ONTARIO'S NURSING CRISIS AMIDST THE COVID-19 PANDEMIC AND THE SHIFT AWAY FROM BEDSIDE CARE: AN EXPLORATORY STUDY

RACHEL ROWNEY

Thesis submitted to the University of Ottawa
in partial fulfillment of the requirements for the
Master of Science in Nursing degree

School of Nursing
Faculty of Health Sciences
University of Ottawa

Preface

Student and Collaborators Contributions to this Dissertation:

1. Rachel Rowney, RN, BScN

   Master of Science in Nursing student, University of Ottawa, Faculty of Health Sciences, School of Nursing

2. Dr. Sandra Harrisson, RN, PhD

   Associate Professor, University of Ottawa, Faculty of Health Sciences, School of Nursing

3. Dr. Michelle Lalonde, RN, PhD

   Full Professor, University of Ottawa, Faculty of Health Sciences, School of Nursing

4. Dr. Kimberly McMillan, RN, PhD, CHPCN(C)

   Associate Professor, University of Ottawa, Faculty of Health Sciences, School of Nursing

This master's thesis is presented in a thesis by article format and includes one article titled *From Pandemic Departure to Pathways Back: Understanding Ontario Nurses' Decisions to Leave Bedside Care and Exploring Re-Entry* [Unpublished manuscript]. This article was prepared for submission to the *Canadian Journal of Nursing Leadership* for publication. The article was written by the student who is the main author of the manuscript. The intention of presenting the results of this thesis in article format are to disseminate the findings to a broader audience to contribute to the discourse on Ontario's nursing crisis and support initiatives and strategies for nursing retention and re-entry to bedside care.

Dr. Harrisson was the Thesis Supervisor, providing guidance at all stages of the research process, contributing to the development of the study and topic, overseeing and approving this dissertation and peer reviewing the manuscript.

Dr. Lalonde and Dr. McMillan were part of the Thesis Advisory Committee, approved the thesis protocol, discussed the thematically analyzed results, served as peer reviewers for the article and reviewed the thesis in its entirety. They both provided editorial feedback and valuable insights. Dr. Lalonde served as the internal examiner for the thesis defense.

Abstract

Ontario experienced a significant rise in nursing turnover during the COVID-19 pandemic, with many nurses leaving bedside care roles. This thesis explores the intentions and experiences of nurses in Ontario who left bedside nursing during the pandemic, focusing on the factors that shaped their decisions to leave as well as their considerations around returning to bedside practice. The study was conducted using an exploratory qualitative design guided by two theoretical frameworks, the Unfolding Model of Voluntary Employee Turnover (Lee & Mitchell, 1994) and the Job Embeddedness Model (Mitchell & Lee, 2001). Data was collected through semi-structured interviews with Ontario Registered Nurse participants ($N = 4$) who left bedside nursing during the pandemic. Interviews were thematically coded to analyze and systematically identify themes, patterns and insights. Three major themes emerged: 1) the Pandemic Exodus from Bedside Nursing, characterized by burnout and moral distress; 2) Rebuilding Bedside Nursing, emphasizing how leadership, mentorship, professional development and teamwork can support retention and re-entry to bedside practice; and 3) Redefining the Nursing Journey Beyond the Bedside, capturing nurses' professional identity and the expanded career pathways within healthcare and the nursing profession. The findings illustrate the complex personal, professional and systemic factors that influenced Ontario nurses' departure from the bedside during the pandemic. They highlight the need for targeted strategies that promote retention, re-entry and career sustainability to strengthen the nursing workforce post pandemic.

Acknowledgements

I would first like to thank my Thesis Supervisor, Dr. Sandra Harrisson, for her guidance, leadership and mentorship throughout the Master of Science in Nursing (MScN) program. I am immensely grateful for Dr. Harrisson's exceptional kindness, patience and encouragement. Dr. Harrisson's confidence in my abilities as a novice researcher, support and motivation have brought this project to fruition.

Thank you to my Thesis Advisory Committee (TAC), Dr. Michelle Lalonde and Dr. Kimberly McMillan for their time and dedication. Their thoughtful feedback, advice, insights and expertise in health services, nursing work, and organizational environments strengthened my knowledge and expanded my learning. Their perspectives enriched this thesis and challenged me to grow as a nurse, a leader and a scholar.

I am especially appreciative for the flexibility and understanding I received from Dr. Harrisson, my TAC, and my workplace throughout this process. Completing this master's degree and thesis while working full time as a Director of Nursing was undeniably challenging and it would not have been possible without the support of those around me. Their accommodation enabled me to balance my professional responsibilities with my academic and personal commitments.

Finally, I am thankful for the nurses who participated in this study and chose to share their experiences with me. Their openness, honestly and willingness to be vulnerable made this research possible. Engaging in these conversations offered a sense of validation and closure for myself and the nurses who participated. I am hopeful that the insights gained from this study will contribute meaningfully to supporting and strengthening Ontario's nursing workforce.

Table of Contents

Preface …..……..…II

Abstract …...……..IV

Acknowledgements …..……..……..…V

Table of Contents ……..……...VI

Acronyms …….....X

Figures ……...……....XI

Tables …….....XII

Chapter One: Introduction …….……1

1.1 Personal Impetus Behind the Research ….……...…..2

1.2 Thesis Organization ……..……...…...3

1.3 Background ……..……3

1.4 Research Objective ……..……...……...…9

1.5 Research Question ……..……...…9

References …...……..…….11

Chapter Two: Literature Review ……..…….17

2.1 The Nursing Shortage ……..……17

2.2 The Progression of Nursing Roles ……..…….20

2.3 Nursing Recruitment and Retention ……..…….22

References ……..……...……25

Chapter Three: Theoretical Foundations ……..……....30

3.1 Epistemological Viewpoint ……..……...…30

3.2 Theoretical Framework ……..……..…31

3.2.1 The Unfolding Model of Voluntary Employee Turnover ……..……..31

3.2.2 Job Embeddedness Model ……..……..…34

3.2.3 Integration of the Models ……..……..…35

References ……..……..……37

Chapter Four: Methodology ……..…….39

4.1 Study Design ……..…….39

4.2 Population ……..……..……40

4.3 Recruitment ……..……..……41

4.4 Data Collection and Management ……..……..…42

4.5 Ethical Considerations ……43

4.6 Data Analysis ……..……43

4.7 Rigour and Scientific Value of the Research Project …….45

References ……..……....48

Chapter Five: Results ……..……..…51

Thesis By Article Rationale ……...…….……....51

From Pandemic Departure to Pathways Back: Understanding Ontario Nurses' Decisions to Leave Bedside Care and Exploring Re-Entry ……..……53

Abstract ……..……54

Introduction ……..…….....55

Methodology ……..…….....56

Theoretical Perspectives on Nursing Turnover and Retention ……..56

Design ……..……...58

Sample & Recruitment ……..……..58

Table 1 ……..……..59

Data Collection ……..…..……..59

Ethical Considerations ……..……..59

Data Analysis ……..……....60

Results ……..……..……...60

Figure 1 ……..……..……..62

Theme 1: The Pandemic Exodus from Bedside Nursing ……...62

Theme 2: Rebuilding Bedside Nursing ……..66

Theme 3: Redefining the Nursing Journey Beyond the Bedside ……..68

Discussion ……..……71

Implications for Nursing Leadership ……..……...73

Limitations ……..74

Conclusion ……..…75

References ……..……..……..76

Chapter Six: Discussion ……..……....80

6.1 Moral Distress as a Catalyst for Leaving Bedside Nursing ……80

6.2 Exploring the Sacrifices of the Pandemic Exodus from Bedside Nursing ……84

6.3 Advancing Professional Nursing Roles in Infection Prevention and Control …..……86

6.4 Implications……..……88

6.4.1 Implications for Nursing Practice ……..……88

6.4.2 Implications for Nursing Education ……..……...89

6.4.3. Implications for Nursing Research ……..……....90

6.5 Strengths and Limitations ……..……..91

References ……..93

Chapter Seven: Conclusion ……...99

References ……..102

Appendix A: Recruitment Poster ……...103

Appendix B: Questionnaire Guide ……..…104

Appendix C: Ethics Approval University of Ottawa & TCPS 2 Certificate …...……106

Appendix D: Consent Form ……109

Acronyms

CIHI: Canadian Institute for Health Information

CNA: Canadian Nurses Association

CNO: College of Nurses of Ontario

CoP: Community of Practice

FLTCA: Fixing Long-Term Care Act, 2021

IPAC: Infection Prevention and Control

LTC: Long-Term Care

NP: Nurse Practitioner

PPE: Personal Protective Equipment

RN: Registered Nurse

RPN: Registered Practical Nurse

RNAO: Registered Nurses' Association of Ontario

TAC: Thesis Advisory Committee

List of Figures

Figure 1: Outline of Research Themes and Subthemes ……62

List of Tables

Table 1: Summary of the four nurse participants who left bedside practice during the COVID-19 pandemic ……...……59

Chapter One: Introduction

Chronic Registered Nurse (RN) understaffing in Ontario has been an ongoing issue spanning several decades (RNAO, 2024). The unprecedented challenges posed by the COVID-19 pandemic including personal protective equipment (PPE) shortages, redeployment, evolving protocols, and overwhelming workloads, placed further strain on an already fragile nursing workforce (Brophy et al., 2021). During the pandemic, bedside[1] nurses reported feeling broken, citing burnout and an inability to effectively manage their personal and professional responsibilities. These experiences led to "breaking points" which were moments shaped by complex individual, societal and organizational stressors that compromised nurses' mental health (Akoo et al., 2024, p. 3). A transformative shift in the nursing and healthcare landscape emerged during the pandemic as new nursing opportunities arose in areas such as infection control, public health, vaccine clinics, mobile testing initiatives and alternative models of care delivery, including telehealth (Lyons et al., 2025). When the Ontario government introduced Bill 124 and imposed wage suppression measures on nurses and other public sector employees, it adversely affected nursing retention and further intensified existing staffing pressures across the nursing workforce (Callan & D'Mello, 2023). Ontario began to see more nurses opting to work for private companies and nursing agencies offering higher rates of pay, as public sector nursing roles remained limited by salary restrictions introduced under Bill 124 (Almost, 2024). The province saw an increase in nursing turnover, with a notable exodus from bedside practice amidst the pandemic; experienced nurses left or retired while other nurses sought out opportunities away from bedside care or the occupation (RNAO, 2024). Ontario's RN staffing

[1] The term bedside nurse, refers to RNs primarily responsible for delivering nursing interventions such as medication administration, performing clinical assessments and monitoring to ensure safe and quality care is being given.

crisis continues to be an issue in a post pandemic world as many nurses have grappled with the decision to leave bedside nursing or the profession all together with their plans of returning remaining ambiguous (RNAO, 2026).

1.1 Personal Impetus Behind the Research

The COVID-19 pandemic was a challenging time for many nurses, myself included. As a novice nurse I was introduced to new experiences and situations that were both unfamiliar and unsettling. At the onset of the pandemic, I was working as a bedside nurse in a Long-Term Care (LTC) facility and was often the only RN in the building. I quickly became aware of the consequences and effects of the pandemic on my resident (patient) population and the broader LTC sector within Ontario's healthcare system. As a new nurse in the Charge Nurse position, I was unprepared for the rapid deterioration of the residents I cared for and struggled to support their escalating needs while navigating rising staff absenteeism and turnover.

Reflecting on the COVID-19 pandemic, I recall society celebrating nurses as heroes. Despite this narrative my shifts at the bedside were often devastating and I felt defeated when I got home from work. There seemed to be this unspoken expectation that it was our professional responsibly and duty as nurses to support the fight against COVID-19 and endure the immense pressures of a healthcare system in crisis. In the fall of 2020, just six months into the pandemic, I made the difficult decision to leave bedside nursing.

Stepping away from bedside nursing during a global pandemic changed the course of my career trajectory. I transitioned into a LTC management role and found purpose in supporting nurses in meaningful ways. My experiences throughout the pandemic both at the bedside and as a manager continue to shape my understanding of the nursing workforce challenges. In my role as a leader, I am a strong advocate for improving nursing work conditions to promote retention

while also exploring strategies to support nurses who left to re-enter bedside roles. This thesis represents a continuation of my commitment to nursing advocacy and empowerment to rebuild and sustain Ontario's nursing workforce.

1.2 Thesis Organization

This thesis is structured into seven chapters. Chapter one provides the background for the study and outlines the research problem and guiding question. Chapter two explores the literature which supports the need for this study. Chapter three discusses the researcher's epistemological viewpoint and the two frameworks used to guide the study. Chapter four provides details of the methodological approach, describing the study design, participant population, data collection methods, and the analysis strategy used to ensure rigor. The results in Chapter five are presented in article format and Chapter six discusses these results in relation to the literature. Chapter seven concludes this thesis.

1.3 Background

Ontario continues to grapple with the nursing shortage and ongoing workforce attrition, with nurse-to-population ratios falling below pre-pandemic levels (RNAO, 2026). Existing research prior to the pandemic highlighted that nurses' rationale for leaving the bedside included dissatisfaction with pay and hours, insufficient staffing, excessive workloads, social status, feelings of inferiority to doctors and lack of career advancement (Alilu et al., 2017). Working conditions for bedside nurses during the pandemic produced an environment conducive to stress, fatigue, burnout and attrition (Gherman et al., 2022). The Canadian Institute for Health Information (CIHI) report on pandemic trends revealed that hospitals heavily relied on agency nurses and mandated overtime, which coincided with increased nursing absenteeism (CIHI, 2023). In 2022, RNs providing bedside care continued to decrease by 1%, nurses and other

health care providers reported sick time increased by 17% and there were 95,800 healthcare job vacancies (CIHI, 2023). Despite there being an insufficient number of nurses working during the pandemic, job demands and workload increased while compensation was not adjusted to reflect these changes (Ali et al., 2023). Post pandemic, nurses continued to report inadequate workplace staffing, increased absenteeism, decreased quality of care and excessive workloads, further contributing to burnout and turnover intention amongst bedside nurses (Durant, 2023).

The Registered Nurses' Association of Ontario (RNAO) surveyed nurse respondents (N = 2102) on their work and wellbeing to understand how the nursing workforce was affected by the pandemic (RNAO, 2021). At the time of data collection 42% of nurses were contemplating leaving the profession and 69% of nurses were planning to leave their position; more than 20% of those nurses being new RNs and Nurse Practitioners (NPs) (RNAO, 2023). The findings from the RNAO survey are significant as the nursing crisis persists post pandemic. While the results represent data collected during the height of the pandemic, they underscored the need to make meaningful investments to protect Ontario nurses and avoid the prolonged workforce instability that has ensued. The results of the RNAO's 2021 survey revealed that 90% of respondents experienced at least moderate amounts of stress with many experiencing high levels of stress (RNAO, 2023). Added work-related stressors, overtime and inadequate compensation had a cumulative effect on nursing in Ontario and was associated with burnout, increased turnover intention and became a significant barrier to retention (RNAO, 2023). In 2026, RN to population staffing ratios remain below pre-pandemic levels and are insufficient to meet the demands of Ontario's ongoing population growth and rising healthcare demands (RNAO, 2026). Post pandemic working conditions have deteriorated with nurses continuing to experience sustained high levels of stress, burnout, anxiety and depression (RNAO, 2026). Early career nurses have

struggled and been disproportionally impacted by these poor work environments, encountering greater challenges in coping and sustaining their roles within the profession (RNAO, 2026). A 2024 national survey conducted by the Canadian Federation of Nurses Unions (CFNU) (N = 5595) revealed that intention to leave has increased since the pandemic with 78% of nurses intending to leave their current position and 76% intending to leave the profession (CFNU, 2024).

The province's nursing crisis post pandemic reveals that Ontario has the lowest levels of RNs per capita in Canada, a metric that continues to decrease (RNAO, 2024). In 2022 the Ontario Nurses' Association (ONA) reported that the average number of RNs in Ontario was 668 per 100,000 people, significantly lower than the national average of 830.5 RNs per 100,000 people (ONA, 2022). CIHI's most recent Canadian health workforce data indicates that Ontario has just 651 RNs per 100,000 Ontarians compared to the national average of 825 RNs per 100,000 people (CIHI, 2025). At the beginning of the pandemic Ontario was already short 24,000 RNs compared to the rest of Canada (RNAO, 2023). Post pandemic, the RN staffing crisis continues to deteriorate leaving Ontario's RN to patient ratio per capita far worse than the rest of Canada with the province needing more than 25,000 RNs to align with the national average (ONA, 2024).

Findings revealed that sustained increases in burnout resultant from the stressors, fears and hectic work environment perpetuated by COVID-19 were higher in nurses when compared to other healthcare professionals, and these compounding pressures ultimately led nurses to transition away from bedside practice (Maunder et al., 2022). The COVID-19 pandemic forced bedside nurses to practice in unsafe situations with insufficient staffing, improper PPE and little support or control over their work (Bourgault, 2022). Moral distress refers to the ethical conflict

nurses experience when they are prevented from acting on what they know is right and this concept gained relevance during the pandemic (Morley et al., 2019). Moral distress became a significant topic as the COVID-19 pandemic presented ethical challenges including restrictive visitation policies, resource scarcity and changes to care provision; these experiences contributed to emotional burnout, compassion fatigue and feelings of powerlessness resulting in increased nursing turnover (Nagle et al., 2023). A key source of psychological distress for healthcare workers that emerged in the research was having an inadequate supply of PPE; the shortage of N95 mask fit respirators in conjunction with staffing shortages, unsustainable workloads and heightened levels of anxiety resulted in burnout and exhaustion amongst nurses (Brophy et al., 2021). Additionally, lack of knowledge about the virus and improper use of PPE led to negative emotions of anxiety, fear and stress that impacted nurses' quality of life during the pandemic (Nair et al., 2022). Burnout and psychological strain greatly contributed to Ontario's nursing crisis. Rebuilding the bedside nursing workforce will require intentional, sustained support that prioritizes the wellbeing of nurses.

The political landscape in Ontario also played a role in perpetuating the nursing crisis. Bill 124, the *Protecting a Sustainable Public Sector for Future Generations Act,* was introduced in 2019 by the provincial conservative government (Government of Ontario, 2019). This Act restricted any increases in salary rates, including nurses, to no "greater than one percent for each 12-month period" (Government of Ontario, 2019, p. 7). Prior to the implementation of Bill 124, Ontario nurses were negotiating wage increases through collective bargaining which was in line with or higher than other public sector agreements and exceeded the 1% wage increase restriction (ONA, n.d.). Given the economic reality in Canada with Statistics Canada reporting inflation reached its highest level in 40 years in 2022, this Bill was deeply consequential and

harmful for nurses (Statistics Canada, 2024). With the cost of basic needs rising, wage suppression legislation negatively affects nurses as they would earn less each year, and this could also impact pre-existing retention and staffing challenges within the profession (Callan & D'Mello, 2023). Concerns about wage disparity resulting from Bill 124 was noted as a contributing factor to retention issues and a key driver of attrition (Callan & D'Mello, 2023). The initial 2022 ruling of Bill 124 was found unconstitutional, however, the Ontario government appealed this decision. In 2024 the Superior Court upheld the original ruling by denying the appeal, confirming that the law was unconstitutional (ONA, 2024).

The conservative government also amplified discourse within the province surrounding the topic of privatizing healthcare in Ontario (CUPE, 2022). The nursing workforce shortfall has had a profound impact on the entire healthcare system as evidence by increased wait times, surgical delays and unit closures across Ontario which have prevented the delivery of timely and effective care (Hajizadeh & Jalili, 2025). Chronic understaffing limits nurses' ability to provide adequate nursing services and has been linked to missed care and increased morbidity and mortality (Ahmed & Bourgeault, 2022). Reshaping the delivery of health services in Ontario creates a tiered labour market where nurses could be attracted away from publicly funded workplaces that are already struggling with understaffing (Baumann & Crea-Arsenio, 2023). Many nurses, particularly newer nurses abandoned the public sector during the pandemic, opting to work for private companies that would offer more competitive salaries and flexible working hours (Almost, 2024). This created uncertainty about the future of Ontario's publicly funded healthcare system, generated division amongst healthcare workers and ultimately impacted RN staffing which further destabilized the public system (Almost, 2024). As a result of the nursing shortage, Ontario healthcare institutions heavily relied on for-profit nursing agencies during the

pandemic and the cost of filling vacancies with agency nurses was often at least double the rate of staff nurses (Dowson, 2023). The growing presence of private, for-profit clinics in Ontario is gradually undermining the longstanding principle of health care as a public good by shifting aspects of healthcare delivery towards private models (CFNU, 2023). Privatizing the province's healthcare system could pose further challenges that impact staffing shortages, health equity, access and the quality of nursing care provided in Ontario.

An examination of the health system implications from the pandemic and Ontario's staffing crisis will allow for a deeper understanding of the broader challenges that threaten the nursing workforce. Recent literature has focused on the causes that led to the mass exodus from bedside nursing, however, there remains a notable absence surrounding the motives and strategies that would entice nurses to re-engage in bedside practice (Baumann & Crea-Arsenio, 2023). Identifying and determining the factors that led Ontario nurses to resign from their positions at the bedside is crucial for healthcare organizations and policymakers and may aid in the recruitment and retention of bedside nurses in a post pandemic world. While research has explored the factors that perpetuated Ontario's nursing shortage, a critical gap exists surrounding nurses' intentions. Specifically, little is known about nurses' plans, goals and aspirations to return to bedside nursing now that the COVID-19 pandemic is no longer considered a global emergency (Baumann & Crea-Arsenio, 2023). An evaluation of the challenges, specific stressors and influences that led to the shift away from traditional nursing roles is important for the development of strategies that address what needs to change to keep new nurses, encourage nurses to return to the bedside and further inform the future of nursing practice in Ontario.

