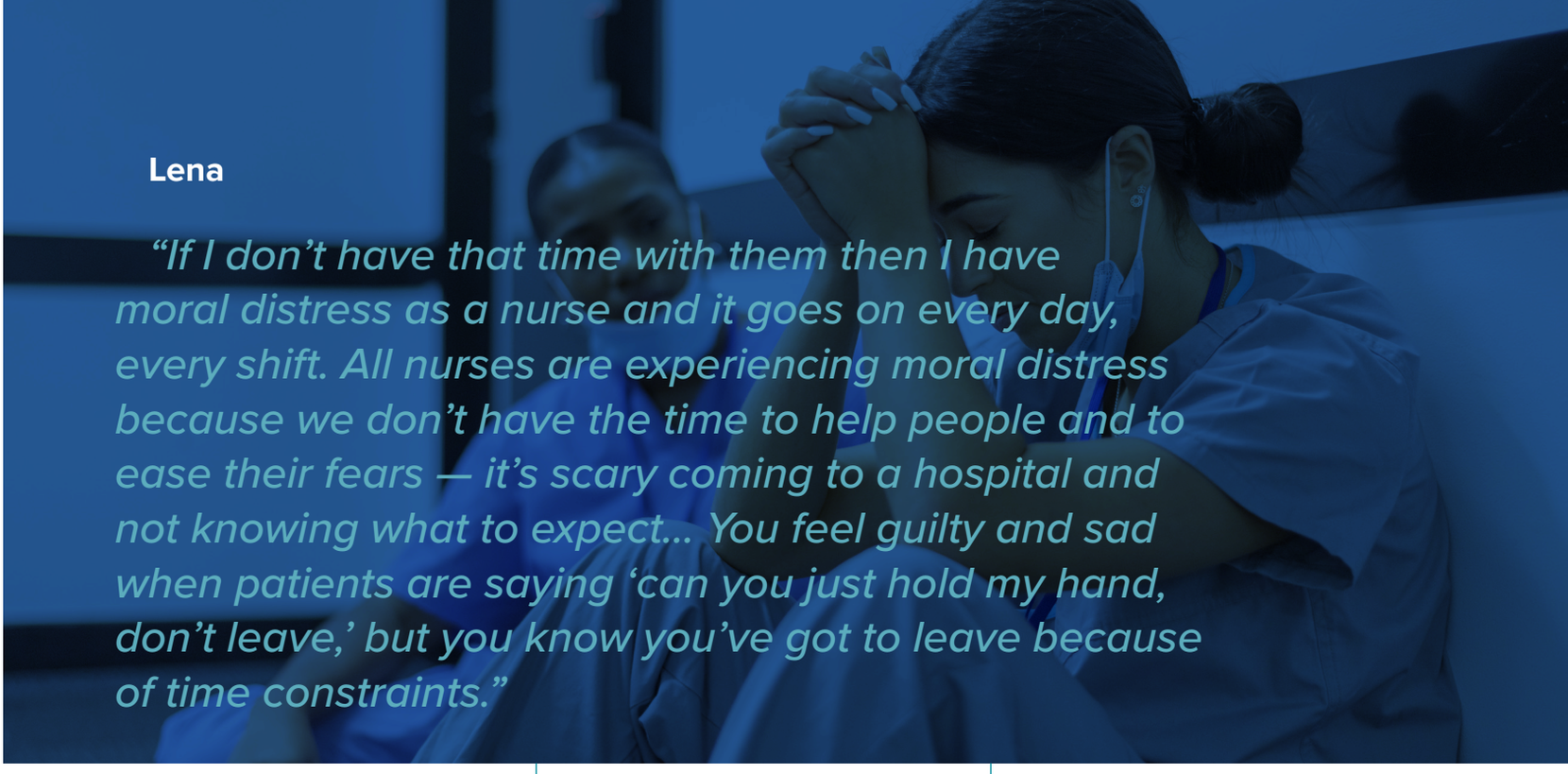
According to the Mental Health Commission of Canada (2022), "40 per cent of health-care workers are burned out" and noted that "higher moral distress relates to higher levels of burnout."

Zahra described the demands placed on her looking after needy newborns.

"When I work in the Neonatal Intensive Care Unit (NICU), I always have a three-baby assignment. A lot of the time you are running off your feet because all the babies basically feed every three hours. You have to think about the timing, you feed, you change, you feed, you change, you feed, you change. But a baby might not like to be fed and they fall asleep. Or sometimes a baby is crying and you feel so guilty because you are holding another baby that you are trying to feed. And then you think, 'I cannot just drop this one to pick up another one.' And they constantly want to cuddle. But you have to just let them cry because you are holding another one. You just feel so bad because you know they need attention, but you can't really give it to them. And, especially for an older baby who is 100 days old or 130 days old. They are there because they were delivered early, so when they hit that 37- or 38-week gestational age, they may already be over 100 days old. They need to gain weight and be stable before they go home. And they don't sleep like newborns, who mostly just eat and sleep. The older ones need more attention, but you don't have the time to give them that care they need -- the constant cuddle attention."

Andy described the concept of moral distress well, as he feels it personally.

"Rapport with patients, that's what drew me into nursing. My whole life, I've always loved helping people… The one core



Lena

"If I don't have that time with them then I have moral distress as a nurse and it goes on every day, every shift. All nurses are experiencing moral distress because we don't have the time to help people and to ease their fears — it's scary coming to a hospital and not knowing what to expect... You feel guilty and sad when patients are saying 'can you just hold my hand, don't leave,' but you know you've got to leave because of time constraints."

value that I will never lose, that I've had through nursing school and into my career, is patient-centered care. I will never forget that... at the end of the day, that's what we are meant to do — even executive staff all the way down to the nursing staff. My job is to make sure that I'm looking after that patient and their individual issues. And if I lose focus of that or I can't fully focus on that, that's where I have ethical issues and I don't know what things to push to the side a lot of the time... beside that patient I've got seven other things I've got to worry about... The one word that always comes to mind when I think about my situation is 'hopelessness'. I've gone through a transition of a time when we were better staffed, were getting support, having proper care done... now we are short-staffed, feeling the retention issues, and that's left me feeling very hopeless for our patients and community. It's difficult. I have many ethical dilemmas."

Claudette shares Andy's sense of hopelessness. She has acquired the broad skills and ability needed to adapt to the various challenges inherent in her job. But now, she feels more like she is simply doing required tasks rather than providing nursing care.

"After a shift, I feel defeated in some ways. And I sometimes feel sad because my work today has changed so much from the way it was when I originally entered nursing. I wanted to be that caring, compassionate provider, but it has started to feel like I am just doing a job. Now it doesn't include all the holistic pieces that we were taught in school. We learned theories on nursing processes and assessment, and the College outlines all these things we're supposed to be doing, accountability and ethics and compassion, but we don't always get to employ those because we have these patient numbers and task-oriented work to do."

Lena feels guilt and sadness about the fact she cannot provide the comfort she, as a caring nurse, is personally compelled to provide.

"Family members of dying patients are having existential crises about their loved ones — and they're human! If I don't have that time with them then I have moral distress as a nurse and it goes on every day, every

shift. All nurses are experiencing moral distress because we don't have the time to help people and to ease their fears — it's scary coming to a hospital and not knowing what to expect... You feel guilty and sad when patients are saying 'can you just hold my hand, don't leave,' but you know you've got to leave because of time constraints. We are acutely aware of the minutes that we have to do it in because we don't have enough time in our shift to accomplish all our tasks and that's distressing because we want to be at the bedside more."

Karla is upset about how the demands of the job are affecting her compassionate side. She often finds it both emotionally and physically intolerable.

"It kind of got to the point when I was working on a medical unit where you care but you also don't — which is so horrible to have to say that out loud. And it lingers a little bit — you try to move on from the guilt of it all. It's the small things; it's always the small things that you know should be done. I was talking to one of my former supervisors last night. We were working the night shift and she said, 'Nowadays patients hopefully get their basic needs met — hopefully.' That's a really sad statement. When you're a patient that can't feed yourself and you need assistance, what time are you actually being fed your breakfast if it arrives at 8:00? I don't know. Could be 8:30, could be 10:00. It's really terrible but that's what I see. Working on medical, I used to lay awake until 3:30 before my first day shift of my schedule block, dreading what was coming for me. And there were days I would cry on my way to work, and I would legitimately hope in ways that I would have a car accident or my tire would fall off my car. I would kind of make a joke out of it, but every day I used to drive in, hoping I'd have a collision in the intersection or something. I used to say it as a joke, and then eventually I realized that it's not funny."

Katherine, a nurse struggling to cope with the demands of her job, expressed her feelings of frustration and disappointment. *"I try not to feel guilty. I do the best I can... But I do feel really disappointed that I'm not able to provide the care that my patients need."* She is not only run off her feet most days but feels sad she isn't able to have more personal connection with patients. She was particularly upset about leaving at the end of a shift without being able to provide comfort to a personal friend — a patient — who was dying. She discovered she knew the newly admitted patient only a few days earlier, when one of the nurses had asked her to help her boost a patient in bed.

"And I went in and looked at the patient — and it was my friend. I didn't know that she was palliative. She was very emotional and wasn't coping well, taking lots of medication for anxiety, in denial and in disbelief that this was it for her. I went and peeked into her room quite often to say hello to her and hold her hand. But one day, I didn't even get in to see her the whole twelve hours I was there. It was a hard day. When I was leaving, I was talking with another nurse in the locker room. We were both saying how much our feet hurt, how exhausted we were. She was saying, 'Oh my gosh, I've got to drive myself home. How am I going to get home? I feel like I'm going to just fall asleep here in the locker room.' We had really had it that day. I heard my friend weeping in the dark room, and I wanted to go in there, but I had nothing left in me. Later I felt really guilty about that, but that's how exhausted I was."

