

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

A Workforce Without Mentors: Valuing Nursing Expertise in an Aging Nursing Workforce

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North Carolina faces surging demand for nursing care alongside accelerating retirements of its most experienced nurses and faculty, threatening access to care and the future of the workforce itself, especially in rural areas. We outline strategies to recognize, retain, and reengage aging nurses, an essential segment of the workforce.

Who Will Be There?

Given publicity around the aging of the nursing workforce, one has to ask: would I want to be a patient today, cared for by an understaffed unit with few experienced nurses? Who will mentor and guide early-career registered nurses (RNs), advanced practice clinicians, or researchers as they enter these roles?

I (Cassandra Dictus) came to nursing through the UNC-Chapel Hill Hillman Scholars in Nursing Innovation Program, which integrated Bachelor of Science in Nursing (BSN) and PhD education. I also completed a full-time, year-long clinical fellowship in long-term care (LTC) before beginning doctoral study.¹ Experienced nurses who mentored me were indispensable. One nurse oriented me to the chaos of day shift. She was kind, fun, and set high standards for person-centered care: “Ms. H. likes her pills in this flat ceramic bowl, not the plastic cup...” After orientation, I worked most of my evening shifts with another nurse, who was calm and steady; I could always go to him for help. He, like so many other nurses, left nursing after the COVID-19 pandemic. Three years in, I was one of the most senior nurses on staff.

North Carolina Under Pressure

The demand for nursing care is rising as North Carolina’s population grows and ages. By 2030, approximately 20% of residents are expected to be 65 or older.² North Carolina now ranks first nationally in domestic migration and second in net retiree migration.³ The nursing workforce is aging too. Nationally, nurses aged 65 and older comprise 18.3% of the RN workforce, representing the largest age cohort in the profession.⁴ About 40% of that cohort plan to leave or retire within the next five years.⁴ This leaves more

people, particularly older adults with complex care needs, entering a health care system that is experiencing an accelerated loss of the most experienced and essential clinicians.

Despite recent gains in nursing graduates, North Carolina continues to fall short by an estimated 2710 RNs and 620 licensed practical nurses (LPNs) annually needed to replace those retiring or leaving practice.⁵ Even modest changes in retirement patterns can have outsized effects. NC Nursecast projections indicate that if nurses leave the workforce just five years earlier than expected, shortages nearly double.⁶ These patterns underscore why retaining experienced nurses is as urgent as recruiting new ones.

These challenges are not evenly distributed across North Carolina regions or settings. For example, Durham and Orange counties reported over 290 RNs per 10,000 residents, while at least 15 counties reported under 40 RNs per 10,000.⁷ Notably, many of the counties with the lowest nurse supply also have higher proportions of nurses nearing retirement age. For example, in Tyrrell County in rural northeastern North Carolina, there are only 24 RNs per 10,000 people, and almost 38% of those RNs are aged 65+.⁷ The impact is also felt acutely in LTC, where nursing employment has declined by approximately 16% in recent years, even as hospital and ambulatory care settings have grown by roughly 12% and 25%, respectively.⁸

The Cyclical Problem

When experienced nurses leave, the burden on those who remain compounds. Research shows that isolation, insufficient social support, and low self-efficacy are linked to nurse attrition in ways that add to but are distinct from burnout.^{9,10} Especially for new nurses, having one experienced nurse to turn to for guidance and support can make the difference between staying or leaving. Senior nurses, now managing understaffed units with diminishing support, become more likely to retire early, and the cycle continues.

Recognizing, Retaining, and Reengaging Experienced Nurses

This problem is not new. Nearly two decades ago, the Robert Wood Johnson Foundation commissioned a landmark report, “Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace,” identifying the looming retirement of experienced nurses as a crisis in the making and outlining concrete strategies to address it.¹¹ Progress, while insufficient, has not been absent. With renewed commitment, North Carolinian organizations and policymakers can strengthen or implement the strategies below.