The COVID-19 pandemic exposed the vulnerabilities of Ontario's fragile nursing workforce (Brophy et al., 2021). The consequences of chronic understaffing and long-standing

system gaps were exacerbated by the pandemic leading to increased operational stress, impacting the effectiveness of the province's health system to deliver care (Murphy et al., 2025). The compounded nursing staffing shortages and the intense workplace demands worsened nurses' mental health during the pandemic leading many to leave their roles or the profession (CFNU, 2022). Nursing in Ontario is at a critical juncture with uncertainty surrounding the future of nursing practice in the province. Understanding why nurses left bedside roles during the pandemic, where they have transitioned within the workforce and if they would consider returning to bedside practice or the profession is warranted. Identification of strategies that retain nurses and encourage re-entry into bedside practice is needed to stabilize the nursing workforce and prevent further attrition.

1.4 Research Objective

The objective of this study was to explore the intentions of nurses who left bedside care during the pandemic and their plans to return or not. This study investigated nurses' rationale for transitioning away from bedside care roles and sought to determine whether they were contemplating returning to bedside practice or intending to progress in roles away from the bedside.

1.5 Research Question

To address the objective of this study, two research questions were formulated to guide the project:

1. Why did nurses leave bedside nursing during the COVID-19 pandemic?
2. And what are the primary factors and considerations that would influence these nurses' re-entry into bedside care?

Ontario's nursing profession has faced longstanding staffing challenges. The next chapter reviews the literature in both a historical and present context related to the nursing shortage, the progression of nursing roles, and the challenges of recruitment and retention.

References

Ahmed, H., & Bourgeault, I. (2022). Sustaining Nursing in Canada. *Canadian Federation of Nurses Unions.* https://nursesunions.ca/wp-content/uploads/2022/11/CHWN-CFNU-Report_-Sustaining-Nursing-in-Canada2022_web.pdf

Akoo, C., McMillan, K., Price, S., Ingraham, K., Ayoub, A., Rolle Sands, S., Shankland, M., & Bourgeault, I. (2024). "I feel broken": Chronicling burnout, mental health, and the limits of individual resilience in nursing. *Nursing Inquiry*, *31*(2), Article e12609. https://doi.org/10.1111/nin.12609

Ali, H., Fatemi, Y., Hamasha, M., & Modi, S. (2023). The Cost of Frontline Nursing: Investigating Perception of Compensation Inadequacy During the COVID-19 Pandemic. *Journal of Multidisciplinary Healthcare*, *16*, 1311–1326. https://doi.org/10.2147/JMDH.S402761

Alilu, L., Zamanzadeh, V., Valizadeh, L., Habibzadeh, H., & Gillespie, M. (2017). A grounded theory study of the intention of nurses to leave the profession. *Revista Latino-Americana de Enfermagem*, *25*, e2894–e2894. https://doi.org/10.1590/1518-8345.1638.2894

Almost, J. (2024). Opening the black box: Unpacking the use of nursing agencies in Canada. *Canadian Federation of Nurses Unions*. https://nursesunions.ca/wp-content/uploads/2024/09/Agency-Full-Report-Final-English-20Sept2024.pdf

Baumann, A., & Crea-Arsenio, M. (2023). The Crisis in the Nursing Labour Market: Canadian Policy Perspectives. *Healthcare (Basel)*, *11*(13), 1954. https://doi.org/10.3390/healthcare11131954

Bourgault, A. M. (2022). The Nursing Shortage and Work Expectations Are in Critical

Condition: Is Anyone Listening? *Critical Care Nurse*, *42*(2), 8–11. https://doi.org/10.4037/ccn2022909

Brophy, J. T., Keith, M. M., Hurley, M., & McArthur, J. E. (2021). Sacrificed: Ontario Healthcare Workers in the Time of COVID-19. *New Solutions*, *30*(4), 267–281. https://doi.org/10.1177/1048291120974358

Callan, I. & D'Mello, C. (2023). Ford government documents admit low wages, Bill 124 worsening health staffing issues. *Global News*. https://globalnews.ca/news/9340310/health-care-ontario-bill-124-ford-government-documents/

CFNU. (2022). Canada's nursing shortage at a glance. *Canadian Federation of Nurses Unions.* https://nursesunions.ca/wp-content/uploads/2022/07/nurses_shortage_media_ref_guide_comp.pdf

CFNU. (2024). CFNU Member Survey Report. *Canadian Federation of Nurses Unions.* https://nursesunions.ca/wp-content/uploads/2024/03/2024-CFNU-Members-Survey-Web-1.pdf

CFNU. (2023). Privatization of Health Care. *Canadian Federation of Nurses Unions.* https://nursesunions.ca/wp-content/uploads/2023/03/2023-03-15_CFNU-Position-Statement_Privatization-of-Health-Care_EN.pdf

CIHI. (2023). Hospital Staffing and Hospital Harm Trends Throughout the Pandemic. *Canadian Institute for Health Information*. https://www.cihi.ca/en/hospital-staffing-and-hospital-harm-trends-throughout-the-pandemic

CIHI. (2025). Nursing in Canada, 2024 – Data Tables. *Canadian Institute for Health*

Information. https://www.cihi.ca/sites/default/files/document/nursing-in-canada-2015-2024-data-tables-en.xlsx

CUPE. (2022). Doug Ford's government is quietly privatizing health care. *Canadian Union of Public Employees.* https://cupe.on.ca/doug-fords-government-is-quietly-privatizing-health-care/

Dowson, A. (2023). The use of agency nursing is exploding. *Canadian Health Coalition.* https://www.healthcoalition.ca/the-use-of-agency-nursing-is-exploding/

Durant, E. (2023). Solutions to Tackle the Nursing Shortage and Burnout Immediately: A Review of the Literature. *Canadian Nurse.* https://www.canadian-nurse.com/blogs/cn-content/2023/04/17/solutions-to-tackle-nursing-shortage

Gherman, M. A., Arhiri, L., Holman, A. C., & Soponaru, C. (2022). The Moral Impact of the COVID-19 Pandemic on Nurses' Burnout, Work Satisfaction and Adaptive Work Performance: The Role of Autobiographical Memories of Potentially Morally Injurious Events and Basic Psychological Needs. *International Journal of Environmental Research and Public Health*, *19*(13), Article 7645. https://doi.org/10.3390/ijerph19137645

Government of Ontario. (2019). Protecting a Sustainable Public Sector for Future Generations Act, 2019, S.O. 2019, c. 12 – Bill 124. https://www.ontario.ca/laws/statute/s19012

Hajizadeh, M., & Jalili, F. (2025). Addressing Healthcare Waiting Time Challenges in Canada: Insights From Emerging Initiatives. *International Journal of Health Policy and Management*, *14*, Article 8986. https://doi.org/10.34172/ijhpm.8986

Lyons, R., Mathews, M., Ryan, D., Hedden, L., Lukewich, J., Marshall, E. G., Gill, P. S., Isenor, J. E., Martin-Misener, R., Wickett, J., Bulman, D., Dufour, E., Meredith, L., Spencer, S., Vaughan, C., & Brown, J. B. (2025). A Qualitative Analysis of the Functions of Primary

Care Nurses in COVID-19 Vaccination. *Journal of Advanced Nursing*, *81*(5), 2510–2520. https://doi.org/10.1111/jan.16468

Maunder, R. G., Heeney, N. D., Hunter, J. J., Strudwick, G., Jeffs, L. P., Ginty, L., Johnstone, J., Kiss, A., Loftus, C. A., & Wiesenfeld, L. A. (2022). Trends in burnout and psychological distress in hospital staff over 12 months of the COVID-19 pandemic: a prospective longitudinal survey. *Journal of Occupational Medicine and Toxicology (London, England)*, *17*(1), 11–11. https://doi.org/10.1186/s12995-022-00352-4

Morley, G., Ives, J., Bradbury-Jones, C., & Irvine, F. (2019). What is 'moral distress'? A narrative synthesis of the literature. *Nursing Ethics*, *26*(3), 646–662. https://doi.org/10.1177/0969733017724354

Murphy, G. T., Sampalli, T., Carson, A., Embrett, M., Sim, M., Chamberland-Rowe, C., Indar, A., MacInnis, M., Murphy-Boyle, K., Rigby, J., Guk, J., Boulos, L., Hancock, K., Altman-Prezioso, J., & Mehrpooya, S. (2025). Impact of the COVID-19 pandemic on the Canadian healthcare workforce: a rapid evidence synthesis of key considerations, lessons learned, and promising practices to address the healthcare workforce crisis. *Health Research Policy and Systems*, *23*(1), Article 132. https://doi.org/10.1186/s12961-025-01395-9

Nagle, E., Šuriņa, S., & Griškēviča, I. (2023). Healthcare Workers' Moral Distress during the COVID-19 Pandemic: A Scoping Review. *Social Sciences (Basel)*, *12*(7), Article 371. https://doi.org/10.3390/socsci12070371

Nair, R., Mohan, K., Jayakrishnan, K., Srinivasan, P., Javeth, A., Sharma, S., & Kumari, B. (2022). Lived Experience of Nurses in COVID-19 Units - A Phenomenological Study

from Eastern India. *Journal of Caring Sciences*, *11*(4), 197–209. https://doi.org/10.34172/jcs.2022.25

ONA. (n.d.). Bill 124. *Ontario Nurses' Association*. https://ona.org/campaign/bill-124/#:~:text=The%20hospital%20sector%20decision%20by,of%202021%2C%202022%20and%202023.

ONA. (2024). New data confirms nurse staffing ratio continues to plumet in Ontario. *Ontario Nurses' Association.* https://ona.org/news/20240725-cihi-data-staffing/

ONA. (2022). Ontario's Nurse Staffing is Falling Further Behind the Rest of Canada, Report Shows. *Ontario Nurses' Association.* https://www.ona.org/news-posts/20221117-nurse-staffing-report/#:~:text=In%20Ontario%2C%20the%20average%20number,%2Dpresident%20Angela%20Preocanin%2C%20RN

RNAO. (2026). Addressing the RN crisis in Ontario. *Registered Nurses' Association of Ontario.* https://rnao.ca/media/10283/download?inline

RNAO. (2024). CIHI data reveals critical nursing shortage in Ontario. *Registered Nurses' Association of Ontario.* https://rnao.ca/news/media-releases/cihi-data-reveals-critical-nursing-shortage-in-ontario

RNAO. (2023). Ontario's RN Understaffing Crisis: Impact and Solution. *Registered Nurses' Association of Ontario.* https://rnao.ca/media/3163/download?attachment

RNAO. (2024). The RN crisis in Ontario. *Registered Nurses' Association of Ontario.* https://rnao.ca/media/7947/download

RNAO. (2021). Work and Wellbeing Survey Results. *Registered Nurses' Association of Ontario.* https://rnao.ca/sites/rnao-ca/files/Nurses_Wellbeing_Survey_Results_-_March_31.pdf

Statistics Canada. (2024). High Inflation in 2022 in Canada: Demand pull or supply-push? https://www150.statcan.gc.ca/n1/pub/36-28-0001/2024005/article/00005-eng.htm

Chapter Two: Literature Review

This chapter presents a literature review that examines Ontario's nursing crisis through a historical lens, highlighting how the COVID-19 pandemic intensified staffing challenges, exposed existing vulnerabilities and reshaped the province's nursing workforce. The complexities of the nursing shortage, the evolution of nursing involving opportunities away from traditional bedside roles and nursing recruitment and retention challenges were examined. This chapter explores the key concepts in the research questions including Ontario nursing attrition during the COVID-19 pandemic, intention to leave and intention to return to bedside nursing. Research aligned with the study objective exploring how nursing roles evolved during the pandemic and the extent to which these shifts influenced nurses' movement away from bedside practice is reviewed. The search was conducted from February to April 2024 on the CINAHL and PubMed databases using the following key words: nursing shortage, nursing crisis, COVID-19, pandemic, turnover, attrition, burnout, bedside, history, new nurse, retention, return, and nursing roles. This chapter reviews three key concepts in the existing research including the nursing shortage, the progression of nursing roles and nursing recruitment and retention.

2.1 The Nursing Shortage

Ontario's nursing shortage predates the COVID-19 pandemic as it has been an ongoing issue for decades across Canada that is only expected to worsen due to a variety of factors including population growth, aging, and a shift in nursing demographics (Durant, 2023). The nursing crisis in its current state represents a complex interplay of historical, economic and social challenges that continue to influence healthcare and the profession. While the literature illustrates reasons why nurses are fleeing the bedside, solutions on how to keep nurses in their current roles remains unclear and requires further evaluation.

When examining the nursing shortage from a historical lens, Canada witnessed a scenario following the Second World War where nurses failed to resume to their pre-war roles as staff nurses, a situation paralleled by todays post-pandemic world (Fink & Millbrath, 2023). The nursing profession transformed during World War Two (WWII) as new nursing roles emerged to address the changing care needs during war time, similarly to how nurses responded to the COVID-19 pandemic (Fink & Millbrath, 2023). Following WWII, much like today's health economy, there grew a staffing supply shortage which was amplified by nurses experiencing stress and burnout resultant of the increased demand for healthcare brought on by the war (Fink & Millbrath, 2023). Nursing shortages continued throughout the 1970s and 1980s with nurses citing poor working conditions and dissatisfaction with healthcare policies as reasons for withdrawing from the profession (McPherson, 2012).

To combat the post war nursing shortage hospitals introduced various subsidiary workers including practical nurses, nursing assistants, ward aids and clerks to reduce the workload of the "professional graduate nurses" (McPherson, 2012, p. 223). Staffing shortages post WWII and COVID-19 were both a consequence of the rapid increase in the demand for healthcare and nursing services. While the nature of nursing roles during the pandemic and WWII were vastly different in their scope and impact, they demonstrated the resilience of the nursing profession and the ability nurses have to adapt and respond to crisis situations in order to meet the evolving healthcare needs of Canadians.

Prior to the start of the COVID-19 pandemic, the nursing profession was experiencing staffing shortages and recruitment difficulties (McGill, 2019). Between 2014 to 2019 a notable shift in the nursing labour market indicated an increase in non-practicing College of Nurses of Ontario (CNO) members by 60% with most practicing nurses in Ontario representing the

younger cohort of the domestic nursing supply (Baumann & Crea-Arsenio, 2023). Incontrovertibly, the aging nursing workforce has been a concern for decades and this concern continues to grow (Price, 2015). 2020 data from the Registered Nurses' Association of Ontario (RNAO) revealed that a third of bedside RNs are over 50 years old and approaching retirement (RNAO, 2021). Additionally changing demographics of Canadian residents has led to a rise in the demand for health services and care needs because of the increased burden of chronic diseases (McGill, 2019). 22.2% of respondents ($N = 2102$) to the RNAO's Work and Wellbeing Survey were already eligible to retire and many have retired since the time of data collection (RNAO, 2021). With a large baby boom cohort of nurses retiring, increased population growth and an aging population there poses a significant problem for the nursing workforce which is already facing a national shortage (Price, 2015).

During the height of the COVID-19 pandemic there was a lack of adequate nursing staff which was an issue across Canada (Durant, 2023). Statistics Canada report on job vacancies revealed the nursing profession continues to experience considerable RN job vacancies for bedside roles with the number increasing by 5475 positions from 2022 to 2023 (Statistics Canada, 2023). Healthcare facilities were required to respond to the pandemic with new polices and contingency plans to meet patients' care needs which inadvertently amplified the staffing problems. Nelson et al. (2023) studied Canadian nursing during the pandemic and noted low base staffing was exacerbated by things such as quarantine requirements, restrictions on work locations and redeployment, particularly during periods of outbreak. The International Council of Nurses (ICN) suggested "mass traumatisation of the nursing workforce" amplified the staffing problems during COVID-19 (ICN, 2021, p. 2). The pandemic impacted the planning of staff which led to an increased workload and higher nurse to patient ratios (Hoogendoorn et al., 2021).

Heavier workloads, insufficient resources, stress, burnout, abuse and trauma were key drivers of attrition that magnified the nursing shortage amidst the COVID-19 pandemic (ICN, 2021).

The nursing shortage has had a profound impact on the heath industry, nursing profession and Ontario's healthcare system. The unique challenges posed by COVID-19 elicited a response from the nursing profession to innovate, expand and reshape the way nurses deliver care across the province. The introduction of new roles within the profession has helped to manage the immediate crisis but has also showed promise for the future of nursing in a post-pandemic world.

2.2 The Progression of Nursing Roles

The role of the nurse has been marked by a revolutionary journey encompassing shifts in responsibilities, advancements in technology and medicine and the ability to adapt to the changing healthcare needs of Canadians (Velji, 2023). Nursing in Canada has continuously developed throughout history, playing a pivotal role in the delivery of essential care services, particularly during times of war and health crisis (Fink & Millbrath, 2023). The COVID-19 pandemic greatly impacted nursing practice in Ontario as new career opportunities emerged for nurses away from traditional bedside roles including testing and screening for COVID-19, vaccine clinics and Infection Prevention and Control (IPAC) nursing (Barría, 2021).

The role of the nurse in Canada has evolved significantly since the nineteenth century as has the Canadian healthcare system. Prior to WWII the majority of both nursing and medical care was delivered in the community using a fee-for service model (Fink & Millbrath, 2023). Nursing graduates provided care in patients homes meanwhile student nurses provided direct patient care in hospitals which were slowly expanding both in size and quantity (McPherson, 2012). Following the Second World War the nature of nursing changed as hospitalization numbers and the demand for nursing care in Canada increased (McPherson, 2012). In 1961, the

concept of cost sharing for health services between the federal and provincial government was proposed leading to the adoption of universal hospital insurance across Canada; this prohibited fee for service billing at the point of care, establishing the universal health system through tax revenue (Naylor, 2014). Accompanying the changes to healthcare financing was a rapid increase in hospital beds nation-wide and the introduction of medical care insurance (Naylor, 2014). The Medical Care Act and Hospitals Act was eventually replaced by the Canada Health Act in 1984 which provides Canadians access to medically necessary care and remains in effect to date (Naylor, 2014). As seen with the introduction of the Canada Health Act, shifts in the Canadian healthcare structure have historically influenced nursing roles, funding mechanisms and impacted nursing demands (RSC, 2022). The COVID-19 pandemic was no exception; the unprecedented challenges posed to the healthcare system required accessible nursing care beyond traditional settings, thereby necessitating the rapid evolution of nursing roles to meet the emerging demands (RSC, 2022).

The pandemic led to an increased demand for community health services, prompting a need to re-evaluate nursing roles in Long-Term Care (LTC) and public health to meet the everchanging demands brought on by the COVID-19 pandemic (RSC, 2022). An emphasis was placed on preventing, managing and controlling the spread of COVID-19 in the community and congregate living facilities which in turn led to the redeployment of nurses from other public health programs to the front-line pandemic efforts (Cava, 2022). Nursing roles changed as they were tasked with conducting screening, testing, managing services for vulnerable groups, contact tracing, optimizing health services, monitoring self-isolated patients online, administering vaccines, collaborating with the government and local COVID-19 task forces and providing education (Akbar et al., 2022). Meanwhile, in the LTC environment, the crucial role of the IPAC

nurse emerged to support pandemic related challenges including directive changes, testing needs, visitation policies, reporting requirements and isolation measures (Jones et al., 2022). COVID-19 highlighted the critical role of community and public health nurses and the need to allocate resources to support and leverage these nursing teams during a public health crisis.

Virtual healthcare during the COVID-19 pandemic allowed for health services to continue operations and became a sought-after job for nurses away from traditional bedside positions (Sanford et al., 2023). Current literature emphasises that virtual nursing significantly improves access to care and the use of it to maintain services during the pandemic was essential (Hughes et al., 2022). Although virtual nursing predates the pandemic, it became more visible and studies suggest that remote work during the pandemic was beneficial, a positive option and may have been protective against healthcare provider burnout (Hoffman et al., 2020). Findings from a qualitative study by Hughes et al. (2022) ($N = 48$) suggested that virtual nursing can facilitate interdisciplinary teamwork for more holistic healthcare. Virtual nurses provide valuable support to the front-line healthcare team and continue to play a vital role in a post pandemic world.

The rapid spread of COVID-19 prompted a change in the delivery of health services to prevent further spread of the virus (Cava, 2022). This in turn led to the creation of new nursing roles which have become integrated into Ontario's healthcare system and reflect the nursing profession's ability to adapt and demonstrate resiliency amidst a global pandemic. Moving forward, the nursing industry must manage the ongoing healthcare demands and offset the adverse effects resultant of the pandemic by examining strategies that sustain a robust nursing workforce in a post pandemic world (Kurtzman et al., 2022).

2.3 Nursing Recruitment and Retention

Ontario has experienced many issues when it comes to nursing recruitment and retention and effective strategies to address the staffing shortage are needed. Post pandemic, rising absenteeism and heavier workloads, coupled with inadequate staffing and comprised care continue to reinforce nurses' intentions to leave bedside practice (Durant, 2023). Research from the RNAO ($N = 2102$) during the pandemic indicated that nursing retention in Ontario has been negatively impacted by work related stressors, excessive overtime and inadequate compensation, all of which are associated with burnout and contribute to increased turnover (RNAO, 2023). Sufficient staffing is important as consequentially higher ratios increased levels of stress, burnout and job dissatisfaction that may perpetuate nurses intentions to leave (Chen et al., 2019).