Karla is distressed about the way nursing has changed.

"When all you have ever known is how things are now and you hear about how things used to be, it makes me feel like I could be doing better because I know that the quality of care used to be better. But now with short-staffing and higher acuity of patients, it feels like you failed a little bit. It definitely leaves a feeling of incompetence. It's hard when you find out towards the end of your shift that your incontinent patient has been wet for hours, and you either didn't know or you didn't get the chance to go in. It's especially hard if a patient requires two people to do any kind of care and you can't find someone else to help, so it gets delayed."

Katherine told a story that exemplified the problem nurses are facing everyday as they try to juggle an overwhelming workload with their heartfelt need to be there to offer comfort to their patients.

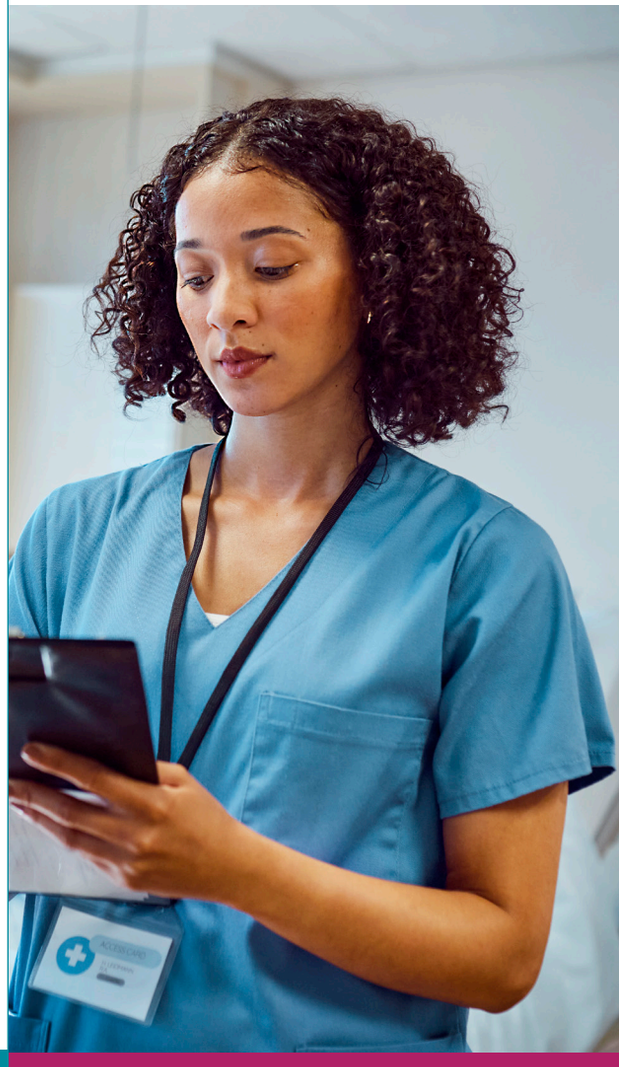
"I work with this really lovely young nurse; everybody loves her. She came out of a patient's room and went to the linen cart and grabbed towels and face cloths and she turned around to me with a smile and she said, 'I'm going in there to wash Mrs. So-and-So. I already washed her, but she's forgotten.' And I said to her, 'Well then say no.' She just looked at me, then turned around and went and washed her anyway. I went home that night and I thought about what a good nurse she is, going above and beyond, and here I am telling her to say no to the patient. She was never going to say no to that patient, and you know, I realized after, I never should have told her that."

Many of the nurses found that their management provided little support for the difficulties they were experiencing. Taking much needed sick days to recover, both mentally and physically, leave them open to discipline.

Karla said they get letters from the hospital suggesting *"they are there to help you but really, they are warning you that you've hit your allowed number of sick days. We destroy our bodies and sometimes our mental health working this job and then they discipline you for taking time off."*

Kim believes the fact that most nurses are women contributes to the demands being made upon them and to the dismissal of their concerns.

"I think our employer does not value nursing care as something important or tangible. 'It's just what women do, mothers do, so just do it. And do all the other things while you're there as well. And put a smile on your face and be thankful you have a job.' I find that it is very misogynistic; it's very sexist. 'Just keep doing more and give of yourself to depletion and work through your breaks and don't go to the washroom and stay overtime.' But you have to beg to be paid for your overtime and justify why you're late. It's ridiculous."





Missed care and medical errors

Canadian and international evidence demonstrates that inadequate nurse staffing is associated with an increase in missed nursing care, medical errors, delayed interventions, medication delays, and adverse patient outcomes (Brophy & Keith, 2025).

A meta-analysis of 85 studies found that "nurse burnout was associated with a lower patient safety climate and patient safety grade; more nosocomial [hospital-acquired] infections, patient falls, medication errors, and adverse events; lower patient satisfaction ratings; and lower nurse-assessed quality of care. The associations were consistent across nurse age, sex, work experience, and geography" (Li et al, 2024).

In 2026, the Canadian Federation of Nurses Unions (CFNU) surveyed nurses from across the country. It found that 57 per cent of respondents say they "are regularly responsible for more patients than they feel they can safely care for... Half of respondents have experienced a near miss or patient safety incident in the past six months. Nearly three in four of them say that understaffing or high patient load were contributing factors."

As researcher Guytano Virdo (2025) points out: "Studies show how nursing work intensification and missed care are a result of managerial downloading." The studies cited by Virdo also show that rushed, overly busy nurses are more likely to make medical errors.

Nurses experience the problem first-hand and it contributes to their stress and anxiety.

Sumaia said, *"If you have a whole bunch of burnt-out nurses, you're not getting good care in the hospital and then you don't get good outcomes. Like we're seeing in the hospital all the time, these babies coming in with 15 per cent weight losses*



because the parents didn't get the correct teaching from us because we were stretched so thin."

Lena explained that the care they are able to give is often less than adequate and puts patients in harm's way.

"Some patients' families or the public might think that their loved one is getting the best care that they can receive. That's true — it's the best that we can give with what we're given to work with. We give the best we can but if patients' families aren't there to advocate, there is a lot less than adequate care, especially with nutrition and positioning on a unit that's overburdened and understaffed. So, they're not getting the outcomes they deserve. And that's sad. Our government needs to hire more nurses."

Ellen said that having adequate nurse staffing in the musculoskeletal rehabilitation unit would help *"in every way."*

"Even a simple thing in my department like getting a patient to the bathroom or keeping them from being incontinent because you are taking care of another patient and there's nobody to pick up the slack. Because every nurse now is working at their maximum assignment. There's nobody. If every nurse has five people, they're going to prioritize what they have to do first before they help you. People's dignity ends up taking a step back because now they couldn't hold their urine or their stool and now, even if they have never been incontinent before, there is nobody to help them to the bathroom. So, now you have to come to a patient and apologize; say 'I'm sorry. I'm late. I was with another patient.' That doesn't change the fact that that person just soiled themself. They lose their dignity because management decided it's okay to work with three staff instead of five. I just think in a lot of ways that's wrong."

She explained that management has put bed alarms and chair alarms in place, but they are not necessarily effective if a patient is kept waiting too long for a nurse. *"Somebody who doesn't want to be incontinent may try to get up and go to the bathroom and fall because they have just had surgery. And now instead of having to recover just from knee surgery, they have a broken hip, which puts them at risk of dying. That's so much trauma to their body."*

Zahra explained that the hospital's system had recently been upgraded to allow for a more efficient ordering process for doctors and nurses. However, this change created a ripple effect of errors and missed care, as medical staff struggled to adapt to the new system. Doctors would often forget to input the mothers' diet orders, sometimes leaving dietary with no clear instructions. She said, *"Sometimes a patient didn't get a tray. They wait until nine or ten and then tell me they didn't get their breakfast. And you feel so bad for them... The workload right now is insane and it's not safe."* She is afraid that her heavy workload could end up causing her to make a mistake. *"Having proper nurse-to-patient ratios would make a huge difference for the patient's safety and it's also for your license safety. I buy my nursing insurance with a very high limit, just in case."*

