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Nurses - Workforce Commodity, or Autonomous Professionals: What Nurses Know about their Value, Working Conditions, Impacts on Patient Care, and Nursing Practice Concerns

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Abstract:
The current focus on the critical shortage of nurses puts nurses at risk for representation as a health workforce commodity, rather than being recognized as an autonomous, knowledge-based profession without which the health of Canada's population is in jeopardy. Nurses' knowledge and professional role includes evaluation of their career, working conditions, and impact on patients and populations of care. The concern that nurses are leaving the profession can be analyzed within a feminist perspective related to autonomy and advocacy. The focus of this reflective commentary is to highlight, at a personal and collective level, that nurses are witnesses to the conditions fueling nursing shortages, the impact on the practice environment and the structural factors influencing these areas. We are therefore compelled to articulate the seriousness of our concerns and assert our knowledge and value as a profession.

Keywords: nursing shortage, knowledge, professional autonomy, working conditions, feminism

The impact of the Covid-19 pandemic on the pre-existing and now critical shortage of nurses creates opportunities for meaningful discussion about the importance of the role of the Registered Nurse (RN) (Bourgeault, 2021; Tomblin Murphy et al., 2022). Editorials in peer-reviewed journals and in the media highlight the risk to the health care system created by a nursing shortage (Ball et al., 2022; Donnelly, 2022; Picard, 2021; Thorne, 2021). Nurses still have to raise their collective voices with little reassurance that their insights and recommendations will be taken seriously (Canadian Federation of Nurses Unions [CFNU], 2022; Donnelly, 2022).

The critical state of the nursing profession, and the ability to meet the health needs of populations, pre-dates the Covid-19 pandemic (Tomblin Murphy et al., 2022), a fact that is not lost on nurses. While there is a

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significant list of pre-pandemic factors contributing to a decrease in the size of the nursing workforce, including attrition, migration, and burnout, the strongest common denominator is the conditions under which we[1] are expected to provide our professional care and the impact of those conditions on our professional morale, ethical and clinical judgement, and ultimately, patient care (Bourgeault, 2021; Dall'Ora et al., 2020; Needleman, 2017; Poindexter, 2022; Scott et al., 2014). Furthermore, during the pandemic conditions escalated to include increased risks for the health and lives of nurses (Sofer, 2022; Tomblin Murphy et al., 2022).

The focus of this commentary is one which blends personal reflection and experience, and possibly resonates with other nurses as we collectively face a critical time in the trajectory of our profession. I write in hope that we do not despair, but rather, consider the significant advantage we have in committing to the articulation of our values and speaking to those who may not fully understand our progress and crucial role as a professional practice discipline. I share my perspective as a Canadian RN, a settler of European ancestry whose practice has been primarily in Western Canada (in direct patient care for three decades), and currently in a post-secondary role. I use the term *nurse* in reference to RNs like myself, I recognize that other nursing designations have a particular voice in these concerns as well.

In this reflective commentary I make the point that nursing is not merely a labour commodity, as some may view us, by highlighting our professional autonomy, professional purpose and value, and key role in advocacy for our working conditions. I assert that we are the safety net for our profession and that we must ensure that we continue to be bold in our expectations for our various roles. Our strength as a relational practice is based in self-refection and shared experience, and this strength drives the understanding of our value and autonomy (Musto et al., 2015).

Professional Autonomy

Embracing our autonomy as a profession has its underpinnings in feminist theory and the evolution of nursing (Burton, 2020). While an overview of feminism within the context of nursing practice is beyond the scope of this discussion, it remains a significant perspective with which to consider how we `appraise the factors that influence our practice settings (Burton, 2020). Additionally, the influence of feminist theory in the evolution of nursing practice, how nursing knowledge is conceptualized, and the rich body of scholarship related to these areas (Burton, 2020; Thorne & Sawatzky, 2014) attest to the intellectual endeavours of nursing and have contributed to my understanding of nursing autonomy and professionalism. Past structures that created barriers for nursing, such as patriarchal hierarchies, gender inequality, economics, political limitations to improving workplace policies, and social factors that determine health care needs, are still prevalent and concerning to nurses (Boamah et al., 2022; Gunn et al., 2019; Musto et al., 2015). Our autonomy as RNs is linked to accountability (Scott et al., 2014) and accounting for the circumstances of our work setting is foundational to our professional responsibility (Goodare, 2017; Needleman, 2017). We see that our autonomy is at risk if we are not included in speaking to the state of current conditions. Despite advances in our education, research, and leadership, nurses are now often reduced to the functional unit of *worker within* a health care system.

