Canadian Journal on Aging / La Revue canadienne du vieillissement

www.cambridge.org/cjg

Who is Looking After Mom and Dad in Atlantic Canada?

Janice Keefe[1], Heather Dicks[1], Kazeem Adefemi[2], Amber Duynisveld[3], Rose McCloskey[4] and Carole A. Estabrooks[5]

[1]Aging and Family Science, Mount Saint Vincent University, Canada; [2]Centre for Applied Health Research, Memorial University of Newfoundland, Canada; [3]Nova Scotia Centre on Aging, Mount Saint Vincent University, Canada; [4]Nursing & Health Sciences, University of New Brunswick Saint John, Canada and [5]Faculty of Nursing, University of Alberta, Canada

Article

Cite this article: Keefe, J., Dicks, H., Adefemi, K., Duynisveld, A., McCloskey, R., & Estabrooks, C.A. (2026). Who is Looking After Mom and Dad in Atlantic Canada? *Canadian Journal on Aging / La Revue canadienne du vieillissement*
https://doi.org/10.1017/S0714980826100853

Received: 16 October 2025 UTC
Accepted: 22 July 2026 UTC

Keywords:
aging; care aides; long-term care; nursing homes; Atlantic Canada; unregulated healthcare workforce

Mots-clés:
vieillissement; aides-soignants; soins de longue durée; maisons de retraite; Canada atlantique; personnel de santé non réglementé

Corresponding author:
La correspondance et les demandes de tirés-à-part doivent être adressées à: / Correspondence and requests for offprints should be sent to: Janice Keefe, Aging and Family Science, Mount Saint Vincent University, 166 Bedford Highway, Halifax, Nova Scotia, Canada, B3M 2J6 (janice.keefe@msvu.ca).

Abstract

Long-term care (LTC) is an increasingly crucial part of Canada's healthcare system, particularly in Atlantic Canada, which has some of the highest current proportions and future projections of adults over the age of 65 nationwide. Most of the direct care within LTC homes is provided by care aides, yet little is known about this critical workforce. In this study, we explore cross-sectional data from 1,338 care aides from the four Atlantic provinces, which were collected through the Atlantic Research Collaboration on Long-term Care (ARC LTC). Overall, we find that these workers are primarily middle-aged women with almost a decade of experience in the sector. While care aides in the region appear to like their work, their commitment is undermined by significant personal and professional strain, with over half at high risk of burnout, nearly a third reporting below-average mental health scores, and one-in-three considering quitting their job.

Résumé

Les soins de longue durée (SLD) occupent une place de plus en plus importante dans le système de santé canadien, en particulier dans les provinces de l'Atlantique, qui comptent actuellement parmi les plus fortes proportions d'adultes âgés de plus de 65 ans et qui devraient connaître la plus forte croissance démographique dans ce groupe d'âge à l'échelle nationale. La plupart des soins directs dans les établissements de SLD sont prodigués par des aides-soignants, mais on sait peu de choses sur cette main-d'œuvre essentielle. Dans cette étude, nous examinons les données transversales recueillies auprès de 1 338 aides-soignants des quatre provinces de l'Atlantique, qui ont été recueillies dans le cadre de l'ARC LTC (*Atlantic Research Collaboration on Long-term Care*). Dans l'ensemble, nous constatons que ces travailleurs sont principalement des femmes d'âge moyen ayant près d'une décennie d'expérience dans le secteur. Si les aides-soignants de la région semblent apprécier leur travail, leur engagement est compromis par d'importantes tensions personnelles et professionnelles, plus de la moitié d'entre eux présentant un risque élevé d'épuisement professionnel, près d'un tiers déclarant des scores de santé mentale inférieurs à la moyenne et un sur trois envisageant de quitter son emploi.

Introduction

Long-term care (LTC) is a crucial part of Canada's healthcare system, and its importance is poised to grow. Canada's population is aging and life expectancy into old age continues to increase (Hallman, 2022). With older age comes increased medical complexity. Over 80% of Canadians aged 85 years and over self-report at least one chronic disease or condition, and almost half experience multimorbidity of two or more conditions, but mortality rates with chronic conditions have decreased (Public Health Agency of Canada, 2020). This means that there are more years lived with medical complexity, and this is reflected in LTC use: almost one in three Canadians over the age of 85 lives in a communal living space, with many ending up in LTC as their final place of residence before death (Hallman, 2022; Hirdes et al., 2011). Residents in Canadian LTC homes have high rates of co-morbidity and symptom complexity, including 75–80% of residents who have some form of age-related dementia (Estabrooks et al., 2015a; Ng et al., 2020). The number of Canadians aged 85 and over could reach 2.7 million by 2046, nearly triple the amount in 2024 (Hallman, 2022; Statistics Canada, 2025a), and the number of Canadians with complex cases and need for LTC is expected to rise as well.

Most of the direct care within LTC homes is provided by care aides (Arain et al., 2017; Berta et al., 2013; Statistics Canada, 2025b); however, this staff group remains largely unregulated in most provinces. The policy framework guiding LTC varies on a per-province basis, which means

© The Author(s), 2026. Published by Cambridge University Press on behalf of The Canadian Association on Gerontology. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (http://creativecommons.org/licenses/by-nc-nd/4.0), which permits non-commercial re-use, distribution, and reproduction in any medium, provided that no alterations are made and the original article is properly cited. The written permission of Cambridge University Press or the rights holder(s) must be obtained prior to any commercial use and/or adaptation of the article.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

that the care aide role can vary significantly across provinces; there are presently no *national* definitions or standards for care aide responsibilities or education (Arain et al., 2017; Estabrooks et al., 2024, 2015b). Care aides often find themselves working outside of their training or typical expectations when demand arises (Berta et al., 2013; Janes et al., 2008), but might not have access to further opportunities for job growth like formal education, training, and vertical movement within an organization (Andersen, 2009; Arain et al., 2017; Berta et al., 2013). Care aides are frequently found to be stressed, burnt out, and overwhelmed (Booi et al., 2021; Costello et al., 2019; Duan et al., 2025). Nevertheless, they maintain a deep sense of commitment for their role and the people they work with, which seems to help them find resilience in the face of challenges (Song et al., 2024). Research into LTC staff can help us understand the impact of policy interventions, link staff indicators to quality-of-care indicators, and address the evolving needs faced at the forefront of care (Cranley et al., 2018; Estabrooks et al., 2009).

There has been some effort to shed light on Canada's unregulated care aides. The Government of Ontario (2020) found provincial care aides to be mostly women between the age of 35–54 years, with visible minorities comprising approximately 41% of this workforce. Furthermore, Estabrooks et al. (2015b) reported a broad profile on care aides in Western Canada as part of the Translating Research in Elder Care (TREC) project. Across Alberta, Manitoba, and Saskatchewan, they found care aides in urban areas were mostly women around the age of 40–49 years; only 40.2% were born in Canada and just over half spoke English as their first language. While burnout scales of emotional exhaustion and cynicism were generally high, so were professional efficacy and job satisfaction. A follow-up paper that additionally sampled British Columbia in place of Saskatchewan found similar trends (Chamberlain et al., 2019). However, almost all of these demographic, wellbeing, and quality of work-life findings differed significantly between provinces at both time points. The generalizability of these findings across provinces has not been established, highlighting the need for regional research into the care aide population.

This need is especially true in Atlantic Canada. The Atlantic provinces have some of the highest current proportions and future projections of adults over the age of 65 and 85 nationwide (Hallman, 2022; Statistics Canada, 2022); already, this region is experiencing high rates of dementia among its older population (Alzheimer Society of Canada, 2022). A 2024 study on Nova Scotian LTC staff found the majority of care aides were born in Canada and speak English as a first language (Keefe et al., 2024). The demographics of care workers in the region are expected to evolve, however, and we are already seeing evidence of this shift in the form of new immigrant pathways, such as the Atlantic Immigration Program, which provides jobs to skilled migrant workers including those with healthcare experience. These programs are typically tied to closed work permits from specific employers, with some Atlantic LTC organizations making use of this recruitment pool (Government of Canada, 2025; Hounsell, 2023).