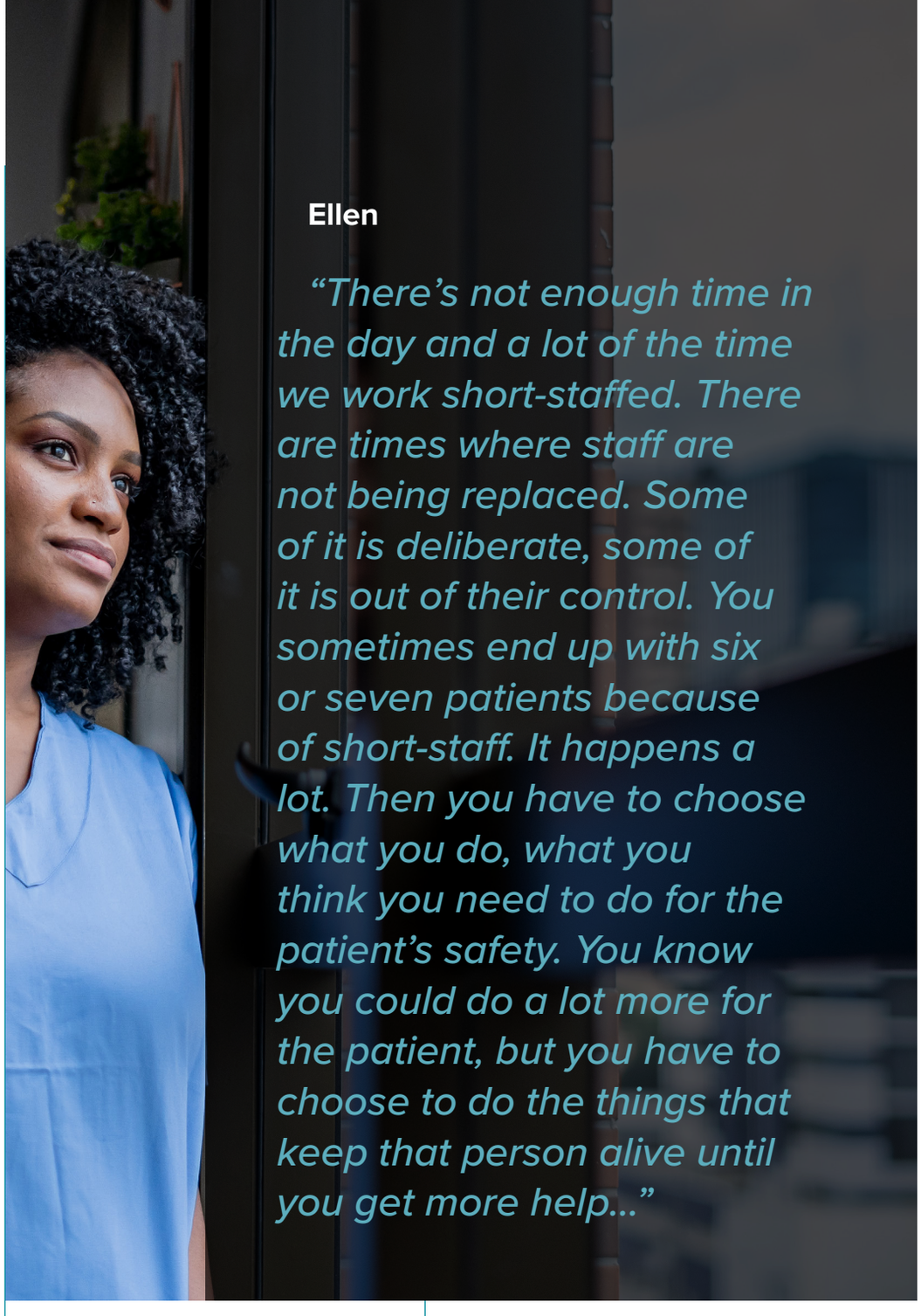
Kim said she is doing the very best she can to give her patients appropriate care but it is not always possible.

"I still love my job and I want to give the best to my patients, even when it's not ideal. I will almost be like a little town crier telling patients, 'I'm your nurse. We are short-staffed today. But

I want you to ring the bell every time you need something. I'm going to come around frequently. If you're having pain, whatever, I'm going to meet those needs. But I just want you to have an awareness that we are too short on the floor.' And I shouldn't even have to say that, but I want them to have a reality check and to manage their expectations. I will always work through my breaks or whatever to meet the needs of my patients and prioritize things, but that means other things are going to the wayside. So maybe I'm not walking a patient today, which is detrimental on a surgical floor post-operatively. But I don't know what else to do, honestly, other than to clearly communicate this is the situation we're in and we'll do the best that we can."

Ellen, in her role as a musculoskeletal rehabilitation nurse, finds it difficult to do all that is demanded of her.

"There's not enough time in the day and a lot of the time we work short-staffed. There are times where staff are not being replaced. Some of it is deliberate, some of it is out of their control. You sometimes end up with six or seven patients because of short-staff. It happens a lot. Then you have to choose what you do, what you think you need to do for the patient's safety. You know



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you could do a lot more for the patient, but you have to choose to do the things that keep that person alive until you get more help... When we have a person that just had knee surgery or hip surgery, it's total care. You have to take them to the washroom;

you have to provide them with their medication. If they have IV medication, you have to set up their IV. You have to do everything. And you might have three or four people who you have to set up the IV for. Especially if it's a weekend,

you're the one who has to do all the blood draws or whatever. At the same time, you might have people who you have to remove staples from, who you have to do dressings for... You get a doctor's order and they expect us to follow it, but then you may not be able to follow that order because you are dealing with a fall or you're dealing with a dressing and you have an admission and there is nobody to pick up the pieces and you miss that order for another patient that was important. But you are just one person. And humans are not infallible. They're human beings and no matter how much they try to do their best, things will happen especially if you put too much on that person's plate."

Mary frequently sees what would be construed as medical errors in the busy work environment she and her co-workers are navigating.

"In our emerge department, we have protocols in place to minimize errors. However, sometimes meds are given late, orders shoot in, or patients need a dose of IV fluid immediately. You try your best to continue on with your day, hoping that the doc's coming shortly, but sometimes they get waylaid in trauma and aren't coming right away."

The patient load and demands in the emergency department can, at times, be impossible to manage and **Mary** is often unable to meet the required times for medication administration.

"If I have five patients in the acute area and all those five patients need all their meds by 9 am and I can't get to it, that is an issue. If they need their insulin when they get their meals and I can't get to it, that's an issue. That is a safety issue for the patients and, by rights, someone could write me up for that — every day. It is a med error... and I would say, five times out of six, I can't always get their medications to them on time. Do I try my best? Absolutely. It is detrimental to the patients because if they need a specific blood thinner or heart medication to keep their rate at a certain level, if I'm missing that or if I'm putting that off because I have to do something else, that is detrimental to the patient. And absolutely we try not to. But it all depends on what comes flying through that door."

Karla feels strongly that having too few nurses on staff contributes to medical errors that impact not only patient safety, but nurses' emotional well-being.

"Medical errors are a big issue as a result of poor staffing levels. Not necessarily because the nurse picked out the wrong medication and administered it, but because the time isn't there to process the orders correctly or to go back and do chart checks on night shifts to make sure everything looks the way it should be — getting that third set of eyes on it. But when you've been running from 7:30 pm until 4:00 am, and you're finally sitting down for the first time, your brain's not in it. Or you're a new nurse and you've got very little orientation, so things get missed. You don't catch potential errors the same way. So then, through no real fault of your own, you've now made a med error, and then the fear comes — the fear of having to tell the patient, the fear of having to tell your boss, the fear of having to call the doctor. It's awful."

Violence

Violence against staff is rampant in Ontario's hospitals. The consequences of uncontrolled abuse, unresolved trauma, and the lack of a supportive environment can be devastating. Ten years ago, the *New England Journal of Medicine* wrote, "Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored" (Phillips, 2016). Little has changed in the decade since then. In fact, there are indications it has gotten even worse. Hospitals and other healthcare facilities have become progressively fragile work environments and the problem of violence has remained largely unaddressed.

Erin Ariss, president of the Ontario Nurses Association (ONA), said: "We know that thousands of nurses and health-care professionals experience workplace violence daily across this province... In the past year alone, 63 per cent of nurses say they have experienced physical violence, with 89 per cent saying they've experienced verbal abuse."

Accepted workers' compensation claims for violence-related incidents in Ontario have increased nearly threefold since 2012 for all nursing occupations, from 406 in 2012 to 1,190 in 2024 (Canadian Federation of Nurses Unions, 2025). Accepted claim statistics significantly underestimate the actual occurrence of violence as most incidents are not filed with the Workplace Safety and Insurance Board or even reported within the nurses' own hospital facilities.

Kim is also of the opinion that violence against healthcare staff has increased.

"We really pushed for having security overnight, weekends, and holidays. We had an incident where a nurse was attacked by a patient in the ER. She was knocked unconscious and had a long-term injury. This patient was angry and upset because the nurse was sitting at the desk and he was shouting and then attacked her from behind. We've definitely had increased violence on our mental health unit, as well as with a patient attempting to breach the nursing station,



kicking in a window. And there is increased verbal disrespect, the language, like people telling you off. I don't know if it's just society in general? If it's just it's a lack of respect? Even with visitors, family members. We know it's a stressful time. Your loved one is sick and you're trying to advocate but there's an appropriate way to go about doing things. I just find overall that, from the beginning of my career to where we are now, there's a greater lack of respect for the nurses and it's very disheartening... It's hard waiting if you are in need; there are reasonable timeframes for waiting. I believe having increased staffing, better nurse-patient ratios, would certainly decrease violence, and it would increase patient safety."

It is **Lena's** experience that violence is indeed on the rise, she believes largely due to the shortages of nurses and beds. There is a growing elderly demographic coming in with dementia, which can result in delirium and combative behaviour. She also feels there is a level of misogyny in the inadequate level of protection the nurses receive.

"It's always traumatic when we're trying to do our job and we get hurt, but most aggression goes unnoticed, like pinching, scratching, hitting, grabbing. Mostly we just label a patient as a behavioural safety risk and that's it. You know we take the extra steps we can to avoid getting hurt but you can't always avoid unpredictable behaviour, which makes nurse-to-patient ratios extra important because we want to ensure that we have the best staffing levels to deal with those patients. If we're short-staffed, we are putting ourselves in danger as well as them... I feel like management would take it more seriously if it was a man getting harassed or hurt on a daily basis. It seems that they just feel that it's happening to women in nursing, so we should deal with it. It's just a part of the job... and if we can label it as a 'behavioural safety risk' that's okay, that's allowed."

Karla said she is particularly angry that very little is being done to protect her or her co-workers.