In a commentary on the state of the nursing workforce, Thorne (2021) advocates for the preservation of the nursing profession, and that we recommit to a "professional vision" (p. 154). This idea of vision echoes an earlier time when nurses' associations created public awareness campaigns asking that people envision a world where there are no nurses. These campaigns showed photos of hospital units empty of nursing staff, and pediatric and adult patients alone in their rooms, and asked viewers to think about the consequences (Ausmed, 2017; Massachusetts Nursing

[1] I will use I/we throughout, to indicate both the personal and collective voice, as I locate myself within the nursing profession.

Association, 2009). Some Canadian nurses may remember the strong visual message sent to the government of Saskatchewan in 1999 when RNs left their shoes on the steps of the legislature building, a rallying image of our value, knowledge, and autonomy. It was a clear message pointing not only to our numbers, but to the connection between unsafe and unacceptable working conditions, the nursing shortage, and risks these conditions create for the health of the province's citizens (Powell, n.d.).

Autonomy is linked to having choice: We can stay, or we can go. In general, we see ourselves as a service profession, yet we are not indentured. While we are called upon by governments during significant conditions, such as large-scale disasters or pandemics, we can make autonomous decisions about where we work, based on our individual circumstances, values, and needs (Musto et al., 2015). Thus, when working conditions deteriorate, we advocate for better conditions for patients and ourselves, and if things do not improve, some of us will choose to leave (Scott et al., 2013; Chachula et al., 2015). Our professional vision is based in our understanding of our value as nurses and our code of ethics; however, when working conditions lead to burnout, that vision becomes hindered (Boamah et al., 2022; Lasater et al, 2020; Musto et al., 2015). This experience may contribute to stress, moral distress, absenteeism, internal transfers of nurses with expertise, and attrition (Bourgeault, 2021; Goodare, 2017; Thorne, 2021). Nursing continues to be challenged with gendered norms regarding traditional roles for women in service professions, and this has an impact on how employers perceive the workforce (Anders, 2021; Burton, 2020). An examination of health care providers' moral distress during COVID 19 using a feminist approach related to the economics of women's work found that health care providers including RNs, were more likely to have multiple roles as paid and unpaid carers, which increased their moral distress (Smith et al., 2023). Gunn et al. (2019) used a macro-level approach to examine the impact of gendered norms in nursing education and hiring policies globally. They found that health care workforce policies still do not adequately address gender influences which have an impact on the professionalization of nursing (Gunn et al., 2019).

Despite such challenges, we did not deny our professional responsibility during the Covid-19 pandemic. We understood that our knowledge, abilities, and a strong nursing identity helped us to stay on the job, knowing our value and commitment as employees in public service. We stayed in nursing education to support the students, knowing that should they stay, they too would be the next role models for courage and care, and they needed those of us who are here now to support that vision. It is important to highlight, though, that the evolution of our profession includes the way gendered attributes have been assigned to nurses, a predominately female-identified profession, and we must ensure that terms such as *caring, nurturing,* and *supportive* do not resurface to elicit what Burton (2020) calls the "caring tax" (p. 273), where employers and governments assume that we will persevere, be good team members, and cope with unsustainable workloads (Burton, 2020).

Nursing practice has evolved away from a handmaiden culture of subservience to a patriarchal system where we were seen as personal assistants to the physician, an iteration of a traditional domestic model; and ideally, to an autonomous, self-regulated profession. Nursing practice reflects our knowledge, our concepts of care, our use of scientific processes of pattern recognition, solution seeking, and evaluation; our theory creation and application; and the integration of our practice domains, which include education, research, public policy, administration, and leadership (Burton, 2020; Scott et al., 2014; Thorne, 2021). We are not widgets in a system called *health*. Nurses do not view health care the same as traditional, for-profit industries.