Keefe et al. (2024) also noted that, while efficacy and job satisfaction were high among care aides in Nova Scotia, mental health and some burnout sub-scales showed more concerning scores than those in Western Canada. The Atlantic LTC workforce seems to differ from reports elsewhere in the country and it is this recognition that fueled the creation of the Atlantic Research Collaboration on Long-term Care (ARC LTC), a research program that partnered with TREC to increase research capacity on LTC within Atlantic Canada (Keefe et al., 2025b). The 2023–2024 wave of data collection marks the first time that in-depth data has been collected on the Atlantic Canadian LTC workforce. With these data, we address two research questions: who makes up Atlantic Canada's LTC care aide workforce? How do demographics, health and wellbeing indicators among this staffing group vary among Atlantic provinces, if at all?

Methods

Data on care aides

The cross-sectional data we use were collected between November 2023 and May 2024 as part of the ARC LTC research program. Our sample included 53 LTC homes from New Brunswick (NB), Newfoundland and Labrador (NL), Nova Scotia (NS), and Prince Edward Island (PEI). Homes were stratified based on size (bed count), owner-operator model, region, and language, then randomly sampled within each province with oversampling in PEI and NL. In addition to facility-level data gathered in each of the 53 homes, the research team collected 2,305 staff surveys of which 1,338 were from care aides (Keefe et al., 2025a).

In this paper, we consider the demographics, family status, education, work experience, job satisfaction, intention to leave, and overall health and wellbeing of care aides working in the LTC sector in Atlantic Canada. For the health and wellbeing variables in particular, we draw from an extensive series of validated scales, which were used with permission from the developers. These scales are described further in Table 1 and in our Supplementary File.

Stratification measures

In our analysis for this paper, we consider three principal means of stratifying our results. First, we look at province, to consider whether the distinct policy environment at the provincial level may relate to any significant differences in terms of the breakdown of care aide characteristics. Second, we consider the ownership model of the LTC home. Here, we look at three potential models that exist in the region: (a) public, not for profit; (b) private, for profit; and (c) voluntary, not for profit. Finally, we consider the size of the LTC home, comparing small (25–69 beds), medium (70–119 beds) and large LTC homes (120+ beds). The results for the provincial-level stratification are captured in the tables below; results stratified by ownership model and size can be found in our Supplementary File.

Statistical analyses

To analyze our categorical variables, we calculated the frequency of responses in each of the variable categories according to our main stratification measures (province, ownership model, and size), and then ran contingency chi-square tests and post-hoc tests to determine if there were any statistical differences across the categories in our stratification variables. For our continuous variables, we calculated the mean and standard deviation corresponding to the categories within our identified stratification measures and then ran one-way ANOVA and post-hoc tests using Bonferroni correction to determine statistical significance. For ease of interpretation, we have re-coded the majority of the variables used in our analysis as categorical variables. Missing data for all except one variable ranged from 0% to 1.5% of the total sample. The only variable with additional missing cases related to the total number of hours worked in a two-week period; 5.9% of cases were missing from this variable. Pairwise deletion was employed to handle all missing cases.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

Table 1. Health and wellbeing variables

Key variables					
Variables		Instrument	Description	# items (sample item)	Scoring
Job satisfaction		Michigan organizational assessment questionnaire-job satisfaction subscale	A global measure of job satisfaction	3 (All in all, I am satisfied with my job)	Dichotomized variable according to (1) those that were neutral or disagreed with the statement and (2) those that agreed with the statement.
Burnout	Exhaustion	The 9-item version of Maslach burnout inventory (MBI)-General survey	Feelings of emotionally exhausted by one's job	3 (I feel burned out from my work)	Mean of the 3 items (range = 0–6) measured on a 7-level scale (never-daily), divided according to pre-determined thresholds*: low risk of burnout = mean score of 1.67; high risk of burnout = mean score > 3.00.
	Cynicism		Feelings of cynical about and detached from work	3 (I have become more cynical about whether my work contributes anything)	Mean of the 3 items (range = 0–6) measured on a 7-level scale (never-daily), divided according to pre-determined thresholds*: low risk of burnout = mean score < 1.00; high risk of burnout = mean score > 2.33.
	Professional efficacy		Feelings of competence and achievement at work	3 (I have accomplished many worthwhile things in this job)	Mean of the 3 items (range = 0–6) measured on a 7-level scale (never-daily), divided according to pre-determined thresholds*: low risk of burnout = mean score > 4.00; high risk of burnout = mean score < 3.30.
Health Status	Physical health	Short form health survey (SF-8)	A broad measure of physical health	8 (During the past 4 weeks, how much did physical health problems limit your usual physical activities)	Sum of the 8 items (range 0–100) measured on a 5-level scale (not at all – could not do), divided according to pre-determined thresholds**: below average = mean score < 40.
	Mental health		A broad measure of mental health	8 (During the past 4 weeks, how much have you been bothered by emotional problems)	Sum of the 8 items (range 0–100) measured on a 5-level scale (not at all – could not do), divided according to pre-determined thresholds**: below average = mean score < 40.
Anxiety	Generalized anxiety	General anxiety disorder (GAD)-2	A brief, two-question tool to identify symptoms of Generalized Anxiety Disorder	2 (Feeling nervous, anxious or on edge)	Sum of the 2 items (range 0–6) measured on a 4-level scale (not at all – nearly every day). A score of 3 or higher = clinically significant anxiety***.
Insomnia		Insomnia severity index (ISI)	A quick measure of 2-week sleep disturbances and symptoms of insomnia	7 (How satisfied are you with your current sleep pattern)	Sum of the 7 items (range 0–28) measured on a 5-level scale (none/not at all – severe/very much). Total scores of 15 or higher = moderate to severe clinically significant insomnia****.
LTC Home Characteristics					
Province		Categorical variable with 4 categories: NB, NL, NS, PEI			
Facility size		Categorical variable with 3 categories: small (25–69 beds), medium (70–119 beds), large (120+ beds)			
Ownership		Categorical variable with 3 categories: public, not for profit; voluntary, not for profit; private, for profit			

*See Estabrooks et al. (2015a).
**See Ware et al. (2001).
***Spitzer et al. (2006).
****See Bastien (2001).

As a final step in our analysis, we re-ran our health, job satisfaction and intention to leave variables across key demographic differences associated with care aides to determine if there are any significant differences associated with these characteristics. The stratification measures used here are (a) place of birth (Canada/outside of Canada), (b) age (under 40 years/40 years and above), and (c) sex at birth (male/female). Again, we used contingency chi-square tests and post-hoc tests to determine statistical significance.

Results

The results that follow represent the first detailed exploration of the care aide workforce in Atlantic Canada. Importantly, these results provide an initial insight into what this workforce looks like, in terms of demographics, education, work, job satisfaction, intention to leave, and health. As these data are cross-sectional and given that we do not employ inferential statistics in this paper, no inferences of causality can be drawn. However, these results serve as a foundational understanding, upon which more in-depth research can be built.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

Demographics of care aides

Our response rate was 61.5% of eligible care aides. The majority of care aides were female (87.8%), White (64.6%) and were born in Canada (73.8%). A little over half of care aides were over the age of 40, and they were mostly married or in common-law relationships. A little less than half had children in their household (43.7%) and a minority of care aides were also caring for aging parents (9.0%) (Table 2).

We found that PEI has a higher proportion of care aides that were born outside of Canada (34.2%) than the other provinces. Similarly, large homes have a significantly higher number of younger care aides who are non-White (45.6%) and were born outside of Canada (38.5%). Considering ownership model, private homes have the highest proportion of non-White care aides (51.3%) that were born outside of Canada (44.9%). Meanwhile, voluntary not for profit homes have significantly more care aides that are older, female and are either separated, widowed or divorced (Supplementary Tables).