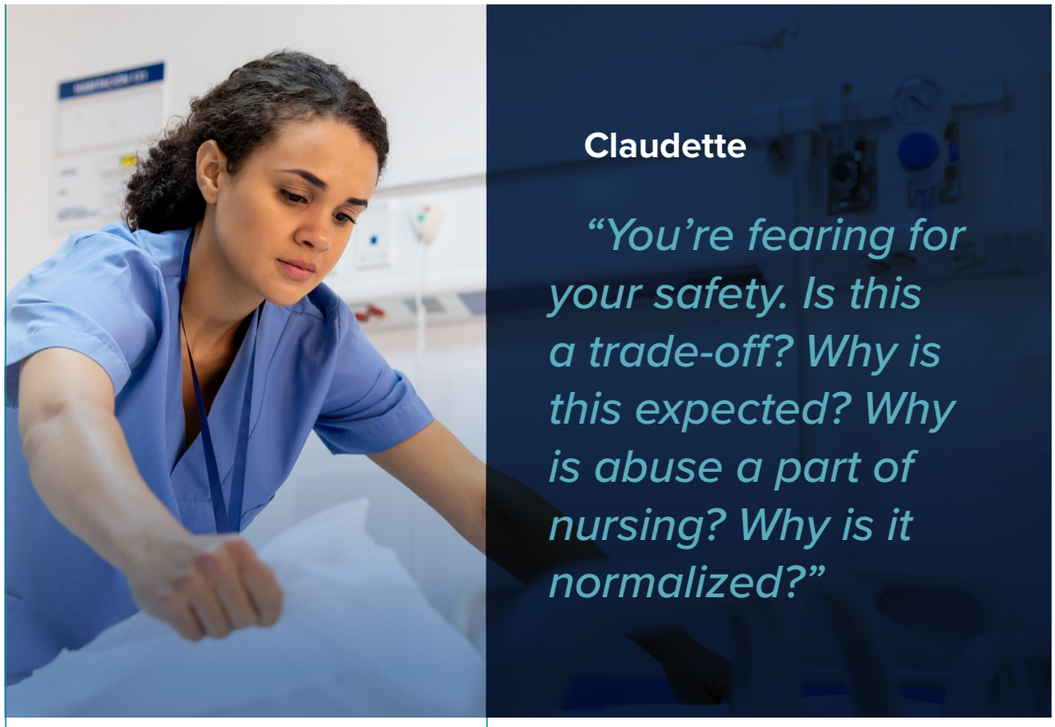
"It's infuriating to know that a person can just repeatedly verbally or physically assault healthcare staff. There have been nurses I know who have been followed to the parking lot after work by patients who are harassing them. Nothing's done about it. Patients and family members can scream at you in the hallways. Nothing's done about it because doctors don't want to discharge abusive patients because of the liability. The hospital put up signs saying we have a no tolerance policy for violence and harassment, but they don't do anything about it."

She described the reaction of management when nurses bring forward concerns or complaints about violence. She considers their response to be sexist.

"There's violence. People think that they can get away with it. Even just the language from management around it is described as, 'Oh, the nurses are complaining.' Like we're not bringing forward a justified concern. They consider it to be basically whining. Anywhere else, if workers were being beaten up, that would just not be tolerated. But when it happens to a woman, we're complaining or grumbling or whining. Actually, no, this is assault! It's a physical assault! It's illegal. It is notifying you of this violent act has taken place. I find the language around it to be very misogynistic."

Claudette, a racialized nurse, described how violence affects her and the other nursing staff. She shared that it is a constant source of fear for her. She recalled a time when she was regularly working with patients who were violent, and it was emotionally draining. The trauma of being physically attacked or verbally abused while trying to do her job left her feeling anxious and questioning her career choice.

"It's really hard because you're trying to do your duties, but you are also fearful just being at work. You are kind of looking over your shoulder, wondering, am I going to be spoken to about my colour? I've had things thrown at me. There's a lot of negative things that I've experienced. You're fearing for your safety. Is this a trade-off? Why is this expected? Why is abuse a part of nursing? Why is it normalized? And what are they doing about it? And you still have to deal with the patient, right? And how do you navigate through a whole 12-hour shift with a person that is abusive or threatening? And there is a high level of violence in the emergency department. People are sick; there are long wait times; they're frustrated, they don't know where and who to go to, and it turns into anger -- some of them are threatening at that point. I remember a gentleman who was upset about the wait time. He was angry and aggressive. He was yelling and shouting and punching -- aggressively saying he wants to see the doctor right now and cursing us out. So, you've got to get security. You end up experiencing a heightened level of stress. And it just makes it psychologically hard to perform throughout the rest of your shift because you're thinking about your safety and concentrating can be a little harder."



Violence can cause injuries that result not only in pain and emotional trauma but also lost time. **Ellen** said, *"I still have a bruise from when a patient waited until I was in their perimeter and then hit me in my chest. I was home for more than two weeks with it."*

Andy said he has experienced violence and sees how it can affect not only the one who has been attacked, but the rest of the staff as well. *"It's a shock. The trauma can spread among staff members, with everyone trying to reassure each other that everything will be okay. But we know it's going to happen again."* He explained that, in order to prevent violence, more proactive measures are needed beyond just assessing patients for risk factors. As it stands now, he believes the assessment tools that are provided are not sufficient to prevent incidents from occurring. *"I've advocated for preceptors. For instance, when people are first coming into the emergency department, we should be flagging potentially aggressive*

people right away and having separate areas for our medical and our flagged patients to go for safety reasons." He said that having more staff on hand would be protective. *"I think having the continuity of the staff and having those who know our community, who might recognize the same violent patients coming in, would be helpful. We need eyes on these people other than just cameras. It would help to protect the other patients there too — which is then an aspect of keeping us safe."*

Erin suggested that part of the problem is that, with impossible workload pressures, nurses do not have enough time to establish a relationship with their patients or to get to know if or why they might be belligerent.

"People want to know about you. We want to know about them because the whole holistic piece is important. That's part of building a therapeutic relationship. Now we don't get to know the patient… to better understand why they are being aggressive. Why are they like that? What is their story? That doesn't happen anymore. The empathetic piece is gone. It's hard to build those relationships now because everything has become mechanical. We have time limits. We have to turn the beds over to new patients… And that's the other thing — you're fighting with people who I need to move into the hallway — and their upset family members."

Lisa described the disturbing conditions in hospitals units and emergency departments, including the increasing prevalence of drug use.

"The violence is crazy. The amount of people yelling, swearing, lashing out. We're now dealing with a lot of fentanyl, which is scary. We've had exposures in bathrooms on units and in emerge… There is a gap in our training about how people should be approaching situations because now it's so unpredictable with the drug use and the exposure. So that's the new challenge right now… The culture out there is different than it was. People are less patient, more demanding. We didn't have this much violence, say fifteen years ago, and if somebody was angry and needing some time, you had the time to spend with that person, to de-escalate, to see what was going on. You don't have that time now… you never know what's coming through the doors and, right now, a lot of drug exposure, a lot of people on something that are completely out of their minds, people bringing in knives."

Laura said that, despite her best efforts to provide quality care and support, she frequently experiences verbal abuse, threats, and hostility from patients in the emergency department who lash out at her with profanity and personal attacks.

"I'm getting things thrown at me or have an aggressive patient that's trying to kick and hit me. I've had a patient inches away from my nose, screaming at me, videotaping me, putting hands in my face, putting their fist up, not necessarily going to hit me, but threatening that they're going to hit me. And that can be the psychiatric patients sometimes, but also it can be the elderly who just have dementia and are completely terrified and don't know why they're there. One night we had an inmate who was able to grab a syringe and scissors and wouldn't let anybody else in the room. We had to call the police to disarm him and walk him out of the ER to maintain everybody else's safety. And I've had a patient who was in post-op delirium. He elbowed my ribs multiple times while we were trying to transfer him and he ended up cracking a rib and separating them little bit and damaging the intercostal muscles."

Mary also talked about the amount of violence she experiences, much of it from mental health patients or those under the influence of drugs.

"We have a room in our emergency department and that's where our mental health patients go and if there is a code white, we are expected to attend to it ... I hate to say it, but I am starting to stand back because, why at the end of my career, should I take the chance of someone kicking me in the head, knocking me out, breaking a bone, busting a tooth out of my head... And that's terrible because they're going through something. Not all of them. Some of them it is behavioural, but some of them are going through things because of drugs and everything else and they are just fighting because that's all they know... These people have strength that you would not believe. I don't know where they get it from... There's violence every day... Lots of times the police will bring in someone that they want assessed by the hospital before they'll take them to jail because, if they threatened to kill themselves, or what have you, they'll bring them in. Lots of times they are so strung out on drugs that they have no clue what they're doing. We take them into a room and we're waiting for psychiatry to get involved, for the mental health nurse to come and assess them, and then all of a sudden, they want out to smoke. They want to get out of there and they've made up their mind that they're leaving so they start arguing; they start yelling, cursing, swearing, slamming stuff. We've had tables picked up and thrown into windows. Multiple times we have had to call the police back in to help us because the patient has become so aggressive. When it comes to that point... a restraint stretcher goes into the room. We call a code white. There are people trained. Now the unfortunate part of it is that a lot of our security are older and frailer... so we will have to hold the patient down. We will have to strap them in. They try to bite; they will spit; they will kick, everything. You've got usually two to three people per limb and they're still screaming and you're trying to hold their head down and it's bad for the patient. It's bad for us, but it's bad for the patient."

Mary talked about a recent incident that happened on the mental health unit sending two injured nurses to the emergency department.

"There was a very fit gentleman up there and they went in to give him some medication and he absolutely went ballistic. There were three mental health nurses. There was a doctor. There was a security guard. He kicked the security guard in the head. He kicked or punched two nurses. One ended up with a laceration right across her nose and under her chin. The other one had a huge bruise on her face. They came down to emerge. It just was awful. It's devastating to see that someone thinks they have the right to do that to someone else and that we have to kind of accept that as part of our job -- but that is not an acceptable part. It's not right to go to work and get kicked, pinched, bit, spit upon, cursed at."

Jane described a violent incident that happened early in her career but has had lasting effects.