Given the geography and population distribution of Canada, providing and ensuring access to health services for all Canadians has always been a struggle. Following the first World War there was a push to bring healthcare and civilization to rural and remote areas of Canada; the increased demand for nursing care in these communities led to the development of hospitals and nursing outposts that encountered significant staffing challenges (Elliott et al., 2008). Interestingly, the government's solution to recruitment and retention following the war was to decrease nurses educational requirements (McCallum et al., 2023). Post WWII the priority placed on preserving the healthcare worker supply outweighed the need to ensure nurses were meeting the standard educational requirements, resulting in a nursing labour force largely comprised of students (Richardson, 2001). While much has changed since the dawn of nursing practice in Canada, nurses continue to grapple with staffing shortages post pandemic and the ability to provide high quality care within the constraints of organizational and government cultures focused on cost containment (RSC, 2022).

In recent years, a trend has emerged amongst Millennial (1981-1996) and Generation Z (1997-2012) nurses to depart from traditional bedside roles earlier than their predecessors. A cross-sectional study (N = 748 nurses) in Poland found that healthcare worker burnout was most prevalent during the pandemic in younger staff aged 26 to 30 years of age (Szczerbińska et al., 2024). According to Kovner et al. (2014) 17.5% of new nurses will leave their job in the first year of work and upwards of 30% will leave the profession within 2 years of practice. Anecdotal evidence suggests that the COVID-19 pandemic has driven novice nurses away from the bedside in higher numbers than previously seen (Jerome-D'Emilia et al., 2022). In a 2024 survey conducted by the Canadian Federation of Nurses Unions (CFNU) (N = 5595), many new nurses, 48.3%, revealed they intend to abandon the public sector to work for private companies that will offer more competitive salaries and flexible working hours (Almost, 2024). With late career nurses retiring and new nurses leaving the profession early on in their careers, failure to recruit and retain qualified nurses could negatively impact current working conditions and leave the future of nursing in Ontario at risk.

The pandemic reshaped the healthcare landscape demanding more services and more nurses to provide care. Evidence on how to recover the nursing workforce from the great resignation that took place amidst the COVID-19 pandemic is needed to guide and support further actions taken by the province. This study, influenced by the epistemological position of pragmatism, seeks to explore these ideas in greater depth using Michell and Lee's theoretical frameworks: The Unfolding Model of Voluntary Employee Turnover (1994) and the Job Embeddedness Model (2001).

References

Akbar, M. A., Juniarti, N., & Yamin, A. (2022). The Roles of Community Health Nurses' in Covid-19 Management in Indonesia: A Qualitative Study. *International Journal of Community Based Nursing and Midwifery*, *10*(2), 96–109. https://doi.org/10.30476/IJCBNM.2021.90884.1739

Almost, J. (2024). Opening the black box: Unpacking the use of nursing agencies in Canada. *Canadian Federation of Nurses Unions*. https://nursesunions.ca/wp-content/uploads/2024/09/Agency-Full-Report-Final-English-20Sept2024.pdf

Barría P, R. M. (2021). Nursing and its Essential Role in the Vaccination against COVID-19: New Challenge in a Pandemic Scenario. *Investigación y Educación En Enfermería*, *39*(3). https://doi.org/10.17533/udea.iee.v39n3e01

Baumann, A., & Crea-Arsenio, M. (2023). The Crisis in the Nursing Labour Market: Canadian Policy Perspectives. *Healthcare (Basel)*, *11*(13), 1954. https://doi.org/10.3390/healthcare11131954

Cava, M. (2022). Important work of public health nurses has been sidelined by response to the pandemic. *Toronto Star*. https://www.thestar.com/opinion/contributors/important-work-of-public-health-nurses-has-been-sidelined-by-response-to-the-pandemic/article_7421d8c7-d5a4-5b07-ae24-d274ae43da59.html

Chen, Y. C., Guo, Y. L. L., Chin, W. S., Cheng, N. Y., Ho, J. J., & Shiao, J. S. C. (2019). Patient-nurse ratio is related to nurses' intention to leave their job through mediating factors of burnout and job dissatisfaction. *International Journal of Environmental Research and Public Health*, *16*(23), 4801-. https://doi.org/10.3390/ijerph16234801

Durant, E. (2023). Solutions to Tackle the Nursing Shortage and Burnout Immediately: A

Review of the Literature. *Canadian Nurse.* https://www.canadian-nurse.com/blogs/cn-content/2023/04/17/solutions-to-tackle-nursing-shortage

Elliott, J., Stuart, M., & Toman, C. (2008). "Suitable Young Women": Red Cross Nursing Pioneers and the Crusade for Healthy Living in Manitoba, 1920-30. In *Place and Practice in Canadian Nursing History*. UBC Press. https://doi.org/10.59962/9780774815598-009

Fink, A. M., & Milbrath, G. R. (2023). A concept analysis of nurses in conflicts after World War II. *Journal of Advanced Nursing*, *79*(1), 31–47. https://doi.org/10.1111/jan.15454

Hoffman, K. E., Garner, D., Koong, A. C., & Woodward, W. A. (2020). Understanding the Intersection of Working from Home and Burnout to Optimize Post-COVID19 Work Arrangements in Radiation Oncology. *International Journal of Radiation Oncology, Biology, Physics*, *108*(2), 370–373. https://doi.org/10.1016/j.ijrobp.2020.06.062

Hoogendoorn, M. E., Brinkman, S., Bosman, R. J., Haringman, J., de Keizer, N. F., & Spijkstra, J. J. (2021). The impact of COVID-19 on nursing workload and planning of nursing staff on the Intensive Care: A prospective descriptive multicenter study. *International Journal of Nursing Studies*, *121*, 104005–104005. https://doi.org/10.1016/j.ijnurstu.2021.104005

Hughes, L., Petrella, A., Phillips, N., & Taylor, R. M. (2022). Virtual care and the impact of COVID-19 on nursing: A single centre evaluation. *Journal of Advanced Nursing*, *78*(2), 498–509. https://doi.org/10.1111/jan.15050

ICN. (2021). Policy brief: The global nursing shortage and nurse retention. *International Council of Nurses.* https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention_0.pdf

Jerome-D'Emilia, B., Suplee, P. D., & Linz, S. (2022). Challenges faced by new nurses during

the COVID-19 pandemic. *Journal of Nursing Scholarship*, *54*(6), 772–786. https://doi.org/10.1111/jnu.12783

Jones, K. M., Mantey, J., Krein, S. L., & Mody, L. (2022). A Whole New World: Changes in the Nursing Home Infection Preventionist Role in Response to the COVID-19 Pandemic. *American Journal of Infection Control*, *50*(7), S8–S8. https://doi.org/10.1016/j.ajic.2022.03.131

Kovner, C. T., Brewer, C. S., Fatehi, F., & Jun, J. (2014). What Does Nurse Turnover Rate Mean and What Is the Rate? *Policy, Politics & Nursing Practice*, *15*(3–4), 64–71. https://doi.org/10.1177/1527154414547953

Kurtzman, E. T., Ghazal, L. V., Girouard, S., Ma, C., Martin, B., McGee, B. T., Pogue, C. A., Riman, K. A., Root, M. C., Schlak, A. E., Smith, J. M., Stolldorf, D. P., Townley, J. N., Turi, E., & Germack, H.-L. (2022). Nursing Workforce Challenges in the Postpandemic World. *Journal of Nursing Regulation*, *13*(2), 49–60. https://doi.org/10.1016/S2155-8256(22)00061-8

Lee, T., & Mitchell, T. (1994). An Alternative Approach – The Unfolding Model of Voluntary Employee Turnover. *The Academy of Management Review*, *19*(1), 51–89. https://doi.org/10.5465/AMR.1994.9410122008

McCallum, A. M., Vandenberg, H. E. R., & Penz, K. L. (2023). Help Wanted, Experience Preferred, Stamina a Must: A Narrative Review of the Contextual Factors Influencing Nursing Recruitment and Retention in Rural and Remote Western Canada from the Early Twentieth Century to 2023. *Canadian Journal of Nursing Research*, 8445621231204962–8445621231204962. https://doi.org/10.1177/08445621231204962

McGill. (2019). Global Shortage of Nurses. *The McGill Nursing Collaborative for Education*

and Innovation in Patient-and Family-Centred Care. https://www.mcgill.ca/nursing/files/nursing/nurse_shortages.pdf

McPherson, K. M. (2012). *Bedside matters : the transformation of Canadian nursing, 1900-1990*. University of Toronto Press.

Mitchell, T., & Lee, T. (2001). The unfolding model of voluntary turnover and job embeddedness: Foundations for a comprehensive theory of attachment. Research in Organizational Behavior, 23, 189-246. https://doi.org/10.1016/S0191-3085(01)23006-8

Naylor, C. (2014). The Canadian Health-Care System: A Developmental Overview. In *Canadian Health Care and the State*. McGill-Queen's University Press.

Nelson, H., Hubbard Murdoch, N., Ziefflie, B., Norman, K., Black, M. H. C., & Rudolph, S. (2023). Nursing during the COVID-19 pandemic: A reflective thematic analysis of how the hamster wheel shifted personal and professional control. *Nursing Open*, *10*(5), 3314–3325. https://doi.org/10.1002/nop2.1583

Price, S. (2015). Bridging the Generational Divide. *Canadian Federation of Nurses Unions.* https://nursesunions.ca/wp-content/uploads/2017/05/Bridging-the-Generational-Divide-Jan-2016-FINAL.pdf

Richardson, S. L. (2001). "Stand up and Be Counted": Nursing at the Calgary General Hospital after the Second World War. *Canadian Bulletin of Medical History*, *18*(2), 297–323. https://doi.org/10.3138/cbmh.18.2.297

RNAO. (2021). Work and Wellbeing Survey Results. *Registered Nurses' Association of Ontario.* https://rnao.ca/sites/rnao-ca/files/Nurses_Wellbeing_Survey_Results_-_March_31.pdf

RSC. (2022). Investing in Canada's Nursing Workforce Post-Pandemic: A Call to Action. *The Royal Society of Canada*. https://rsc-src.ca/sites/default/files/Nursing%20PB_EN.pdf

Sanford, K., Schuelke, S., Lee, M., & Mossburg, S. (2023). Virtual Nursing: Improving Patient Care and Meeting Workforce Challenges. *Agency for Healthcare Research and Quality.* https://psnet.ahrq.gov/perspective/virtual-nursing-improving-patient-care-and-meeting-workforce-challenges

Statistics Canada. (2023). Nurses: Working Harder, More Hours amid Increased Labour Shortage. https://www.statcan.gc.ca/o1/en/plus/4165-nurses-working-harder-more-hours-amid-increased-labour-shortage

Szczerbińska, K., Barańska, I., Kijowska, V., Stodolska, A., Wójcik, G., Różańska, A., & Wójkowska-Mach, J. (2024). Factors associated with burnout among hospital-based healthcare workers during the COVID-19 pandemic: A cross-sectional CRACoV-HHS study. *Journal of Clinical Nursing*, *33*(1), 304–321. https://doi.org/10.1111/jocn.16654

Velji, K. (2023). Innovating health care – transforming the role of nurses. *Canadian Nurse.* https://www.canadian-nurse.com/blogs/cn-content/2023/05/01/transforming-the-role-of-nurses

Chapter Three: Theoretical Foundations

3.1 Epistemological Viewpoint

Paradigms form the philosophical foundation for individual beliefs and guide nursing research, offering a structured framework and lens that shape disciplinary practices (Weaver & Olson, 2006). Paradigms address nursing knowledge gaps by providing the philosophical foundations that shape both qualitative and quantitative research approaches (Weaver & Olson, 2006). Pragmatism served as the philosophical underpinning of this study rejecting traditional abstract and metaphysical ideas in favour of a more practical, experience-based approach to understand knowledge and truth (Elder-Vass, 2022).

Considering the consequences of the nursing crisis, a pragmatic epistemological viewpoint aligns well with the urgent need to guide interventions that address the health workforce shortages in Ontario. Pragmatism is founded on the idea that truth is determined by its practical value and usability of its findings, thus this paradigm is centred around doing what works to resolve real world problems (Hannes & Lockwood, 2011). Developed as a logical method for analyzing concepts, pragmatism examines the practical consequences that contribute to a diverse range of meanings and perspectives (Nowell, 2015). My epistemological stance of pragmatism prioritized a practical understanding of the research problem to focus on real-world application. The adaptable and practical nature of pragmatism as an epistemological viewpoint supports a study investigating the complex factors which led to nursing turnover during the COVID-19 pandemic to yield actionable insights.

Pragmatism aligns well with the goals of this research which are to ensure it can be realistically applied to support the development of more effective workplace policies, proactively prevent future healthcare shortages, guide leaders and strengthen the nursing workforce. While

this study is not trying to offer a tangible solution to the nursing crisis, it seeks "practical and useful answers that can solve or provide direction in addressing concrete problems" (Patton, 2015, p.15). In nursing research, the pragmatic paradigm is focused on "understanding the underlying causes of phenomena" (Polit & Beck, 2021, p. 7). This epistemological viewpoint accepts that unique challenges such as stress, burnout, and safety may have impacted nursing turnover during the pandemic and a deeper understanding into these context specific factors is needed.

3.2 Theoretical Framework

This study will use two theoretical frameworks both developed by University of Washington (UW) professors Terence R. Mitchell and Thomas W. Lee: The Unfolding Model of Voluntary Employee Turnover (1994) and the Job Embeddedness Model (2001). The Job Embeddedness Model is a theoretical approach developed to explain and understand why people stay whereas the Unfolding Model explains why people leave their work (Mitchell & Lee, 2001). Guided by the integration of these theoretical frameworks, this study explores what led to the high levels of nursing turnover during the COVID-19 pandemic and what factors would embed or encourage nurses to return and stay at the bedside.

3.2.1 The Unfolding Model of Voluntary Employee Turnover

In the beginning, Lee and Mitchell's research primarily focused on why people leave their place of work. The general principal of the Unfolding model is that employee turnover results from different physiological deliberations and follows one of four unfolding decision paths characterized by shocks, scripts and image violations (Mitchell & Lee, 2001). Essentially, the Unfolding Model argues that employees do not just randomly quit, rather the decision to leave their position is precipitated by a situation that forces the employee to evaluate their

employment (Lee & Mitchell, 1994). This model was designed to better understand turnover and the different ways and paths in which people leave their jobs.

Two key concepts of the Unfolding Model of Voluntary Employee Turnover include shocks to the system and decision frames. Lee and Mitchell (1994) describe a shock as a distinct event that prompts an employee to make conscious evaluations about their job which leads them to consider leaving voluntarily. While the shock may be positive, negative or neutral, it carries significance about an individual's job and impacts the person's belief system, thus it cannot be ignored (Lee & Mitchell, 1994). A decision frame refers to the way an employee interprets and responds to the shock based on their personal context to the situation which initiates the individual to follow one of the four paths (Mitchell & Lee, 2001).

Decision path #1 involves a shock to the system that activates a pre-determined response to the situation based on the employee's personal characteristics or life experiences; Mitchell and Lee (2001) refer to this as "A Script-Driven Decision" (p. 200). The decision to quit is largely automatic, driven by a memory match and requires minimal mental deliberation (Lee & Mitchell, 1994). An example of decision path #1 could be a nurse working in a non-for-profit LTC facility deciding to quit when the nursing home is acquired by a large for profit company; the nurse has a pre-determined script with a rule that they will never work in a for-profit LTC home.

Decision path #2 requires more mental deliberation than decision path #1 as it is not associated with personal experiences or a pre-determined script, rather it is a "push decision" (Lee & Mitchell, 1994, p. 65). The employee's choice to quit does not involve any job alternatives nor a ready response to the shock. Decision Path #2 prompts an internal compatibility assessment of the shock and how it impacts their values, career trajectory and personal image (Mitchell & Lee, 2001).

In Decision Path #3 the choice to stay or quit is centred around the circumstances resulting from the shock which facilitates a "pull decision" (Mitchell & Lee, 2001, p. 205). Similarly to Decision Path #2, the employee judges their job compatibility following a shock. With Decision Path #3 should the individual determine that they are dissatisfied and no longer compatible with their job they will search for alternatives (Lee & Mitchell, 1994).

In contrast to other decision paths, Decision Path #4 does not include a shock to the system and is more of a routine assessment of an employee's general satisfaction with their workplace (Mitchell & Lee, 2001). In Decision Path #4, the employee reflects on their overall perception, dedication and level of attachment to their current organization and leaves if they realize they are unhappy (Lee & Mitchell, 1994). Unlike the other decision paths, there are two routes that can be taken with Decision #4 and the difference lies in whether or not the employee assesses alternatives (Mitchell & Lee, 2001). Decision Path #4A occurs when an employee chooses to leave the organization regardless of job prospects whereas with Decision Path #4B the individual considers other career opportunities prior to making the decision to resign (Mitchell & Lee, 2001).

The Unfolding Model of Voluntary Employee Turnover is a psychology-based organizational behaviour framework which can be applied to evaluate turnover and attrition across diverse industries, offering a broad approach to understand why employees choose to leave (Lee & Mitchell, 1994). Although this model has not been applied in the context of the COVID-19 pandemic related nursing exodus, it was tested on a sample of 44 nurses in Lee et al.'s 1996 study. The findings of this study indicated that among the nurses who resigned, the majority (58%) experienced a shock, suggesting that nursing turnover is often precipitated by impactful experiences (Lee et al., 1996).

While the focus of the Unfolding Model of Voluntary Employee Turnover evaluates the reasons people quit, it is also important to understand what factors promote employees to remain in their roles. After many years spent researching job turnover, Lee suggested switching the research focus from why people leave to why they stay (Lee et al., 2014). The Job Embeddedness Model is centred around the influences and forces that support employee retention (Coetzee et al., 2018).

3.2.2 Job Embeddedness Model

The initial constructs of the Job Embeddedness Model came about when Mitchell reflected upon reasons why he stayed at the UW which was largely a result of fit; Mitchell cited his connection to the Seattle community and the sacrifices he would have to make if he left including losing his Seattle Seahawks season tickets (Lee et al., 2014). In general, embeddedness refers to the degree of attachment or "stuckness" one has to their employment (Lee & Mitchell, 2001, p. 216). The literature reveals that "job embeddedness not only predicts staying, but also other significant work outcomes such as absenteeism and counterproductive work behaviours" (Coetzee et al., 2018, p. 96). Job Embeddedness can be interpreted as a reflection of the accumulated motivations that keep a person at their place of work and satisfied. This model categorises reasons people stay in their jobs into three main factors which are Links, Fit and Sacrifice (Mitchell & Lee, 2001).

Links refer to connections including relationships, work affiliations, groups, friendships both on and off the job which impact an individual's likelihood of staying or leaving a job (Mitchell & Lee, 2001). Having a strong attachment to the workplace community and being highly linked to people and activities contributes to job embeddedness (Mitchell et al., 2001).

Essentially, the more links and interconnections an employee has within the organization, the greater the chances they will remain in their role.

Fit refers to an employee's sense of compatibility towards their workplace and the larger community environment (Mitchell et al., 2001). A worker whose personal values, ambitions and goals are aligned with the organization will have a stronger attachment to their workplace and be a better fit (Mitchell & Lee, 2001). Employee retention is a demonstrated outcome in the research when a person is compatible with their job and the organization; Person-Organization fit or P-O fit is a strong predictor of turnover (Chan, 1996).

Finally, Sacrifice encapsulates the perceived loss an employee might experience if they choose to leave an organization (Mitchell et al., 2001). Sacrifice refers to both physical and psychological elements such as a person losing stability and being forced to relinquish their stock options, benefits, and or leave behind a beloved community if they were to quit their job (Mitchell & Lee, 2001). In relation to the nursing crisis, the negative factors associated with staying in bedside nursing roles such as, burnout, exhaustion, emotional distress, poor working conditions and so forth are highlighted. This framework provides a different perspective by contemplating what nurses would be sacrificing by leaving the bedside as opposed to staying and may offer new insights into how we understand nursing turnover. As demonstrated in the literature, organizations that provide enticements and invest in their employees are less likely to experience voluntary turnover; effectively, the greater the sacrifice, the more an employee may choose to remain in their current role (Shaw et al., 1998).

3.2.3 Integration of the Models

The incorporation of Mitchell and Lee's Unfolding Model of Voluntary Employee Turnover (1994) into this study can help explain why nurses left during the COVID-19

pandemic, meanwhile Mitchell and Lee's Job Embeddedness Model (2001) can be used to better understand what considerations would lead these nurses to return to the bedside. The study guide was deliberately designed to reflect the core concepts of each model from a pragmatic epistemological viewpoint (Appendix B). Interview questions were intentionally aligned with the theoretical frameworks by incorporating questions about shock and the themes of links, fit, and sacrifice, thereby integrating the decision paths and underlying concepts of the models. The integration of these two organizational behaviour research models offers a balanced framework to examine the forces that have influenced turnover, analyze attrition amongst the health workforce and support retention of nurses in a post pandemic world. The Unfolding Model of Voluntary Employee Turnover (1994) and the Job Embeddedness Model (2001) were important in guiding the exploration into why nurses left the bedside during the COVID-19 pandemic and provided valuable insights into the factors that contributed to this problem.

