Saskatchewan
Nurse Retention Forum

QUESTIONS ASKED - During the *Saskatchewan Nurse Retention Forum*

The following questions were submitted by participants during the Saskatchewan Nurse Retention Forum on June 11, 2026. Some were addressed during the Forum, while others required additional follow-up. Responses reflect the Forum discussion, the Saskatchewan Nurse Retention Project, the Environmental Scan, and the toolkits and information presented during the event.

1) ***Is there a lack research on LPNs and utilization of LPNs? Does this create a barrier for the practice/ retention of LPNs?*** Here in Saskatchewan, the Association of Professional Nurses of Saskatchewan (APNS) has been advocating about the utilization of LPNs to full scope for many years. Many other LPN practice interest groups have advocated for this as well. There is currently an SHA-Ministry-stakeholder working group that is actively engaged in addressing the scope of practice issues and any restrictive policies. Join APNS to be in the loop on ongoing advocacy work on this topic.

2) ***Are there statistics on the demographics of nurses leaving the profession? Are we struggling to retain new nurses or mid to late career nurses equally?*** The data points clearly to one end of the career spectrum being the bigger problem right now.

   Canada is losing young/new nurses at a high and worsening rate:

   - In 2023, for every 100 nurses under 35 who entered the workforce, 40 left. In 2014, the same age group saw only 36 leave per 100 who joined; so the young-nurse exit rate has been climbing.
   - The average age of nurses in Canada is actually decreasing – in 2014, 27.7% of registered nurses were under 35; by 2023 that had grown to almost 31%. That means a larger share of the workforce now sits in the highest-turnover age bracket, which compounds the problem.
   - Provincially, this varies: Ontario saw 38 nurses under 35 leave for every 100 who started in 2023, while British Columbia cut young-nurse turnover by 50% since 2014 – suggesting local interventions (like BC's streamlined credentialing) can meaningfully bend this curve.

   New grads specifically are the highest-risk group:

   - In Canada, 18% to 30% of newly graduated RNs leave the profession in their first year, and 37% to 57% leave by their second year.
   - Transition shock during the first year of practice is strongly linked to turnover intention, and nurses with only 2–5 months of experience tend to have the hardest time adapting.

Mid/late-career nurses leave too, but for different reasons

The broader CFNU survey data suggests the drivers for the workforce overall — involuntary overtime and workplace violence/abuse — hit experienced nurses hard as well, but it shows up more as job-to-job movement, reduced hours, or "considering" leaving (about 20% of all working nurses were considering leaving their current job, and another 10% were considering leaving the profession altogether) rather than the sharp early-career attrition cliff.

Bottom line: the data doesn't support "equal struggle"; early-career/new-grad attrition is the more acute and worsening problem nationally, even though burnout and overtime affect nurses at every stage. That has practical implications: retention investment aimed specifically at the first 1–2 years (transition support, mentorship, workload protection) is likely to have outsized impact on the overall numbers, while mid/late-career retention is more about chronic working-condition fixes (overtime, violence prevention, workload).

3) ***I would appreciate a picture of Saskatchewan nurse demographics and areas of practice that are being used to inform strategy.*** This is covered in more detail in our environmental scan, including the breakdown by [age/area of practice/etc.]

4) ***What mentorship support does SHA have in place for new grads and incoming nurses in the workplace?*** The SHA has a general Mentorship Program which is a voluntary, six-month program available to all SHA employees on an ongoing basis. The program aims to foster meaningful connections, encourage knowledge sharing, and support greater collaboration across the organization. The program includes courses offered in multiple formats: self-led modules, facilitated online sessions, and in-person workshops. It is designed to offer flexibility, allowing each matched pair to connect on a schedule that works best for them, within the context of their roles and professional responsibilities.

5) ***How does the toolkit hold leadership accountable?*** The Government of Canada's **Nursing Retention Toolkit** is not an accountability mechanism; rather, it provides leaders with an evidence-informed framework to guide action. Accountability comes from how organizations choose to implement it. The toolkit encourages organizations to establish measurable retention goals, engage nurses in co-

designing solutions, monitor progress using workforce and experience data, and regularly report on outcomes. Ultimately, leadership accountability is strengthened when retention becomes part of organizational strategy, performance measurement, and continuous quality improvement rather than a standalone human resources initiative.

6) ***What is being done to reduce moral distress/injury because if we don't help soothe and fix this, any retention strategies attempted will be less effective.*** (question noted – thank you)

7) ***When will we stop accepting "that's just nursing culture" as an excuse and address workplace bullying as a retention issue?*** (question noted – thank you)

8) ***Why is it necessary to frame retention as a patient safety issue? Why not also as a staff safety issue?*** Asked and answered during the Forum – we agree it is both.