"I was working in emerge on night shift and I was doing my rounds on my patients. And one was an IV drug user. I was just going over to make sure he was breathing. I crouched down and he grabbed my hair and he hit my face off the side rail. I had to scream and try and fight my way out of it and then security came and other nurses came to

rescue me. I'll never forget it. My nose was bleeding. I was very sore and tense and now, talking about it, I feel the trauma from it all so, even though it's been a long time, it's still something I very much remember."

She then talked about a more recent and unsettling situation and the terror it made her feel. A boyfriend of one of her patients threatened her. The patient revealed to the nurse that her boyfriend knew details about her vehicle, license plate, and even her home address. Her manager and even the police were not able to provide much protection. She said, *"I was left asking how is this safe. I still have to go back to this hospital and provide care for this woman when her partner is stalking me."* She said there was no resolution, and luckily, she wasn't hurt. But it left her feeling vulnerable, blamed, and unsupported. *"It just doesn't make sense to me. I was made to feel like I was the issue and I was the problem because I wanted to feel safe and they couldn't do that for me."*

Healthcare unions, organizations, and parliamentarians have successfully lobbied to have amendments made to Canada's Criminal Code specifically addressing violence against healthcare workers. In October 2025, Parliament took an important step with Bill S-233, recognizing assaults against healthcare workers and first responders as an aggravating factor in sentencing. But it does not go far enough. It does nothing to address the underlying causes or structural factors, such as understaffing.

According to researcher Linda Aiken (2025):

> *Studies have shown that having more nurses helps to reduce the level of violence and the trauma it causes.*



Insufficient nurse staffing, because of nurses' impact on overall organization of care, contributes to inefficiencies, delays in care, and frustration of providers, patients, and visitors, that sometimes result in harsh and hurtful verbal abuse directed at nurses and occasionally physical abuse. A solution to verbal and physical abuse of nurses is to prevent chaotic care environments by providing adequate nurse staffing.

In other words, the implementation of mNPRs would help to reduce the staff workload, related wait times, and hectic assembly line care in busy departments, thereby contributing to a calmer, more relational patient-centred care environment that is so important for the well-being of nurses and their patients.

Impacts outside of work

Nurses who are experiencing exhaustion and burnout carry the effects home with them. Many have childcare responsibilities. According to the Registered Nurses Association of Ontario (RNAO) (2022), 31.4 per cent of hospital nurses have children at home to take care of; 20.5 per cent have other care-giving responsibilities besides childcare.; and then there is the issue of their own quality of life.

Lena is painfully aware that what happens at work doesn't just stay at work. The pain, fatigue, and stress follow her into her home and personal life.

"At the end of the shift you go home and you're burnt out. I don't want to talk to my family. I just want to have time alone to process my day. Often, I experience physical sickness from work where I have terrible migraine headaches, and I have to take medication to help me sleep because sometimes you can't stop thinking about all the suffering that you see; it really takes a toll. I know it's something that I have to bear alone because I don't want my family to see that... Many times I leave work and I go home crying. Or I just go home and my back is so sore. I feel defeated sometimes because of the stress that I have to deal with on an everyday basis what with the healthcare cuts and most often being short-staffed and having to deal with the existential crises that are coming in. It's not just the patients, it's the families and it's dealing with the family dynamics. We are often left unsupported at the end of the shift. Management is gone. They work nine to five, eight to four. It's the nurses that are left dealing with the families. And I cry. I cry because I feel like I could be doing more but I just don't have the capacity. And not only do I cry going home, I wonder can I make it another day."

Kim said she too is often unable to shake off the distress of a difficult day when she goes home to her family.

"Some shifts are horrible. When I go home, I just feel exhausted and I have three young children who are super excited to see me. I want to be happy and be present for them as well, and it's challenging to just turn that off. I've had horrible, horrible shifts. Like one where we've lost a child, a toddler dying. There's nothing worse than that. And to hear family crying because they've lost a child. Screams ringing out in a department. It's just devastating. It hits your heart; there's no way to prepare for

that. And you're trying to support the family and then other patients are angry and waiting and you think, 'Wow. A child has just died here and you're angry about a salmon sandwich?' It's hard to have compassion for people when they're mad over such a silly thing while you are trying to support a family in that time of loss. But you still have to work through it; you've still got to do all the things you need to do. And then you go home to your own children, and you feel guilty."

Although **Katherine** does not have children waiting for her at home, she understands what the young mothers she works with are experiencing.

"I think about the young girls that I work with who have young children and they go home as tired as I do and they're getting home at quarter to eight at night and putting their kids straight to bed. So, they've missed dinner; they've missed everything. Sometimes they tell me they fall asleep as soon as they hit the bed. Or they don't even finish reading the story; they are asleep and the children are still awake. I do feel sorry for the young ones."

Ellen thinks about the details of the day after she leaves work and feels anxious about having possibly missed something important.

"Sometimes you leave work and you're walking away and you're thinking, 'Did I remember to do this? Did I do that?' And you know fully well that you didn't do everything that you're supposed to do. But you're hoping that it's not so drastic that it brings harm to your patient. You wonder did you chart everything? Like a lot of things, you likely did do it — because in the moment you have to do it -- but did you have the time to sit down and chart it appropriately?"

After a tiring day in the emergency department, **Laura** said she is often left feeling frazzled and self-guessing.

"Some days I go home and I'm feeling badly. It definitely hits you because I got into nursing to help people, not to hurt people. And when you're short-staffed and you're overrun and you're not doing all that you're supposed to be doing or up to the standard, you go home feeling like it's your fault... Today is my only day off this week. So, I'm spending it on the couch. I don't go out visiting, seeing people. I just rest and relax and do my own thing. I self-isolate a little. I have two children and they feel it. I didn't always just lay on the couch on my days off. I had energy to do other things, but now I find that, after a few years in, on my days off I can't really bring myself to do much because I am so exhausted on all fronts."

As a busy medical-surgical nurse, **Erin** said she often has nothing left to give her family.

"I go home and sometimes I'm too tired to think. My husband will attest...Physically, I do my best, but at home, I'm too tired to maintain my house. We have elderly parents. We're the ones taking care of them. We have children at home... It's not fair to my family, but I have a hard time. I get frustrated easily. I also have wonderful friends, but I find I'm so exhausted, I cannot spend a lot of emotional time outside of my own environment, at the end of the day, to text, to call, to say let's get together. I don't have the emotional bandwidth or the energy to do it. I just can't. And just the thought of somebody dropping by puts me into a tailspin. I don't have the energy to spend time with my friends. I'm just sleeping. I'm just resting. I don't even have the energy to read a book. And I love to read.

Lisa used to work as a medical-surgical nurse before she transferred to day surgery. She said she simply could not handle the hours or the unrealistic demands.

"You go home, you do what you've got to do, and then hopefully get a decent night's sleep and you do it again… Unless you're in nursing, on the floors, running for twelve hours, you don't really understand exhaustion and the mental fatigue at the end of that as well. There's no way I would ever want to go out after a twelve-hour shift, I can tell you that."

Jane said very little support is available to burnt out nurses. *"My employer says to just call the Employee Assistance Program. But I don't have time to do that. I'm spending half of my life at this hospital and you expect me to spend more time talking about it? I just want to forget and move forward. But, after a hard shift, I often just make it to my truck and then start crying."*

Retention

For many nurses, work has simply become unbearable and leaving their cherished profession is the only option they can contemplate. There are multiple reasons for their job dissatisfaction.

A survey conducted for the Canadian Federation of Nurses Unions (CFNU) (2026) found that: "Over a third of respondents are considering leaving their current job or the nursing workforce within the next year… Insufficient staffing levels such as inadequate nurse-patient ratios was ranked as the top factor that respondents considered when leaving a job."

A Nanos poll conducted for OCHU/CUPE found that among the healthcare workers surveyed, many of whom were nurses, 43 per cent were considering or somewhat considering leaving their current position in the next year. "Those who are considering or somewhat considering leaving cite the job being stressful / hard (19%) and being understaffed / not enough help (19%) as the top reasons for consideration" (Nanos, 2023).

Similarly, WeRPN found that "43 per cent of RPNs surveyed intend to or are considering leaving the profession… Thirty-two per cent plan to leave within one to two years" (Registered Practical Nurses Association of Ontario, 2026)

Mary said she has begun to consider early retirement due to the increasingly unreasonable demands of her job. *"It gets very frustrating. I don't want to leave because I do love my job, but at the later stage of the game, I've started to look at retirement because of all the changes that have happened. And I never thought I would be the one to say that, unfortunately."*

According to Linda Silas, President of the Canadian Federation of Nurses Unions (CFNU) (2023), "Nurses are shouldering the weight of an overcapacity healthcare system where overtime has become the go-to band-aid to systemic staffing shortages. In the absence of staff to replace nurses when their shifts end, they are working increasingly long hours. It's not safe for nurses, and it's certainly not safe for patients." Silas pointed out that nurses overwhelmingly cite high workloads and insufficient staffing levels as the top reasons they are considering leaving their workplace or the profession altogether. More than 75 per cent of nurses report workplaces that are regularly overcapacity, demonstrating the widespread challenge.

Sumaia cannot imagine continuing as conditions have changed so much that her workload is unbearable. *"But when I tell my friends and family now that I don't really want to be a nurse anymore, their jaw drops because I always said it was my calling."* She explained that the workload and high-stress responsibilities have played a role in her desire to leave nursing.

"The hospitals have recently been adding a lot of tasks for us to do. One of my co-workers actually went through all of the policies and procedures that we're expected to do in a twelve-hour shift for four dyads and calculated it's about fifteen hours' worth of work -- work that we're expected to do in twelve hours. And we're expected to have a break. And now they're adding more tasks for us. Now they want us to do babies' blood work... I think that's part of why I don't want to do this anymore. I feel like I can never give enough. I always come home wondering 'Did I do enough? Did I chart enough? Did I give everyone my all?' Which you can't do when you have up to five moms and five babies. You can't properly care for them all like that. For five families. I know that BC now has regulations. Their ratio is three dyads per nurse. I don't understand why there is such a big difference between the two provinces. I see a lot of readmissions now for high weight loss for babies or breastfeeding issues. All of this could have been resolved the first time in hospital."