References

Chan, D. (1996). Cognitive misfit of problem-solving style at work: A facet of person-organization fit. *Organizational Behavior and Human Decision Processes*, *68*(3), 194–207. https://doi.org/10.1006/obhd.1996.0099

Coetzee, M., Potgieter, I. L., & Ferreira, N. (2018). *Psychology of Retention: Theory, Research and Practice* (1st ed. 2018.). Springer International Publishing AG. https://doi.org/10.1007/978-3-319-98920-4

Elder-Vass, D. (2022). Pragmatism, critical realism and the study of value. *Journal of Critical Realism*, *21*(3), 261–287. https://doi.org/10.1080/14767430.2022.2049088

Hannes, K., & Lockwood, C. (2011). Pragmatism as the philosophical foundation for the Joanna Briggs meta-aggregative approach to qualitative evidence synthesis. *Journal of Advanced Nursing*, *67*(7), 1632–1642. https://doi.org/10.1111/j.1365-2648.2011.05636.x

Lee, T., Burch, T., & Mitchell, T. (2014). The Story of Why We Stay: A Review of Job Embeddedness. *Annual Review of Organizational Psychology and Organizational Behavior*, *1*(1), 199–216. https://doi.org/10.1146/annurev-orgpsych-031413-091244

Lee, T., & Mitchell, T. (1994). An Alternative Approach – The Unfolding Model of Voluntary Employee Turnover. *The Academy of Management Review*, *19*(1), 51–89. https://doi.org/10.5465/AMR.1994.9410122008

Lee, T. W., Mitchell, T. R., Wise, L., & Fireman, S. (1996). An Unfolding Model of Voluntary Employee Turnover. *Academy of Management Journal*, *39*(1), 5–36. https://doi.org/10.5465/256629

Mitchell, T., Holtom, B., Lee, T., Sablynski, C., & Erez, M. (2001). Why People Stay: Using Job

Embeddedness to Predict Voluntary Turnover. *Academy of Management Journal, 44*(6), 1102– 1121. https://doi.org/10.2307/3069391

Mitchell, T., & Lee, T. (2001). The unfolding model of voluntary turnover and job embeddedness: Foundations for a comprehensive theory of attachment. Research in Organizational Behavior, 23, 189-246. https://doi.org/10.1016/S0191-3085(01)23006-8

Nowell, L. (2015). Pragmatism and integrated knowledge translation: exploring the compatibilities and tensions. *Nursing Open*, *2*(3), 141–148. https://doi.org/10.1002/nop2.30

Patton, M. Q. (2015). *Qualitative research & evaluation methods : integrating theory and practice* (Fourth edition.). SAGE Publications, Inc.

Polit, D. F., & Beck, C. T. (2021). *Nursing research: generating and assessing evidence for nursing practice* (Eleventh edition.). Wolters Kluwer.

Shaw, J. D., Delery, J. E., Jenkins, G. D., & Gupta, N. (1998). An Organization-Level Analysis of Voluntary and Involuntary Turnover. *Academy of Management Journal*, *41*(5), 511–525. https://doi.org/10.5465/256939

Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing*, *53*(4), 459–469. https://doi.org/10.1111/j.1365-2648.2006.03740.x

Chapter Four: Methodology

This chapter outlines the methodological approaches used to guide this thesis. An overview of the qualitative exploratory design is described followed by the criteria for the study population and recruitment strategies. Details on how the data was collected and managed are provided as well as ethical considerations. And finally, this chapter describes the method of the data analysis process used to ensure rigour and enhance the quality of the study.

4.1 Study Design

This study was conducted using a qualitative exploratory design guided by a pragmatic philosophical perspective. Qualitative methods in nursing provide researchers the opportunity to deeply understand and empathize with participants, using listening and observation to connect with their experiences (Beck, 2013). These methods are compassionate and human-centered, drawing on clinical knowledge to collect, analyze, and share insights, ultimately to disseminate the research and guide effective nursing interventions (Beck, 2013). An exploratory study design provided flexibility to capture rich, experience-based insights to inform actionable change.

In an exploratory study the researcher continually reflects on the study goals while exploring emerging themes from the participants lived reality to understand "what is going on here?" (Crossman & Bordia, 2021, p. 118). Exploratory qualitative research utilizes "responsive interviewing techniques and emotional attentiveness" which enables both the researcher and participants to thoroughly explore the phenomenon being studied (Crossman & Bordia, 2021, p. 119). This kind of study design was a good fit for exploring why nurses left bedside roles during the pandemic and what it would take for them to return; this design allowed for a rich, in-depth investigation into these nurses' personal experiences and provided an opportunity for them to share insights into the complex factors that influenced their departure from bedside care.

Exploratory studies are well suited to examine problems where existing research is limited and are often conducted by researchers who bring prior knowledge or experience related to the phenomena being studied (Crossman & Bordia, 2021). As the student researcher for this study, my connection to the topic stems from my decision to leave my position as a Charge Nurse in a Long-Term Care (LTC) facility during the pandemic in pursuit of a career away from the bedside in nursing management. Alternative methods were considered, but were rejected because they either lacked depth, were not feasible, or did not align with the pragmatic goal of the study to generate practical insights to prevent bedside nursing turnover, support retention and encourage return to practice. An exploratory qualitative study design offered flexibility to capture both individual experiences and system-level influences. This approach is consistent with my pragmatic epistemological perspective as the insights from this research offer a deeper understanding of how a global pandemic impacted Ontario's nursing workforce and suggest practical changes to improve healthcare workplace conditions.

The Unfolding Model (1994) was incorporated into this research through the development of the questionnaire guide (Appendix B). Semi-structured interviews were conducted to better understand nurses' decision making process and evaluate if their departure could be described by the four decision paths outlined in the framework. The Job Embeddedness Model (2001) looked at the sacrifices nurses faced and the degree of fit with the job including links to the organization and how that impacted their decision to leave bedside nursing during the pandemic. Using a qualitative approach this study explored the lived experience of nurses who left the bedside during the COVID-19 pandemic and investigated the factors that would encourage re-entry into practice.

4.2 Population

The population of this study included any licensed RN with the College of Nurses' of Ontario (CNO) who worked in the province as a bedside nurse and chose to leave during the COVID-19 pandemic with less than 10 years of nursing experience. As highlighted in the background and literature review, new nurses have been departing earlier than previous generations in Ontario, with the proportion of RNs leaving under the age of 35 increasing to 25.7% in 2025 (RNAO, 2026). Registered Practical Nurses (RPNs), nurses working outside of the province or not registered with the CNO during the Coronavirus pandemic were not eligible to participate in the study. Given the exploratory nature of this thesis, a smaller sample size aimed at recruiting 4 to 6 participants was intentionally selected to enable a comprehensive understanding of the phenomenon and generate insights to inform future research. Small sample sizes are common in exploratory research grounded in social, behaviour and management sciences (Jung & Lee, 2011). Given that Mitchell and Lee's theoretical frameworks are rooted in organizational behaviour and designed to examine turnover processes, a smaller sample size is methodologically appropriate for an exploration into why nurses left the bedside during the COVID-19 pandemic. All participants were screened to ensure they met the inclusion criteria. Eligibility was verified through verbal confirmation with the participants and by cross-referencing publicly available information on the CNO website which includes registration history, practice and work experience.

4.3 Recruitment

Recruitment of the target study population was achieved using social media and correspondence through professional connections. By utilizing the student researcher's professional network and thesis committee the recruitment poster (Appendix A) was shared to social media sites including LinkedIn, Discord, and Facebook. The poster was shared in a post

on the student researcher's LinkedIn profile on April 15, 2025 and was reposted by connections. The poster was also shared in a Discord group titled "UOttawa MScN" and the "Ottawa Nurses" Facebook group. The recruitment poster included a brief description of the study, eligibility criteria, an overview of the participants' involvement and the student researcher's contact information. The recruitment period occurred between April 2025 to May 2025, during which a sufficient sample size was successfully attained in this timeframe. Eligible participants interested in participating in the study were asked to contact the student researcher by email to express their interest in the study. Selection of participants was done on a first come first serve basis. A total of four participants were recruited for the study.

4.4 Data Collection and Management

Data collection consisted of semi-structured interviews guided by a list of 8 questions (Appendix B). The study guide was developed using both Mitchell and Lee's Unfolding Model of Voluntary Employee Turnover (1994) and the Job Embeddedness Model (2001) to ensure alignment with the study's theoretical frameworks and epistemological perspective. The interview questions were designed to capture key concepts from both models including shocks, links, fit and sacrifice to collectively reflect the decision pathways that influenced participants' departures from bedside nursing. The questions and study guide were thoroughly reviewed, discussed and practiced between the student and thesis supervisor to ensure they aligned with the study's research objectives.

Virtual interviews were conducted using Microsoft Teams. Participants received an email invitation containing the meeting link, along with the scheduled date and time. Each interview lasted approximately 40 minutes on average. The interviews were transcribed verbatim using the Microsoft Teams transcription feature, then reviewed by the student researcher for accuracy and

subsequently anonymized. The data collected including video recordings, transcripts, consent forms and notes were kept in a secure matter, stored in locked computer-based files and on an encrypted external hard drive. Only the student researcher had access to these files. Information was not disclosed to anyone outside of the research team. All personal identifiers were removed to ensure confidentiality and participants were identified by number. The name of the specific healthcare setting where participants worked was not included in the publication of the results. Healthcare and other work settings are described in general terms to minimize the risk of identifying participants while still providing relevant contextual information. All recordings and transcripts will remain in locked password protected electronic folders for the full data retention period and destroyed five years after completion of the study.

4.5 Ethical Considerations

Ethical approval was obtained from the University of Ottawa's Health Sciences and Science Research Ethics Board. The Certificate of Ethics Approval from the University of Ottawa was granted in March 2025. Participants completed a consent form (Appendix D) which was electronically signed prior to being interviewed. Interviews were conducted once written consent was provided and the form was returned to the student researcher. Participants were informed of their right to withdraw from the study at any point, and their decision would be respected without prejudice.

4.6 Data Analysis

This research used Braun and Clarke's 2022 method for thematic analysis to understand why nurses left bedside care during the Coronavirus pandemic to gain insight into nurses intentions to return or not. The qualitative data analysis process began during the data collection stages and included transcription of data from interviews, developing a coding scheme to code

data into meaningful units and connect common themes (Polit & Beck, 2021). Thematic analysis is a process of interpretation wherein "researchers begin to identify themes and categories (or stages in a process), which are used to build a rich description or theory of the phenomenon" (Polit & Beck, 2021, p. 55). Following Braun and Clarke's approach, this thesis was conducted using reflexive thematic analysis which emphasizes the researcher's active engagement in interpreting the data and constructing meaningful themes (Byrne, 2022). Data was thematically coded to analyze and identify recurring themes, subthemes and other patterns throughout the interview process. Thematic analysis, from a pragmatic viewpoint seeks to better understand emerging ideas and focuses on identifying patterns and themes that emerge in the research interviews (Aronson, 1995). The method for thematic analysis as outlined by Braun and Clarke (2022) was employed to analyze the interview data collected from nurses who left bedside care during the COVID-19 pandemic. This analysis followed six steps and provided a systematic approach to identify, categorize and examine patterns to describe the data and interpret the research topic (Braun & Clarke, 2022). The qualitative data analysis software, Nvivo, was used to organize the data and support the thematic analysis process.

The first step in Braun & Clarke's step-by-step process to data analysis began with familiarization of the data. The transcriptions of the interviews were reviewed to capture preliminary observations and reflections and build a foundational understanding of the participants experiences (Braun & Clarke, 2022). The second step of the Braun & Clarke thematic analysis method (2022) involved generating codes related to the mass exodus from bedside nursing to create a comprehensive set of data points in Nvivo for further analysis. A total of 49 code categories were created in Nvivo with 321 references from the interviews assigned to a code. Phase three involved looking for themes and sorting the relevant coded data into more

broad categories to reflect the experiences described by the nurses (Braun & Clarke, 2022). The code categories with the most references as well as codes which included references from all participants were interpreted further. The codes with the highest levels of engagement were used to develop the initial themes. The fourth phase involved reviewing and refining the themes to create a map that fit with the data set and represented the relationships between themes (Braun & Clarke, 2022). Nvivo was used to generate diagrams of each participant's primary codes and these diagrams were compared to support the development of overarching themes. The code categories were further refined based on the themes that were created from each highly referenced code. The fifth step in Braun and Clarke's method for thematic analysis (2022) ensured each theme was clearly defined, specified and distinct from other themes to convey its meaning, clarify its scope and capture its significance. The themes and sub-themes were discussed with the Thesis Supervisor to verify clarity, comprehensibility and accuracy of the definitions while maintaining links to the theoretical approach guiding the research project. Given the study guide facilitated a discussion around why nurses left the bedside and what factors contributed to their decision, the Pandemic Exodus from Bedside Nursing emerged as a key theme. Questions exploring participants' connection to bedside nursing and the sacrifices involved in leaving prompted conversations centred on the theme of rebuilding bedside nursing. Participants were asked to reflect on their values, professional identity and the factors that anchor them to the nursing profession, which contributed to the development of the theme redefining the nursing journey beyond the bedside. Finally, the last phase in Braun and Clarke's method (2022) was reporting. The student researcher reported the results of the thematic analysis to the Thesis Advisory Committee (TAC) and provided evidence to support the interpretation of the data.

4.7 Rigour and Scientific Value of the Research Project

Techniques to support scientific rigour included transparency, an iterative data collection and analysis approach, re-examination of the data and peer debriefing to support the research process and enhance the quality of the study. Braun and Clarke's six step process to thematic analysis (2022) supported a rigorous exploration into the interview data and allowed for an authentic representation of the nurses lived experiences and insights into the factors that influenced their decisions to leave bedside care during the COVID-19 pandemic. The validity and reliability of this qualitative nursing study are strengthened by applying Lincoln and Guba's (1985) trustworthiness criteria which includes credibility, transferability, dependability, and confirmability. Credibility, refers to the extent to which findings align with participants' lived reality (Stahl & King, 2020). Credibility was reinforced through the student researcher's sustained engagement with the interview data and coding process and was further supported by ongoing self-reflection and debriefing (Ahmed, 2024). The student researcher repeatedly re-examined the data by listening, reading, writing, and continuously reviewing it to gain insights during analysis (Kekeya, 2016). The qualitative data analysis software, NVivo, was used as a tool to organize and analyze the data to benefit research efficiency, produce high quality outcomes and gain deeper insights (Maher et al., 2018). Participants documented responses revealed notable similarities in their experiences of leaving the bedside during the pandemic, irrespective of their specific clinical practice settings. The stability, consistency and coherence of findings across contexts suggest that the results could be replicated, supporting both transferability and dependability of the study's results (Ahmed, 2024). Confirmability was strengthened through transparent, step-by-step systematic coding which was reviewed during peer debriefing sessions with the Thesis Supervisor (Stahl & King, 2020). Iterative coding was conducted with the research team through repeated cycles of independent review and discussion

to increase transparency and methodological rigour (Neale, 2016). This transparent analytic process ensured themes were inductively derived from participant accounts and based on data rather than assumptions or researcher interpretation (Neale, 2016). The student researcher and supervisor met to discuss the initial codes, reviewing and reflecting on the interview data collected. Once all codes were created and further refined into defined themes, the findings were presented to the TAC and reported on. Results included direct participant quotes to ensure the findings were grounded in data rather than researcher bias (Korstjens & Moser, 2018). Involving the TAC members who were not directly involved in the analysis enhanced the study's rigour by providing an external layer of scrutiny through critical inquiry into the methods and analysis decisions which further validated the study findings and increased transparency (Cena et al., 2024). Braun and Clarke's approach to thematic analysis strengthened rigour and supported the replicability of the thematic analysis process of this study to ensure a systematic and in-depth engagement with the data (Ahmed et al., 2025). In summary, rigour was ensured through a transparent and collaborative analytic process that prioritized participants' voices over researcher assumptions.

References

Ahmed, S. K., Mohammed, R. A., Nashwan, A. J., Ibrahim, R. H., Abdalla, A. Q., M. Ameen, B. M., & Khdhir, R. M. (2025). Using thematic analysis in qualitative research. *Journal of Medicine, Surgery, and Public Health*, *6*, Article 100198. https://doi.org/10.1016/j.glmedi.2025.100198

Ahmed, S. K. (2024). The pillars of trustworthiness in qualitative research. *Journal of Medicine, Surgery, and Public Health*, *2*, Article 100051. https://doi.org/10.1016/j.glmedi.2024.100051

Aronson, J. (1995). A Pragmatic View of Thematic Analysis. *Qualitative Report*. https://doi.org/10.46743/2160-3715/1995.2069

Beck, C. T. (2013). *Routledge international handbook of qualitative nursing research*. Routledge. https://doi.org/10.4324/9780203409527

Braun, V., & Clarke, V. (2022). *Thematic analysis : a practical guide*. SAGE.

Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity*, *56*(3), 1391–1412. https://doi.org/10.1007/s11135-021-01182-y

Cena, E., Brooks, J., Day, W., Goodman, S., Rousaki, A., Ruby-Granger, V., & Seymour-Smith, S. (2024). Quality Criteria: General and Specific Guidelines for Qualitative Approaches in Psychology Research. A Concise Guide for Novice Researchers and Reviewers. *International Journal of Qualitative Methods*, *23*. https://doi.org/10.1177/16094069241282843

Crossman, J., & Bordia, S. (Eds.). (2021). *Handbook of qualitative research methodologies in workplace contexts*. Edward Elgar Publishing Limited.

Jung, S., & Lee, S. (2011). Exploratory factor analysis for small samples. *Behavior Research Methods*, *43*(3), 701–709. https://doi.org/10.3758/s13428-011-0077-9

Kekeya, J. (2016). Analysing qualitative data using an iterative process. *Contemporary PNG Studies*, *24*, 86–94.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *The European Journal of General Practice*, *24*(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Lee, T., & Mitchell, T. (1994). An Alternative Approach – The Unfolding Model of Voluntary Employee Turnover. *The Academy of Management Review*, *19*(1), 51–89. https://doi.org/10.5465/AMR.1994.9410122008

Lincoln, Y. S., Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage.

Maher, C., Hadfield, M., Hutchings, M., & de Eyto, A. (2018). Ensuring Rigor in Qualitative Data Analysis: A Design Research Approach to Coding Combining NVivo With Traditional Material Methods. *International Journal of Qualitative Methods*, *17*(1). https://doi.org/10.1177/1609406918786362

Mitchell, T., & Lee, T. (2001). The unfolding model of voluntary turnover and job embeddedness: Foundations for a comprehensive theory of attachment. Research in Organizational Behavior, 23, 189-246. https://doi.org/10.1016/S0191-3085(01)23006-8

Neale, J. (2016). Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction (Abingdon, England)*, *111*(6), 1096–1106. https://doi.org/10.1111/add.13314

Polit, D. F., & Beck, C. T. (2021). *Nursing research: generating and assessing evidence for nursing practice* (Eleventh edition.). Wolters Kluwer.

RNAO. (2026). Addressing the RN crisis in Ontario. *Registered Nurses' Association of Ontario.* https://rnao.ca/media/10283/download?inline

Stahl, N. A., & King, J. R. (2020). Expanding Approaches for Research: Understanding and Using Trustworthiness in Qualitative Research. *Journal of Developmental Education*, *44*(1), 26–28.

Chapter Five: Results

The results of this master's research are presented in the form of a peer reviewed article prepared for submission to the *Canadian Journal of Nursing Leadership* for publication. The article was formatted in accordance with the journal's guidelines for accepted manuscripts, including the preferred 12-15 page length, structured layout, and sections to ensure alignment with the publication requirements. For the purpose of this thesis, the article has been revised to include a more comprehensive and expanded findings section. The results presented in the article will explore the study objective to investigate the intentions of nurses who transitioned away from bedside nursing during the pandemic and their plans to return or progress in roles away from the bedside. The article will also address the research questions, "why did nurses leave bedside nursing during the COVID-19 pandemic? And what are the primary factors and considerations that would influence these nurses' re-entry into bedside care?" The version submitted for publication will be adapted to align with and adhere to the specific guidelines of the target journal. The thesis by article format was chosen to ensure the study findings reach a broader audience including nursing and organizational leaders, policy makers, and researchers. Disseminating the results in this way encourages knowledge translation to inform those who can support change in the nursing profession. Publishing this work aligns with the research goal to promote nursing retention and re-entry to bedside care. The article presents three themes and seven subthemes that emerged during analysis. It reflects information relevant to the nursing crisis that can inform leadership, policy development and workforce strategies. The translational impact of the article is to move the results beyond academia to make findings readily available to support actionable change. This article is intended to contribute to the discourse surrounding the nursing crisis, guide future research, and support the development of evidence-informed

strategies to strengthen and sustain Ontario's nursing workforce following the COVID-19 pandemic.

From Pandemic Departure to Pathways Back: Understanding Ontario Nurses' Decisions to Leave Bedside Care and Exploring Re-Entry

This is an unpublished manuscript formatted for submission to the Canadian Journal of Nursing Leadership. This version of the manuscript includes an expanded results section for the purpose of the thesis.

