

Sustainable Nursing Advocacy: Politics, Policy, and Nurse Wellness

Melissa Lehan Mackin, PhD, RN, Associate Professor, University of New Mexico College of Nursing and Population Health; and Michael Baker, MPH, RN, Associate Scientist, UNM Office of Community Health, UNM College of Nursing PhD Student

Introduction

Nursing care does not operate outside of politics. Politics refers to the processes, structures, and relationships through which individuals and groups make collective decisions about priorities, resource allocation, and the establishment of policies and rules (Birkland, 2020). In the current socio-political context, many individuals report fatigue, frustration, anxiety, and distrust (Associated Press, 2026; Gallup, 2026)—conditions that may stand as barriers to political involvement. Nurses are not immune to these pressures, and politics are not restricted to the federal government. Politics also exist within organizations. These political environments shape how easily nurses can engage in public discourse or advocate for change without fear of backlash or fatigue. At the same time, nurses are experiencing elevated levels of moral distress, burnout, and constrained agency in the workplace leaving little capacity for sustained advocacy (Shah, 2021).

Although our professional organizations have established advocacy as a nursing obligation (ANA, 2015), expecting nurses to engage in large-scale or highly visible advocacy efforts may feel like a “pile on” amid present social and workplace realities. Nurses practice in systems where expectations for quality and safety continue to rise, even as staffing instability, moral distress, and organizational constraints limit their ability to meet those expectations (NASEM, 2019). These conditions threaten collective

nurse wellness and the capacity to provide safe, ethical, and equitable care. In this paper, we propose meaningful forms of nursing advocacy that use local workplace policies and structure to contribute to nurse wellness.

Advocacy through “nurse wellness”

Nurse wellness is defined here as a capacity to work and practice safely, ethically, and sustain contributions to the profession over time (NASEM, 2019). Although nurses also have an ethical obligation to their own self-care, personal safety, and preserving integrity - wellness is not solely the responsibility of the individual nurse (ANA, 2015; NASEM, 2019). Nurses cannot “self-care” their way through the serious problems in the healthcare system. However, nurses can engage in policy processes in their workplaces to develop and revise policies that shape the conditions in which they practice. This organizational advocacy transforms wellness from individual coping to a collective structural and organizational priority.

Policy is defined as deliberate decisions, laws, regulations, procedures, or institutional rules (Birkland, 2020). Policies exist at all levels from federal law (e.g., Medicare funding) to state policy (e.g., nurse licensure requirements), or organization or unit policy (e.g., workplace violence protocols). Organizational and unit policies standardize care, allocate responsibility, operationalize safety, structure workflow, and ensure accountability. Because these policies direct the

daily working conditions of nurses, they are a powerful lever for change. By engaging in the development and revision of these policies, nurses can address structural contributors to burnout, clarify workload expectations, and embed psychological safety into practice. Here, we present three practical examples of how advocacy for nurse wellness could be undertaken by nurses in their unit or organization.

Example 1: Achieving safer staffing and reducing burnout

Safer staffing is foundational to nurse wellness because chronic understaffing, fatigue, and missed care strain nurses, cause burnout, and compromise patient safety (NASEM, 2019). Contemporary guidance increasingly treats burnout as a systems problem, making unit-level staffing policies, break protections, and limits on excessive scheduling practical and appropriate advocacy targets.

Policy revision typically begins with identifying patterned strain (Birkland, 2020; NPSF, 2015). Nurses may document missed breaks, fatigue from consecutive shifts, sick leave usage, errors or near-misses using staffing logs, incident reports, and informal tracking. When these data are presented to shared governance or staffing committees, individual frustration is reframed as a systems issue embedded in existing policy. Bring this data to shared governance or staffing committees, discuss findings during meetings, and make peers aware of efforts.