Having our presence analyzed, debated, and sometimes dismissed - due to the politics and economics of hiring nurses - undervalues all members of the health team with whom we work and the patients who trust that we will be there due to our professional knowledge, skills, and abilities (Goodare, 2017; Scott et al., 2014).

Professional Advocacy

If our value as a practice profession is reduced to an organizational expense, then nursing is undermined. I know my worth because my qualifications and experience enable me to think like an RN; I stand with RNs, and I know what I/we bring to the health care setting, or education, or community setting. I know how that translates into my economic wellbeing and compensation. I am always conscious of those who came before me to do that work and support the socio-economic wellbeing of nurses (Canadian Federation of Nurses Unions, 2023). I/we can see, in the messy juxtaposition between a public health care system and a business model, that I/we have some expectations for our professional autonomy, the use of our tax dollars and my wages. We are all going to be patients at some stage. That fact may be a wise consideration for government, employers, and policy makers.

Nurses know their role as patient advocates in a relational practice paradigm, and we expect our voices to be heard and respected (Musto, 2015; Scott et al., 2013). We advocate for our profession because we know our value, we mitigate risks during every shift, and we see the big picture, including the political landscape that impacts our patients and communities, and our professional practice. We work, as both professional and employee, amid each wave of new vision and mission statements, as they roll in and out with each new leader, board, and provincial government. We are caught in the power play, often referred to as the *dynamic environment,* with its competing priorities, and between the government budget and the score card of the health organization and its leaders. We are asked to embrace the strategic plans and reminded to be open to change. I do not believe that we are resistant to change. In nursing, change is a *status quo* variable. When things don't change or we identify change for the sake of change, nurses, as members of an autonomous profession, will question the *status quo*. It is, as Thorne (2021) reminds us, this autonomy as a professional practice that "we must strenuously protect" (p. 153).

Perhaps then, advocating for our current state means taking the focus of this discussion outward. At individual and collective levels, we need to articulate more clearly, yet again, to government, policy, and organizational decision makers, and the public, the value of our knowledge and professional autonomy (Bender, 2018). We can, and do, speak for ourselves, we know who we are, we know what nursing is, why we chose a nursing career, how we support each other, and our team colleagues under difficult conditions, and we know our contributions are significant for those in our classrooms, our care, and our society. (Bender, 2018). Nurses need to be present at more public panel discussions where health is the topic, finding opportunities to speak at public lectures and seeking invitations to more tables where health care decisions are being made. Nationally, the Canadian Nurses Association (CNA) and the CFNU have lobbied the federal government to attend to the impact of the nursing shortage, both prior to and during the COVID-19 pandemic (CNA, 2022a; CFNU, 2022). The development of an email template addressing the nursing shortage, for nurses to send a message to their member of parliament, is an important advocacy strategy (CNA, 2022). The reinstatement of the Chief Nursing Officer position brings hope that nurses at every level will have the opportunity to support improvements to nursing practice (CNA, 2022b). Nurses in direct patient care should be supported, through continued education, to contribute to health care policy and be key stakeholders in innovations to improve working conditions and patient care (Anders, 2021; Udod, 2023).

Professional Reality

I make a bold assumption that if I were to share the following brief observations from my career experience they would resonate with other nurses:

- Nurses working in acute hospital settings accept that every shift is an opportunity and a risk. As nurses become more experienced, they develop a vison of every shift. The care required and the care delivery depends largely on the nurse-patient ratio workload, assessment of patient acuity and stability, available resources, and the many moving parts of

the system. Of these many parts, some can be predicted (i.e., the number of elective surgeries performed, the number of patients likely to be discharged, the number of assessments done per shift); however; the unpredictable is also anticipated and ongoing adaptive strategies must be prioritized amid changing needs. Factors such as trauma admissions, deteriorating patient health status requiring transfer to specialized observation units or intensive care, surgical delays due to emergency case admissions, or intraoperative complications, and staff illness all are part of the reality of a nurse's shift. In maternal and child health care there are similar unpredictable variables. The ongoing assessment, critical judgement, evaluation, organizational skills, communication, and leadership are key knowledge-based strategies that professional nurses use minute by hour to care for patients and manage the health setting environment. Nurses in urban settings know geography is an important factor in the health care landscape. Rural and remote acute health needs include hours of transportation, ambulance availability, and triage support. Ask a community health nurse or home care RN about the unpredictability of their care setting and you will hear more about uncontrolled conditions that are navigated while providing care and arranging referrals for additional services.