Authors

Rachel Rowney, RN, BScN

School of Nursing, Faculty of Health Sciences, University of Ottawa

Sandra Harrisson, RN, PhD

Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

Michelle Lalonde, RN, PhD

Full Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

Research Chair on the Health of Francophones in Ontario, Institut du Savoir Montfort

Kimberly McMillan, RN, PhD, CHPCN(C)

Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

Abstract

Background: During the COVID-19 pandemic, Ontario's nursing workforce experienced an increase in turnover and a notable departure of nurses from bedside care roles. A study was conducted to explore the intentions of nurses who left bedside nursing during the pandemic, emphasizing the factors that influenced their decision to leave and their considerations around returning to bedside practice.

Method: This study was conducted using an exploratory qualitative design. Data was collected through semi-structured interviews using questions guided by two theoretical frameworks: The Unfolding Model of Voluntary Employee Turnover and the Job Embeddedness Model. Interviews with Ontario Registered Nurse (RN) respondents ($N = 4$) who left bedside nursing during the pandemic were thematically coded to analyze and systematically identify themes and patterns.

Results: Three key themes and seven subthemes emerged: The Pandemic Exodus from Bedside Nursing, encompassing burnout and moral distress; Rebuilding Bedside Nursing, emphasizing the role of leadership, mentorship, professional development and teamwork in supporting re-entry and retention; and Redefining the Nursing Journey Beyond the Bedside, exploring nurses' professional identity and the broader career opportunities within the nursing profession and healthcare.

Conclusion: Many complex factors influenced Ontario nurses' departure from the bedside during the pandemic. Findings highlight the need to address the challenges identified in the study and invest in professional development strategies informed by nurses' perspectives. Supporting nurses both at or away from bedside practice is essential in sustaining and rebuilding a stronger, more resilient workforce post pandemic.

Introduction

Ontario's Registered Nurse (RN) workforce has faced persistent staffing issues for decades. The COVID-19 pandemic introduced new challenges that had a significant impact on health systems globally, with distinct implications for the nursing profession. The COVID-19 pandemic exacerbated Ontario's RN shortage leading to an increase in turnover with many nurses departing from bedside nursing roles (Maunder et al., 2022). Bedside nurses, referring to nurses who provide direct patient care, primarily responsible for medication administration, performing clinical assessments and ongoing monitoring, experienced extraordinary workplace challenges during the COVID-19 pandemic. These intensified working conditions brought on by the pandemic significantly contributed to stress, fatigue and burnout, ultimately pushing nurses to their breaking point (Akoo et al., 2024). Bedside nurses struggled to balance the convergence of pre-existing job pressures with the heightened demands of the pandemic. The role of the bedside nurse was intensified, positioning nursing as one of the most stressful occupations (Lorente et al., 2021). Ontario's nursing shortage has profoundly impacted the healthcare system and remains a critical issue to date. Post pandemic, Ontario reported the lowest ratio of RNs and RNs working in bedside roles per capita in Canada (CIHI, 2025). Although RN staffing challenges have been a longstanding concern in Ontario, the COVID-19 pandemic accelerated the province's shortage to crisis levels with more than 25,000 RNs needed to align with the national average (ONA, 2024).

Many nurses across the province grapple with the decision to leave bedside nursing. The Registered Nurses' Association of Ontario (RNAO)'s 2023 Work and Wellbeing Survey (N = 2102) revealed that over the next five years 69% of nurses are contemplating leaving their position with 42% of nurses considering leaving the profession. Recent literature has focused on

the causes that drove nurses away from bedside roles including burnout, illness, stress and retirement (Baumann & Crea-Arsenio, 2023). What remains ambiguous is the intentions of nurses who have left bedside care, particularly whether they would consider returning. There is limited evidence surrounding the motives and strategies that would entice nurses to re-engage in bedside practice post pandemic. It is unclear if recruitment and retention approaches that existed prior to the COVID-19 pandemic remain relevant to address the nursing exodus from bedside practice in the current context (Buckley et al., 2024). Now that the COVID-19 pandemic is no longer considered a global emergency, an exploration into strategies to encourage re-entry and prevent further attrition amongst the nursing workforce in Ontario is needed. The purpose of this study was to explore the intentions of Ontario RNs who left bedside roles during the COVID-19 pandemic, including their reasons for leaving, prospects for returning and ambitions within the profession. The aim of this research sought to understand the factors that led nurses to leave bedside nursing during the pandemic and the considerations that may shape their return to practice.

Methodology

Theoretical Perspectives on Nursing Turnover and Retention

Two organizational behaviour research models were used to guide this study's investigation into the factors that led to bedside nursing turnover during the Coronavirus pandemic and the considerations that would encourage nursing re-entry and retention at the bedside. The Unfolding Model of Voluntary Employee Turnover (1994) explains why people leave their positions, whereas the Job Embeddedness Model (2001) is a theoretical approach developed to explain and understand why people stay in their jobs. The integration of these two theoretical models offered a balanced framework to examine bedside nursing attrition during the

COVID-19 pandemic, provide valuable insights into the influences that contributed to this problem and explore nursing re-entry and retention strategies in Ontario post pandemic.

The Unfolding Model of Voluntary Employee Turnover proposes that turnover results from different psychological deliberations triggered by Shocks to the System, representing significant events that prompt job evaluation, and Decision Paths which guide the response to the shock (Lee & Mitchell, 1994). Decision Path #1, a "Script-Driven Decision", occurs when a shock triggers an automatic response that prompts a pre-determined decision (Mitchel & Lee, 2001, p. 200). Decision Path #2, a "Push Decision", involves an assessment of the shock and its impact on the employee's values, career trajectory, and personal image (Lee & Mitchell, 1994, p. 65). Decision Path #3 is a "Pull Decision" occurring when a shock results in discontent leading the employee to seek job alternatives (Mitchell & Lee, 2001, p. 205). Decision Path #4 does not involve a shock and is a routine assessment of job satisfaction where turnover occurs when the employee leaves either without job alternatives (Path 4A) or after evaluating other opportunities (Path 4B) (Mitchell & Lee, 2001).

The Job Embeddedness Model reflects the degree of "stuckness" individuals feel towards their employment and evaluates the influences that encourage employee retention including Links, Fit and Sacrifice (Lee & Mitchell, 2001, p. 216). Links refer to the connections and relationships both on and off the job that increase attachment to the place of work; links are the personal and professional connections that strengthen attachment to the workplace and increase job embeddedness (Mitchell et al., 2001). Fit represents the degree of compatibility and alignment of goals, values and aspirations an employee has in relation to their organization and larger community environment (Mitchell & Lee, 2001). Sacrifice reflects the perceived physical and psychological losses associated with leaving a job, where greater sacrifice is associated with

a higher likelihood of employee retention (Mitchell et al., 2001). The integration of these two organizational behaviour research models can help explain why nurses left the bedside during the COVID-19 pandemic, examine the forces that influenced turnover, analyze attrition and better understand what considerations would lead these nurses to return to the bedside in a post pandemic world.

Design

This research was guided by a pragmatic epistemological viewpoint and conducted using a qualitative exploratory design. Pragmatism, as the philosophical underpinning of this study, examines truth and knowledge by the usability of its findings. It supports a practical approach to understand bedside nursing turnover during the pandemic to generate insights that inform actionable strategies (Elder-Vass, 2022). The qualitative exploratory design used responsive, reflective and attentive interviewing to gain an in depth understanding nurses experiences during the COVID-19 pandemic and their rationale for transitioning away from bedside nursing (Crossman & Bordia, 2021). The study involved semi-structured interviews that explored meaningful conversations about nurses' lived reality while offering insights into the complex factors that influenced their pandemic departure from bedside nursing.

Sample & Recruitment

The target study population for recruitment consisted of a convenience sample accessed through professional connections and social networking including LinkedIn, Discord and Facebook. Given the emerging trend of younger nurses leaving the bedside, the inclusion criteria for this study was comprised of RNs practicing nursing in Ontario licensed by the College of Nurses' of Ontario (CNO) with less than 10 years of experience when they left bedside nursing during the COVID-19 pandemic (Jerome-D'Emilia et al., 2022). Participants were screened to

ensure they met the inclusion criteria. Years of experience was verified by the individual and through the CNO website which includes information on registration and employment history. As this was a master's project and an exploratory study, a smaller sample size of participants was selected to allow for an in depth understanding of the phenomenon of interest and to generate insights that may guide future research. A total of four participants were recruited for the study (Table 1).

Table 1 summary of the four nurse participants who left bedside practice during the COVID-19 pandemic including their specialties, years of experience and post bedside roles.

Participant Number	Gender	Area of Bedside Nursing Practice	Years of Bedside Nursing Experience	Year Left Bedside Practice	Current/Post Bedside Role
1	Female	Mental Health	7	2022	Research and Education
2	Female	Intensive Care	4	2022	Healthcare Business
3	Female	Medical-Surgical	1	2021	Nursing Management
4	Female	Internal Medicine	2	2022	Virtual Healthcare Consulting

Data Collection

Individual interviews with each of the participants occurred virtually and were video recorded and transcribed using Microsoft Teams. On average, interviews lasted approximately 40 minutes. All interviews were reviewed and verified by the researcher and personal identifiers were removed to ensure confidentiality.

Ethical Considerations

Ethical approval was obtained by the University of Ottawa's Health Sciences and Science Research Ethics Board. Participants provided written consent prior to being interviewed and all participants were informed of their right to withdraw from the study at any time without consequence.

Data Analysis

This research used Braun and Clarke's 2022 thematic analysis method to analyze the interview data. The qualitative data analysis software, Nvivo, supported the thematic analysis process wherein themes were identified, reviewed, refined, defined and reported (Braun & Clarke, 2022). During analysis, the data was repeatedly re-examined through listening, reading and writing to generate insights and deepen understanding (Kekeya, 2016). Iterative coding was conducted with the research team by repeated cycles of independent review and discussion to increase transparency and methodological rigour (Neale, 2016). This systematic method ensured a rigorous exploration into the interview data and an authentic representation of the nurses lived experiences during the COVID-19 pandemic.

Results

Nurses shared their bedside care experiences during the COVID-19 pandemic, explaining the significance of their decision to leave bedside nursing, the factors that influenced them, the impact on their professional identify, relationships and sacrifices that were encountered. Nurses also discussed their evolving career trajectories, professional ambitions, perceptions of the profession and changes needed to encourage re-entry of nurses into bedside roles. Interview transcripts were carefully reviewed to document the initial observations, reflections and to build a foundational understanding of the participants experiences including the factors involved in their decision to leave bedside nursing during the pandemic. Themes were subsequently

developed through a systematic, step-by-step thematic analysis guided Braun & Clarke's (2022) method, which involved generating codes to establish a comprehensive dataset for further analysis.

Key topics emerged through the process of thematic analysis including three major themes with seven subthemes which are outlined in Figure 1. The first identified theme, the Pandemic Exodus from Bedside Nursing, arose from participants detailed accounts of leaving bedside roles during the COVID-19 pandemic. This theme directly addresses both the research objective, to investigate the intentions of nurses who left during the pandemic, and the research question examining why they chose to leave. Across interviews, nurses consistently highlighted burnout and moral distress as significant factors that influenced their departure from bedside practice. As the study guide was intentionally structured to elicit reflection on the influences, factors and reasons for nurses' decisions to leave, these narratives were prominent and recurring. This resulted in the Pandemic Exodus from bedside Nursing becoming a foundational theme in the analysis with the subthemes of burnout and moral distress. The second theme, Rebuilding Bedside Nursing, developed as participants shifted from describing their departure to consider what would support a potential return to bedside practice. This theme highlights the study objective, exploring nurses plans to return as well as the question of what factors and considerations would influence re-entry to bedside nursing. Discussions centred on what changes would be necessary to make bedside practice sustainable and attractive. Within these accounts, the subthemes of Transforming Leadership to Support Nurse Re-Entry into Bedside Practice, the Power of the Team, Mentorship and Professional Development surfaced as conditions essential for rebuilding the bedside environment. This theme captures not only the challenges nurses identified but also their perspectives on the changes needed to encourage nursing re-entry and

retention. The final theme is Redefining the Nursing Journey Beyond the Bedside, including, Expanding Opportunities in the Nursing Profession and Sustaining Professional Identity as secondary themes. This overarching theme directly aligns with the study objective of examining nurses' future career intentions following their departure from bedside practice. This theme arose from reflective conversations about personal values, identity, career aspirations and factors that continue to anchor participants to the nursing profession. Despite leaving the bedside, participants articulated expanded understandings of nursing that extended beyond traditional bedside roles. Their reflections illustrate how they reconciled their departure from bedside practice not as leaving the profession, but rather a deliberate progression, redefining, reframing and evolving in their nursing careers.

Figure 1 Outline of Findings Themes and Subthemes

Theme 1: The Pandemic Exodus from Bedside Nursing

The Pandemic Exodus from Bedside Nursing as a theme captures the departure of Ontario RNs ($N = 4$) from bedside care roles during the COVID-19 pandemic. Nurses faced intense workforce challenges including frequent floating, redeployment, unsustainable staffing compliments and overwhelming workloads which contributed to burnout. Nurses found themselves trapped between the expectation of providing compassionate care while also

complying with pandemic directives, making moral distress a defining factor in their experience. The culmination of these key stressors, burnout and moral distress, ultimately led nurses away from bedside care.

The subtheme of burnout reflects the cumulative impact of unsafe staffing, excessive workloads, shifting responsibilities, and the intense physical and mental demands nurses faced while providing care during a global pandemic. The World Health Organization (WHO) defines burnout as a work-related phenomenon resultant from chronic stress, characterized by exhaustion, reduced work efficacy, emotional frustration, lack of energy and motivation (WHO, 2019). Participants voiced that nurses are experiencing burnout within five years of entering the workforce, yet Ontario's healthcare system has not implemented measures to address this issue which in turn has further perpetuated the staffing crisis.

> Before I was five years out of practice I knew I couldn't do this for 30 to 40 years. […]. There's this whole idea of lets just open more seats to train more nurses because we're burning them out in five years or less so we just need to keep this conveyor belt going to replace them. There's no thought about retention or keeping healthcare staff period, we're disposable. We're just throwaways and it's so horrible that nursing will steal your mind, body and soul within five years and chew you up and spit you out and nobody cares, because there's somebody coming right behind you. And it feels like the system refuses to change. It will gladly chew you up and spit you out because you are replaceable. But then, they will cry about a staffing crisis, even though it is the system that's perpetuating this crisis. And we're villainized as nurses when we leave the frontline because the health care system is crumbling and it is in crisis […]. Nursing is almost like these golden handcuffs of well, we'll pay you a good wage and you can work anywhere and you'll have job security and you'll have a pension and all of this, but we're going to break you to have those things (Participant 1).

While burnout is not unique to the nursing profession it was a symptom of the pandemic that eventually led many to leave nursing.

> During the pandemic I was working a lot of hours, I was a fairly new grad and I found myself in charge role positions. I felt like I was forced to make decisions where I was uncomfortable and felt like it should have been a more senior nurse. […]. I couldn't continue. […]. I was unwell. Just from stress (Participant 3).

Nurses' experiences immersed in high-stress, emotionally taxing environments with limited support, highlight the urgent need to address and prevent further normalization of burnout in nursing practice.

> I was feeling burnt out. I didn't want to admit that to myself, but looking back I was showing signs of it. At that time I wasn't sure if I wanted to continue in bedside nursing (Participant 4).

Participants also described being unable to take time off or fully disconnect from work due to staffing shortages which limited their opportunity to rest and recover from work.

> I was certainly not getting vacation during the pandemic as a nurse and actually was having vacation denied frequently. I was told that there's not enough nurses working or not enough RNs this week (Participant 2).

The concept of moral distress in nursing as described by Jameton (2013) arises when a nurse is put in a difficult situation where they are prevented from acting in accordance with what they believe to be right based on their ethical or professional judgement. Moral Distress was a key topic nurses discussed during interviews, participants reflected on the emotional, psychological and ethical discomfort they experienced while working at the bedside during the COVID-19 pandemic. Participants expressed that these sustained feelings of distress were heightened by necessary compliance and enforcement of inhumane policies that may have caused preventable suffering. Participants identified restrictive visitor policies during the pandemic, which resulted in patients dying without visitors, as a significant ethical concern. One participant described a distressing situation where a patient on life support's family made the difficult decision to turn off the ventilator and withdraw care. Unfortunately, hospital visitor restrictions prevented the family from being present with their loved one at the end of their life.

> The hospital administrators said that the family could not come in to say goodbye. It's not the hospital administrators that have to communicate that message to a

> grieving family, it's us on the front lines that have to make that call. It's us that don't agree with that call and we're the ones that have to break that horrible news that their father is dead, but that we won't let them come in to say goodbye. And that's wrong (Participant 1).

Within the subtheme of moral distress, participants highlighted the broader nursing crisis and chronic understaffing as a significant source of concern. Some participants experienced being redeployed in accordance with their workplace policies and procedures, often without choice, adequate preparation or appropriate training. These nurses were required to practice in clinical environments with insufficient staffing which resulted in working conditions perceived to be both wrong and unsafe, ultimately intensifying their sense of moral distress.

> I just constantly felt like #1 no one gave the support needed when floating and there was no appreciation for how stressful that was. And then #2, I actually thought I was gonna kill someone. I genuinely believed that I was going to make a mistake where someone would die and then I would go to jail for the rest of my life. I didn't want to kill someone, but I also didn't want to be held personally responsible for a mistake made in an environment I hadn't been trained to work in. […]. Someone's gonna die today, and it's probably gonna be this guy who keeps coding. But it could just as easily be my own patient who's in the room next door who's not getting the care he deserves because I'm over here trying to help the other nurse. There just weren't enough of us (Participant 2).

As public health restrictions were heightened during the pandemic, mental health services were downscaled to abide by these measures (Bonello et al., 2021). During the pandemic, people were advised to stay home and only go to the hospital if there was a medical emergency which inadvertently impacted access to mental health care for those in crisis as discussed by Participant 1:

> People were dying alone and not from COVID, but from their isolation, their depression, from overdose, and nobody cared. To see that my patients didn't matter like that. That still really upsets me to this day. […]. On the PICU we were inappropriately secluding people because they couldn't wear a mask, we had everybody locked up in seclusion rooms for weeks until their psychosis resolved because they couldn't follow IPAC protocols and how is that ethical practice […] The moral distress that I still feel in those settings. It's too much. And just feeling like we have too much responsibility and not enough control over what happens

> […]. I was absolutely miserable, morally distressed, burned out and couldn't sleep at night. I'd have nightmares about my job and hear call bells for hours.

Although moral distress as a concept in nursing is not new, the pandemic introduced clinical situations that increased both the frequency and intensity of nurses' moral distress which contributed significantly to nurses' departure from bedside care.

Theme 2: Rebuilding Bedside Nursing

Rebuilding bedside nursing as a theme presents the perspectives and insights of the participants (who have all left direct patient care) and examines the key factors that could influence re-entry into these nursing roles. Subthemes were identified as transforming leadership, mentorship and professional development and the power of the team. The evidence presented here illustrates the need for supportive leaders and managers, opportunities to enhance clinical competencies and the positive influence effective teams have on workplace satisfaction. Collectively, rebuilding bedside nursing requires not only systemic change but a renewed commitment to leadership and management, professional development, mentorship, and teamwork to create a supportive environment that encourages re-engagement at the bedside.

Transforming leadership practices to support nurse re-entry to bedside practice underscores the need for changes in leadership and management practices. Participant 4 expressed her frustration with her management team during the pandemic, stating:

> It was like we were doing so much for the patients, for each other, for other healthcare professionals within the hospital, and yet, there was still a lack of appreciation from management […]. If there was more recognition for the work that was being done it would make nurses more motivated […]. There's a general lack of appreciation and that would definitely have to be something that I would have to think about a lot when I'm considering another role at the bedside […]. Management is not the front lines. They weren't there fighting the battle with us on the battlefield as the soldiers out there.

This subtheme highlights the importance of supportive leaders and managers who understand the clinical realities of nursing, recognize, appreciate and value the work that nurses do.

> I think it's important to have leaders that understand what you know and worked on the frontline and understand what everybody went through. I think that's really valuable, especially as a manager [...]. I continue to see myself working in management. I'm taking what I've learned throughout the pandemic, and how that also affected the staff along with me (Participant 3).

Participants highlighted that transforming leadership and management practices is needed to foster a supportive work environment and promote re-entry at the bedside.

The study findings emphasize the need for mentorship and professional development opportunities to support nurses returning to bedside practice. Many participants who left bedside nursing cited a lack of mentorship, training, education and skill development as key factors that influenced their departure. Participants emphasized that professional growth was highly valued among nurses and needed, especially for those working at the bedside.

> Nurses should continue to upgrade their skills and upgrade their knowledge […]. Nurses would benefit from opportunities for professional development, so things like the ability to take further courses or to learn more things. Maybe some dedicated time to set aside so that they can advance their career (Participant 4).

The need for re-familiarization with clinical skills was identified as something nurses would require to return to a bedside care position.

> There would need to be some sort of program to help nurses transition back into that role […]. I would need some sort of re-familiarization with clinical skills. Placing an IV or trach care or anything like that, I haven't done for a while. So yes, I can still run through the process, but do I have the knowledge, skill and judgment to do it? I don't know if I have the skill piece anymore. So there would be that, but also part of it would just be taking the jump and I feel like I'm pretty comfortable away from the bedside now and I don't know if I could just jump back in (Participant 3).