Education and work

Looking at the education and experience of care aides in the region (Table 3), our data show that care aides have been working in the sector for about 9.6 years, and a large majority (80.4%) hold a care aide certification; however, they are not frequently attending on-the-job training. When the team surveyed the 53 LTC homes, moreover, a little under half (26 homes: 49.1% of total) reported that they have a Clinical Educator within the home. As such, approximately 58.4% of all care aides within our sample had access to a Clinical Educator within their LTC home.

Comparing across provinces and ownership models, we note that a startlingly low proportion of care aides in NB have access to a Clinical Educator in their LTC home: only 6.1%. By comparison,

Table 2. Demographics & family status

	Province					χ^2/ ANOVA	
Variables	Nova Scotia (NS) *n* = 589	New Brunswick (NB) *n* = 257	Prince Edward Island (PE) *n* = 228	Newfoundland & Labrador (NL) *n* = 257	Total *n* = 1338	ρ value	post-hoc
Age [n (%)]							
Under 40	248 (42.1%)	112 (42.4%)	119 (52.2%)	149 (58.0%)	628 (46.9%)	<0.001	NB-NL; NL-NS
40 and over	341 (57.9%)	152 (57.6%)	109 (47.8%)	108 (42.0%)	710 (53.1%)		NB-NL; NL-NS
Sex at birth [n (%)]							
Male	62 (10.5%)	35 (13.3%)	26 (11.4%)	40 (15.6%)	163 (12.2%)	0.194	N/A
Female	526 (89.5%)	229 (86.7%)	202 (88.6%)	216 (84.4%)	1173 (87.8%)		N/A
Where were you born? [n (%)]							
Canada	460 (78.1%)	181 (68.6%)	150 (65.8%)	197 (76.7%)	988 (73.8%)	<0.001	NB-NS; NL-PE; NS-PE
Elsewhere	129 (21.9%)	83 (31.4%)	78 (34.2%)	60 (23.3%)	350 (26.2%)		NB-NS; NL-PE; NS-PE
Racial/ethnic identity [n (%)]							
White	400 (68.1%)	164 (63.1%)	136 (59.9%)	158 (62.0%)	858 (64.6%)	<0.001	None
Filipino	80 (13.6%)	47 (18.1%)	16 (7.0%)	25 (9.8%)	168 (12.6%)		NB-NL; NB-PE
Black	15 (2.6%)	17 (6.5%)	10 (4.4%)	13 (5.1%)	55 (4.1%)		NB-NS
South, Southeast, and East Asian	26 (4.4%)	7 (2.7%)	48 (21.1%)	13 (5.1%)	94 (7.1%)		NB-PE; NL-PE, NS-PE
Other	66 (11.2%)	25 (9.6%)	17 (7.5%)	46 (18.0%)	154 (11.6%)		NB-NL; NL-NS; NL-PE
Marital status [n (%)]							
Married or common-law	347 (59.1%)	155 (58.7%)	140 (61.4%)	143 (55.6%)	785 (58.8%)	0.462	N/A
Separated, divorced or widowed	89 (15.2%)	38 (14.4%)	27 (11.8%)	31 (12.1%)	185 (13.8%)		N/A
Single, never married	151 (25.7%)	71 (26.9%)	61 (26.8%)	83 (32.3%)	366 (27.4%)		N/A
Any person(s) under 18 years of age living in your household? [n (%)]							
Yes	244 (41.4%)	111 (42.0%)	89 (39.0%)	141 (54.9%)	585 (43.7%)	<0.001	NB-NL; NL-NS; NL-PE
No	345 (58.6%)	153 (58.0%)	139 (61.0%)	116 (45.1%)	753 (56.3%)		NB-NL; NL-NS; NL-PE
Are you caring for any aging parents at home? [n (%)]							
Yes	46 (7.8%)	32 (12.1%)	16 (7.0%)	26 (10.1%)	120 (9.0%)	0.134	N/A
No	540 (92.2%)	232 (87.9%)	212 (93.0%)	231 (89.9%)	1215 (91.0%)		N/A

Used chi-square test for categorical variables and one-way ANOVA for continuous variables.
The post-hoc test was examined using Bonferroni correction for continuous outcomes. The paired province list represents those provinces with differences that are statistically significant (ex: NS-NB = Nova Scotia and New Brunswick have significantly different outcomes for this variable).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

Table 3. Education & work

Variables	Province					χ^2/ ANOVA	
	Nova Scotia (NS) *n* = 589	New Brunswick (NB) *n* = 257	Prince Edward Island (PE) *n* = 228	Newfoundland & Labrador (NL) *n* = 257	Total *n* = 1338	*ρ* value	post-hoc
Have you completed a Care Aide certificate? [n (%)]							
Yes	486 (82.5%)	198 (76.2%)	187 (82.0%)	201 (78.2%)	1072 (80.4%)	0.122	N/A
No	103 (17.5%)	62 (23.8%)	41 (18.0%)	56 (21.8%)	262 (19.6%)		N/A
In the past year, how often have you attended in-services, workshops or courses in your facility? [n (%)]							
Never or rarely	256 (43.7%)	145 (54.9%)	99 (43.6%)	139 (54.1%)	639 (47.9%)	0.009	NB-NS; NL-NS
Occasionally	185 (31.6%)	71 (26.9%)	73 (32.2%)	75 (29.2%)	404 (30.3%)		None
Frequently or almost always	145 (24.7%)	48 (18.2%)	55 (24.2%)	43 (16.7%)	291 (21.8%)		None
In the past year, how often have you attended in-services, workshops or courses outside your facility? [n (%)]							
Never or rarely	416 (71.4%)	205 (78.2%)	150 (66.4%)	208 (81.6%)	979 (73.8%)	0.003	NB-PE; NL-NS; NL-PE
Occasionally	95 (16.3%)	35 (13.4%)	48 (21.2%)	28 (11.0%)	206 (15.5%)		NL-PE
Frequently or almost always	72 (12.3%)	22 (8.4%)	28 (12.4%)	19 (7.5%)	141 (10.6%)		None
Do you have a Clinical Educator in your facility? [n (%)]							
Yes	356 (60.4%)	16 (6.1%)	153 (67.1%)	257 (100.0%)	782 (58.4%)	<0.001	NB-NL; NB-NS; NB-PE; NL-NS; NL-PE
No	233 (39.6%)	248 (93.9%)	75 (32.9%)	0 (0.0%)	556 (41.6%)		NB-NL; NB-NS; NB-PE; NL-NS; NL-PE
How many homes do you work in now? [n (%)]							
One home	561 (95.2%)	249 (94.3%)	209 (91.7%)	241 (93.8%)	1260 (94.2%)	0.269	N/A
More than one	28 (4.8%)	15 (5.7%)	19 (8.3%)	16 (6.2%)	78 (5.8%)		N/A
Do you work any other jobs in locations other than LTC homes? [n (%)]							
Yes	59 (10.0%)	32 (12.2%)	23 (10.1%)	9 (3.5%)	123 (9.2%)	0.004	NB-NL; NL-NS; NL-PE
No	530 (90.0%)	231 (87.8%)	205 (89.9%)	248 (96.5%)	1214 (90.8%)		NB-NL; NL-NS; NL-PE
Total number of years worked as Care Aide [mean (SD)]	10.3 (9.9)	10.2 (8.6)	9.3 (8.5)	7.8 (7.1)	9.6 (9.0)	0.002	NB-NL; NL-NS
Number of years worked on unit [mean (SD)]	5.0 (6.3)	5.2 (6.6)	5.3 (6.3)	3.9 (4.6)	4.9 (6.1)	0.05	N/A
Number of hours worked in a typical 2-week period [mean (SD)]	74.1 (14.3)	70.3 (14.8)	70.5 (12.1)	75.4 (14.3)	73.0 (14.2)	<0.001	NB-NL; NB-NS; NL-PE; NS-PE

SD = standard deviation.
Used chi-square test for categorical variables and one-way ANOVA for continuous variables.
The post-hoc test was examined using Bonferroni correction for continuous outcomes. The paired province list represents those provinces with differences that are statistically significant (ex: NS-NB = Nova Scotia and New Brunswick have significantly different outcomes for this variable).