- Within the nurses' vision for each shift is the knowledge that a hospital unit with too few experienced RNs increases the risk for potential safety and treatment complications because the mentoring and leadership for new staff is missing. Nurses who are responsible for educating nursing students are concerned that the shortage of experienced nurses on a unit has an impact on the learning environment for students, faculty instructors, and preceptors, and on patient safety. The class called, "How to work short staffed" is not in the nursing curriculum. Nursing students in their final practicum experience are faced with the challenging realities of the work environment that awaits them. As new graduates they will need the mentorship and support of experienced nurses.
- Nurse colleagues who teach and work in community settings are concerned that the lack of commitment by governments to improve community health programs and support primary health care makes people more dependent on walk-in clinics and emergency departments.
- Nurses in these all these health settings, and nurse educators and researchers, understand that Canada and its health care system, even with its flaws, remain a beacon to those from low-resource and war-torn countries, and we worry how the health needs of newcomers will be met under the current conditions.

My assumption that these observations may resonate with other nurses is rooted in my belief that we have a shared professional lived experience.

I do not believe nurses take the trust of the public for granted. We value the support of our professional associations in articulating to government leaders that if the public continues to receive messages highlighting the overloaded conditions in hospitals, lack of resources, and the nursing shortage, they will come to hospital afraid or angry, and many will avoid seeking services, resulting in declining health status and potential death.

Professional Purpose

What nurses know is our *worth it* factor. We are not here for the platitudes—"Oh, the nurses were wonderful! Oh, you all pulled together!" We are here due to our knowledge and clinical judgement, our service commitment, and our research that improves care and safe practice (Tomblin Murphy et al., 2022).

In many health settings, as part of sound labour practice, nurses invest in the professional process of writing reports about their work situations. This is an act of advocacy for their professional practice and for the public good. The analysis of this data and escalation of the concerns to organizational leaders and

stakeholders is a mechanism that supports the ethical standards that RNs commit to as a self-regulated, autonomous profession. We want our insights and recommendations heard, not just so that a stakeholder *tic box* can be checked off, but so our knowledgeable perspectives about working conditions and patient care are considered. We have the right to evaluate the outcomes of top-down decisions, and the impact for patients and on our work environment.

Ask nurses about that other significant shortage they have been talking about for years– the shortage of roles for nurses where their full scope of practice will be realized: team leads in community care programs, RNs in schools whose roles are funded by the Ministry of Health, not the Ministry of Education; specialists in older adult care, bridging programs for mental health, health education and outreach, advanced practice roles, clinical nurse specialists, funded support for nurse practitioner-led interprofessional clinics and health centres. Nurses' vision for the future includes these underfunded and, in some cases, unrealized roles and that we know we can provide assessment, diagnostic and preventative support, and follow up care that decreases hospital admissions and supports the lifespan health needs of the population (Tomblin Murphy et al., 2022). While the support for increasing seats for nursing students is needed, nurses are aware of the time that it takes to graduate nurses and the impact this has for retention and attrition, nationally and globally (International Council of Nurses, n.d.).

Conclusion

The impact of the Covid-19 pandemic certainly brought into public view many concerns about the nursing workforce. The knowledge and experience of nurses, our evolution as a practice profession, autonomous in our decision making and how we create our standards of practice, is what guides us first and foremost. We do not leave this behind as we cross the threshold of the entry-to-practice portal, new licence in hand. It is our nursing education, education systems, our knowledge and journey toward practice expertise that brings our value to the health care system. This is the significant distinction between being recognized as the professional group we are rather than represented as a generic human resource with deployable skills.

