Employed Student Nurse Programming: Strengthening the Role as a Workforce Strategy

This research project is to assist the program partners to determine the direction and efficacy of actions needed to build better quality, equitable, inclusive and sustainable employed student experiences.

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1 LIST OF ABBREVIATIONS

ACG	Advisory Consultation Group
AFMC	Association of Faculties of Medicine in Canada
B.C.	British Columbia
BCCNM	British Columbia College of Nurses and Midwives
BCNU	British Columbia Nurses Union
BSN	Bachelor of Science in Nursing
CFNU	Canadian Federation of Nursing Unions
CNSA	Canadian Nursing Students Association
EPA	entrusted professional activities
ESN	employed student nurse
ESPN	employed student psychiatric nurse
FNHA	First Nations Health Authority
HA	health authority
HCA	Health Care Aide
HEABC	Health Employers Association of British Columbia
HPOA	Health Professions and Occupations Act
HSA	health services area
IEN	internationally educated nurse
JBI	Joanna Briggs Institute
LPN	Licensed Practical Nurse
MoH	Ministry of Health
NBA	Nurses Bargaining Association
NGTP	new graduate transition program
NP	Nurse Practitioner
PICO	population, intervention, comparison, outcome
PIPSC	Professional Institute of the Public Service of Canada
PP	paid preceptorship
PSI	Post-Secondary Institution
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
UGN	undergraduate nurse
UK	United Kingdom
UNBC	University of Northern British Columbia
UVic	University of Victoria
USA	United States of America

2 EXECUTIVE SUMMARY

Background

The formal employment of student nurses in British Columbia (B.C.) began in 2001 as the *Undergraduate Nurse Employment Demonstration Project*. Initially a pilot funded by the Ministry of Health, the program aimed to evaluate the impact of paid employment for third- and fourth-year nursing students in acute care facilities. Early evaluations demonstrated significant success, citing improved patient care, reduced registered nurse (RN) workloads, and enhanced job readiness for graduates. This project was followed by the creation of an employed student nurse (ESN) classification that was rapidly taken up by health authorities (HAs) across the province. While the ESN program is accepted to be a successful innovation that has benefited students, new graduates, employers, and the healthcare system in general, no further evaluation of this role has occurred since 2003.

The role is designed as a supernumerary, optional employment model that remains legally and structurally separate from the core educational curriculum. Over the decades since its establishment, the healthcare landscape has evolved, marked by increased acuity, technological advancements, chronic staffing shortages, and the need to increase the focus on high need areas such as rural and remote settings with Indigenous populations. As a result, the need to review, transform, and integrate the ESN role has become paramount. This report explores the current state of the ESN role to propose a more robust, sustainable, and integrated program for this important career training resource.

Methodology

The research utilized a three-step multimethod approach to identify structural principles and opportunities for system change. First, an international environmental scan and rapid review of literature (2000–2025) were conducted to benchmark B.C.'s model against global practices. Second, the research project employed narrative inquiry, conducting 43 semi-structured interviews with ESNs and representatives from HAs, the British Columbia College of Nurses and Midwives (BCCNM), and the British Columbia Nurses' Union (BCNU). These interviews focused on "episodes" of lived experience to understand professional identity and operational challenges. Finally, an Advisory Consultation Group (ACG), consisting of 14 experts, validated the findings and provided feedback on proposed innovations. The study was analyzed through the lens of critical realism, to understand how the existing role determinants and underlying structures lead to program outcomes and to identify opportunities for transformation at the system level.

Key Findings

The findings reveal a program of immense value that is currently hampered by systemic misalignments.

1. Benefits for Students and Employers

Gap Filling: Students consistently reported that ESN roles fill critical gaps in formal clinical placements, providing the repetition and skill consolidation necessary to build clinical assurance.

Professional Identity: The role is a transformative space where students "fall in love with nursing" and move from "standing in the corner" to feeling like a valued team member.