100% of care aides in NL have access to a Clinical Educator in their LTC home. Meanwhile, private homes have the lowest proportion of care aides that hold a care aide certification (71.0%); however, they also have a higher proportion of care aides that are accessing on-the-job training (Supplementary Tables).

Job satisfaction & intention to leave

While most care aides (89.5%) report that "in general, they like their work," a concerning one-third (31.1%) often think about quitting (Table 4).

New Brunswick has the lowest job satisfaction scores and a higher proportion of care aides that often think about quitting (38.2%) or are looking for another job (14.1%). PEI has the highest job satisfaction scores among the provinces. Turning to ownership models, we find that public not-for-profit homes have the highest proportion of care aides that often think about quitting (37.9%) (Supplementary Tables).

Health

As outlined in Table 1, the metric used to assess the physical and mental health of care aides was a validated scale, which derives a health value between 1 and 100, of which 50 represents the absolute average for the general population; a value of under 40 is considered significantly below average (Ware et al., 2001). Based on our research, we find that, across Atlantic Canada, close to a quarter of all care aides (24.1%) rank significantly below the general population average in terms of their physical health and even more (29.8%) fall significantly below average in terms of mental health. Further, the majority of care aides are at risk of burnout on two of the MBI subscales: exhaustion (53.0%) and cynicism (54.0%);

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

Table 4. Job satisfaction & intention to leave

Variables	Province					χ^2/ ANOVA	
	Nova Scotia (NS) *n* = 589	New Brunswick (NB) *n* = 257	Prince Edward Island (PE) *n* = 228	Newfoundland & Labrador (NL) *n* = 257	Total *n* = 1338	*p* value	post-hoc
All in all, I am satisfied with my job							
Neutral or disagree	168 (28.5%)	107 (40.7%)	63 (27.8%)	82 (31.9%)	420 (31.4%)	0.003	NB-NS; NB-PE
Agree or strongly agree	421 (71.5%)	156 (59.3%)	164 (72.2%)	175 (68.1%)	916 (68.6%)		NB-NS; NB-PE
In general, I like my work							
Neutral or disagree	56 (9.5%)	40 (15.3%)	16 (7.0%)	28 (10.9%)	140 (10.5%)	0.19	NB-PE
Agree or strongly agree	532 (90.5%)	222 (84.7%)	212 (93.0%)	229 (89.1%)	1195 (89.5%)		NB-PE
In general, I like working here							
Neutral or disagree	112 (19.0%)	60 (23.0%)	33 (14.5%)	61 (23.7%)	266 (19.9%)	0.05	N/A
Agree or strongly agree	477 (81.0%)	201 (77.0%)	195 (85.5%)	196 (76.3%)	1069 (80.1%)		N/A
I often think about quitting							
Neutral or disagree	429 (72.8%)	162 (61.8%)	165 (73.0%)	163 (63.4%)	919 (68.9%)	0.001	NB-NS; NL-NS
Agree or strongly agree	160 (27.2%)	100 (38.2%)	61 (27.0%)	94 (36.6%)	415 (31.1%)		NB-NS; NL-NS
I will probably look for another job within the next year							
Neutral or disagree	497 (84.4%)	193 (73.7%)	175 (76.8%)	209 (81.3%)	1074 (80.4%)	0.001	NB-NS
Agree or strongly agree	92 (15.6%)	69 (26.3%)	53 (23.2%)	48 (18.7%)	262 (19.6%)		NB-NS
I am currently looking for a new job							
Neutral or disagree	555 (94.2%)	226 (85.9%)	197 (86.8%)	232 (90.3%)	1210 (90.6%)	<0.001	NB-NS; NS-PE
Agree or strongly agree	34 (5.8%)	37 (14.1%)	30 (13.2%)	25 (9.7%)	126 (9.4%)		NB-NS; NS-PE

Used chi-square test for categorical variables and one-way ANOVA for continuous variables.
The post-hoc test was examined using Bonferroni correction for continuous outcomes. The paired province list represents those provinces with differences that are statistically significant (ex: NS-NB = Nova Scotia and New Brunswick have significantly different outcomes for this variable).

however, they have strong efficacy, with only 9.7% at high risk of burnout associated with this subscale. Finally, a little over a quarter of all care aides (25.8%) suffer from moderate (21.6%) to severe (4.2%) insomnia, and a little under a quarter (24.5%) suffer from clinically significant anxiety (Table 5).

We find that NB has the largest proportion of care aides (63.4%) at high risk of exhaustion-related burnout, and PEI has the lowest proportion (42.2%). Meanwhile, private homes also have the lowest rates of clinically significant anxiety (19.5%) compared to both public (26.3%) and voluntary homes (28.0%) (Supplementary Tables).

A closer look at health, job satisfaction and intention to leave

As an additional step in our stratification of results, we looked at the health indicators of care aides disaggregating according to some key demographic differences. In particular, we noted differences according to place of birth, age and gender (Table 6).

Here, we see that care aides born outside of Canada are more satisfied with their job and fewer often think about quitting compared to care aides born in Canada. Additionally, care aides born outside of Canada reported having better mental health, lower anxiety and less insomnia, compared to care aides born in the country.

Comparing care aides that are under 40 years of age to those that are over, we found that younger care aides are less satisfied with their work and a higher proportion are looking for other jobs than older care aides. A higher percentage of younger care aides are at high risk of burnout on both the exhaustion and cynicism subscale; they also reported worse mental health and have higher anxiety levels than their older colleagues.

There were few statistically significant differences between male and female care aides; however, we note that a lower proportion of male care aides reported liking their work and a lower proportion suffer from clinically significant anxiety, compared to female care aides.

Discussion

Our findings provide the first comprehensive profile of the care aide workforce in Atlantic Canada's LTC sector. While these findings are descriptive only (i.e., non-inferential), they nonetheless, help us answer the vital question: "Who is looking after Mom and Dad in Atlantic Canada?" A key distinction from other parts of Canada is that the vast majority of the Atlantic workforce is Canadian-born, whereas studies in urban Western Canada have found that a majority of care aides were born outside of Canada and in Ontario just over 40% were born abroad (Chamberlain et al., 2019; Estabrooks et al., 2015b; Government of Ontario, 2020). Overall, these workers are primarily middle-aged women with almost a decade of experience in the sector. While this workforce appears to be strongly committed to their work, their dedication is