Participants expressed concern that bedside nurses have limited opportunities to develop and strengthen their clinical competence, emphasizing that expanded professional development

opportunities and mentorship are key conditions for supporting nurses in practice and those transitioning back into bedside care.

Participants identified the Power of the Team as a key factor that would influence their decision to return to bedside nursing. Nurses emphasized the unparalleled solidarity and resilience that came from working within well-functioning nursing teams that were supportive and reliable. Participant 2 expressed that leaving the team was her "biggest loss in leaving nursing". The intense clinical environments that nurses worked in were made more bearable by the unique team bonds which were forged during the pandemic.

> I've never found that sort of community outside of nursing. You don't have that life or death in the balance and you don't form those sorts of relationships at a regular job (Participant 2).

The concept of teamwork on the COVID-19 front lines was described in the words of Participant 3 as being "in the trenches" together, highlighting a shared sense of solidarity and collective responsibility in battling both the nursing crisis and the challenges of the pandemic. Teamwork and a collaborative work environment promoted professional fulfillment and psychological safety. Participant 4 stated that the team is "a reason why I want to go back":

> I felt a really big sense of team camaraderie […]. I felt very close to the people on my unit because of how much we had gone through the pandemic together. All of us, we trauma bonded with each other. I feel really lucky to have been working with them as part of their team at that time […]. I really value teamwork and working together. I think that we can accomplish more together than we can individually. And so I place a high importance on that in my nursing career.

Participants emphasized the power of strong nursing teams and it was cited as a major reason why some nurses who left considered staying or have contemplated returning to the bedside.

Theme 3: Redefining the Nursing Journey Beyond the Bedside

Redefining the nursing journey beyond the bedside explores the evolving professional identities of nurses who made the difficult decision to leave bedside care roles during the

COVID-19 pandemic but chose to remain within the nursing profession or broader healthcare community. Nurses maintain pride in the profession, recognize the influence they have and the value of nursing expertise in healthcare. Participants indicated they did not intend to return to bedside roles at this time. Although some participants explained they might consider returning in the future, they clarified that their current plans involved pursuing or continuing in alternate positions within the broader nursing and healthcare sector. This theme affirms that leaving traditional bedside roles does not mean leaving nursing; nurses are redefining what it means to be a nurse by advancing Ontario's health system away from the bedside.

Expanding opportunities in the nursing profession as a subtheme explores how the COVID-19 pandemic served as a professional turning point, leading many nurses to discover and pursue new positions away from traditional bedside care roles. As Ontario's healthcare system adapted to a global pandemic, the nursing profession innovated and evolved by expanding, redefining and revealing the impact nurses have on patients and the healthcare team. Nurses contributed through education, leadership, virtual care, public health, infection control and research in new and meaningful ways. Participant 4 transitioned away from bedside nursing into a remote consulting role, highlighting the positive impact of nursing perspectives on the healthcare system:

> Nurses have experience and insight that not many people have, especially nurses that have worked during the pandemic […]. I'm a prime example that even when you are not working bedside, there are so many stakeholders. There's so many organizations and institutions that really value your input and experience as a nurse and they are looking for that. They're actively seeking that.

Participants highlighted how alternative roles away from the bedside allowed them to continue practicing nursing in new and important ways. Participant 3 left the bedside to pursue a role as an Infection Prevention and Control (IPAC) nurse in a Long-Term Care (LTC) facility. While this

transition ultimately reaffirmed her decision which was made in part due to the negative impact bedside nursing had on her mental health, she initially questioned whether leaving aligned with her professional obligations:

> I think through nursing school you get told to become a nurse and go to the hospital and work bedside and you take care of people at the bedside. And so I was questioning if I would keep my license. My license is very valuable to me, but would I still be a nurse? And would people still look at me as a nurse, if I wasn't at the bedside? And then I left the bedside during a pandemic. Am I doing what's right for the profession? I took an oath as a nurse. Am I still abiding by that by leaving at this time […]. I quickly realized that I still upheld the expectations and standards of the College in my new IPAC nursing job, and I was very pleased with my decision, but it was difficult […]. I would say my perception of nursing and the nursing profession has evolved greatly. Nurses, do a whole lot more than I even knew of […]. I love being a nurse. I love caring for people. So where I am currently, is it direct bedside? No. Do I miss that? Yes. Learning the tidbits about the patients, I miss. I feel like I don't get that exposure in my current role that I have and that is one thing that I miss. But I think still being able to help people and shape their care is something that I love and I will never ever leave the nursing profession.

The subtheme of sustaining professional identity emerged in the study as nurses who left bedside care during the pandemic continue to uphold the core values and identity of the nursing profession. All nurses in the study have redefined how they practice and continue to remain connected and committed to the foundational principles of nursing. Participant 2 expressed that she remains proud of her professional identity, sharing “I still say I am a nurse.” Participant 1 reflected on the qualities inherent to the nursing profession, including:

> An alternate perspective to traditional biomedical views […]. Nurses are taught to think about the bigger picture and people's lives in context. […]. You care and you listen and you understand and you took the time and we need to push for that. […]. Even beyond COVID nurses have so much to offer and that keeps me grounded because I think that we can be a beacon of rationality that's based in ethics. And we need that desperately now. I want to push the nursing profession a little bit further from this adherence to biomedicine and all of that, because we do like that and we like to have proximity to that because it grants us authority and we're able to speak with authority because we're able to appeal to this whole line of thinking. We're able to talk the talk that is respected. But that is not where I think our power lies. I think it's in all the other stuff that we have to offer that's

> missing and is desperately needed now. So I hope that in doing research and maybe doing education and whatever I can be a part of to push that line of thinking forward we can feel empowered and we can go back to the roots of why we were all drawn to this profession. If we were able to embody all of that nursing essence that we're all craving, I think that more people would stay in nursing.

Participant 3 reflected on her decision to leave bedside nursing during the pandemic, emphasising that it did not diminish her identity as a nurse:

> I did what was right for me, and I do still feel like I'm a nurse. I feel like I still care for people […]. Even to tell my family I'm leaving the bedside and they were like, well, you're a nurse and you went to school for that. I said yes I did and there's lots of avenues for nursing.

This subtheme highlights the essence of nursing by emphasizing its holistic perspective, adaptability and resilience, illustrating how these core attributes can be honoured across diverse roles and settings within an evolving healthcare landscape.

Discussion

This study explored the reasons nurses left bedside care roles during the pandemic and what factors or considerations would bring them back. Participants echoed the need for supportive leadership and management, mentorship, professional development, and teamwork. Central to the rebuilding beside nursing theme was the need to transform nursing leadership and management as a foundation to promote re-entry to bedside practice.

Nurses in the study explained in the findings that during the pandemic they felt underappreciated and unsupported by management, particularly when leaders lacked a nursing background. These results are consistent with existing literature; research highlights the pivotal role that nurse managers play in positive health and organizational outcomes including their impact on staff retention (Haddad et al., 2022). Nurse managers play a key role in improving health outcomes and optimizing patient-centred care, specifically when their leadership styles are

aligned with organizational goals, supporting safe and effective care (Nurmeksela et al., 2021). Participants expressed that the leaders they felt least supported by were those who did not have visibility into their job functions which in turn led to feelings of betrayal, resentment and lack of appreciation for failing to recognize the incredibly important and challenging work required of nurses during the pandemic. The Nursing Retention Toolkit recognizes that managers in nursing environments should be nurses; nurse managers possess special skills and competencies, including understanding clinical practice and nursing values (Health Canada, 2024). Nursing perspectives are essential in strategic planning and healthcare administration as nurses contribute unique insights that enhance organizational adaptation, resilience and crisis response whereas non-nurse leaders may lack comparable experience (Wang et al., 2025). Managers who are nurses with bedside experience provide a deeper understanding of the clinical needs and realities of nurses, which nurses who left bedside practice identified as essential for fostering meaningful support and would influence their decision to return to the bedside or not.

Improving nursing management and leadership has the potential to strengthen nurses' job embeddedness, thereby promoting nurses to return and remain in bedside roles. The Unfolding Model of Voluntary Employee Turnover and the Job Embeddedness Model focus on predictors of turnover and should be incorporated into leadership practices because understanding why people leave provides insights for leaders to support employee retention (Felps et al., 2009). As nurse participants have highlighted, a lack of supportive management during the pandemic was a key factor that influenced their decision to leave. Studies on nursing leadership in healthcare organizations acknowledge the impact nurses have in managerial positions as crucial, particularly for their decision making skills during public health emergencies (Wang et al., 2025). Participants reported being thrust into charge roles or redeployed during the pandemic

without adequate experience, preparation, or support from managers and leaders. Leadership and management play a pivotal role in retention and are especially important when addressing the needs of novice nurses who require structure and mentorship to promote their professional development (Goens & Giannotti, 2024). Ineffective leadership heightens nurses' intention to leave and further exemplifies the need for strong nurse managers with clinical experience and the ability to provide meaningful support to the bedside nursing team.

Implications for Nursing Leadership

This study underscores the importance of effective nursing leadership and management, particularly in times of crisis as seen during the COVID-19 pandemic. Recognizing and addressing the factors that led to nursing turnover is crucial. Results of this study may provide useful insights for healthcare policymakers, leaders and managers to inform the development of strategies that support nurses at and away from the bedside, promote nursing workforce sustainability and encourage re-entry of bedside RNs post pandemic.

An important leadership implication arising from the study is the need for leaders to address the underlying structural and ethical conditions that drove bedside nursing turnover during the pandemic. Leaders must develop a strong understanding of burnout and moral distress to avoid their normalization and mitigate the associated consequences. Through the intentional integration of the theoretical models used in the study, leadership approaches can be more effectively aligned with targeted strategies to address attrition while also strengthening the factors that support retention and return to practice. The Unfolding Model of Voluntary Employee Turnover suggests that for the first three decision paths, turnover occurs following a "shock to the system" which prompts job evaluation (Lee & Mitchell, 1994, p. 61). Study findings imply that turnover is often more gradual and accumulative rather than sudden like the

theoretical framework suggests. This challenges leaders to reconceptualize turnover during the pandemic as a result of prolonged burnout, ongoing exposure to distressing situations, and an erosion of links, fit and sacrifice over time. Leadership strategies must address these conditions that contributed to attrition and foster a practice environment that is worth returning to, not one that is simply tolerated.

The importance of supportive nursing leadership and management highlights the need for organizational structure review that ensures nursing teams are led by nurses who foster teamwork, provide practical support, mentorship and professional development opportunities for bedside nurses. And finally, it is important to recognize that some nurses who have left bedside roles may not return but can contribute meaningfully to the nursing profession. Nurses who worked at the bedside during the pandemic gained valuable clinical experience that can be leveraged across multiple domains of healthcare, including leadership, research, administration, policy development, advocacy and education. Supporting nurses in sustaining their professional identity affirms the value of their contributions to the profession and strengthens Ontario's nursing workforce while also promoting resilience both at and away from the beside.

Limitations

While this was an exploratory study intended to understand why nurses departed from bedside care during the pandemic and investigate their intentions to return, the sample size was a limitation. A larger group of participants may have uncovered additional discoveries and captured different perspectives, particularly from those who had returned to bedside nursing. Results from the study reflect views on what would hypothetically support nurses re-entering bedside practice rather than evidence based on lived experiences from nurses who left, then returned. A larger sample that encompasses nurses who have returned to bedside roles may offer

a more comprehensive understanding of why nurses left during the pandemic and which supports are needed or effective in facilitating return to practice.

Conclusion

This research highlights the vital perspectives and insights of nurses during the COVID-19 pandemic, contributing to a more comprehensive understanding of the current and future needs of the nursing workforce in the province of Ontario. Identification of the factors and influences that contributed to nurses leaving bedside roles during the pandemic and what would encourage their return may help inform policies, practices and lead to actionable changes that can support Ontario's nursing industry. The significance of this study provides a foundation to support nurses both at and away from the bedside, inform strategies for nursing re-entry to bedside care, address the challenges nurses faced during the pandemic, and promote a more resilient and adaptable nursing workforce.

References

Akoo, C., McMillan, K., Price, S., Ingraham, K., Ayoub, A., Rolle Sands, S., Shankland, M., & Bourgeault, I. (2024). “I feel broken”: Chronicling burnout, mental health, and the limits of individual resilience in nursing. *Nursing Inquiry*, *31*(2), Article e12609. https://doi.org/10.1111/nin.12609

Baumann, A., & Crea-Arsenio, M. (2023). The Crisis in the Nursing Labour Market: Canadian Policy Perspectives. *Healthcare (Basel)*, *11*(13), 1954. https://doi.org/10.3390/healthcare11131954

Bonello, F., Zammit, D., Grech, A., Camilleri, V., & Cremona, R. (2021). Effect of COVID-19 pandemic on mental health hospital admissions: comparative population-based study. *BJPsych Open*, *7*(5), Article e141. https://doi.org/10.1192/bjo.2021.975

Braun, V., & Clarke, V. (2022). *Thematic analysis : a practical guide*. SAGE.

Buckley, L., McGillis Hall, L., Price, S., Visekruna, S., & McTavish, C. (2024). What is known about nurse retention in peri-COVID-19 and post-COVID-19 work environments: protocol for a scoping review of factors, strategies and interventions. *BMJ Open*, *14*(9), Article e087948. https://doi.org/10.1136/bmjopen-2024-087948

CIHI. (2025). Nursing in Canada, 2024 – Data Tables. *Canadian Institute for Health Information*. https://www.cihi.ca/sites/default/files/document/nursing-in-canada-2015-2024-data-tables-en.xlsx

Crossman, J., & Bordia, S. (Eds.). (2021). *Handbook of qualitative research methodologies in workplace contexts*. Edward Elgar Publishing Limited.

Dowson, A. (2023). The use of agency nursing is exploding. *Canadian Health Coalition.* https://www.healthcoalition.ca/the-use-of-agency-nursing-is-exploding/

Elder-Vass, D. (2022). Pragmatism, critical realism and the study of value. *Journal of Critical Realism*, *21*(3), 261–287. https://doi.org/10.1080/14767430.2022.2049088

Felps, W., Mitchell, T. R., Hekman, D. R., Lee, T. W., Holtom, B. C., & Harman, W. S. (2009). Turnover Contagion: How Coworkers' Job Embeddedness and Job Search Behaviors Influence Quitting. *Academy of Management Journal*, *52*(3), 545–561. https://doi.org/10.5465/amj.2009.41331075

Goens, B., & Giannotti, N. (2024). Transformational Leadership and Nursing Retention: An Integrative Review. *Nursing Research and Practice*, *2024*(1), 3179141. https://doi.org/10.1155/2024/3179141

Haddad, M. E., Faithfull-Byrne, A., Thompson, L., Wilkinson, G., & Moss, C. (2022). Nurse unit managers' work and impacts on clinical leadership: A cross-sectional study. *Collegian (Royal College of Nursing, Australia)*, *29*(5), 635–644. https://doi.org/10.1016/j.colegn.2022.02.004

Health Canada. (2024). *Nursing retention toolkit:improving the working lives of nurses in Canada.* Health Canada = Santé Canada,. https://publications.gc.ca/collections/collection_2024/sc-hc/H22-4-38-2024-eng.pdf

Jameton, A. (2013). A Reflection on Moral Distress in Nursing Together With a Current Application of the Concept. *Journal of Bioethical Inquiry*, *10*(3), 297–308. https://doi.org/10.1007/s11673-013-9466-3

Jerome-D'Emilia, B., Suplee, P. D., & Linz, S. (2022). Challenges faced by new nurses during the COVID-19 pandemic. *Journal of Nursing Scholarship*, *54*(6), 772–786. https://doi.org/10.1111/jnu.12783

Kekeya, J. (2016). Analysing qualitative data using an iterative process. *Contemporary PNG*

Studies, *24*, 86–94.

Lee, T., & Mitchell, T. (1994). An Alternative Approach – The Unfolding Model of Voluntary Employee Turnover. *The Academy of Management Review*, *19*(1), 51–89. https://doi.org/10.5465/AMR.1994.9410122008

Lorente, L., Vera, M., & Peiró, T. (2021). Nurses´ stressors and psychological distress during the COVID-19 pandemic: The mediating role of coping and resilience. *Journal of Advanced Nursing*, *77*(3), 1335–1344. https://doi.org/10.1111/jan.14695

Maunder, R. G., Heeney, N. D., Hunter, J. J., Strudwick, G., Jeffs, L. P., Ginty, L., Johnstone, J., Kiss, A., Loftus, C. A., & Wiesenfeld, L. A. (2022). Trends in burnout and psychological distress in hospital staff over 12 months of the COVID-19 pandemic: a prospective longitudinal survey. *Journal of Occupational Medicine and Toxicology (London, England)*, *17*(1), 11–11. https://doi.org/10.1186/s12995-022-00352-4

Mitchell, T., Holtom, B., Lee, T., Sablynski, C., & Erez, M. (2001). Why People Stay: Using Job Embeddedness to Predict Voluntary Turnover. *Academy of Management Journal, 44*(6), 1102– 1121. https://doi.org/10.2307/3069391

Mitchell, T., & Lee, T. (2001). The unfolding model of voluntary turnover and job embeddedness: Foundations for a comprehensive theory of attachment. Research in Organizational Behavior, 23, 189-246. https://doi.org/10.1016/S0191-3085(01)23006-8

Neale, J. (2016). Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction (Abingdon, England)*, *111*(6), 1096–1106. https://doi.org/10.1111/add.13314

Nurmeksela, A., Mikkonen, S., Kinnunen, J., & Kvist, T. (2021). Relationships between nurse

managers' work activities, nurses' job satisfaction, patient satisfaction, and medication errors at the unit level: a correlational study. *BMC Health Services Research*, *21*(1), Article 296. https://doi.org/10.1186/s12913-021-06288-5

ONA. (2024). New data confirms nurse staffing ratio continues to plumet in Ontario. *Ontario Nurses' Association.* https://ona.org/news/20240725-cihi-data-staffing/

RNAO. (2023). Ontario's RN Understaffing Crisis: Impact and Solution. *Registered Nurses' Association of Ontario.* https://rnao.ca/media/3163/download?attachment

Wang, X., Lian, J., Ji, M., Lee, G., & Hu, Y. (2025). Nurse Managers' Experiences in Organisational Adaptation During Public Health Emergencies: A Qualitative Study. *Journal of Advanced Nursing*, *81*(7), 4172–4186. https://doi.org/10.1111/jan.16626

WHO. (2019). Burn-Out an "occupational phenomenon": International Classification of Diseases. *World Health Organization.* https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

Chapter Six: Discussion

This section presents a discussion of the findings in relation to current research. The purpose of this study was to explore the reasons why nurses transitioned away from bedside care during the pandemic, their professional goals and ambitions and their intentions surrounding re-entry to practice. Nurse participants in the study cited several reasons for their departure from bedside care, shared insights into the factors that would improve bedside nursing and potentially support their return and reflected on the nursing profession's influence away from direct care. This section will examine these topics against the literature, highlight theoretical reflections, discuss implications for nursing practice, education, and future research and review the strengths and limitations of the study.

6.1 Moral Distress as a Catalyst for Leaving Bedside Nursing

The province of Ontario continues to be impacted by the nursing crisis following the COVID-19 pandemic. Considerable Registered Nurse (RN) vacancies remain for bedside roles with the number of nursing job vacancies increasing by 5475 positions from 2022 to 2023 (Statistics Canada, 2023). While the literature has explored some of the factors that led nurses to leave during the pandemic including personal protective equipment (PPE) shortages, staffing challenges, workload, fear, anxiety, exhaustion and burnout, limited evidence exists surrounding whether or not the nurses who left would return to bedside practice (Brophy et al., 2021). Preventing further attrition from bedside nursing is necessary to support the future of healthcare in Ontario.

The Pandemic Exodus from Bedside Nursing as an overarching theme contains subthemes Burnout and Moral Distress as significant influences that contributed to nurses' decisions to leave the bedside during the COVID-19 pandemic. These findings highlight the

ways in which the clinical and ethical situations introduced during the pandemic impacted nurses' mental health, values and principles. It is essential to understand nurses' rationale for leaving during the pandemic to support the development of strategies that would both retain nurses and encourage those who left to return.

Moral distress in nursing was first introduced as a concept in 1984 by bioethics philosopher and professor, Andrew Jameton, defined as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Participants described facing ethical dilemmas during the COVID-19 pandemic that they had never encountered before, recalling the emotional and psychological discomfort they felt enforcing strict isolation measures on patients who were experiencing mental health crises or nearing the end of their life. Studies on moral distress in nursing during the pandemic found that imposing visitation restrictions on dying patients was viewed as undignified, creating a direct conflict between the ethical principles of beneficence and non-maleficence (Ariander et al., 2024). Patients were dying alone in isolation and this experience was viewed as universally traumatic and wrong by participants in this study.

The COVID-19 pandemic heightened infection prevention and control (IPAC) standards to minimize the spread of infection. This intensified focus on infection control introduced new pressures as guidelines were rapidly evolving, workloads surged, PPE depleted, and increased professional obligations triggered moral distress amongst healthcare workers (Mason et al., 2025). While IPAC measures mitigated the transmission of COVID-19, participants expressed that they were expected to not only adhere to infection control practices but also enforce them with patients to ensure compliance. Nurses felt misaligned and powerless trying to balance clinical ethics and IPAC responsibilities within the constraints of the organization and this

contributed significantly to moral distress during the pandemic (Clark et al., 2025). These sustained feelings of psychological discomfort and ethical conflict ultimately became a key factor that led many nurses to disengage from bedside care.