Recruitment Pipeline: Employers view the ESN role as their primary strategy for recruiting new graduates, noting that ESNs who transition to RN roles "hit the ground running".

Symbiotic Labour Support: While supernumerary, ESNs provide an "extra pair of hands and eyes", improving patient safety and re-energizing veteran staff through their eagerness to learn.

2. Systemic Challenges

Scope Ambiguity: A frustration point for ESNs and employers was the lack of understanding and varying "scope of practice" for ESNs, and the supervision requirements; leading to confusion and anxiety for both students and RN supervisors.

The "Inability to Teach" Paradox: ESNs and employers felt restricted by rules preventing them from being taught or learning new skills that had not been covered in their academic curriculum, resulting in missed learning opportunities.

Administrative Redundancy: Significant duplication exists in onboarding; students often complete the same administrative processes twice, once as a student and once as an employee, within the same HA.

Funding Precariousness: Lack of stable, long-term funding creates financial insecurity for students and prevents HAs from making sustained recruitment commitments.

Discussion

The research identifies the ESN role as existing in a liminal space, a transitional zone where the learner is more than a student but less than a fully autonomous nurse. This space is where the most significant professional growth occurs, yet it is currently managed through parallel universes where post-secondary institutions (PSIs) and HAs operate in silos.

The PSI-Learner-HA Triad

There is a need for a shift toward a triadic partnership where education and employment are continuous rather than fragmented. The employer’s role is no longer just as a service provider, they are now functioning as a shaper of practice readiness, and an essential component of the educational system for students. A shared mechanism would allow for integrated learning progression, address curriculum gaps, facilitate the removal of costly duplicative processes for both the PSI and HA, and

address the well-known theory-practice gap through the utilization of educational and career supporting/learning tools.



Addressing Scope through EPAs

The grey area of clinical scope and supervision can be addressed through the adoption of entrustable professional activities (EPAs). EPAs define discrete, observable units of work that can be progressively entrusted to a learner. By implementing an EPA framework, B.C. could provide a standardized, transparent method for RNs to know exactly which tasks an ESN is competent to perform, thereby reducing supervisory anxiety and liberating learning. This model, already used in B.C. medical schools, would link everyday workplace enactment with structured, intentional learning.

Structural Reform and Technology

To bridge the PSI-HA gap, there is also a need to incorporate learner-based digital platforms. Such platforms (e.g., e-portfolios) would allow students to carry evidence of their skills and entrustment between their PSI and various employment sites, ensuring all stakeholders are updated on a student's current mastery. Furthermore, centralizing administrative processes, such as a province-wide portal for advertising and onboarding, would eliminate costly duplicative efforts and facilitate ESN movement between HAs.

Rural and Remote Sustainability

The ESN role is a powerful lever for rural recruitment, as students who experience rural practice often stay longer than those in urban settings. However, success requires addressing structural barriers such as the additional costs associated with housing and travel, and providing rural, community and Indigenous education. The use of an "extended immersion" model, combining formal clinical placements with ESN work hours, has been shown to build a more rural-ready workforce. The use of EPAs, improved supervision training, and potential hybrid models could assist with the challenges of providing regulatory supervision.

ESN as a Workforce Development Investment

The ESN program should be viewed not merely as a job, but as a vital workforce development mechanism. Without the developmental bridge the ESN role provides, the retention of new graduates remains fragile, potentially worsening early career attrition. Investing in the ESN program is a strategic

necessity to ensure that the resources spent on nursing education translate into a stable, practice-ready workforce.

Recommendations

To ensure the ESN program remains a sustainable and effective pillar of the B.C. healthcare system, the following summarized recommendations are proposed: (Please see Section 11, p.74 for the full list of recommendations).

1. Sustainable Funding and Access

Embed permanent Ministry funding and specified budget lines to protect the role from HA budget re-prioritizations.