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

Table 5. Health

Variables	Province					χ^2/ ANOVA	
	Nova Scotia (NS) *n* = 589	New Brunswick (NB) *n* = 257	Prince Edward Island (PE) *n* = 228	Newfoundland & Labrador (NL) *n* = 257	Total *n* = 1338	*p* value	post-hoc
Physical health (SF8)							
Below average	137 (23.6%)	72 (27.5%)	39 (17.5%)	70 (27.3%)	318 (24.1%)	0.05	N/A
Within the average range or above	443 (76.4%)	190 (72.5%)	184 (82.5%)	186 (72.7%)	1003 (75.9%)		N/A
Mental health (SF8)							
Below average	167 (28.8%)	84 (32.1%)	54 (24.2%)	89 (34.8%)	394 (29.8%)	0.064	N/A
Within the average range or above	413 (71.2%)	178 (67.9%)	169 (75.8%)	167 (65.2%)	927 (70.2%)		N/A
Insomnia (ISI)							
No insomnia	182 (31.0%)	81 (30.9%)	89 (39.4%)	87 (34.1%)	439 (33.0%)	0.227	N/A
Mild insomnia	256 (43.6%)	107 (40.8%)	91 (40.3%)	94 (36.9%)	548 (41.2%)		N/A
Moderate insomnia	122 (20.8%)	65 (24.8%)	39 (17.3%)	61 (23.9%)	287 (21.6%)		N/A
Severe insomnia	27 (4.6%)	9 (3.4%)	7 (3.1%)	13 (5.1%)	56 (4.2%)		N/A
Burnout – exhaustion							
Low risk of burnout	109 (18.7%)	35 (13.4%)	59 (26.5%)	39 (15.3%)	242 (18.3%)	<0.001	NB-PE; NL-PE
Medium risk of burnout	181 (31.1%)	61 (23.3%)	70 (31.4%)	67 (26.3%)	379 (28.7%)		None
High risk of burnout	292 (50.2%)	166 (63.4%)	94 (42.2%)	149 (58.4%)	701 (53.0%)		NB-NS; NB-PE; NL-PE
Burnout – cynicism							
Low risk of burnout	107 (18.3%)	41 (15.6%)	41 (18.6%)	36 (14.2%)	225 (17.0%)	0.448	N/A
Medium risk of burnout	170 (29.1%)	70 (26.6%)	70 (31.8%)	72 (28.5%)	382 (28.9%)		N/A
High risk of burnout	307 (52.6%)	152 (57.8%)	109 (49.5%)	145 (57.3%)	713 (54.0%)		N/A
Burnout – efficacy							
Low risk of burnout	443 (76.0%)	199 (76.5%)	157 (69.5%)	196 (76.9%)	995 (75.2%)	0.194	N/A
Medium risk of burnout	87 (14.9%)	41 (15.8%)	36 (15.9%)	37 (14.5%)	201 (15.2%)		N/A
High risk of burnout	53 (9.1%)	20 (7.7%)	33 (14.6%)	22 (8.6%)	128 (9.7%)		N/A
Anxiety							
No significant anxiety	449 (76.4%)	189 (71.9%)	181 (79.7%)	189 (73.5%)	1008 (75.5%)	0.183	N/A
Clinically significant anxiety	139 (23.6%)	74 (28.1%)	46 (20.3%)	68 (26.5%)	327 (24.5%)		N/A

Used chi-square test for categorical variables and one-way ANOVA for continuous variables.
The post-hoc test was examined using Bonferroni correction for continuous outcomes. The paired province list represents those provinces with differences that are statistically significant (ex: NS-NB = Nova Scotia and New Brunswick have significantly different outcomes for this variable).

undermined by significant personal and professional strain, with over half at high risk of burnout, nearly a third reporting mental health scores below the general population average, and one-in-three considering quitting their job. These findings point to a need for interventions to support these workers both with respect to their mental health and well-being and the retention of this critical workforce. Part of this problem may stem from healthcare worker shortages in the region, as perceived inadequacies in staffing have been linked to care aide burnout prior to and during the COVID-19 pandemic (Costello et al., 2019). This aligns with systemic and structural issues of staffing shortages, high vacancy rates, and recruitment challenges identified in both broader literature (Armstrong, 2024) and specifically in recent reports on reviews of the LTC sector undertaken by the governments of all four Atlantic provinces (Minister's Expert Advisory Panel, Keefe et al., 2018; New Brunswick Seniors' Advocates, 2024; Keefe et al., 2025b; PEI Department of Health, 2021). These findings also mirror those found in other high-income countries, including countries throughout Europe, the UK and Australia; researchers point out that the care aide workforce is indeed highly feminized and that chronic shortages associated with workplace stress are highly concerning at a time when the aging population is set to steadily rise and, with it, the need for LTC services (Blake et al., 2024; Dubois et al., 2020; Felder et al., 2026; Gil, 2022).

On the other hand, our finding of high professional efficacy—a worker's sense of achievement and competence—is consistent with the "unusually high" job efficacy reported among care aides in Western Canada (Estabrooks et al., 2015b). This may reflect the

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

Table 6. Health, job satisfaction and intention to leave across key demographic variables

	Place of birth		Age		Sex at birth	
Variables	Canada *n* = 988	Outside Canada *n* = 350	Under 40 *n* = 628	40 and over *n* = 710	Male *n* = 163	Female *n* = 1173
All in all, I am satisfied with my job						
Neutral or disagree	335 (33.9%)***	85 (24.4%)***	217 (34.6%)*	203 (28.6%)*	47 (29.0%)	373 (31.8%)
Agree or strongly agree	652 (66.1%)***	264 (75.6%)***	410 (65.4%)*	506 (71.4%)*	115 (71.0%)	799 (68.2%)
In general, I like my work						
Neutral or disagree	92 (9.3%)*	48 (13.8%)*	87 (13.9%)***	53 (7.5%)***	28 (17.3%)**	112 (9.6%)**
Agree or strongly agree	895 (90.7%)*	300 (86.2%)*	540 (86.1%)***	655 (92.5%)***	134 (82.7%)**	1059 (90.4%)**
In general, I like working here						
Neutral or disagree	204 (20.7%)	62 (17.8%)	165 (26.4%)***	101 (14.2%)***	36 (22.2%)	230 (19.6%)
Agree or strongly agree	782 (79.3%)	287 (82.2%)	461 (73.6%)***	608 (85.8%)***	126 (77.8%)	941 (80.4%)
I often think about quitting						
Neutral or disagree	642 (65.0%)***	277 (79.8%)***	432 (69.0%)	487 (68.8%)	117 (72.7%)	800 (68.3%)
Agree or strongly agree	345 (35.0%)***	70 (20.2%)***	194 (31.0%)	221 (31.2%)	44 (27.3%)	371 (31.7%)
I will probably look for another job within the next year						
Neutral or disagree	827 (83.7%)***	247 (71.0%)***	463 (73.8%)***	611 (86.2%)***	122 (75.8%)	950 (81.0%)
Agree or strongly agree	161 (16.3%)***	101 (29.0%)***	164 (26.2%)***	98 (13.8%)***	39 (24.2%)	223 (19.0%)
I am currently looking for a new job						
Neutral or disagree	897 (90.8%)	313 (89.9%)	551 (87.9%)**	659 (92.9%)**	141 (87.0%)	1067 (91.0%)
Agree or strongly agree	91 (9.2%)	35 (10.1%)	76 (12.1%)**	50 (7.1%)**	21 (13.0%)	105 (9.0%)
Physical health (SF8)						
Below average	244 (24.9%)	74 (21.6%)	133 (21.5%)*	185 (26.4%)*	31 (19.5%)	286 (24.7%)
Within the average range or above	734 (75.1%)	269 (78.4%)	487 (78.5%)*	516 (73.6%)*	128 (80.5%)	874 (75.3%)
Mental health (SF8)						
Below average	340 (34.8%)***	54 (15.7%)***	236 (38.1%)***	158 (22.5%)***	38 (23.9%)	356 (30.7%)
Within the average range or above	638 (65.2%)***	289 (84.3%)***	384 (61.9%)***	543 (77.5%)***	121 (76.1%)	804 (69.3%)
Insomnia (ISI)						
No insomnia	302 (30.7%)***	137 (39.6%)***	185 (29.6%)*	254 (36.0%)*	64 (39.5%)	374 (32.1%)
Mild insomnia	402 (40.9%)	146 (42.2%)	262 (41.9%)	286 (40.6%)	62 (38.3%)	485 (41.6%)
Moderate insomnia	232 (23.6%)***	55 (15.9%)***	147 (23.5%)	140 (19.9%)	30 (18.5%)	257 (22.0%)
Severe insomnia	48 (4.9%)***	8 (2.3%)***	31 (5.0%)	25 (3.5%)	6 (3.7%)	50 (4.3%)
Burnout – exhaustion						
Low risk of burnout	178 (18.2%)	64 (18.7%)	78 (12.6%)***	164 (23.3%)***	29 (18.1%)	212 (18.3%)
Medium risk of burnout	272 (27.8%)	107 (31.2%)	168 (27.2%)	211 (30.0%)	49 (30.6%)	329 (28.4%)
High risk of burnout	529 (54.0%)	172 (50.1%)	372 (60.2%)***	329 (46.7%)***	82 (51.2%)	619 (53.4%)
Burnout – cynicism						
Low risk of burnout	188 (19.2%)***	37 (10.8%)***	67 (10.8%)***	158 (22.5%)***	18 (11.5%)	207 (17.8%)
Medium risk of burnout	284 (29.0%)***	98 (28.7%)***	176 (28.5%)	206 (29.3%)	52 (33.1%)	329 (28.3%)
High risk of burnout	506 (51.7%)***	207 (60.5%)***	375 (60.7%)***	338 (48.1%)***	87 (55.4%)	625 (53.8%)
Burnout – efficacy						
Low risk of burnout	741 (75.7%)	254 (73.6%)	460 (74.1%)	535 (76.1%)	112 (70.0%)	881 (75.8%)
Medium risk of burnout	146 (14.9%)	55 (15.9%)	99 (15.9%)	102 (14.5%)	26 (16.3%)	175 (15.1%)
High risk of burnout	92 (9.4%)	36 (10.4%)	62 (10.0%)	66 (9.4%)	22 (13.8%)	106 (9.1%)