Ethical and moral distress is experienced by nurses who know in their hearts and minds that when the working conditions become dire, the outcome will be their inability to fulfill their mandate to adequately support the health needs of those they serve. We practice amidst many variables–social, economic, and structural–that contribute to the health of the population, many of which are not related to nurses or the nursing shortage. If nurses leave the profession, it is likely a last resort reflection of nurses' autonomy, heavily weighted within the dichotomous state as both professional and employee, an ethical decision, driven by the challenging conditions of the practice environment. Not leaving the profession is also an act of autonomy, where we assert our knowledge and ability together, to reflect individually, discuss and debate collectively, and take a stand for nursing. We are not a commodity within the system; we can speak to that in all the places where we are located. Increased roles for advance practice nurses and community nurses and improved wages and working conditions are not new action items. Nurse leaders and health organization leaders need to work together to leverage the expertise of nurses in practice. Consideration of paid secondments to special working groups, engagement in health policy improvement, nurse speakers at public panels, and the development of formal mentorship opportunities to support new graduates could also be operationalized. Improving the nursing workforce cannot focus solely on the number needed. Maintaining the vision of how and why we expect our autonomy and expertise to be respected within the landscape of our practice domains is our ongoing challenge.

Ethical Permission

Ethical permission was not required for this discussion paper.

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References

Anders R. L. (2021). Engaging nurses in health policy in the era of COVID-19. *Nursing Forum, 56(1),* 89-94. https://doi.org/10.1111/nuf.12514

Ausmed. (2017). *A world without nurses* [YouTube video]. https://www.youtube.com/watch?v=zo_OrcYEwGU

Ball, C. G., Engels, P. T., Gregg, S., & Harvey, E. J. (2022). The intersection of COVID-19 and public health care in Canada: What does the future hold for the surgical patients and health care workers left behind? *Canadian Journal of Surgery*, *65*(1), E52–E53. https://doi.org/10.1503/CJS.000422

Bender, M. (2018). Re-conceptualizing the nursing metaparadigm: Articulating the philosophical ontology of the nursing discipline that orients inquiry and practice. *Nursing Inquiry*, *25*(3), e12243 n/a. https://doi.org/10.1111/nin.12243

Boamah, S. A., Hamadi, H. Y., Havaei, F., Smith, H., & Webb, F. (2022). Striking a balance between work and play: The effects of work-life interference and burnout on faculty turnover intentions and career satisfaction. *International Journal of Environmental Research and Public Health*, *19*(2), 809. https://doi.org/10.3390/ijerph19020809

Bourgeault, I. L. (2021). Vulnerabilities in the nursing workforce in Canada: The anatomy and physiology of nursing workforce challenges and potential solutions for better planning, policy and management. *Nursing Leadership*, *34*(4), 11-18. https://doi.org/10.12927/cjnl.2021.26694

Burton, C.W. (2020). Paying the caring tax: The detrimental influences of gender expectations on the development of nursing education and science. *Advances in Nursing Science*, *43*(3), 266–277. https://doi.org/10.1097/ANS.0000000000000319

Canadian Federation of Nurses Unions. (2022). *Agency nurses: Position statement.* https://nursesunions.ca/wp-content/uploads/2023/03/2022_CFNU-Position-Statement_Agency-Nurses_EN.pdf

Canadian Nurses Association. (2022a). *Governments must work together to combat nurse burnout, CNA, CFNU say*. CNA News Room. https://www.cna-aiic.ca/en/blogs/cn-content/2022/01/20/governments-must-work-together-to-combat-nurse-bur

Canadian Nurses Association (2022b). *CNA applauds federal government for reinstating chief nursing officer for Canada.* CNA News Room. https://www.cna-aiic.ca/en/blogs/cn-content/2022/02/01/cna-applauds-federal-government-for-reinstating-ch

Chachula, K., Myrick, F., & Yonge, O. (2015). Letting go: How newly graduated registered nurses in Western Canada decide to exit the nursing profession. *Nurse Education Today*, *35*(7), 912–918. https://doi.org/10.1016/j.nedt.2015.02.024

Dall'Ora, C., Ball, J., Reinius, M., & Griffiths, P. (2020). Burnout in nursing: A theoretical review. *Human Resources for Health*, *18*(1), 1–41. https://doi.org/10.1186/s12960-020-00469-9

Donnelly, G. (2022). Nursing shortage: The perfect storm. *Holistic Nursing Practice*, *36*(6), 333–333. https://doi.org/10.1097/HNP.0000000000000555

Goodare, P. (2017). Literature review: Why do we continue to lose our nurses? *Australian Journal of Advanced Nursing*, *34*(4), 50–56.