Provide funding for 80% to 100% of eligible students to work up to 600 hours over the course of their program.

Transition to province-wide/student-based allocation of funding rather than individual HA budgets to ensure equitable access across all locations.

2. Provincial Program Alignment

Integrate the ESN and New Graduate Transition Program (NGTP) into a single, two-phase structure (pre- and post-registration) to optimize human and financial resources.

Establish a provincial ESN Working Group to develop common supervision standards and a province-wide guide to PSI curricula to help employers understand student readiness.

Review and centralize administrative processes for hiring and onboarding to reduce duplication between PSIs and HAs.

3. Educational Innovation

Develop a provincial EPA Framework for RN education to link required core competencies directly to professional activities in the workplace.

Adopt learner-based digital platforms to track and record evidence of learning across education and practice settings.

4. Focused Rural and Indigenous Support

Dedicate a minimum of 10% of ESN positions to rural, remote, and Indigenous locations.

Provide dedicated funding for housing and travel support in rural areas, and the First Nations Health Authority (FNHA).

Provide specific support to FNHA and First Nations self-government spaces to develop the ESN role.

Utilize extended immersion models that combine clinical placements with ESN components in rural settings.

5. Continuous Evaluation

Develop a common evaluation framework across all HAs to track recruitment, 5-year retention, and career movement.

Embed workforce data collection relating to transition to practice, recruitment, retention, and career progression into the annual BCCNM registration process to provide a real-time snapshot of the nursing pipeline.

Conclusion

The ESN role is far more than an employment opportunity; it is a developmental bridge that alleviates transition shock and fosters early professional identity. While the program has been a success of accidental integration, its future depends on a deliberate, system-wide redesign. Effective ESN programs rely on strong supervision, clear role definitions, and stable funding, serving as crucial support rather than just extra workforce. Supportive environments foster competence, identity, and resilience, helping reduce burnout, enhance well-being, and ease the shift to RN status while improving retention and integration of new staff. By bridging the parallel universes of academia and the workplace through shared accountability, educational innovations (EPAs and e-platforms), and stable funding, B.C. can transform the ESN role into a world-class model for health human resource sustainability.

3 PROJECT BACKGROUND

The formal employment of undergraduate student nurses in British Columbia (B.C.) began in 2001 as a pilot project: *Undergraduate Nurse Employment Demonstration Project*. Developed from the outcomes of the University of Victoria (UVic) fourth year nursing course, *Nurses Influencing Change*, and funded by the B.C. Ministry of Health (MoH) through a Health Action Plan grant, this demonstration project was implemented in four Health Service Areas (HSAs)[1] located in what are now known as Island and Interior Health Authorities. This pilot project had two components, the *Undergraduate Nurse (UGN) Employment Project* and the *Paid Final Preceptorship Project* (PP) (Gamroth & Lougheed, 2004).

The UGN pilot project was conducted over a two-year period with 193 participants and included a three-year evaluation component extending up to 20 months following graduation. Although implementation varied across each HSA, the program was generally accessible to third- and fourth-year students and operated for periods ranging from three to nine months annually until project funding was depleted. The program evaluation, which included questionnaires, focus groups, and key informant interviews, showed it to be a significant success in acute care facilities with “people wanting more of it”. The role quickly spread to non-pilot sites with 11 additional HSAs implementing the program by the end of the first year and many more by the end of the second year despite there being no direct funding for its continuation. HSAs, and later the newly formed health authorities (HAs), had to find internal methods to fund these positions or negotiate with the MoH for specific funding to continue the program (Gamroth & Lougheed, 2004).

The evaluation of the UGN project showed a range of positive outcomes from the perspectives of the student nurse, and the HA and their employees. These outcomes included improved patient care, reduced workload for registered nurses (RNs), an increase in staff morale, enhanced job readiness for new graduates, and positive economic benefits by reducing post-graduate RN orientation times for the employer and providing financial assistance to students. The students indicated that they advanced their clinical skills, became part of the team, got the ‘feel’ of the floor, felt they were a member of the workforce, learnt, and were able to teach peers. The pilot project evaluation did not include any impacts on recruitment or retention of either new graduates or existing RNs (Gamroth & Lougheed, 2004).