As a mother with young children, she believes that leaving nursing and pursuing another career would be in her own best interest as well as her family's.

"I don't want to be a nurse anymore. I used to get so excited to go to work and I just don't anymore. It's daunting for me. My husband can tell when I have a couple of shifts coming up. I start getting anxious. I don't let it affect my children, or I try not to, because I want to be their mom. That's my main priority in life... I'm still young but I'm one of the oldest nurses at my place of work, so that's kind of scary when you think about it, because that's a whole generation ahead of me that's already left the bedside. And now my generation wants to leave too. So that just leaves a lot of young, new staff. Even the young ones are getting burnt out pretty fast. Almost all the time, I'm the one with the most experience. They just can't keep staff anymore."

Zahra talked about how often she and her co-workers would discuss quitting. The conversations were often lighthearted, but beneath the humor lay a sense of frustration and resignation.

"We really don't have a lot of options. You have kids going to school; you have a mortgage to pay. So, we actually buy a group lottery ticket where the prize is seventy million dollars, so maybe we won't have to come to work tomorrow... I have a co-worker who originally planned to stay until the end of the year. After an incident, where she was assigned what she considered to be an unsafe number of patients, and after a series of shifts where her patient load was barely manageable, she had a meltdown. She decided to retire early. She told me that for a couple of extra dollars of pension, it's not worth her mental health to stay."

Erin is clear about the reasons so many nurses are leaving their jobs in the public hospitals.

"I can't always control it, but it bothers me when I cannot get to my patients and give them what they need when they need it. Nurses are frustrated and fed up

and they move on. A lot of them will not stay... Hospital nursing is too stressful. We are going to keep losing nurses. If we had better staffing, I think they would stay. I think they would stay if they knew they had the proper support because then nurses wouldn't have to be so scared of making a mistake."

Lisa also understands why many nurses are choosing to quit.

"I think people just have had enough. They don't want to work; the money is not worth it. I mean, we are not unrealistic. We know that there's going to be days that are rougher than others, but for it to be the norm now is what's getting people burnt out... Health care, I think, is in crisis, the atmosphere and the morale on the units is not okay, and it's going to be a long career for people just starting out if it doesn't change. It's supposed to be rewarding; you're supposed to like your job, not dread going into work. A lot of people are asking, 'Why did I do this? What am I doing in this job?'"

Research consistently links early exits to poor working conditions. Statistics Canada (2023) data show that among nurses considering leaving their jobs, over half (55 per cent) report burnout or job-related stress.

Andy reported that there is a lot of staff turnover now at his hospital. Older staff members are leaving the profession or dropping down from full-time to part-time positions or to casual positions. The same is happening with the young full-time nurses. In some cases, they are leaving the profession altogether.

"They're burnt out; they feel hopeless and they can't handle the workload anymore, so they have to move on to something else for their own health. And our retirees that leave don't want to come back when they have the opportunity to return as casual staff. It's too dangerous. It's too unhealthy. And I see where they're coming from. I wouldn't come back either. Many times, in the middle of my shift, I've gone to the stairwell and just needed to let everything out, and I've had many times where I've thought myself about leaving. It's very difficult because I love looking after people and I know this is my calling in life. So, I'm just going to push through because I have to."

Ellen said that many nurses are leaving for their own self-protection. *"They say, 'I'm not doing this anymore because it's going to kill me.'"* But, despite the hardships, she has chosen to continue working. *"For now, I stay because I feel that I still have something to contribute."*

Lena is struggling. She feels at times that she would be better off leaving nursing but feels it is a profession where she, and others like her, are urgently needed.

"It's easy to desensitize yourself when you are working in an environment that doesn't support you. Sometimes it's easier to give up than to keep fighting a broken system. I've actually thought to myself, this is too much responsibility. This job requires too much from one person... I think about it all the time. But I keep nursing because I want to help. I do it because there's a need to help others and I want to make a difference. And I hope when I'm sick, there's someone there to help me. I'm worried that there won't be and that is why it's so important that the public knows that there is a crisis going on and the government needs to step in. I think the future is bleak. I think you'll see many nurses leaving the profession because they feel unheard and unsupported. I think that without



more help in this broken system, it's just going to continue to fall apart. Everything is ending up on the backs of nurses and pretty soon I think we'll see more nurses retiring early and looking for other forms of work... I see my co-workers crying openly on shifts. I hear them say, 'I want out. I want to quit.' I hear it all the time. I see the strain when are short. It's hard to do all the required care -- we have to feed, bathe, medicate, coordinate. We have to wear all these hats and each of us is just one person. I see people retire earlier than in previous years and I think it's because of all the changes in the healthcare system and all the cutbacks. A co-worker just retired in her fifties -- she was done. She just couldn't do bedside nursing anymore. That's a lot younger than I used to see. And I see younger nurses leaving bedside nursing in droves."

Researchers examined the reasons nurses leave by surveying nurses working in acute care hospitals in Ontario (Nowrouzi-Kia & Fox, 2020). Not surprisingly, they found, "Nurses who reported greater job satisfaction, flexible interprofessional relationships, and resource availability were less likely to express an intent to leave their hospital workplaces."

Katherine said she thinks she is *"the last nurse left that has worked here for a long time. Everybody has retired early; given up and gone. A lot left through COVID. And when the new software system came in, they said 'I'm not going through this one more time; I am out of here.'"* She primarily blames the heavy workload.

Andy described working conditions that deeply impact nurses' level of job satisfaction and that explain why some people are voting with their feet. *"The culture has deteriorated. All my senior nursing colleagues have left and have found somewhere else to work that's somewhat healthier... all we can do is watch the bus crash."*

Poor mental health resulting from overwork, stress, and lack of respect contribute to the intent to leave (Brophy et al., 2024).

Laura talked about how unsatisfying work has become and how the lack of understanding from both the public and management makes the workload more difficult to tolerate.

"I think nurses are leaving because the job and the career itself has just become a bit thankless and, in the bigger picture, a lot of the times, if it's not patients that are yelling at us, it can be family members that are agitated and mad at the care that's being provided to their loved ones. And then it's management as well that can be yelling at us too to work harder and do more, but we don't have more. We're doing the best that we can... I really wish the public understood how bad nursing is right now. They would understand if they were to actually just spend time in an ER or spend time beside a nurse on a floor working six patients on a day shift on a weekday."



Claudette has seen an exodus of co-workers who are seeking more manageable working conditions. Others are dropping down to part-time or are going to other jobs where there is more flexibility. She said, *"I had a co-worker who I worked with who left and went into insurance."* She, herself, has decided she has to leave.

"Because it has taken such a toll on me, I've actually made plans to exit my career. I'm back into school. I'm going to be doing something where there's less pressure. I have been increasingly worried about my license and my safety. When I was much younger, I had the ability to try at least to keep up, but I'm older and I can't physically do it. I'm burnt. My quality of life is poor because I'm so tired and, on my two days off, one and a half are spent sleeping and trying to catch up but I don't even have the ability to catch up. Then after my next three shifts in a row, I'm like this again. It's psychologically hard. And I know I would have stayed longer in health care if it wasn't like this. I had to make a choice



about my physical health and my mental health and weigh the pros and cons of staying. There are such repercussions for not being able to meet the demands that are literally impossible now. I'm at risk of being considered liable. So, I had to make a choice. I decided that I'm just going to leave nursing, although it's something I love."

Jane, a medical-surgical nurse, is deeply committed to patient-centred care but said that now, with staffing levels far below what is needed, she wonders if she can continue nursing as the demands on her are leaving her stressed, exhausted, and concerned about how her family is being affected.

"I have a young family at home. I can't go home burnt out anymore because I then can't be a good mom. And that kills me because I'm leaving a career that I absolutely love and I have poured my life and my heart into day after day, but I have to think of myself and my family. I'm really questioning what's going on in my life and I wonder if I go to a different job am I going to feel fulfilled? But is a fulfilling but exhausting job worth it? I've decided, the way it's going, it's really not worth it to me."

The Canadian Institute for Health Information's (CIHI) workforce data reveal a concerning pattern — an increasing proportion of younger nurses are leaving the profession. In 2023, for every 100 nurses under the age of 35 who registered to practise, about 38 ended up leaving. In Ontario, the number of younger nurses who are leaving the profession has risen by 68 per cent in the past decade (Faubert, 2025).

Karla remembers that when she first started nursing school, she spoke to a woman who was working at Costco. When she found out she was training to be a nurse she said, *"'Don't do it. I was a nurse, but I quit and now I'm working here.' I don't know if I'll last in this job either."*

Kim is very aware of the retention problem where she works. She sees it among the new graduates and even the students who are doing their hospital practicum.

"What's concerning to me is we have newer grads who are absolutely miserable... I think they're overworked and I honestly think it's so sad that someone that young and new in their career is that miserable already. They feel overwhelmed. They're angry. They don't feel respected. They're working through their breaks. They feel they are being taken advantage of. They feel underpaid for the work and responsibility that they have. And they're wanting to change careers, which is sad. A few that have left, have become clerks. They've left the nursing field because they could not manage their workload. They were emotional and full-on crying at the desk almost every day. And there are people who have left the hospital. You'll see them working for public health or something like that; they've completely left acute care nursing. Some nursing students don't even want to complete their studies; they want to get out. I'm hearing this from nursing students who are working on the units. They already want a career change. It's a very urgent problem that needs to be addressed. Proper funding is what we need so we can increase the nurse-to-patient ratio so the workload is manageable. Then people will stay in the profession and students will complete their studies."