(Continued)

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

Table 6. *Continued*

Variables	Place of birth		Age		Sex at birth	
	Canada *n* = 988	Outside Canada *n* = 350	Under 40 *n* = 628	40 and over *n* = 710	Male *n* = 163	Female *n* = 1173
Anxiety						
No significant anxiety	699 (70.9%)***	309 (88.5%)***	442 (70.5%)***	566 (79.9%)***	139 (85.8%)**	868 (74.1%)**
Clinically significant anxiety	287 (29.1%)***	40 (11.5%)***	185 (29.5%)***	142 (20.1%)***	23 (14.2%)**	303 (25.9%)**

*ρ value <0.05; ** ρ value <0.01; *** ρ value <0.001.
Used chi-square test to determine statistically significant differences.

strong sense of commitment that to date has enabled care aides to remain resilient in spite of significant stress and burnout (Song et al., 2024).

While similar studies conducted across the European Union and the UK have also found troubling metrics associated with quality of work life and intention to leave among care staff working in LTC homes, like our findings here reveal, care staff in these countries also feel competent and recognize the importance of their work (Blake et al., 2024; Dubois et al., 2020).

Importantly, the overall averages for Atlantic Canada mask profound diversity in experience and outcomes across the region. The diversity we observed reflects deep-seated provincial differences in policy and system structure. Of particular note, NB's care aides report the lowest job satisfaction and highest intention to leave; meanwhile, they also demonstrate significantly poor access to Clinical Educators. This finding is contextualized by provincial reports identifying NB's LTC system as critically under-resourced and fragmented (New Brunswick Seniors' Advocate, 2024). The apparent rarity of in-house learning support leaves direct care staff ill-equipped to manage evolving resident complexity, particularly in dementia care, which in turn affects their own wellbeing and that of residents. As research on professional networks shows, formal and informal advice from credible leaders is crucial for diffusing best practices (Cranley et al., 2019; Keefe et al., 2021); without these structures, staff are left isolated and unsupported in a high-stress environment. While our findings show that all Atlantic provinces face challenges, the particularly poor staff outcomes in NB highlight the tangible cost of systemic under-investment in the workforce.

Likewise, we note considerable differences in outcomes based on place of birth and age. In particular, we find that foreign-born care aides report significantly better health outcomes than their Canadian-born counterparts. Although this may represent an important strength for the sector, this finding should also be interpreted with caution. While our sample's proportion of foreign-born workers is lower than reported from Western Canada, especially urban centers (Chamberlain et al., 2019; Estabrooks et al., 2015b), there is an emerging and increasing reliance on newcomers to fill essential roles within this sector (Harun & Walton-Roberts, 2022), a trend that will continue to change the dynamics of care in the region. This shift introduces new complexities to an already strained workplace; provincial LTC review reports acknowledge challenges with hiring foreign workers (Minister's Expert Advisory Panel, 2018) and instances of racism towards internationally educated staff (NL Expert Advisory Panel, 2025). The cultural and linguistic contrast between an increasingly diverse workforce and a resident population that is predominantly of White, Western European descent, as noted in Estabrooks et al. (2015b), is a dynamic that will require careful management and culturally sensitive training to ensure high-quality, person-centered care. Following established best practices (Public Health Agency of Canada, 2022), research and policy formulation should include the application of an intersectional lens to expose and address issues associated with workplace inequities, power imbalances and marginalization.

Finally, we also find that younger care aides report faring worse on almost all health-related measures. This is consistent with some broader research on care aides (Costello et al., 2019) and suggests there may be important generational considerations associated with the work life experience of care aides in the region. It is possible that younger workers have had less time to develop the necessary coping mechanisms for a challenging work environment or that older workers have simply resigned themselves to working under duress (Ellis et al., 2025). It is difficult to surmise the drivers behind the age-related differences we are seeing here without further exploration into this trend; nevertheless, this overall finding represents a critical warning. The high turnover and recruitment difficulties highlighted in all Atlantic provincial reports—with some private homes in PEI, for instance, reporting annual turnover rates close to 100% for some LTC staff (PEI Department of Health, 2021)—point to the urgent need to support and *retain* this next generation of caregivers. The COVID-19 pandemic exacerbated pre-existing workforce fragilities, though it has also spurred a much-needed push for review, and hopefully, reform, across the region. Addressing sub-optimal workplace culture, low staff morale, structural issues and funding gaps identified in these reviews (NL Expert Advisory Panel, 2025; PEI Department of Health, 2021) is paramount to making LTC a viable and attractive career path for new workers.

Policy implications

Our findings, supported by a growing body of national research and regional reports, point to several key areas for policy intervention to support the LTC workforce and improve resident care. We recommend that provincial governments and LTC organizations in Atlantic Canada:

- Reflect on and address stark provincial disparities by collaborating on pan-Atlantic standards for care aide education, certification, and scope of practice. Critically, access to key supports like Clinical Educators—found to be a major deficit in some areas—could be mandated and funded to ensure staff are equipped to handle increasing resident complexity.
- A one-size-fits-all approach to human resources will not be adequate. Specific retention programs, including mentorship and clear career pathways, must be developed for younger workers who are currently at the highest risk of burnout. Meanwhile, older care aides face significantly different physical health risks than their younger counterparts and this should be considered within workplace policies and practices. Also, ethical recruitment and integration pathways are needed for the growing

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

cohort of newcomer care aides to transition them from precarious work to stable, long-term careers.
- Effective workforce planning is impossible without good data. Reiterating the long-standing recommendations from Estabrooks et al. (2015b), the implementation of mandatory provincial registries for care aides is a foundational step for tracking, planning, and ensuring quality and accountability in the sector, as well as, for future regulation. This is already occurring in NS but has not yet been implemented in the other Atlantic provinces.
- Tracking the experiences of residents and staff in the long-term care system is of paramount importance and other countries have begun to adopt measures to do so; for instance, the UK has implemented an annual "adult social care workforce survey," which regularly tracks key metrics associated with the long-term care sector in the country. As the needs for long-term care increase across Canada, we could benefit from instituting a similar measure (Department of Health & Social Care, 2025).
- Provincial funding and regulatory frameworks must evolve beyond a primary focus on safety and security to actively promote a healthy work environment and resident quality of life. This should include ensuring staffing levels at minimum meet the recommended national standard of at least 4.1 hours of direct care per resident per day (Health Standards Organization, 2023) and that funding models enable organizations to invest in the well-being and professional development of their staff.

Limitations

This study has a number of limitations. The data are cross-sectional, which prevents us from inferring causality, and are based on self-reported measures. While our sample is large and spans all four provinces, it may not fully represent experiences in all settings, especially rural homes.