To facilitate the UGN project a special category of membership was established under the ‘*Rules*’ of the ‘*Nurse (Registered) Act*’ in early 2001, designating them as student members of the Registered

[1] At the time of this project there were 52 HSAs in the province which were subsequently redistributed into five geographical and one provincial health authorities in 2002 – 3. The pilot project was undertaken in two HSAs which are now located in Island Health Authority and two in Interior Health Authority.

Nurses Association of British Columbia[2]. These roles were formally recognized and included in the agreement between the HEABC[3] and the Nurses Bargaining Association (NBA) in April 2001.

The PP project occurred once in 2002 at two sites in these HSAs, two different models were utilized, and 44 students participated. The project evaluation showed that it was well received and provided improved supports for preceptorship, however it was not viewed as high-value for continued funding compared to the UGN because the PP benefited the student only, while the UGN benefitted both the student and the employer (Gamroth & Lougheed, 2004).

Following the pilot projects, B.C. created a separate employed student nurse (ESN) classification instead of continuing to fund preceptorships; this was not as an educational preference but as a structural, legal, labour relations, and political approach (B.C. Employment Standards Act, B.C. Reg. 396/95, Regulations Part 7, Section 33[4]). As a required educational course, the final clinical preceptorship is a pre-requisite to graduation; it does not need an employee contract, and the post-secondary education sector controls the evaluation. If students were to be paid during a preceptorship they would be considered employees, requiring bargaining-unit work by the NBA, and the British Columbia Nurses Union (BCNU) could argue this could result in job erosion or displacement. Overall, by keeping this preceptorship unpaid preserved educational primacy; provided clear lines of supervision, responsibility, and accountability; and provided a legal separation of the ESN role from both the educational sector and employer staffing establishment. Since student nurses' educational seats are publicly subsidized and clinical placements are a composite part of experiential learning, there was a concern that payment could be seen as taxpayers funding education twice or that students could be viewed as workforce subsidy. To address these challenges, the ESN role was originally designed to make employment optional rather than required, detached from the core curriculum, and aligned the ESN model with workforce strategy instead of educational requirements. Additionally, by having BCCNM register ESNs, any performance management issues could be addressed by employers without affecting educational advancement.

Over the subsequent two decades ESN opportunities have been rolled out province-wide, with implementation varying at the health service level, (i.e., hours worked, contract duration, and employment unit type). Initially these positions existed only for student RNs, however with the amalgamation of the nursing regulators in 2018 employed student psychiatric nurse (ESPN) positions became available. Service and HA job descriptions were initially based on province-wide descriptions, however variation in post-secondary educational program design, content delivery and clinical skill

[2] Registered Nurses Association of British Columbia was the RN regulator at this time.
[3] Health Employers Association of BC (HEABC) is the bargaining authority representing all publicly funded health employers in BC.
[4] The Employment Standards Act, Regulations, Part 7, Section 33, specifically excludes nursing students from the provisions of the Employment Standards Act and prohibits the payment of students on educationally required practicum. (See Appendix 1 for more information on these regulations and the current context surrounding this issue.)

acquisition has resulted in local adaptations to job descriptions. No formal ties exist between post-secondary education institutions (PSIs) and employer provided ESN/ESPN[5] positions, with British Columbia College of Nurses and Midwives (BCCNM) (current nursing and midwifery regulator) citing that ESNs and ESPNs do not have a "scope of practice" in regulation, nor do they have authority to autonomously perform restricted activities unless authorized by the nurse practitioner (NP), registered psychiatric nurse (RPN) or RN who has accepted the responsibility for regulatory supervision of the employed student as described in the *Practice Standard: Regulatory Supervision of Students* (British Columbia College of Nurses and Midwives, 2025), which applies to all students[6] undertaking formal educational programs and ESNs. Licensed practical nurses (LPNs) are not authorized to supervise employed student registrants per BCCNM Bylaws. All employed students can practice in areas where they have gained competency as assessed by BCCNM approved educational program faculty or equivalent: Equivalency allows Canadian out of province nursing students to also gain employment through these ESN positions.