Resilience

Healthcare workers can't be expected to deal with understaffing, overwork, stress, disrespect, or violence by becoming more "resilient" as many employers would suggest. Nor can they fix the problems themselves by taking more personal responsibility. In an article entitled *Burnout or Exploitation? Resiliency is Not the Solution*, Anna Varda (2024) writes:

In essence, this approach sends a message that it is the individual nurse's fault that they are suffering from physical and mental health issues and experiencing burnout, rather than the organizational factors clearly identified in the research. This is a form of gaslighting that contributes to ongoing harm to nurses.

As **Lena**, who works in palliative care, said, *"It doesn't feel like we're supported. We're working short-staffed and they're not seeing that. We're working with less, doing more now. And it's burning us out."*

Sarah Butler (2025), a UK researcher, has studied the causes and solutions for nurses' stress and burnout. In terms of the need for increased resilience, she states that it is not simply a matter of a nurse taking individual responsibility for it, but rather that "fostering nurses' well-being requires support for resilience through structural reforms, supportive workplace environments, and access to mental health resources.

In an article published in *Witness: The Canadian Journal of Critical Nursing Discourse*, researchers Christianson et al. (2025) are also critical of the individual focus on building nurses' resilience. They critique "resilience training as a method of individualizing a systemic problem by problematizing a response to chronic stress exposure. Resilience training may furthermore serve as a mechanism which allows subversion of institutional responsibility for nurses' well-being in the workplace." They argue that to truly address burnout and promote sustainable change, it is essential to recognize that this is not an individual issue, but rather a systemic one that requires a multifaceted approach.

It is easy to see why improved personal resilience would not fix the problem of chronic understaffing. **Lisa** described how nursing shortages in her hospital would render resilience training almost meaningless.

"Staff are burnt out. The units just seem more of a disaster than they ever have been before. It's always chaos when I go up to the floors. Nurses are staying thirteen-hour shifts. None of the floors actually

Ratios Implementation	
Phase 1	
SETTING	**RATIO**
General Medical / Surgical Inpatient	1:4 24/7
Rehabilitation	1:5 Day/Evening 1:7 Night
Palliative	1:3
Focused (Special) Care	1:3
High Acuity / Step Down	1:2
Intensive Care	1:1
Pediatric Medical / Surgical	1:4
Pediatric Focused (Special)	1:3
Pediatric Intensive Care Units	1:1
Pediatric High Acuity Units	1:2
Phase 2	
SETTING	**RATIO**
Neonatal Intensive Care Unit (NICU)	1:1 to 1:3
Post-Anesthesia Care Unit (PACU)	2:1 to 1:2
Maternity Care - Antepartum	1:3
Maternity Care - Labour & Delivery	1:1 during active labour; 2:1 at birth
Maternity Care - Postpartum	1:3 for dyad care (nurse for both parent and newborn); 1:4 for birth parent only
Maternity Care - Newborn Care Nursery	1:3
Operating Room (OR)	2.5:1
Alternative Level of Care	1:7
Emergency Department - General Emergency	1:3
Emergency Department - Short Stay Observation	1:4
Emergency Department - Medical/Surgical Short Stay	1:4
Emergency Department - Trauma	1:1
Emergency Department - Critical Care	1:1
Emergency Department - Fast Track	1:4
Emergency Department - Waiting/Triage	Visits per year

Figure 3: mNPRs in British Columbia

work with regularly based staff on very often, it's usually short. We have one unit right now where they said they were short-staffed for several days in a row and they were each taking care of ten patients. They had PSWs on the floor, which were helping with some of the care, but the nurses were doing blood transfusions... dressings, treatments, combative patients, patients detoxing, and they weren't getting breaks. They feel that the standard of care they can give is compromised and they're just drained."

Lena broke into tears talking about how deeply affected she is — in both body and spirit — by the impossible conditions of work.

"Just talking about it now makes me cry because you don't realize how much it affects you until you do it for years and years and your body and your mental, physical, and emotional status really takes a beating. I have nerve damage in my arm from many years of providing physical care for my patients and lifting and it's hard. It's hard on the body, it's hard on the mind, it's hard on the heart."



WHY MINIMUM NURSE-TO-PATIENT RATIOS ARE NEEDED

There is ample evidence of the value of mNPRs to both patients and nurses in jurisdictions across the globe (Brophy & Keith, 2025). The implementation of safe nurse staffing levels in Canada has already begun. British Columbia has legislated minimum nurse-to-patient ratios (mNPRs). Nova Scotia has a system in place ensuring safe nurse staffing negotiated through collective bargaining. Manitoba has recently announced it is beginning the process of establishing mNPRs.

Not only are the benefits of mNPRs well-documented — so too is the need. Lasater et al. (2025) conducted a baseline study in British Columbia at the outset of the implementation of mNPRs. The study concluded:

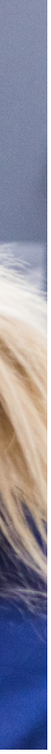
> *More patients per nurse were associated with poorer hospital mortality and readmission rates, poorer job outcomes for nurses, more adverse events for patients, less favourable ratings of quality of care and patient safety, more missed nursing care, and poorer ratings of staffing adequacy and management.*

The ratios are being implemented in British Columbia in phases. It is just the beginning of a longer-term plan. "The Ministry of Health and BCNU is working with health authorities to implement the first phase of minimum nurse-to-patient ratios. Work continues to establish mNPRs for remaining hospital settings and non-hospital settings, such as long-term care and health authority community settings" (BC Nurses' Union, 2026). The chart on page 69 shows Phases 1 and 2. (See *Figure 3: mNPRs in British Columbia*)

All those interviewed for this report said they believe an increase in nurses is essential in order to eliminate the unsafe workloads plaguing Ontario's hospitals.

Laura stated that even an addition of two nurses per shift in the emergency department would provide meaningful improvements.

"Nursing care directly impacts patient care and the patients are the ones who are suffering right now. Staffing level to patient ratio would improve, which means patient care will improve, which means tasks are getting done on time, meds are being given on time, less med errors are happening, people's



dressings are getting changed according to the doctors' orders. Dressings can cause wounds to become infected if they're not changed properly."

Lena talked about how understaffed they are now in her palliative care unit and outlined some of the benefits that would be realized from having an adequate number of nurses on the floor.

"Our nurse-to-patient ratio is five patients to one nurse; that's the norm. But quite often we're short, so it usually is six. At my hospital, we don't have any PSWs assigned to us on a regular basis, so we often don't get any extra help. Sometimes there are externs that are hired by the hospital at a cheaper wage and there are student nurses that are helpers, but that's occasional, not steady... Being short-staffed is really hard on us... Having enough nurses would really help with medication administration and there would be more time for clinical treatments, more time to do the necessary things to ensure that patients are safe and healthy. They would be getting their dressings changed. They would be getting repositioned more to prevent pressure injuries, ideally every two hours. It is impossible to do all the treatments and tasks that we're required to do if we are working short. It is so important for patient outcomes that we are able to adequately take care of them -- that they get the care they deserve... And better nurse-patient ratios would help staff morale so much. I used to love coming to work. And I love the work I do, I still love the work, but a lot of times it's just exhausting physically and mentally to do the work of two people and the expectations that our management and the hospitals are putting on the nurses are just devastating to our morale because we can't keep up with all of the demands. We're trying our best and it would help us tremendously to have enough nurses... I feel guilty sometimes talking to family members for longer than five minutes because I'm needed elsewhere. I'm pulled in so many directions and that makes me sad... I think that we need to sound the alarm -- we need to hire more nurses. We need to retain more nurses. We need to open more positions with safe nurse-to-patient ratios. That is the only way. We can't keep getting cuts on the front lines. It's not fair and it's not going to hold up. We can't keep doing the job of ten people, all the extra jobs that they keep piling on the nurses, the frontline staff, that are giving the medications, the treatments, the support for families and patients. Staffing appropriately needs to be done. And fund PSWs to help your nurses with the care so we can better facilitate safe medication administration and we can prevent falls. It all works together. It all comes down to hiring people to provide care. It's what we deserve and what the public deserves -- what your mother, your father, your grandma deserves."

Most advocate for the province-wide implementation of legislated minimum nurse-to-patient ratios, which would help to provide structural protections for nurses and patients. It would likely stem the exodus of nurses from the public system. And it would counteract some of the more negative aspects of managerial cost-cutting. While mNPRs would not correct all that is currently wrong, they would significantly improve conditions.

Andy said having mNPRs in place would completely change his attitude about going to work and would eliminate many of the stressors, permitting him to provide the care his patients need and deserve.

"If I knew that on every day shift, I wasn't going to have a one to six ratio or one to eight or one to ten on night shift, I would be excited to go to work. I would keep my sanity. I want to get back to the days where I'd love to go to work. I'd know that I'm

not going to be stressed out as soon as I show up. And I could focus on my job. The people would have time to train each other, would want to do more within our jobs. I could focus on my patients... It would definitely give family members a sense of confidence. I don't want them to always be worrying about their loved one in the public system. I don't want them to have to think that they have to come in every single day just to make sure that their loved one isn't getting worse. With mNPRs, patients would be getting the best care. I and the rest of the staff would not be burnt out to the point we can't provide proper care. And it would allow me to look after myself at the same time."

Karla believes that having mNPRs would help nurses both mentally and physically.

"If we could provide better care without feeling overwhelmed by an excessive number of patients, I think it would lead to greater workplace satisfaction. When nurses are only dealing with a manageable four high-acuity patients instead of eight, they're more likely to feel that their work is making a difference. If you felt that you could actually do beyond the bare minimum of care, you wouldn't have to go home and say, 'Well, at least no one died and that's as good as it gets'... And with more nurses there would be more time to feel like you bonded with the patient maybe a little bit and I think your patient and their family are more likely to be appreciative rather than cursing you out for everything that they didn't get."