Also, our analysis for this study is primarily descriptive in nature. While it successfully paints a detailed picture of the LTC care aide workforce, as we intended, more robust statistical analysis is needed to formally test the associations between the work environment, policy contexts, and care aide wellbeing. Future research will employ regression modeling to explicitly examine how factors like ownership model, access to educational supports, and workplace characteristics are associated with outcomes such as burnout, job satisfaction and intention to leave.

Furthermore, we reiterate the need for longitudinal studies in Atlantic Canada to track workforce trends over time, similar to the follow-up work conducted in Western Canada (Chamberlain et al., 2019). A comparative policy analysis, as modeled by Irwin et al. (2023), is also needed to explicitly link specific provincial policies and care models to the divergent workforce outcomes found in our study. Finally, qualitative research would provide invaluable context for the stark provincial differences we observed, particularly in NB, and the unique challenges faced by younger and newcomer care aides.

Conclusion

The care aides looking after mom and dad in Atlantic Canada are an experienced and dedicated workforce whose intrinsic sense of purpose is being severely tested by systemic pressures. Our findings confirm that this workforce is struggling under the strain of high burnout and poor mental health, with experiences varying depending on their province, employer, age, and origin. While challenges like workforce shortages and increasing resident acuity are national issues, their manifestation in Atlantic Canada presents a unique and urgent call to action. Supporting this essential workforce through evidence-informed provincial policy, improved workplace supports, and targeted retention strategies is not merely a labour issue—it is a fundamental imperative for ensuring the quality of care and dignity of the region's most vulnerable seniors.

Supplementary material. The supplementary material for this article can be found at http://doi.org/10.1017/S0714980826100853.

Acknowledgements. The authors have received funding from the Canadian Institute of Health Research (FRN 186055), Research Nova Scotia (RNS 2022-2407), Research New Brunswick, Newfoundland and Labrador Centre for Health Research, Health Prince Edward Island and Nova Scotia Health.

References

Alzheimer Society of Canada. (2022). *The Landmark Study: Navigating the path forward for dementia in Canada—Report 1*. https://alzheimer.ca/sites/default/files/documents/Landmark-Study-Report-1-Path_Alzheimer-Society-Canada.pdf

Andersen, E. A. (2009). Working in Long-term residential Care: A qualitative Metasummary encompassing roles, working environments, work satisfaction, and factors affecting recruitment and retention of nurse aides. *Global Journal of Health Science*, **1**(2), p2. https://doi.org/10.5539/gjhs.v1n2p2

Arain, M. A., Deutschlander, S., & Charland, P. (2017). Are healthcare aides underused in long-term care? A cross-sectional study on continuing care facilities in Canada. *BMJ Open*, **7**(5), e015521. https://doi.org/10.1136/bmjopen-2016-015521

Armstrong, P. (2024). Introduction: Quality care and quality work. In P. Armstrong, H. Armstrong, & J. A. Choiniere (Eds.), *The labour crisis in Long-term Care* (pp. 1–27). Edward Elgar Publishing. https://doi.org/10.4337/9781035340309.00006

Bastien, C. (2001). Validation of the Insomnia Severity Index as an outcome measure for insomnia research. *Sleep Medicine*, **2**(4), 297–307. https://doi.org/10.1016/S1389-9457(00)00065-4

Berta, W., Laporte, A., Deber, R., Baumann, A., & Gamble, B. (2013). The evolving role of health care aides in the long-term care and home and community care sectors in Canada. *Human Resources for Health*, **11**(1). https://doi.org/10.1186/1478-4491-11-25

Blake, M., Lambert, C., Gregory, F., Ridge, M.-C., Stadler, T., Figgett, D., Geddes, G., Towers, A.-M., Rand, S., Palmer, S., Allan, S., Silarova, B., & Brookes, N. (2024). *The adult social Care workforce and their work- related quality of life*. University of Kent

Booi, L., Sixsmith, J., Chaudhury, H., O'Connor, D., Young, M., & Sixsmith, A. (2021). 'I wouldn't choose this work again': Perspectives and experiences of care aides in long-term residential care. *Journal of Advanced Nursing*, **77**(9), 3842–3852. https://doi.org/10.1111/jan.14948

Chamberlain, S. A., Hoben, M., Squires, J. E., Cummings, G. G., Norton, P., & Estabrooks, C. A. (2019). Who is (still) looking after mom and dad? Few improvements in care aides' quality-of-work life. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, **38**(1), 35–50. https://doi.org/10.1017/s0714980818000338

Costello, H., Walsh, S., Cooper, C., & Livingston, G. (2019). A systematic review and meta-analysis of the prevalence and associations of stress and burnout among staff in long-term care facilities for people with dementia. *International Psychogeriatrics*, **31**(8), 1203–1216. https://doi.org/10.1017/s1041610218001606

Cranley, L. A., Hoben, M., Yeung, J., Estabrooks, C. A., Norton, P. G., & Wagg, A. (2018). SCOPEOUT: Sustainability and spread of quality improvement activities in long-term care- a mixed methods approach. *BMC Health Services Research*, **18**(1). https://doi.org/10.1186/s12913-018-2978-0

Cranley, L. A., Keefe, J. M., Taylor, D., Thompson, G., Beacom, A. M., Squires, J. E., Estabrooks, C. A., Dearing, J. W., Norton, P. G., & Berta, W. B. (2019). Understanding professional advice networks in long-term care: An outside-

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

inside view of best practice pathways for diffusion. *Implementation Science*, **14**(1), 10. https://doi.org/10.1186/s13012-019-0858-6

Department of Health & Social Care. (2025). *Adult social care workforce survey*. https://www.gov.uk/government/statistics/adult-social-care-workforce-survey-april-2025/adult-social-care-workforce-survey-april-2025-report

Duan, Y., Smith, L. J., DeGraves, B. S., Angel, C., Wang, A., Saeidzadeh, S., Lanius, R. A., & Estabrooks, C. A. (2025). Dissociation in Long-term Care home staff during COVID-19: Challenges and promising practices. *Journal of the American Medical Directors Association*, **26**(1), 105357. https://doi.org/10.1016/j.jamda.2024.105357

Dubois, H., Leončikas, T., Molinuevo, D., & Wilkens, M. (2020). *Long-term care workforce: Employment and working conditions*. European Foundation for the Improvement of Living and Working Conditions. https://data.europa.eu/doi/10.2806/531180

Ellis, L. A., Schroeder, T., Saba, M., Churruca, K., Long, J. C., Haver, A., Akerjordet, K., Ludlow, K., Bergerød, I. J., Nevantaus, S., Weenink, J.-W., Gonzales, Z., Spanos, S., Lyng, H. B., Haraldseid-Driftland, C., Lungu, D. A., Glette, M. K., Lahti, M., Tibu, F., … Department of Health and Social Management. (2025). Supporting the mental wellbeing of aged care workers: A systematic review of factors and interventions. *AIMS Public Health*, **12**(2), 600–631. https://doi.org/10.3934/publichealth.2025032

Estabrooks, C., Armstrong, P., Bourbonnais, A., Donner, G., Flood, C., Keefe, J., Pringle, D., Silvius, J., Straus, S., Wolfson, M., McNeil, J., Black, N., Dupuis-Blanchard, S., & Graham, I. (2024). *Repair and Recovery in Long-Term Care: Restoring Trust in the Aftermath of COVID-19 (2020–2023)*. Royal Society of Canada.