When nurses have defined avenues to influence organizational priorities, staffing standards, and safety initiatives, advocacy becomes embedded in governance rather than dependent on individual persistence. Expanding nurse representation within institutional policy structures thus promotes both collective wellness and a more ethically responsive practice environment.

Nurses can then propose measurable revisions, such as adjustments to staffing grids, dedicated break coverage roles, or limits on consecutive shifts. Collaborative engagement with leadership and stakeholders is essential to ensure buy-in. Proposals may be piloted with plans for data collection on workload, safety outcomes, and retention. If successful, changes can be codified into formal policy. Through this process, staffing strain is transformed into structured reform.

Example 2: Using organizational infrastructure to develop peer support policy

Peer support or “second victim” programs provide structured support for clinicians and providers, including nurses, following emotionally difficult events (Merandi et al., 2017). One specific program implemented by Nationwide Children’s Hospital, was the “YOU Matter” peer-support program that included psychological first aid, confidential support, and pathways for professional counseling. Importantly, staff who received support from “YOU Matter” reported improved emotional state and improved return-to-work metrics.

Developing similar peer support programs can utilize existing organizational infrastructure such as patient safety committees. Because regulatory and accreditation standards often require organizations to have committees that review adverse events, most nurses can identify a workplace group focused on reducing harm and improving system re-

liability. These committees already collect data and conduct root cause analyses under regulatory and accreditation expectations (The Joint Commission, 2026). This same data can be used to justify peer-support programs.

Data collected to monitor quality and safety such as code blue frequencies, psychological safety scores, and nurse turnover can be indicators of workforce wellness. By framing clinician distress as an occupational exposure that intersects with safety culture, nurses can advocate for wellness programs that can be formally embedded into institutional policy, shifting emotional recovery from personal coping to structural support.

Example 3: Expanded nurse representation in governance

Increasing administrative control, staffing instability, financial pressures, and escalating patient acuity may constrain nurses’ clinical discretion (NASEM, 2019; Shah, 2021). Nurses often carry high responsibility with limited control, diminishing professional agency and advocacy capacity. Expanding nurse participation in governance structures can restore voice and influence and enable nurses to contribute to meaningful solutions to problems in healthcare and the workplace (Booth, 2025).

The first step is identifying where nursing representation is absent or limited, such as committees restricted to management or bodies without frontline

voting roles. These could be committees addressing policy development, patient safety, or unit-specific procedures. Complementing this, evidence is also needed to support nursing’s low perceived voice and a need for better representation. This could be obtained from survey data about role in organizational decisions and policies, in addition to turnover metrics, specific examples of policy decisions that misaligned with workflow and patient priorities, and documentation of repeated concerns.

Next, make people in the organization aware of issues along with evidence that can demonstrate impact. Use existing governance structures such as shared governance councils, unit-based practice committees, or quality improvement forums to communicate issues and their impact. These forums can also be used to advocate and propose nursing participation that extends beyond advisory roles, protects meeting times, and increases transparency in committee decisions that impact nurses. Aligning proposals with accreditation standards, safety metrics, retention goals, or national burnout recommendations strengthens legitimacy. Piloting expanded representation with evaluation plans may increase buy-in and acceptance.

When nurses have defined avenues to influence organizational priorities, staffing standards, and safety initiatives, advocacy becomes embedded in governance rather than dependent on individual persistence. Expanding nurse representation within institutional policy structures thus promotes both collective wellness and a more ethically responsive practice environment.

Conclusion

The examples provided illustrate how nurses can meaningfully engage in changing policies that can improve nurse and workplace wellness. Across the examples, nurses were directed to identify patterned strain, reframe distress as a systems issue, use formal gover-

nance channels, propose measurable policy language, and propose changes that could be piloted and then codified. Through this process, wellness becomes embedded in institutional design. Organizational and unit policy shifts wellness from informal aspiration to institutional expectation, converting workplace strain into structured, sustainable reform.