Gunn, V., Muntaner, C., Ng, E., Villeneuve, M., Gea-Sanchez, M., & Chung, H. (2019). Gender equality policies, nursing professionalization, and the nursing workforce: A cross-sectional, time-series analysis of 22 countries, 2000–2015. *International Journal of Nursing*

*Studies, 99,*103388. https://doi.org/10.1016/j.ijnurstu.2019.103388

International Council of Nurses. (n.d.). *The global nursing shortage and nurse retention. International Council of Nurses policy brief.* https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention_0.pdf

Lasater, K. B., Aiken, L. H., Sloane, D. M., French, R., Martin, B., Reneau, K., Alexander, M., & McHugh, M. D. (2020). Chronic hospital nurse understaffing meets COVID-19: An observational study. *BMJ Quality & Safety*, *30*(8), 639–647. https://doi.org/10.1136/bmjqs-2020-011512

Massachusetts Nursing Association. (2009). *Imagine a world without nurses* [YouTube Video]. https://www.youtube.com/watch?v=hLRDpQ3x7KQ

Musto, L. C., Rodney, P. A., & Vanderheide, R. (2015). Toward interventions to address moral distress: Navigating structure and agency. *Nursing Ethics*, *22*(1), 91–102. https://doi.org/10.1177/0969733014534879

Needleman, J. (2017). Nursing skill mix and patient outcomes. *BMJ Quality & Safety*, *26*(7), 525–528. https://doi.org/10.1136/bmjqs-2016-006197

Picard, A. (2021, February,16). Canada's nursing shortage is a gaping wound in our health care system. *The Globe and Mail.* *https://www.theglobeandmail.com/opinion/article-canadas-nursing-shortage-is-a-gaping-wound-in-our-health-care-system/*

Poindexter, K. (2022). The great resignation in health care and academia: Rebuilding the postpandemic nursing workforce. *Nursing Education Perspectives*, *43*(4), 207–208. https://doi.org/10.1097/01.NEP.0000000000001003

Powell, C. (n.d.). Saskatchewan Union of Nurses. *The Encyclopedia of Saskatchewan*. https://esask.uregina.ca/entry/saskatchewan_union_of_nurses_strike.html

Scott, P. A., Matthews, A., & Kirwan, M. (2014). What is nursing in the 21st century and what does the 21st century health system require of nursing*? Nursing Philosophy*, *15*(1), 23-34. https://doi.org/10.1111/nup.12032

Sofer, D. (2022). Nursing shortage or exodus? *The American Journal of Nursing*, *122*(3), 12– 13. https://doi.org/10.1097/01.NAJ.0000822928.16774.9a

Smith, J., Korzuchowski, A., Memmott, C., Oveisi, N., Tan, H.-L., & Morgan, R. (2023). Double distress: Women healthcare providers and moral distress during COVID-19. *Nursing Ethics*, *30*(1), 46–57. https://doi.org/10.1177/09697330221114329

Thorne, S. (2021). Commentary: Regaining our professional vision. *Nursing Leadership*, *34*(4), 151-156. https://doi.org/10.12927/cjnl.2021.26676

Thorne, S., Sawatzky, R. (2014). Particularizing the general: Sustaining theoretical integrity in the context of an evidence-based practice agenda. *Advances in Nursing Science*, *37*(1), 5–18. https://doi.org/10.1097/ANS.0000000000000011

Tomblin Murphy, G., Sampalli, T., Bourque Bearskin, L., Cashen, N., Cummings, G., Elliott Rose, A., Etowa, J., Grinspun, D., Jones, E. W., Lavoie-Tremblay, M., MacMillan, K., MacQuarrie, C., Martin-Misener, R., Oulton, J., Ricciardelli, R., Silas, L., Thorne, S., & Villeneuve, M. (2022). Investing in Canada's nursing workforce post-pandemic: A call to action. *Facets*, *7*, 1051–1120. https://doi.org/10.1139/facets-2022-0002

Udod, S., (2023). A call for urgent action: Innovations for nurse retention in addressing the nursing shortage. *Nursing Reports*, *13*(1), 145–147. https://doi.org/10.3390/nursrep13010015