9) ***As the largest profession in health care, how do we empower the utilization of Data to inform decisions & measure impact? We don't understand what nursing offers***. Asked and answered during the Forum

10) ***How are nurse patient ratios and overall workload addressed in the toolkits?*** The Government of Canada's **Nursing Retention Toolkit** recognizes staffing and schedule as one significant factor influencing nurse wellbeing and retention. Rather than prescribing specific staffing ratios, it encourages organizations to examine evidence-based staffing models, nurse workload, scheduling practices, team composition, and the overall practice environment within an organization's local context. The emphasis is on creating sustainable staffing and scheduling models that allow nurses to provide safe, high-quality care while supporting their own wellbeing. Appropriate staffing which may include nurse patient ratios is presented as one important component of a broader workforce retention strategy.

11) ***Where can we find the toolkit?*** (links to the Toolkits are provided throughout this document)

12) ***How can we balance students and new employee orientation for frontline support without burning out our staff?*** Orientation has a workload that needs its own staffing plan, not an add-on to existing patient care. A few concrete levers:

a. **Adjust assignments when precepting** – a preceptor with a student or new hire isn't doing full patient care plus teaching; their load should flex down accordingly.

b. **Rotate the preceptor pool** so the same few "reliable" nurses aren't tapped every time. More people precepting less often beats fewer people precepting constantly.

c. **Pay and credential the role** (differential, clinical ladder credit, protected time) so it's recognized work, not an unpaid tax on good nurses. {The speakers recognize that this is a union issue and not something unit managers would have direct influence over.}

d. **Stagger onboarding waves** – avoid stacking student rotations and new-hire cohorts on the same unit at the same time.

e. **Add a tiered support layer** (charge nurse/educator/resource nurse) so the preceptor isn't the only point of contact for every question.

13) ***The evidence-based interventions in the toolkits are great resources but need to be implemented locally by nurses and managers/directors. Please comment on how.***

For managers/directors:

- Use the framework to do a local gap assessment. Which of the eight themes are weakest on your unit right now? Not every theme needs equal attention everywhere.
- Translate the toolkit's example initiatives into resourced action: staffing/scheduling changes, budget, policy updates. The toolkit gives a menu; leadership has to fund and authorize the order.
- Build a short feedback loop with frontline staff to check whether what's implemented is actually landing and adjust.

For nurses:

- Bring lived experience into which initiatives get prioritized. The toolkit draws on the lived and living experiences of point-of-care nurses, so frontline input is part of how it's meant to be used, not an afterthought.
- Participate in unit-level committees or working groups where retention initiatives are shaped, since the toolkit was built through pan-Canadian collaboration involving nurses at the point of care, nurse employers, regulators, and others.
- Give direct feedback on what's working vs. what's policy-on-paper only.

The general pattern for local success: treat the toolkit as a starting framework to localize, not a finished program. Pick the 2-3 themes most relevant to your context, assign clear ownership (who implements, who tracks), and revisit periodically rather than treating it as a one-time rollout.

14) ***Follow up question - will this toolkit serve as common ground for all managers across the province despite our biases?*** A toolkit can create shared language and structure, but it doesn't eliminate bias on its own.

Where it genuinely helps create common ground:

- It gives every manager the same eight themes and evidence base to start from, rather than each person operating off personal experience or anecdote alone. That's a real leveler, it moves the conversation from "what I've noticed on my unit" to "what the evidence across the province says matters."
- It's explicitly designed to be evidence-based and developed with point-of-care nurses, regulators, and unions, so it's harder to dismiss as one manager's opinion or one region's priority.
- A shared framework gives people common vocabulary for comparing notes across units/regions ("we're weak on theme 3, how are you handling that?"), that cross-talk is hard to have without a shared structure.

Where bias still gets in, even with a common toolkit, consider:

- **Which themes get prioritized locally.** The toolkit itself says relevance varies by context; that's appropriate, but it also means a manager who's biased toward, say, financial/workload metrics over psychological safety can legitimately point to "local context" to justify underinvesting in the themes that make them less comfortable.
- **How initiatives get implemented.** Two managers can use the identical toolkit example and apply it in very different ways; one consultative, one top-down, and get very different staff trust outcomes from "the same" intervention.
- **Whose voice shapes the local adaptation.** If frontline input is sought selectively (e.g., only from staff who agree with the manager already), the toolkit's "by nurses, for nurses" credibility gets borrowed without actually being honored locally.
- **Confirmation bias in self-assessment.** Managers doing their own gap analysis against the eight themes may rate their own units more favorably than an outside observer would; the toolkit doesn't include an external audit mechanism by default.

The toolkit can be the common *reference point*, but consistency in practice across the province depends on governance, shared metrics, transparency, and some form of accountability layered on top. Without that, you'll get genuine alignment on language and goals, but real variation in how seriously and evenly it's applied.