As the participant population skewed towards the younger RN demographic, their moral sensitivity may have been influenced by their relative inexperience. The evidences shows that the transition to nursing is a stressful period and nurses beginning their career may be more susceptible to moral distress (Xu et al., 2024). New graduate nurses are particularly vulnerable to moral distress due to factors such as limited clinical experience, low self-confidence, insufficient ethical knowledge, fear, and a perceived inadequacy in their competence and decision making capacity (Kovanci & Atli Özbaş, 2025). Participants experienced significant distress as a result of fear, lack of support, being assigned charge responsibilities as new graduate nurses, and working within a culture of blame marked by tension between the bedside staff, management and the general public.

Lee and Mitchell's Unfolding Model of Voluntary Employee Turnover theorizes that employees decisions to leave are a result of psychological considerations shaped by a workplace satisfaction assessment, an internal script, or are a push or pull decision (1994). Essentially, employees, in this case nurses, do not just randomly decide to quit, rather their decision to leave is precipitated by a situation or accumulation of experiences that force them to evaluate their employment. A shock is a distinct significant event that can be positive, negative or neutral; the response to the shock is based on decision frames incorporated by the individual's lived and personal experiences which unfold over time and reflect their degree of job embeddedness (Mitchell & Lee, 2001). Participant 1 left bedside nursing following decision path 1, a script driven decision. Decision path 1 represents a relatively automatic response to quitting based on

an individual's unique characteristics, rules, or circumstances that result in this scripted behaviour (Lee & Mitchell, 1994). This nurse was shocked by the COVID-19 pandemic's impact on mental healthcare which challenged their beliefs and principles leading to their voluntary decision to resign from bedside nursing. Participant 1 explained that they observed negative stigma towards psychiatric and mental healthcare during the pandemic resulting in prejudice and treatment barriers that were harmful. As public health restrictions were heightened during the pandemic, mental health services were downscaled to abide by these measures (Bonello et al., 2021). Participant 1 felt that mental health crises were no longer considered an emergency and the messaging to patients facing these challenges was to stay at home and avoid coming to the hospital. The research demonstrates that the pandemic had unprecedented impacts on the lives of people with severe mental illness and led to increased rates of depression, anxiety, substance abuse, suicide, and psychosis in some cases (Kassam et al., 2023). When participant 1's ethics were misaligned with the organization they did not need to deliberate their decision to leave, citing moral distress as their primary reason for resigning from bedside nursing.

The COVID-19 pandemic introduced ethical dilemmas that caused moral distress and influenced participants decision to leave bedside nursing. The concept of moral distress predates the pandemic and will continue to be a problem in a post pandemic world. Sources of moral distress are similar to the conditions that contribute to burnout including prolonged patient suffering, ineffective care, low wages, under staffing, long hours, healthcare inadequacies and unsupportive management (Salari et al., 2022). Moving forward, it is important to increase nurses' and leaders' awareness of moral distress, develop protective strategies that prevent moral distress in nursing and support nurses who have experienced it overcome and cope with its effects. Understanding professional ethics and recognizing the factors that contribute to moral

distress is essential in supporting nurses' moral and ethical competence to improve decision making and counteract the consequences associated with moral distress (Wiisak et al., 2024). Acknowledging and addressing the presence of moral distress and its impact on Ontario's nursing workforce is essential to building ethical resilience, improving workplace culture and supporting retention.

6.2 Exploring the Sacrifices of the Pandemic Exodus from Bedside Nursing

To better understand nurses' departure from bedside practice during the pandemic, it is essential to examine the personal and professional sacrifices that contributed to their decisions, considering the perspectives of both remaining in and departing from the bedside. Sacrifice is defined as "the act of giving up or losing something of value for the sake of something else" (Merriam-Webster, 2025). Nursing is often portrayed as the embodiment of psychiatrist, psychologist and psychotherapist Carl Jung's Caregiver archetype: selfless, self-sacrificing and placing patients' needs above their own (Norris, 2023). Nursing culture is often perceived as being self-sacrificing, carrying an unwritten expectation that nurses will place their patients' needs above their own, blurring the boundaries between professional responsibilities and personal attachment, ultimately contributing to increased levels of burnout (Bolt, 2025). While the nursing exodus from bedside practice often emphasizes the negative connotations that contributed to this departure, it is equally as important to consider the positive and meaningful components of bedside nursing that were sacrificed when nurses left.

Much of the literature examines why nurses left bedside care during the pandemic, emphasizing the detriments and sacrifices of staying in a bedside role including burnout, stress, increased workload and other job pressures (Ciezar-Andersen & King-Shier, 2021). This focus can be broadened and reshaped in relation to the Job Embeddedness Model. This framework

discusses the concept of sacrifice, referring to the anticipated loss a person may feel if they were to quit their job (Mitchell et al., 2001). Job embeddedness reflects the accumulation of motivations that keep people connected and satisfied with their work, the model suggests that the greater the perceived sacrifice, the less likely an employee is to leave (Shaw et al., 1998). Rather than concentrating on the factors that drove nurses away from bedside practice during the pandemic, the concept of sacrifice in the Job Embeddedness Model reframes the discussion by considering what nurses felt they were giving up when they chose to leave the bedside.

A major theme that emerged from participants in this study was the overwhelming sadness associated with leaving their team, which many cited as the greatest sacrifice of leaving bedside nursing. During the pandemic, maintaining teamwork under pressure was associated with positive health outcomes, enhanced safety, increased performance and improved the overall wellbeing of the healthcare team (Rehder et al., 2023). Direct care is a unique and intense work environment where teamwork and trust are essential, making the support of a strong team foundation a crucial part of bedside nursing. The importance of adaptability, coordination, leadership and conflict resolution are core components of teamwork that enable the successful and effective functioning of healthcare teams (Rosen et al., 2018).

When viewed through the lens of the Job Embeddedness Model, these findings illustrate how the perceived value of workplace relationships strengthens embeddedness as leaving a strong and supportive team represents a significant sacrifice. Some nurses in this study expressed that the connection to their team continues to be a major consideration that would influence their decision to return to bedside practice. This insight highlights the importance of prioritizing and investing in strong healthcare teams, recognizing that teamwork is a key factor in supporting nursing retention and may encourage nurses who left the bedside to return.

6.3 Advancing Professional Nursing Roles in Infection Prevention and Control (IPAC)

IPAC has long been recognized as an essential function of healthcare, gaining important relevance during the COVID-19 pandemic. Its roots in nursing can be traced back to Florence Nightingale, whose early advocacy for the hygiene of therapeutic environments laid the foundational principles of modern IPAC practices (Fabbri, 2025). While Florence Nightingale contributed to the early development of infection control in nursing, IPAC only recently became recognized as a specialty nursing practice by the Canadian Nurses Association (CNA) in 2017 (IPAC Canada, 2025). The sustained presence of IPAC in nursing post pandemic reflects its contribution to effective infection prevention practices to ensure safe, high quality care across healthcare settings.

The COVID-19 pandemic uncovered significant vulnerabilities in congregate living environments, particularly in Long-Term Care (LTC) facilities, where the physical infrastructure, crowding and clinical susceptibilities of the resident population led to greater incidences of outbreak-associated respiratory infections and increased mortality rates (Leece et al., 2023). The Registered Nurses' Association of Ontario (RNAO) issued an IPAC Human Resources survey in 2020 to all 626 LTC facilities in Ontario to assess IPAC needs. The findings revealed significant capacity deficiencies within the LTC sector to ensure compliance with infection control requirements, underscoring the need for provincial funding to implement a RN or Registered Practical Nurse (RPN) in an IPAC role to support infection control initiatives and education (RNAO, 2020). Prior to 2020 there was significant lack of IPAC funding to Ontario LTC facilities and the pandemic quickly exposed this gap resulting in severe outbreaks, prompting significant investments including the introduction of a dedicated IPAC lead to support LTC homes with proactive infection control, prevention and containment measures (Government of

Ontario, 2021). In 2022, the F*ixing Long-Term Care Act, 2021* (FLTCA) came into effect, shaped by recommendations from the LTC COVID-19 Commission report, updating the regulations previously established under the *Long-Term Care Homes Act, 2007* (Government of Ontario, 2024). The requirements under the FLTCA, 2021 outlined a standard for LTC licensees to comply with the new regulation ensuring every LTC facility has an IPAC program and an IPAC Lead whose primary responsibility is to lead the program (Government of Ontario, 2022). According to the FLTCA, 2021, the IPAC lead is required to obtain Certification in Infection Control (CIC) by the Certification Board of Infection Control and Epidemiology (CBIC) within three years by April 2025 (Government of Ontario, 2024). To support this requirement, educational resources and guidance were provided through Communities of Practice (CoP), IPAC Canada, IPAC Hubs, and Public Health Ontario (Public Health Ontario, 2022). These legislative changes, professional requirements and sustained investments in infection control continue to influence nursing and the LTC sector in post pandemic world.

The formal introduction of the IPAC Lead in LTC homes has resulted in the development of a specialized workforce largely comprised of nurses; although the IPAC position is not limited to a single profession, nursing expertise aligns well with the educational and clinical competencies the role demands likely contributing to the strong representation of nurses in these positions. While there is limited published data identifying the professional experience of IPAC Leads in LTC, participants surveyed in CoP IPAC sessions ($N = 181$) indicated that the majority of IPAC Leads were nurses, with 80.7% ($n = 150$) reporting a nursing background (Callahan et al., 2025). This suggests that the IPAC Lead in Ontario LTC facilities, which has retained both regulatory and practical relevance post pandemic, has become integral to LTC operations and a non-traditional nursing role that leverages nursing expertise away from bedside care. The

literature shows that clinical nursing IPAC leadership increases healthcare teams' knowledge on infection control practices and has a positive impact on compliance (Andrew & Marais, 2023). The establishment of ongoing IPAC support represents an important evolution, positioning nurses as leaders in infection prevention, leveraging their clinical expertise to guide system improvements, enhance safety, education, advocacy and practical decision making (Olwani et al., 2024). The pandemic demonstrated the essential role of IPAC nursing in mitigating the spread of COVID-19; Nursing involvement in IPAC provides essential insights and supports the dissemination of clinical expertise to influence care away from the bedside.

6.4 Implications

The findings of this master's thesis have important implications for the nursing profession. Collectively, the results provide valuable insights and practical strategies that can support the evolution of nursing in Ontario, strengthen and sustain the current and future needs of the province's RN workforce. This section will provide an overview of the implications of this research as it pertains to nursing practice, education and research.

6.4.1 Implications for Nursing Practice

Addressing Ontario's nursing shortage from a pragmatic standpoint acknowledges the resultant consequences of the crisis while seeking to understand the specific challenges encountered in recent years and the impact of the pandemic on the profession. The intention of this pragmatic study was to generate practical and useful insights and provide direction on how to address the nursing crisis (Patton, 2015). As revealed in both the literature and in interviews with participants, the COVID-19 pandemic negatively impacted nurses workload adding additional pressures which contributed to fatigue, extreme levels of stress and burnout (Akoo et al., 2024). The theme, Rebuilding Bedside Nursing, provides a foundation to inform effective

workplace strategies to support nurse re-entry to practice and guide healthcare organizations to implement actionable and practical changes that strengthen Ontario's nursing workforce.

The findings of this research, highlight the insights of nurses who left and what factors would influence their re-entry to bedside practice. The study highlighted the conditions that would be required for nurses to consider re-engaging in bedside roles and offers a forward thinking perspective to workforce planning. Nurses returning to bedside practice may feel unprepared, fearful, overwhelmed or lack confidence in their clinical skills after time away from direct care. Mentorship, training and professional development opportunities stood out in the interviews as actionable changes that could be made to encourage nurses to return to bedside practice. Similar to existing programs for new graduate nurses entering the workforce, nurses who left and want to return would benefit from clinical practice and competency re-orientation. Nurses working in roles away from the bedside are often not practicing their clinical skills and may lose them over time. Skill decay is a phenomenon that occurs over time resulting in the loss of clinical knowledge and practical skills from lack of consistent use (Olson et al., 2024). A meaningful strategy to support nurses returning to the bedside is to provide opportunities to engage in education and training that enhances their competence, confidence, and skill development, enabling nurses who left the bedside to safely re-enter direct care practice. The implications for nursing practice from this study, emphasize the need for structured re-entry programs and educational pathways that help nurses' transition back to bedside roles.

6.4.2 Implications for Nursing Education

Ontario Bachelor of Science in Nursing programs generally focus on traditional acute care and bedside nursing roles for clinical placements. The findings of this study align with broader trends indicating that early-career nurses are experiencing burnout and exiting bedside

roles earlier than previous generations (Szczerbińska et al., 2024). Notably, RN attrition in nurses under 35 years of age rose to 25.7% in 2025, underscoring the disproportionate impact of the pandemic on new nurses (RNAO, 2026). Links, fit and sacrifice are important concepts in Mitchell and Lee's Job Embeddedness model and may provide insight into why some new graduate nurses leave nursing and the bedside. Not every nurse is suited to work in direct care practice and new graduate nurses may not feel connected or aligned with the bedside environment but still want to be a nurse.

Participants in this study, highlighted the important influence nurses have on Ontario's healthcare system and the value of nursing expertise away from the bedside. The pandemic introduced many new nursing career paths and emerging opportunities that could be further integrated into the BScN curriculum. Providing future nurses with a broader understanding of the evolving nursing landscape and exploring alternative roles and non-traditional pathways could support students in finding jobs that align with their preferences, goals and strengths. The implications of exposing nursing students to different roles away from the bedside may support new graduate nurses in making an informed career choice and could reduce early attrition ultimately contributing to a stronger, more invested and stable nursing workforce.

6.4.3 Implications for Nursing Research

This study provides important implications that can influence nursing research. Since none of the participants had yet returned to bedside practice at the time of their interviews, the findings surrounding re-entering bedside nursing remain theoretical rather than grounded in lived experience. Future research could build on this work by investigating the perspectives of nurses who have transitioned back to bedside roles after leaving. This presents an opportunity to

understand the experiences of nurses who re-entered bedside practice including what motivations and factors would support return-to-practice initiatives that are evidence based.

Additional research could compare the experiences of nurses who returned to bedside practice with those who have no intention of going back to direct care. This comparative study could contribute to a deeper understanding of nurses' career motivations, personal and professional identities and guide future workforce planning in a post pandemic context. Ultimately, further research stemming from this exploratory study would help develop evidence informed strategies aimed at rebuilding, retaining and sustaining Ontario's nursing workforce both at and away from the bedside.

6.5 Strengths & limitations

There are several strengths and limitations of this thesis. To the student author's knowledge, this is the first study that explored the conditions necessary to encourage RNs who left bedside nursing during the COVID-19 pandemic to re-enter practice. While existing research has investigated the factors that led nurses to leave bedside care during the pandemic, this study shifts the focus to understand what considerations and influences would support nurses who left to return. This study offers insights that may contribute to policy development targeted at recruitment, retention and re-entry of nurses who left, assist with organizational strategies and workforce planning and guide future research.

The qualitative exploratory study design is a strength as it enabled meaningful dialogue that uncovered a more profound understanding of nurses lived experiences when they decided to leave the bedside during the COVID-19 pandemic. The semi-structured interviews allowed participants to share their perspectives and discuss the complex dynamics that influenced their decision to leave which is beyond what could have been achieved through a quantitative research

design. Many nurses expressed that the research process helped validate their experiences, previously marked by feelings of guilt, and some nurses shared that participating in the study provided them with a sense of closure. Additionally, participants discussed their unique career trajectories and impact on Ontario's healthcare system away from the bedside, highlighting the significant and positive contributions of nurses working in non-traditional roles.

Recruitment for this study was a challenge and the sample size was a limitation. As this was an exploratory study, the intent was to understand the phenomenon surrounding nurses' departure from bedside care including their potential return post pandemic. The interview data yielded valuable findings, however, a larger sample size may have uncovered additional discoveries. Another weakness of the study was the inclusion criteria which limited participants' nursing experience to less than ten years. This resulted in the perspectives of early career nurses being captured in the study but excluded mid or late career nurses who may have left for different reasons. A final limitation of the study was that none of the participants had returned to bedside nursing. Results from the study represent reflective views on what would hypothetically support nurses re-entering direct care rather than evidence based on lived experiences from nurses who left then returned to the bedside. Expanding future research to include a larger sample size, nurses from all career stages and those who have successfully transitioned back to a bedside role would provide a more comprehensive understanding of the supports needed to facilitate return-to-practice for Ontario nurses in a post pandemic context.

References

Akoo, C., McMillan, K., Price, S., Ingraham, K., Ayoub, A., Rolle Sands, S., Shankland, M., & Bourgeault, I. (2024). “I feel broken”: Chronicling burnout, mental health, and the limits of individual resilience in nursing. *Nursing Inquiry*, *31*(2), Article e12609. https://doi.org/10.1111/nin.12609

Andrew, J., & Marais, D. (2023). An exploratory study of nurses’ ideas on how to improve compliance with the use of personal protective equipment when caring for patients on additional precautions. *Canadian Journal of Infection Control*, *38*(4), 178–189. https://doi.org/10.36584/cjic.2023.004.02.178.189

Ariander, A., Olaison, A., Andersson, C., Sjödahl, R., Nilsson, L., & Kastbom, L. (2024). Ethical challenges causing moral distress: nursing home staff’s experiences of working during the COVID-19 pandemic. *Scandinavian Journal of Primary Health Care*, *42*(2), 266–275. https://doi.org/10.1080/02813432.2024.2308573

Bolt, E. (2025). Nurses need care too – how curbing self-sacrifice can prevent burnouts. *University of Leeds*. https://business.leeds.ac.uk/research-ceric/dir-record/research-blog/2358/nurses-need-care-too-how-curbing-self-sacrifice-can-prevent-burnouts

Bonello, F., Zammit, D., Grech, A., Camilleri, V., & Cremona, R. (2021). Effect of COVID-19 pandemic on mental health hospital admissions: comparative population-based study. *BJPsych Open*, *7*(5), Article e141. https://doi.org/10.1192/bjo.2021.975

Brophy, J. T., Keith, M. M., Hurley, M., & McArthur, J. E. (2021). Sacrificed: Ontario Healthcare Workers in the Time of COVID-19. *New Solutions*, *30*(4), 267–281. https://doi.org/10.1177/1048291120974358

Callahan, J., Chan, C. K., Ofner, M., Chevrier, J., Serapion, V., Fabro, H., O’Brien, J., Michelle,

A., Morales, B., Dechen C., Augustin, N., Fedsin, S., & Pascual, B. (2025). Pursuit of long-term care certification in infection prevention: A community of practice approach. *Canadian Journal of Infection Control*, *40*(2).

Ciezar-Andersen, S., & King-Shier, K. (2021). Detriments of a Self-Sacrificing Nursing Culture on Recruitment and Retention: A Qualitative Descriptive Study. *Canadian Journal of Nursing Research*, *53*(3), 233–241. https://doi.org/10.1177/0844562120908747

Clark, D. B. A., Smith, K., Alonso-Prieto, E., & Virani, A. (2025). Addressing Moral Distress During the COVID-19 Pandemic: Insights About Future Directions From Canadian Ethicists and Healthcare Leaders. *Nursing Inquiry*, *32*(4), e70051. https://doi.org/10.1111/nin.70051

Fabbri, E. (2025). Introduction to Infection Prevention and Control: From Florence Nightingale to the Present. In B. Oomen & S. Gastaldi (Eds.), *Principles of Nursing Infection Prevention Control* (pp. 9–16). Springer. https://doi.org/10.1007/978-3-031-84469-0_2

Government of Ontario. (2024). Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1. https://www.ontario.ca/laws/statute/21f39

Government of Ontario. (2022). Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes. https://ltchomes.net/LTCHPORTAL/Content/12.%20IPAC%20Standard%20-%20EN.pdf

Government of Ontario. (2021). Long-Term Care COVID-19 Commission: Final report and progress on interim recommendations. https://www.ontario.ca/page/long-term-care-covid-19-commission-progress-interim-recommendations

IPAC Canada (2025). *Infection Prevention and Control Canada.*

https://ipac-canada.org/wp-content/uploads/2025/09/154456_IPAC_Media-Kit_2025_FINAL.pdf

Jameton, A. (2013). A Reflection on Moral Distress in Nursing Together With a Current Application of the Concept. *Journal of Bioethical Inquiry*, *10*(3), 297–308. https://doi.org/10.1007/s11673-013-9466-3

Jameton, A. (1984). *Nursing practice, the ethical issues*. Prentice-Hall.