A systematic review identified six factors that promote working until and beyond retirement age among nurses: good health and work ability, meaningful work, sufficient income, supportive workplace relationships, individually tailored arrangements, and organizational recognition—a framework that cuts across almost every strategy discussed below.¹²

Flexible Work Arrangements

Flexible work arrangements are among the strongest drivers of nurses' intention to stay. Notably, the perceived availability of flexibility mattered nearly as much as its actual use.¹³ Evidence from rural and remote settings indicates that retired nurses who continue to practice often do so out of deep community connection, describing retirement as a new phase of nursing rather than an exit, suggesting flexible strategies that honor that identity may be especially effective in rural North Carolinian communities.¹⁴

Financial Supports

Financial incentives can make staying in the workforce more attractive than leaving. Addressing wage compression, where nurses with decades of experience earn similar pay to new graduates, is a starting point; nurses themselves have called this “insulting.”¹⁵ Some health systems and unions have responded with long-service pay additions at career milestones as a reward for staying.¹⁶ Beyond salary, phased retirement programs that allow nurses to reduce hours while retaining benefits or begin drawing from retirement make continuing to work financially feasible.¹⁷ Loan forgiveness and tuition support for nurses who practice in rural areas and fill faculty roles could also be powerful incentives to retain aging nurses.

Mentorship Programs

Mentorship has emerged as particularly meaningful for both experienced and inexperienced nurses. Inexperienced nurses gain support and guidance, while experienced nurses gain a greater sense of purpose and enthusiasm at work and report higher intent to stay.¹³ An important caveat is that mentoring added to already heavy workloads and can cause guilt and stress for some nurses. Mentorship must be built into workloads, not added to existing workloads, and should be formally counted as productive nursing work.¹³

Physical Health and Injury Prevention

Efforts to promote nurses' health hold promise for retaining experienced nurses, with the strongest evidence coming from randomized controlled trials. A Tai Chi intervention for older nurses improved physical and mental health, reduced injury risk, and paid for itself through reductions in lost work time. A nurse lifting and back safety program cut injury-related costs from over \$48,000 to under \$3,000 per year.¹³ Environmental design, such as repositioning equipment and anti-fatigue mats, and organization-wide

budgets for worker accommodations can decrease financial burdens from any single unit and intra-unit competition for staff.¹⁷ These programs matter for nurses' well-being and sustaining careers in physically demanding roles and settings.

Reducing Documentation and Administrative Tasks

Administrative and documentation burdens are increasingly urgent retention levers in nursing. Mercy Health's Project ANEW (Advancing Nursing Efficiency and Workflows) reduced charting time by 32 minutes per nurse per day, bringing meaningful improvements in nurses' well-being and experience scores.¹⁸

Virtual Nursing

Virtual models offer a promising way to retain experienced nurses with or without physical limitations. Although more research is needed, Atrium Health in Charlotte, North Carolina is a leader in building and scaling this model.¹⁹ Its parent, Advocate Health, now has one of the largest virtual nursing footprints in the country.

Improving Organizational Culture and Leadership

This may be the most foundational strategy of all. Transformational leaders who inspire shared vision, recognize individual contributions, involve nurses in practice-focused decisions, and create a sense of purpose consistently improve nurses' job satisfaction and retention. Shared governance structures that give nurses a voice in shaping policies affecting their practice strengthen both nurses' well-being and commitment.¹³ Organizational culture must also actively counter ageism. Research finds that negative age stereotypes are prevalent in workplaces, contributing directly to early retirement and diminished professional engagement among experienced nurses.²⁰

Reengaging Nurses

Attracting experienced nurses who have left the workforce represents an underutilized strategy. Refresher programs that combine didactic and clinical skills components, simulation-based training, streamlined re-licensure pathways, and mentorship with experienced active nurses have shown promise nationally. The North Carolina Area Health Education Centers (NC AHEC) already provides the infrastructure needed to build these pathways. Targeted policy investments, including funded reentry subsidies, hybrid learning options for rural areas, and Clinical Instructor Partnerships, could help draw experienced nurses back into the workforce.^{21,22}