15) ***Where has retention been the highest? Urban? Rural? Acute, LTC?*** The environmental scan indicates that rural/remote retention is the clearest pressure point relative to urban; the workforce is growing overall, but rural nursing numbers have actually declined. We don't have a province-specific acute vs. LTC breakdown; the scan flags that as a data gap, not something Saskatchewan currently tracks publicly.

16) ***Are there plans for advocacy and public awareness initiatives to recognize LPNs as "nurses"?*** The Association of Professional Nurses of Saskatchewan is the professional association representing and advocating for licensed practical nurses (LPNs), registered psychiatric nurses (RPNs), nurse practitioners (NPs), registered nurses (RNs), graduate nurses, nursing students, and retired nurses in Saskatchewan. Feel free to contact info@apnsask.ca about specific concerns or areas of advocacy that you want to advance forward.

17) ***Do you consider "Nurse" a key role in healthcare? If yes, why and how?*** Yes – the Forum was designed to support and retain nurses as a fundamental role in our healthcare system.

18) ***It can feel overwhelming to work in a challenging system and be asked to change the system at the same time. What keeps your hope going in your work?***
Being part of the teams building solutions to this healthcare human resource challenge can be very hopeful work. We encourage all leaders attending the Forum to bring hopeful energy back to the teams dealing with the current challenges – and to reach out for support and mentorship as required.

The environmental scan's findings point to a few things for consideration.

- Stewart et al. found that organizational commitment was strongly associated with lower intent to leave among rural nurses – not the absence of hard conditions, but a sense of mattering to the place and people you work with.

- Tomblin Murphy et al. found something similar: nurses who felt recognized and supported, even amid workload and staffing pressure, were more resilient to burnout than nurses with lighter loads but no sense of being valued.
- And Rhéaume's critical incident work found it wasn't one big breaking point that pushed nurses toward leaving, it was the accumulation of small moments of feeling unsupported or unheard.
- The flip side of that is hopeful: small things like being asked your opinion, having a colleague notice you're struggling, seeing one piece of friction actually get fixed because you raised it can carry real weight. They don't undo systemic strain, but they're not nothing either.

19) ***How do we push beyond the safe spaces where ideas can be shared to actually feeling like our nurse leaders are going to help move our voices to further action?*** By engaging in Forums like these, and supplementary discussions, we hope that people can feel the momentum shift and be part of co-designing future workplaces.

20) ***Are there resources in the toolkit specifically designed for new nurses entering the profession? And to support seasoned nurses while orienting new nurses?*** Yes. Government of Canada's **Nursing Retention Toolkit** highlights the importance of supporting nurses across the entire career trajectory, with particular attention to the transition into practice for new graduates, new nurses and IENs. Evidence consistently shows that the first years of practice are associated with the highest risk of turnover. The toolkit includes examples such as structured onboarding, mentorship, residency or transition-to-practice programs, peer support, protected learning opportunities, and leadership practices that help new nurses build confidence.

    The toolkit also recognizes the important role experienced nurses play in supporting new colleagues and encourages organizations to provide appropriate time, recognition, and resources for preceptors and mentors so this work is sustainable.

21) ***Would these toolkits benefit managers who do not have a nursing background?*** Great question and I believe they will. You do not need a nursing background to identify with the leadership principles laid out in the toolkits.

22) ***Is there a "toolkit " for communities to consistently engage in the healthcare field. Nurses need support from their communities that they care for.*** The **Healthcare Practitioner Community Support Toolkit** from the Saskatchewan Healthcare Recruitment Agency (SHRA) is meant to be a resource for communities generally across Saskatchewan as a means to educate them on some of the documented issues impacting retention of all healthcare workers (both in and outside of the workplace, no matter the employer). These issues can occur in a private clinic as easily as a larger facility.

As mentioned during the panel discussion, the toolkit is currently lacking in content related to indigenous communities and indigenous health workers. The SHRA is working to address this by reaching out to indigenous health science and medical students, current practitioners and communities with majority indigenous populations.

23) ***What specific steps are being taken to ensure that men in nursing feel welcome? Some report leaving the profession due to discrimination or exclusion.*** This may be a question for the Nursing Team Taskforce or SHRA broader anti-discrimination commitments made by organizations (zero-tolerance for bullying/racism/violence).

24) ***How can senior leadership support front line managers to improve retention?*** The Toolkits presented during the Forum, the book provided to participants (The Billion Dollar Blindspot), and the co-design lab are intended to support leaders to improve retention of nurses across the system. We welcome your insights and ideas in the second phase of the project, as we move to research on the implementation, measurement and evaluation of the actions taken.