Kassam, A., Beder, M., Sediqzadah, S., Levy, M., Ritts, M., Maher, J., Kirwan, N., & Law, S. (2023). Impact of COVID-19 on the lives of people with severe mental illness—front-line community psychiatry workers observation from a provincial survey of assertive community treatment teams in Ontario, Canada. *International Journal of Mental Health Systems*, *17*(1), Article 18. https://doi.org/10.1186/s13033-023-00585-8

Kovanci, M. S., & Atli Özbaş, A. (2025). Newly graduated nurses' experiences of moral distress during transition process: a convergent mixed methods study. *BMC Nursing*, *24*(1), Article 246. https://doi.org/10.1186/s12912-025-02863-x

Leece, P., Whelan, M., Costa, A. P., Daneman, N., Johnstone, J., McGeer, A., Rochon, P., Schwartz, K. L., & Brown, K. A. (2023). Nursing home crowding and its association with outbreak-associated respiratory infection in Ontario, Canada before the COVID-19 pandemic (2014–19): a retrospective cohort study. *The Lancet. Healthy Longevity*, *4*(3), e107–e114. https://doi.org/10.1016/S2666-7568(23)00018-1

Lee, T., & Mitchell, T. (1994). An Alternative Approach – The Unfolding Model of Voluntary Employee Turnover. *The Academy of Management Review*, *19*(1), 51–89. https://doi.org/10.5465/AMR.1994.9410122008

Marriam-Webster. (2025). Sacrifice. https://www.merriam-webster.com/dictionary/sacrifice

Mason, M., Im, B., Basseal, J. M., & Zimmerman, P.-A. (2025). Moral distress among infection prevention and control professionals: A scoping review. *Infection, Disease & Health*, *30*(2), 152–161. https://doi.org/10.1016/j.idh.2024.10.002

Mitchell, T., Holtom, B., Lee, T., Sablynski, C., & Erez, M. (2001). Why People Stay: Using Job Embeddedness to Predict Voluntary Turnover. *Academy of Management Journal, 44*(6), 1102– 1121. https://doi.org/10.2307/3069391

Mitchell, T., & Lee, T. (2001). The unfolding model of voluntary turnover and job embeddedness: Foundations for a comprehensive theory of attachment. Research in Organizational Behavior, 23, 189-246. https://doi.org/10.1016/S0191-3085(01)23006-8

Norris, R. E. (2023). Are America's Caregivers on the Brink of Extinction? The Pandemic Straw that Broke the Nurses' Back. *Neurologic Clinics*, *41*(2), 415–423. https://doi.org/10.1016/j.ncl.2022.11.001

Olson, J., Ko, A., Nowak, K. A., Latack, K., & Bozimowsky, G. (2024). Using Simulation Training to Reduce Skill Decay Among Certified Registered Nurse Anesthetists. *The Journal of Continuing Education in Nursing*, *55*(4), 187–194. https://doi.org/10.3928/00220124-20231130-22

Olwani, J. M., Al-Ruwali, N. A.-F., Al-Ruwaili, S. A. A., Olwani, Z. M., Al-Zare, L. J. A., Alshammri, Z. M., Alenazy, S. A., Aldean, S. A., Aljedaani, R. A., Jwkhab, H. I., Qaysi, L. H.m Zurban, A. A., Aljedaani, M. A., Asiri, R. J. M., Asiri, Z. H. A. (2024). From Bedside to Policy: The Nurse's Role in Advancing Hospital Infection Control *Journal of Posthumanism*, *4*(3), 1632–1650. https://doi.org/10.63332/joph.v4i3.3359

Patton, M. Q. (2015). *Qualitative research & evaluation methods : integrating theory and practice* (Fourth edition.). SAGE Publications, Inc.

Public Health Ontario. (2022). Orientation for Infection prevention and Control Leads in Long-Term Care. https://www.publichealthontario.ca/en/Health-Topics/Infection-Prevention-Control/LTC-Orientation

Rehder, K. J., Adair, K. C., Eckert, E., Lang, R. W., Frankel, A. S., Proulx, J., & Sexton, J. B. (2023). Teamwork Before and During COVID-19: The Good, the Same, and the Ugly. *Journal of Patient Safety*, *19*(1), 36–41. https://doi.org/10.1097/PTS.0000000000001070

RNAO. (2026). Addressing the RN crisis in Ontario. *Registered Nurses' Association of Ontario.* https://rnao.ca/media/10283/download?inline

RNAO. (2020). Ontario's Long-Term Care Homes IPAC Human Resources Survey Report. *Registered Nurses' Association of Ontario*. https://rnao.ca/sites/default/files/2020-12/IPAC%20Survey%20Results%20Report-final.pdf

Rosen, M. A., DiazGranados, D., Dietz, A. S., Benishek, L. E., Thompson, D., Pronovost, P. J., & Weaver, S. J. (2018). Teamwork in Healthcare: Key Discoveries Enabling Safer, High-Quality Care. *The American Psychologist*, *73*(4), 433–450. https://doi.org/10.1037/amp0000298

Salari, N., Shohaimi, S., Khaledi-Paveh, B., Kazeminia, M., Bazrafshan, M.-R., & Mohammadi, M. (2022). The severity of moral distress in nurses: a systematic review and meta-analysis. *Philosophy, Ethics, and Humanities in Medicine : PEHM*, *17*(1), Article 13. https://doi.org/10.1186/s13010-022-00126-0

Shaw, J. D., Delery, J. E., Jenkins, G. D., & Gupta, N. (1998). An Organization-Level Analysis of Voluntary and Involuntary Turnover. *Academy of Management Journal*, *41*(5), 511–525. https://doi.org/10.5465/256939

Statistics Canada. (2023). Nurses: Working Harder, More Hours amid Increased Labour

Shortage. https://www.statcan.gc.ca/o1/en/plus/4165-nurses-working-harder-more-hours-amid-increased-labour-shortage

Szczerbińska, K., Barańska, I., Kijowska, V., Stodolska, A., Wójcik, G., Różańska, A., & Wójkowska-Mach, J. (2024). Factors associated with burnout among hospital-based healthcare workers during the COVID-19 pandemic: A cross-sectional CRACoV-HHS study. *Journal of Clinical Nursing*, *33*(1), 304–321. https://doi.org/10.1111/jocn.16654

Wiisak, J., Stolt, M., Igoumenidis, M., Chiappinotto, S., Gastmans, C., Keogh, B., Mertens, E., Palese, A., Papastavrou, E., Mc Cabe, C., & Suhonen, R. (2024). Factors contributing to the promotion of moral competence in nursing. *Nursing Ethics*, *31*(8), 1367–1388. https://doi.org/10.1177/09697330241235305

Xu, X., Wang, Y., Meng, J., Xia, X., Cao, W., & Liu, Y. (2025). The Relationship Between Moral Sensitivity, Missed Nursing Care and Moral Distress Among New Nurses: A Cross-Sectional Study. *Journal of Clinical Nursing*, *34*(6), 2262–2275. https://doi.org/10.1111/jocn.17420

Chapter Seven: Conclusions

This master's thesis used an exploratory qualitative study design to understand why Ontario Registered Nurses (RNs) left bedside nursing during the COVID-19 pandemic and what factors would support re-entry to practice in this population. This research method was used as no prior studies on this topic existed exploring this group of nurses in the context of pandemic-driven turnover and the conditions necessary to support re-entry to bedside practice. Mitchell and Lee's Unfolding Model of Voluntary Employee Turnover (1994) and the Job Embeddedness Model (2001), theoretically guided this research to understand why nurses left the bedside during the COVID-19 pandemic and what elements of direct care nursing would encourage embeddedness and possible return to bedside nursing.

This study examined the root of the problem, why nurses left, which revealed the pandemic exodus was largely a result of burnout and moral distress. Participants described pandemic experiences that challenged their values and caused emotional strain. The COVID-19 pandemic was a "Shock to the System", which triggered "Decision Frames" leading nurses down a pathway to resignation as outlined in Mitchell and Lee's Unfolding Model of Voluntary Employee Turnover (Mitchell & Lee, 2001, p. 199). These causes of nursing turnover reported in the study underscore the need to address burnout and moral distress and mitigate their impact to support both nurses at and away from the bedside.

Through interviews with nurses who left bedside care, it was revealed that cohesive teams, changes to organizational leadership structures and investment in the professional development of the bedside team would encourage re-entry to practice and support retention of the current nursing workforce. Participants identified the loss of their nursing team was the greatest sacrifice when leaving bedside nursing, suggesting that strong and supportive teams are

important for both retention and re-entry to bedside nursing within the framework of Mitchell and Lee's Job Embeddedness Model (2001). Improved organizational and nursing leadership invested in supporting nursing teams and attuned to the realities of their work was identified as a crucial element to strengthen retention and encourage nurses who left to consider returning. Additionally, participants expressed that further investments in professional development opportunities for bedside nurses and return to practice clinical support for nurses who left could support retention and encourage re-entry to direct care practice.

While some participants expressed that they are contemplating returning to bedside nursing, others did not foresee themselves ever returning to the bedside. The findings highlighted that nurses in non-traditional jobs play a key role in disseminating foundational clinical knowledge, impacting safe care delivery, representing the nursing voice and advocating for the profession. Emerging roles, such as Infection Prevention and Control (IPAC) nursing, continue to make significant contributions, particularly within the LTC environment, highlighting the essential value nurses bring to non bedside positions that strengthen healthcare in the province. Regardless of whether nurses are engaged in direct care practice, the outcome of this study emphasises the important contributions and ongoing influence nurses have on Ontario's healthcare system both at and away from the bedside.

This study provides valuable insights into the complex factors that contributed to nurses' departure from bedside care during the coronavirus pandemic and the conditions that may facilitate re-entry. Understanding the factors that led nurses to leave and investing in the supports, leadership structures, teams, and opportunities that encourage retention and re-entry is essential. The COVID-19 pandemic introduced many new and important nursing roles that continue to positively impact the healthcare system post pandemic. This demonstrates the

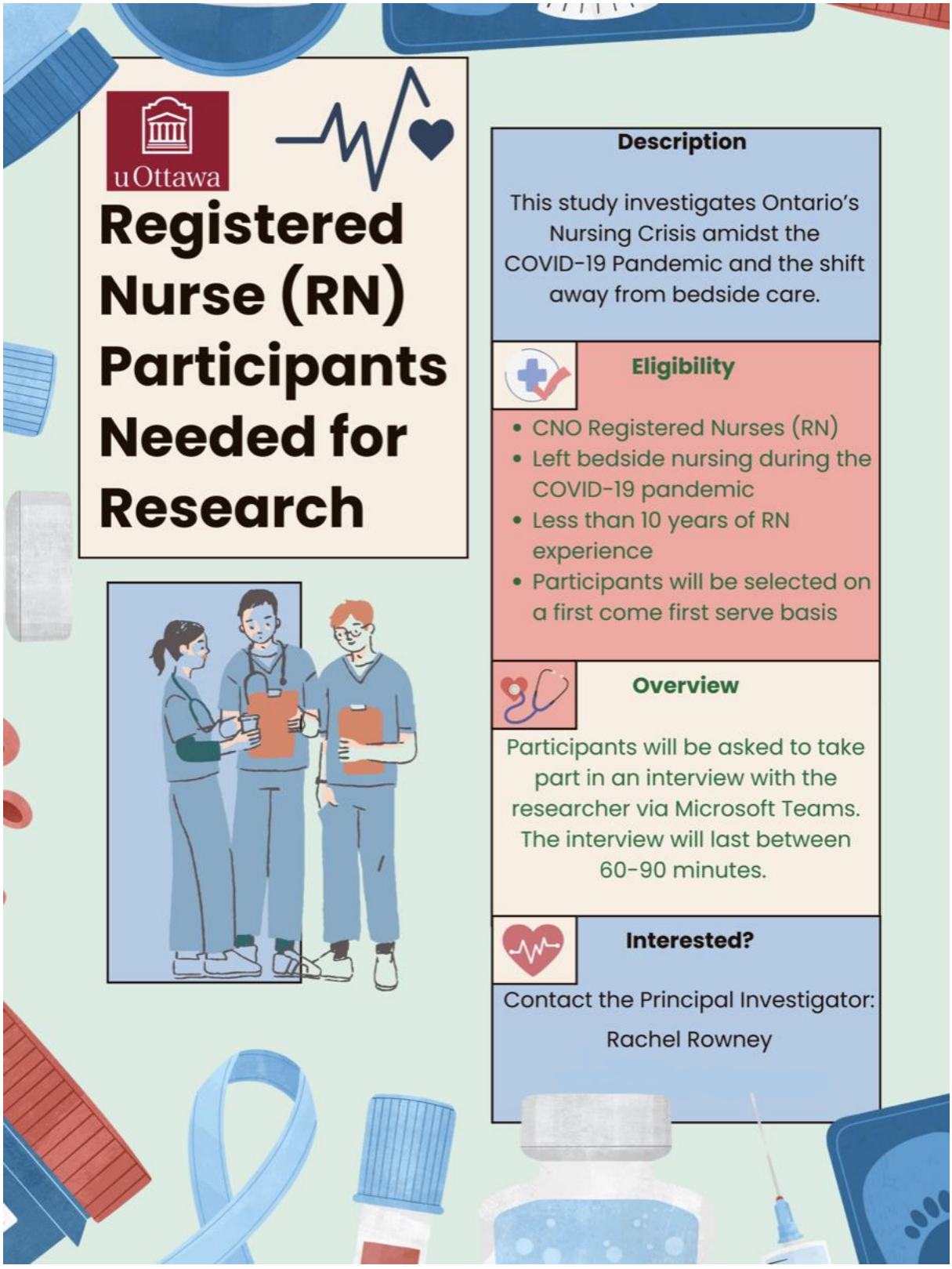
nursing profession's ability to contribute meaningfully beyond the bedside, reflecting the value of non-traditional nursing roles. The findings of this thesis underscore the need for responsive strategies that honour nurses experiences and help rebuild a resilient and sustainable nursing workforce in Ontario.

References

Lee, T., & Mitchell, T. (1994). An Alternative Approach – The Unfolding Model of Voluntary Employee Turnover. *The Academy of Management Review*, *19*(1), 51–89. https://doi.org/10.5465/AMR.1994.9410122008

Mitchell, T., & Lee, T. (2001). The unfolding model of voluntary turnover and job embeddedness: Foundations for a comprehensive theory of attachment. Research in Organizational Behavior, 23, 189-246. https://doi.org/10.1016/S0191-3085(01)23006-8

Appendix A: Recruitment Poster



Appendix B: Questionnaire Guide

Interview Guide & Study Questions

Hello,

My name is Rachel Rowney and I am a Registered Nurse, a member of the College of Nurses of Ontario (CNO) and a Master of Science in Nursing student at the University of Ottawa under the supervision of Professor Sandra Harrisson. Thank you for your willingness to participate in this study which aims to explore why nurses left the bedside during the COVID-19 pandemic and what factors and considerations may influence re-entry into direct care practice. Your insights will contribute valuable information to understanding how the profession can address Ontario's nursing crisis in a post pandemic world.

Duration and Recording:

This interview is expected to last approximately 60 to 90 minutes and will be recorded using the recording feature on Microsoft Teams to ensure I accurately capture your responses. The recording will be securely stored and used only for research purposes. Personal identifiers will be removed to ensure confidentiality. Information will not be disclosed to anyone outside of the research team. Once the study is complete, all recordings and transcripts will remain in locked files for the full data retention period and destroyed five years after completion of the study. Should you feel uncomfortable with me recording this interview at any point, please let me know.

Consent and Confidentiality:

Your participation in this study is completely voluntary and you are free to decline to answer any question or withdraw from the study at any time knowing your decision will be respected without any negative consequences. Should you decide to withdraw from the study, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study.

Before we begin, I want to confirm that you have read the consent form and if you have any questions or concerns about the study, now is the time to ask.

If you do not have any questions or concerns, please send your signed copy of the consent form to my email now. Once I receive it we can begin the interview if you are comfortable and ready. Again, thank you for your time and sharing your experiences with me.

Questions:

1. The COVID-19 pandemic was a significant event that was a shock to everyone, can you walk me through your thought process when you made the decision to leave your role as a bedside nurse?
2. Can you describe your experiences working as a bedside nurse during the COVID-19 pandemic and what factors influenced your decision to leave?

3. How did the COVID-19 pandemic affect your personal values, career trajectory, and professional identity, leading to your decision to transition away from direct patient care? And how have your career goals or professional ambitions within the nursing profession changed since the pandemic?
4. What factors or conditions would influence your decision to return to bedside nursing; are there any specific supports or changes within the healthcare system that you believe would make re-entry into bedside nursing more appealing or feasible for you?
5. Which specific circumstances or factors during the pandemic pulled you away from bedside nursing and contributed to your choice to depart from direct patient care?
6. What potential losses (financial, professional, or personal) did you consider when deciding to leave bedside care? How significant were these perceived sacrifices in your decision-making process to transition out of bedside care?
7. Can you describe the relationships and connections you had with colleagues and the broader healthcare community before and during the COVID-19 pandemic? How did this interconnectedness with your workplace contribute to your sense of attachment to your job and influence your decision to leave bedside care?
8. Considering your future in nursing, how has your perception of the nursing profession evolved since the onset of the pandemic and are there elements of your current or potential role that might anchor you to the profession, even if you're not in bedside care?

Appendix C: Ethics Approval University of Ottawa & TCPS 2 Certificate

19/03/2025

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-02-25-11141
Titre du projet / Project Title	An Exploratory Study Analyzing Ontario's Nursing Crisis Amidst the COVID-19 Pandemic and the Shift Away from Bedside Care
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	19/03/2025
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	18/03/2026

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Rachel ROWNEY	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Sandra HARRISSON	École des sciences infirmières / School of Nursing	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street, Room 154
Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie I www.recherche.uottawa.ca/ethics

19/03/2025

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Riana MARCOTTE
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board**

550, rue Cumberland, pièce 154 Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street, Room 154 Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie I www.recherche.uottawa.ca/ethics

PANEL ON RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE 2022

Certificate of Completion

This document certifies that

Rachel Rowney

successfully completed the Course on Research Ethics based on the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE 2022)

Certificate # 0000362281 **23 February, 2023**

Appendix D: Consent Form

ÉCOLE DES SCIENCES INFIRMIÈRES
Programmes des études supérieures

uOttawa
Faculté des sciences de la santé
Faculty of Health Sciences

SCHOOL OF NURSING
Graduate Programs

Consent Form

Title of the study: An Exploratory Study Analyzing Ontario's Nursing Crisis Amidst the COVID-19 Pandemic and the Shift Away from Bedside Care

Study Investigators:
Principal Investigator:
Rachel Rowney, RN, BScN, MScN (candidate)
School of Nursing, Faculty of Health Sciences
University of Ottawa

Supervisor:
Dr. Sandra Harrisson, RN, PhD
Associate Professor
School of Nursing, Faculty of Health Sciences
University of Ottawa

Invitation to Participate: I am invited to participate in the above mentioned research study conducted by Rachel Rowney in the context of a Master's thesis, under the supervision of Dr. Sandra Harrisson. Choosing whether or not to participate is entirely my choice. If I decide not to participate, there will be no negative impacts on my relationship with the researcher. The information provided in this form tells me about what is involved in the research, what I will be asked to do and any potential risks or benefits.

Purpose of the Study: The purpose of the study is to explore nurses decision to leave bedside care during the pandemic and their intentions to return or not. This study will investigate nurses' rationale for transitioning away from direct patient care roles and seeks to understand and ascertain these nurses professional career goals and ambitions within the profession.

Participation: My participation will consist of a semi-structured interview with the primary researcher guided by a list of questions. The interview is expected to take between 60 to 90 minutes. During the interview I will be asked questions that explore why I left bedside nursing during the pandemic and what factors and considerations would influence my re-entry into practice. All interviews will be conducted virtually via Microsoft Teams and recorded.

Risks: My participation in this study will entail that I discuss my choice to leave bedside nursing which may cause me to feel psychological discomfort and emotional about working as a nurse during the COVID-19 pandemic and the factors that led to my decision including possible considerations that may influence my return to direct care. I have received assurance from the researchers that every effort will be made to minimize this risk. I have the option to refuse answering questions and am free to withdraw from the study at any point knowing my decision will be respected without prejudice. Should I experience such feelings, the research team invites me to consult ConnexOntario for mental health support: https://connexontario.ca/.

Benefits: My participation in this study will provide insights to inform policies and practices that will enhance Ontario's nursing industry. This study aims to offer strategies to support the nursing workforce in a post-pandemic context. The findings will help understand the nursing workforce's current and future needs, guide retention approaches and promote a more resilient healthcare system.

Confidentiality and Privacy: I have received assurance from the researchers that the information I share will remain strictly confidential. I understand that the contents will be used for thematic data analysis to identify recurring themes, subthemes and other patterns throughout the interview process to better understand why nurses left direct care during the COVID-19 pandemic and gain insights into nurses intentions to return to bedside or not. Personal identifiers will be removed to ensure confidentiality and anonymity of all participants. Additionally, the name of the specific healthcare institution where you worked or currently work will not be published, however, the healthcare setting will be described in general terms. While this helps maintain confidentiality, there remains a small possibility that individuals familiar with your role or workplace may infer your identity based on this information. If you have any concerns about anonymity, please discuss them with the researcher before agreeing to participate.

Conservation of Data: The data collected including video and audio recordings, transcripts, consent forms, and the researchers' notes will be kept in a secure matter stored in locked computer-based files and on an encrypted hard drive. Information will not be disclosed to anyone outside of the research team. Once the research project is complete, all recordings and transcripts will remain in locked files for the full data retention period and destroyed five years after the data collection date.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study.

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5800 ext. 5387).

It is recommended that I *(keep/print/save)* a copy of this consent form for my records.

Acceptance: By selecting the consent statement and signing my name below, I agree to participate in this research study.

- ☐ Yes, I want to participate.
  Name: _____
  Email: _____
- ☐ No, I do not want to participate.

Participant's name: _____ Date: _____
Participant's signature: _____ Date: _____
Researcher's signature: _____ Date: _____