Structural Changes

Finally, efforts are needed to value nurses in organizations and health systems. Across all strategies outlined here, a common theme is that programs layered on top of existing heavy workloads add stress to nurses, and their effectiveness fades over time. These strategies require genuine organizational investments with dedicated time in nurses' schedules, ongoing support rather than one-off interventions, and willingness to view workforce health as an investment in patient care quality and institutional sustainability. A paradigm shift is needed in the measurement of nurse productivity so that organizations count mentorship, knowledge transfer, and clinical judgment alongside direct patient care tasks.¹³ Until the value of experienced nurses—their knowledge, skills, and attitudes about patients, practice, and colleagues—is recognized, the loss of vital expertise will go unrecognized until it is unrecoverable. The quantitative value of nurses, or the costs relative to quality outcomes achieved, is a start; however, it is often the qualitative value of nurses to patients, families, communities, their colleagues, and health systems that enhances organizational reputations, creates fulfillment for nurses, and retains them in practice.

A Problem Behind the Problem: Losing Teachers and Faculty Mentors

A less visible but critical dimension of the nursing workforce crisis is the aging and attrition of nursing faculty.²³ Most nursing schools report faculty shortages as a top reason for turning away qualified applicants, with US nursing schools turning away over 80,000 qualified applications in 2024 alone.²³ Nurse educators are disproportionately older and more likely to leave the workforce sooner than their clinical counterparts, according to NC Nursecast.⁶ Lower faculty salaries discourage many from academia, with master's-prepared nursing professors earning a median of \$93,958 compared to \$129,480 for advanced practice nurses.²³

For those entering nursing research, a critical area of need in nursing, the stakes of this shortage are personal. A difficult job and funding market creates worries that, like bedside nurses, early-career researchers will be asked to do more work with less mentoring and support. The problem in nursing education is not only about producing enough entry-level or graduate nurses; it is about having sufficient experienced faculty to train and mentor students *and* new faculty.

North Carolina is fortunate to have strong nursing programs. Given geographic workforce disparities, the NC AHEC network and community colleges are especially important in supporting nurses working in rural communities. Programs like North Carolina's Regionally Increasing Baccalaureate Nurses (RIBN) supported students' academic progression through partnerships between community colleges and universities to provide

affordable BSN pathways. Research consistently shows that nurses trained in communities are more likely to practice there,²⁴ but these programs depend on having sufficient experienced faculty to grow and sustain them.

Retaining nurse faculty requires the same commitment made to retain nurses at the bedside: salaries competitive with practice, protected mentorship and onboarding time,²⁵ and recognition that experienced nurse educator skills are irreplaceable.²⁶ The AACN website outlines specific promising national programs and state policies.²³ In North Carolina, making sustained investments in academic progression programs like RIBN to build local nursing careers, the Clinical Instructor Partner Program to support dual-role faculty,²² continued advocacy in the General Assembly and university systems to close the faculty salary gap, and deliberate succession planning are needed before valued mentors leave the workforce.

Wisdom We Cannot Afford to Lose

Even though I no longer work at the bedside, I still think about the two mentors who were essential in shaping my clinical practice and knowledge, and the patients and families who benefited from their mentorship. I consider what might have been lost had I not received their guidance, and the losses today across North Carolina, as experienced nurses retire without systems in place to extend or honor their careers.

The loss of human capital and the accumulated knowledge, clinical judgment, and relational skills that take years to build cannot be replaced by new graduate nurses, however talented or well-trained. The loss of nursing wisdom is felt by everyone left behind: new nurses with no one to turn to; senior nurses who burn out faster because they carry too much alone; patients and families whose care depends on their expertise. North Carolina is becoming an older state, cared for by an older workforce, trained by faculty who are also aging. The question is not whether this trajectory can be stopped. It cannot. The question is whether needed changes will be made to support and honor the nursing mentors who have supported the North Carolina health care and academic systems so far.

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Declaration of Interests

The authors have no conflicts of interest to declare.

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