Estabrooks, C. A., Hoben, M., Poss, J. W., Chamberlain, S. A., Thompson, G. N., Silvius, J. L., & Norton, P. G. (2015a). Dying in a nursing home: Treatable symptom burden and its link to modifiable features of work context. *Journal of the American Medical Directors Association*, **16**(6), 515–520. https://doi.org/10.1016/j.jamda.2015.02.007

Estabrooks, C. A., Squires, J. E., Carleton, H. L., Cummings, G. G., & Norton, P. G. (2015b). Who is looking after mom and dad? Unregulated workers in Canadian long-term care homes. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, **34**(1), 47–59. https://doi.org/10.1017/s0714980814000506

Estabrooks, C. A., Squires, J. E., Cummings, G. G., Teare, G. F., & Norton, P. G. (2009). Study protocol for the translating research in elder care (TREC): Building context – An organizational monitoring program in long-term care project (project one). *Implementation Science*, **4**(1). https://doi.org/10.1186/1748-5908-4-52

Felder, M., Bal, R., Ree, E., Sogstad, M., Stoddart, S., Ellis, L. A., Tibu, F., Vola, F., Cantarelli, P., Delgado-Saborit, J. M., Aparicio, E., Lahti, M., Kankaanpää, E., Wiig, S., Wallenburg, I., & Lyng, H. B. (2026). Different systems, same challenges: A comparative analysis of long-term care resilience in Norway, Finland, the Netherlands, Romania, Spain, Italy and Australia. *Health Policy*, **163**, 105484. https://doi.org/10.1016/j.healthpol.2025.105484

Gil, A. P. (2022). (IIn)Decent work conditions and quality care: An issue for long-term care policy. *Ageing and Society*, **42**(9), 2154–2179. https://doi.org/10.1017/S0144686X20002032

Government of Canada. (2025, June 17). *An Atlantic Immigration Pilot applicant needs a work permit*. https://www.canada.ca/en/immigration-refugees-citizenship/services/work-canada/need-permit/atlantic-immigration-pilot.html

Government of Ontario. (2020). *Long-Term Care Staffing Study*. https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

Hallman, S. (2022). *A portrait of Canada's growing population aged 85 and older from the 2021 Census: Census of population, 2021*. Statistics Canada = Statistique Canada.

Harun, R., & Walton-Roberts, M. (2022). Assessing the contribution of immigrants to Canada's nursing and health care support occupations: A multi-scalar analysis. *Human Resources for Health*, **20**(1), 53. https://doi.org/10.1186/s12960-022-00748-7

Health Standards Organization. (2023). *Long-term care services* (National Standard of Canada CAN/HSO 21001:2023 (E). https://healthstandards.org/standard/long-term-care-services-can-hso21001-2023-e/

Hirdes, J. P., Mitchell, L., Maxwell, C. J., & White, N. (2011). Beyond the 'iron lungs of gerontology': Using evidence to shape the future of nursing homes in Canada. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, **30**(3), 371–390. https://doi.org/10.1017/s0714980811000304

Hounsell, K. (2023, October 16). Former refugees arrive in Nova Scotia to be health-care workers. *CBC News*. https://www.cbc.ca/news/canada/nova-scotia/refugees-arrive-nova-scotia-health-care-workers-1.6996622

Irwin, P., Taylor, D., & Keefe, J. M. (2023). Provincial policies affecting resident quality of life in Canadian residential long-term care. *BMC Geriatrics*, **23**(1), 362. https://doi.org/10.1186/s12877-023-04074-y

Janes, N., Sidani, S., Cott, C., & Rappolt, S. (2008). Figuring it out in the moment: A theory of unregulated Care providers' knowledge utilization in dementia Care settings. *Worldviews on Evidence-Based Nursing*, **5**(1), 13–24. https://doi.org/10.1111/j.1741-6787.2008.00114.x

Keefe, J. M., Cranley, L., Berta, W. B., Taylor, D., Beacom, A. M., McAfee, E., MacEachern, L. E., Boudreau, D., Hall, J., Thompson, G., Squires, J. E., Wagg, A., & Estabrooks, C. A. (2021). Role of policy in best-practice dissemination: Informal professional advice networks in Canadian Long-term Care. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, **40**(1), 166–176. https://doi.org/10.1017/S0714980820000057

Keefe, J. M., Duynisveld, A., Stevens, S., & Estabrooks, C. (2024). Quality of work life and mental well-being for long-term Care staff in Nova Scotia. *Healthcare Policy / Politiques de Santé*, **19**(4), 32–41. https://doi.org/10.12927/hcpol.2024.27348

Keefe, J. M., McCloskey, R., Hodgins, M. J., McArthur, C., MacKenzie, A., Weeks, L. E., & Estabrooks, C. A. (2025a). Examining quality of work life in Atlantic Canadian long-term care homes: Protocol for a cross-sectional survey study. *JMIR Research Protocols*, **14**, e66338. https://doi.org/10.2196/66338

Keefe, J. M., Mercer, S., O'Brien, K., & Daye, L. (2025b). *Newfoundland and Labrador Long Term Care and Personal Care Home Review*. https://www.gov.nl.ca/hcs/files/Long-Term-Care-and-Personal-Care-Home-Review.pdf

Keefe, J. M., Smith, C. A., & Archibald, G. (2018). *Minister's Expert Advisory Panel on Long Term Care—Recommendations*. https://novascotia.ca/dhw/publications/Minister-Expert-Advisory-Panel-on-Long-Term-Care.pdf

New Brunswick Seniors' Advocate. (2024). *What we all want* (ISBN#: 978–1–4605-3893-7)

Ng, R., Lane, N., Tanuseputro, P., Mojaverian, N., Talarico, R., Wodchis, W. P., Bronskill, S. E., & Hsu, A. T. (2020). Increasing complexity of new nursing home residents in Ontario, Canada: A serial cross-sectional study. *Journal of the American Geriatrics Society*, **68**(6), 1293–1300. https://doi.org/10.1111/jgs.16394

Prince Edward Island Department of Health. (2021). *Internal Long-Term Care Review*. https://www.princeedwardisland.ca/sites/default/files/publications/20220609dhwlongtermcarereview.pdf

Public Health Agency of Canada. (2020). *Aging and chronic diseases: A profile of canadian seniors*. https://www.canada.ca/content/dam/hc-sc/documents/services/publications/diseases-and-conditions/aging-chronic-diseases/canadian-seniors-report_2021-eng.pdf

Public Health Agency of Canada. (2022). *How to integrate intersectionality theory in quantitative health equity analysis?* https://www.canada.ca/en/public-health/services/publications/science-research-data/how-integrate-intersectionality-theory-quantitative-health-equity-analysis.html

Song, Y., Keefe, J. M., Squires, J., deGraves, B., Duan, Y., Cummings, G., Doupe, M. B., Hoben, M., Duynisveld, A., Norton, P., Poss, J., & Estabrooks, C. A. (2024). Changes in health and well-being of care aides in nursing homes from a pre-pandemic baseline in February 2020 to December 2021. *Journal of Applied Gerontology*, **43**(1), 3–12. https://doi.org/10.1177/07334648231197074

Spitzer, R.L., Kroenke, K., Williams, J.B.W., & Löwe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives of Internal Medicine*, **166**(10), 1092. https://doi.org/10.1001/archinte.166.10.1092

Statistics Canada. (2022, April 27). *In the midst of high job vacancies and historically low unemployment, Canada faces record retirements from an*

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853

aging labour force: Number of seniors aged 65 and older grows six times faster than children 0–14. https://www150.statcan.gc.ca/n1/en/daily-quotidien/220427/dq220427a-eng.pdf?st=UnOTzWe4

Statistics Canada. (2025a). *Population estimates on July 1, by age and gender* [Dataset]. Government of Canada. https://doi.org/10.25318/1710000501-ENG

Statistics Canada. (2025b). Staffing levels and expenses in Canadian long-term care facilities by ownership status before and during the COVID-19 pandemic. *Health Reports*. https://doi.org/10.25318/82-003-X202500700001-ENG

Ware, J., Kosinski, M., Dewey, J., & Gandek, B. (2001). *How to score and interpret single-item health status measures: A manual for users of the SF-8™ health survey*. QualityMetric Inc.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 19 Nov 2026 at 21:33:27, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S0714980826100853