25) ***If there was a norovirus outbreak, it'd be all hands on deck, & fixed quickly. If it's an incivility issue, or toxic work environment we just accept it. Why!?*** (question noted – thank you)

26) ***Do you have any advice on where to start as a frontline leader?*** See answer to Q#24 above and please stay connected with this project as there will be additional supports for leaders working on retention.

27) ***How can we reform unfair seniority benefits, such as only allocating overtime to senior workers, to ensure all staff are properly compensated?*** (question noted – thank you)

28) ***What is most important to take from the various toolkits and consider during the co-design lab this afternoon?*** Asked and answered during the Forum. The summary report of the co-design lab will offer additional insights for how to support retention.

29) ***Is there a plan to establish standardized nurse-to-patient ratios by the government?*** (this question is noted – but it extends beyond the scope of the Forum)

30) ***Is the SK toolkit specific to the SHA, or does it also directly support recruitment and retention for nurses employed elsewhere (ex: First Nations communities)?*** Asked and answered during the Forum (and see answer to Q#22 above – the Toolkit is intended to support communities and employers across the province, not just the SHA).

31) ***Are there any plans for addressing the competency concerns with internationally trained nurses?*** The SHA has supports in place to address clinical performance gaps for all nurses, including internationally educated nurses (IENs). Current initiatives include a high-fidelity simulation pilot project to enhance clinical competence and confidence in a safe learning environment. Additional Transition to Practice resources are available on the SHA website, linked here: **Transition to Practice – Clinical Standards | SaskHealthAuthority,** with further supports to be released as they become available. There are also mechanisms in place to address competency concerns. Contact info@apnsask.ca for more information.

32) ***The ratio of RN to LPN's is growing tremendously. Are there any initiatives to train and recruit more LPN's?*** (this question is noted – options are being explored - but it extends beyond the scope of the Forum)

33) ***Is team-based care addressed in the toolkit?*** Yes. The **Health Canada Nursing Retention Toolkit** recognizes that nursing retention depends not only on the nursing workforce itself, but also on how teams function together. Effective team-based care, where all health professionals are able to contribute to their full scope of practice, can improve workload distribution, interprofessional collaboration, psychological safety, and quality of care while also reducing administrative burden.

The **HEC Health Workforce Innovation Challenge Toolkit**, which will be launched later this year, provides tools that are designed to support teams working together to strengthen their workforces and deliver safer, higher-quality care.

34) ***What intersection is there with Canada's Health Workforce Wellbeing Plan - have we used data from this group which engaged on behalf of different providers?*** The toolkits align closely with broader national work to improve health workforce wellbeing, recognizing that workforce challenges are interconnected across professions and require system-level solutions. While the **Government of Canada's Nursing Retention Toolkit** focuses specifically on nurses, many of its recommendations – such as strengthening leadership, improving workplace culture, supporting wellbeing, reducing burnout, and measuring outcomes – are consistent with priorities identified through Canada's broader health workforce initiatives and as such, are generalizable to other professions besides nursing.

The **HEC Health Workforce Innovation Challenge Toolkit**, which will be launched later this year, is based on the program and experience of the near 150 teams that participated in **Healthcare Excellence Canada's Health Workforce Innovation Challenge.**

35) ***Unnecessary restriction of LPN, RN, RPN, NP is not in the best interest of the client. How do you plan to improve better supported teams for all nursing groups?*** In Saskatchewan, the Nursing associations (APNS and SANP) have been advocating about the utilization of nurses to full scope for many years. There are currently working groups working on addressing the scope of practice issues and any restrictive policies for nurses. Join APNS and SANP to be in the loop on ongoing advocacy work on this topic.

36) ***What patient outcomes can or should be measured related to decreasing Nurse retention? Until real outcomes are/can be measured, this issue will persist.*** (thank you for the question – this is a potential research project, but outside the scope of the current SHRF funded research project)

37) ***What steps did Manitoba take to legislate nurse to patient ratios?*** Manitoba has not taken any formal steps for the nurse-to-patient ratio although the Manitoba Nurses Union is promoting this strategy. This is really a long-term strategy because you cannot guarantee the ratio without enough nurses.

38) ***What are some lessons Saskatchewan can learn from Manitoba regarding utilization of LPNs and how does this affect retention?*** Good question, but we have not pursued this avenue yet in Manitoba. It took considerable effort to get RNs in the same room as nurse leaders.

39) ***We have a unit mentoring program but struggle with how to get senior staff members to engage and want to mentor the junior staff. Any suggestions?*** Contact info@apnsask.ca for more information on encouraging participation in mentorship in the workplace. There will likely be additional guidance provided on how to support leaders with mentorship, given that it was mentioned a lot during the Forum.

40) ***Retention thoughts: Remain conscious of our 1. post partum/return to work family development retention. 2. Also, mid to late career RNs satisfaction and value***. Great points! Thank you for the question.