Acknowledging the current political and workplace context's impact on nursing advocacy means scaling advocacy to capacity, risk, and context. Engaging local policy that contributes to nurse wellness is less likely to perpetuate a professional environment that results in depletion. Rather than nurse advocacy becoming another unpaid, invisible expectation, it becomes necessary and sustainable action toward positive change. We continue a discussion of sustainable nurse advocacy in Part 2: Sustainable Nursing Advocacy: Micro-advocacy for Macro-impact. ■

References

- American Nurses Association (ANA). (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Publishing. <https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/>
- Associated Press. (2026, February 4). *Americans are exceptionally anxious about their political system, new Gallup polling shows*. <https://apnews.com/article/2b04063cf966a7227715b85410fbd4fa>
- Birkland, T. (2020). *An introduction to the policy process: Theories, concepts, and models of public policy making* (5th ed.). Routledge Press.
- Booth, A. T., Hines, B., Newton, A., Self, A., Beierle, J., Russell, K., & Hess, R. (2025). Using the Hess Index of Professional Nursing Governance to explore nurses' perceptions of shared decision-making in a Magnet® designated medical center. *The Journal of nursing administration, 55*(8), 472–478. <https://doi.org/10.1097/NNA.0000000000001612>
- Gallup. (2026, January 5). *Americans predict challenging 2026 across 13 dimensions*. <https://news.gallup.com/poll/700448/americans-predict-challenging-2026-across-dimensions.aspx>
- Merandi, J., Liao, N., Lewe, D., Morvay, S., Stewart, B., Catt, C., & Scott, S. D. (2017). Deployment of a second victim peer support program: A replication study. *Pediatric Quality & Safety, 2*(4), e031. <https://doi.org/10.1097/pq9.000000000000031>
- National Academies of Sciences, Engineering, and Medicine (NASEM). (2019). *Taking action against clinician burnout: A systems approach to professional well-being*. The National Academies Press. Washington, DC. <https://www.nationalacademies.org/projects/HMD-HCS-17-09/publication/25521>
- National Patient Safety Foundation (NPSF). (2015). *RCA²: Improving root cause analyses and actions to prevent harm*. National Patient Safety Foundation. <https://www.ih.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx>
- Shah, M. K., Gandrakota, N., Cimiotti, J. P., Ghose, N., Moore, M., & Ali, M. K. (2021). Prevalence of and factors associated with nurse burnout in the US. *JAMA Network Open, 4*(2), e2036469. <https://doi.org/10.1001/jamanetworkopen.2020.36469>

ISSUES FOR THE NEW MEXICO NURSING COMMUNITY:

Preparation for the 2027 Legislative Session

Deborah Walker MSN, RN; Executive Director NMNA

By the NM State Constitution, the 30-day legislative sessions that occur in even-numbered years are convened to address the budget for the State. Legislation of import can also be provided a “message” from the Governor so the bill can be introduced and go through the regular process as well. The second regular session of the 57th Legislature saw 268 bill and 44 memorials introduced on issues of interest to legislators and their constituencies. While some were ruled germane and might have had a hearing, without a message from the Governor they could not progress.

These bills can be construed as markers for what legislation will be dropped in 2027. Additionally, bills with fiscal impact can be addressed through the appropriations process. Memorials also can be introduced and passed in a 30-day session and those with substance can lay the groundwork for legislation and appropriations in the next session. Some of these have implications for the nursing community and their issues should be considered over the interim with an eye to the 2027 legislative session. Several of note are briefly presented here.*

Safe Harbor for Nurses Act

The Safe Harbor for Nurses Act was a hard-fought effort in 2019 by NMNA with strong bipartisan, bicameral support. The law now provides nurses with the ability to protect their patients, their practices and their licenses by using their own best judgment to reject an assignment without retaliation or discipline. This also includes questioning another health care provider's orders which the nurse is expected to implement. The law rests upon the NM Nursing Practice Act, the ANA Code of Ethics for Nurses, scope and standards of practice, and the individual