Sumaia, who has decided she has to leave nursing, for her own and her family's best interests, said that, if Ontario were to implement mNPRs, she would consider staying.

"It would make such an enormous difference. I work for two hospitals. One hospital has decided to do the three dyads and kind of follow in BC's footsteps and the staff morale there is incredible. In general, I feel like there's much more support because if one nurse is given a heavier assignment just by accident, there's always staff to support you. Where at my other facility, it doesn't work like that, and all the staff are run so thin."

Erin believes having mNPRs in place would solve many of the problems she encounters and would be a boon to the patients' care and comfort.

"I usually have a five to one ratio. If we're short, I can go up to six to one. On Monday, I had eight to one. I have to compartmentalize. You're just numb. And this is just the way it becomes. You're not empathetic anymore. I've been running on robot mode for years. I think COVID put us right into that, where you become unemotional. Okay, this is my job I have to do it. This is my duty. These are my patients. This is what's going on along the floor. Okay, this is my task now, then I move on to the next one, and to the next and make sure everyone's okay... If we had proper nurse-patient ratios, we could give quality care. How do you get proper care now? If I only had three or four patients, maybe I'd be able to walk my patients. I'd be able to make sure they were turned and positioned on a routine. I'd be on top of their pain management without them calling and me saying, 'I'll be right back.' and then I get pulled somewhere else and then, oh shoot, I didn't get their pain management."

Jane believes having mNPRs would help to retain nurses currently working and encourage retired nurses to return. She said, *"I think having a mandated nurse-to-patient-ratio, where it's a piece of language or legislation for a one to four ratio, is going to bring people back to the workforce because they'll be able to go back to what nursing was."*

When asked if she would stay if mNPRs were mandated, **Claudette**, who is on the verge of quitting, said she would definitely consider it.

"Understaffing is the driver for me wanting to leave. I see it just running out of control and I physically can't maintain it and keep people safe. I'd rather leave than harm people… When I started years ago, four was the usual ratio. There was a general consensus that this was manageable. This kept people okay. Then it started moving to five. Then it started moving to six and seven. And there's no consideration for the population and the health dynamics. People are sicker. They don't factor that into healthcare management. There's data showing comorbidities are high and it requires more work."

A LOOK INTO THE FUTURE

The Financial Accountability Office of Ontario (FAO) (2025) paints a grim picture for the future.

- Overall, the FAO estimates that health sector spending would need to grow by an average annual rate of 4.0 per cent over the next three years to maintain current service levels.
- The 2025 budget spending plan is below the FAO's cost driver projection by $3.4 billion in 2025-26, $6.4 billion in 2026-27 and $9.6 billion in 2027-28. This means that the Province will need to implement health sector efficiencies (i.e., provide the same level of services with less resources) and/or commit additional funding to the health sector to maintain 2024-25 service levels.

This can only mean a continuation or worsening of conditions for nurses as well as having dire implications for health care itself. The suggestion of needing further "efficiencies" if funding is not increased is chilling. It brings to the fore the very essence of the austerity-managerialism approach that has so damaged the universally accessible healthcare system we have held so dear.

The FAO's projections affirm the nurses' concerns. Many of those interviewed discussed their fears about the future of health care in Ontario and how it might impact them or their family members should they require hospital care.

Andy said that even now, he worries that if a loved one were admitted to hospital, they might not receive proper care.

"I talk very cautiously when I'm at the bedside and to family members — they are very nervous about what's going on, even for us as staff members. I know I don't want my mom or dad to get sick or my grandparent to get sick and have to come to this hospital because I don't know what care they're going to get. It's not good. Everyone is nervous. As soon as they come in and see what's going on, they are shocked."

Katherine is afraid that the lack of nurses and the care they can provide will lead more patients to choose to end their life rather than endure hardship and suffering in an under-resourced hospital.

"I see a lot of MAID [medical assistance in dying] in the future. For myself included. From everything that I've experienced, how the care of people has

declined over the years, makes me really fearful for my own journey when I'm older. I've already given a lot of thought as to how far I would want to go with any illness before I say, 'I'm out of here, I don't want to go through that.' A major reason, unfortunately, is that the care is not there.'"

Claudette sees nurses leaving the profession and is fearful the deterioration of the system will get even worse.

"I'm worried about the future. I'm worried in terms of even me getting older and needing care. I'm wanting to leave nursing and I know other people want to leave. There's an exodus. I'm worried there will be an even bigger shortage of nurses. Who's going to be there to take care of us in the future? What will happen? I already see more people getting less quality of care. It's just not sustainable."

Lena said, *"I feel like the hospitals just aren't listening to the staff. We're the glue that's holding it together. And we feel broken. So that's why I'm saying the system itself is broken — because we're at the foundation and if we — the nurses — can't get fixed, how is the system going to hold together?"*

Katherine said that, in the absence of management understanding and support, the nurses must rely upon each other. *"Nurses have to support each other because they're not going to get support from management. They're not going to get support from the government. I feel like nothing is going to change; it's getting worse and worse. If we don't stick together, then how are we going to make it?"*

Several of the nurses said they wished the public better understood their plight and acted accordingly. **Claudette** recalled the days when nurses were seen as heroes rather than being taken for granted as they seem to be now, or worse, exploited.

"I wish people would remember how they treated each other during the first six months of COVID. There was a brief window where people realized that healthcare staff, the grocery store staff, the truck drivers -- the essential workers -- they were the ones that kept things going. And people were suddenly kind and compassionate and supportive, so supportive of the struggles in health care and so understanding and patient. I want people to go back to that mindset -- that brief window where they seemed to actually try to understand what we were going through because it really hasn't gotten better since then."

What's behind the decline? Many nurses place responsibility firmly at the door of Queen's Park.

Kim has a message she wants to share with the provincial government. She holds them accountable for the decline of the public healthcare system. She is especially unwavering in her opinion that the public system be saved and that mNPRs be put into place.

"There are so many studies that have concluded that better staffing improves patient outcomes, it decreases mortality, it decreases staff burnout, decreases staff and patient injury, decreases staff sick time. There are just so many positive things for the patient and for the healthcare worker, and also for the employer, I might add, because it decreases expenditure overall. Proper funding is better care. And they can afford it, and they're just choosing not to. I would like to ask them, 'Why are you choosing to not serve the public who elected you? I find that to be problematic leadership.



Not everybody was born with a silver spoon in their mouth… And you were elected to serve the people, serve their best interest, and it is not the best interest of the public to intentionally underfund health care so that patients have to endure fourteen or twenty hour waits in the ER or have delayed surgery and die waiting. You are failing to do your job.'"

Dr Iris Gorfinkel, a family physician and clinical researcher, is disheartened by the hardships her patients now have to endure and also sees the role the current government is playing. "It seems bent on dismantling public health care. Its laws have reduced staffing, lengthened ER waits, and stripped away the dignity of Ontarians." She contends that it has "turned moral injury into a daily reality for healthcare workers" and asks, "How long must my patients pay the price?"

As a float nurse, **Claudette** has seen the healthcare system from nearly every angle. And what she sees deeply concerns her. *"I'm worried about the future,"* she said. *"It's not sustainable."* She shared that it is with great regret she is planning to leave.





CONCLUSION

In many ways, the nurses' interviews and their insights speak for themselves. We need more nurses. Urgently. Not only have nurses sent a clear message that immediate action is needed, so too have innumerable studies, surveys, statistical reports, and patient testimonies. Ignoring the extensive and irrefutable evidence is inexcusable.

The transformation of Ontario hospitals under neoliberalism and its inherent business-style management poses a fundamental threat to the well-being of our population. As John Ralston Saul (1999) warned:

> *...we have slipped into a two-tier health care system without any public debate over whether citizens wished to abandon the universal system. Worse still, our elites continue to talk as if we still have a universal system. They, and therefore we, condemn ourselves to live a lie... medicare can only work if it is driven by ideas, by policy... our growing dependency on managers is killing medicare..."*

If, as you have been reading this research report, this chilling exposé, you have wondered how the story ends, we look to you — the public, the healthcare workers, our elected representatives — to decide. We need to speak up loudly and communicate clearly to those currently in control of policy and funding that we prioritize human needs over economic enrichment, that we believe the primary focus for those making decisions, supposedly on our behalf, should be on justice, equality, and high-quality care, including for those who have been underserviced or systemically marginalized. In that pursuit, we must increase funding to our public healthcare system and re-introduce a more democratic oversight of it functioning through publicly elected boards. We need to head off the creeping privatization that threatens this vital social safety net. We need to embrace the inherent value of compassion and kindness — to put patients first, not just as customers or clients, but as individuals who deserve respect, dignity, and care.

Nurses are an essential aspect of such care. Maya Angelou famously said, "As a nurse, we have the opportunity to heal the heart, mind, soul, and body of our patients, their families, and ourselves. They may forget your name, but they will never forget how you made them feel."

As **Katherine** said, in the words of a doctor she once worked with, *"The definition of health care is people helping people."* She urged those in charge of the healthcare system to *"take care of the people who take care of the patients. It should be the number one priority."* It is therefore essential that we achieve the proper staffing of nurses and other healthcare workers. The enactment of minimum nurse-to-patient ratios is a much needed first step.

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AUTHORS

James T. Brophy, PhD, and Margaret M. Keith, PhD, are occupational and environmental health researchers. They are both adjunct faculty members of the Department of Sociology and Criminology at the University of Windsor in Ontario. This work is a continuation of research they have been conducting over the past decade regarding working conditions within Ontario's strained healthcare system.

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