The number of ESN positions within HAs vary with each annual budgetary cycle. Currently, ESN positions operate across most HAs and in diverse care environments in urban, sub-urban and rural contexts with significant variation in structure and support, and employment numbers. Variations in the availability of ESN positions and placement opportunities are governed by each HA and based on service area capacity to accommodate placements. Further, the ESN position is service determined, with employers and nurse supervisors deciding the extent of practice for each position. However, the necessary knowledge and skill prerequisites are taught in an educational context with no interface between the employed student and their working practice. RNs and employers set the conditions for the student to perform activities with consideration of the person's health status, preferences, and needs; the nature and complexity of the activities to perform; the level of supervision required; and identification of mechanisms that ensure the RN is aware of the care the ESN is delivering. While the ESN program is accepted to be a successful innovation that has benefited students, new graduates, employers, and the healthcare system in general, no further evaluation of this role has occurred since 2003.

The B.C. introduction of this employment model for students appears to be the first of its kind in Canada, with other Canadian jurisdictions following suit shortly after (Gamroth et al., 2006). At the

[5] ESN positions are available to students enrolled in registered nurse (RN) educational programs and ESPN positions are available to students enrolled in registered psychiatric nurse (RPN) educational programs. For simplicity, this report will refer to both these positions as ESN positions with the understanding that this covers both categories of students.
In the BC context, RNs provide in-hospital care to obstetrical patients. Midwives are primary care providers working in community-based practices providing pregnancy, birth and after delivery care, they hold hospital admitting and discharge privileges and can undertake deliveries at home or in hospital. There is no employed student program available to midwifery students.

[6] Students in this context refers to any student in a BCCNM-recognized entry-level or re-entry nursing, practical nursing, or psychiatric nursing education program. It also includes a student from the same type of program from an institution elsewhere in Canada, approved by that province or territory's regulator (BCCNM, 2025).

same time as the introduction of the B.C. program, a variation on this model involving a three-way partnership between the academic institution, employer, and student was also taking place in some states in the United States (Kee & Ryser, 2001). Australian jurisdictions began offering variations on this employment model in the late 2000's with most states now offering employment of some description to nursing and midwifery students (Lindsay et al., 2023). Other jurisdictions such as Ireland, New Zealand, and the UK also offer different forms of student employment with some of it in the form of a paid internship or preceptorship period (Lydon et al., 2024; Mitchell, 2020). ESN positions aim to consolidate learning, provide opportunities to experience different clinical environments, promote practice readiness, reduce transition to practice concerns post-graduation, reduce debt burden, and build a clinical practice community to support nurses in their early careers (Algoso & Peters, 2012).

Extrapolating from current RN workforce data and service providers' recruitment figures, it appears that almost 4% of the B.C. nursing workforce consists of ESNs. While the total number and duration of ESN positions have increased over the last decade, considerable variation appears to exist in the number, duration, and utilization of these positions across the different provincial HAs. ESNs are hired as casual staff similar to the time of the pilot project (Gamroth et al., 2006). The positions are funded through a combination of dedicated MoH allocations and HA operational budgets. In some cases, vacant position funding within HAs has been used to supplement provincial ESN funding, or to sustain, or expand opportunities. In periods of fiscal constraint, reductions in HA discretionary spending may indirectly affect the availability of ESN roles, as these positions can be vulnerable to budgetary reprioritization. Over the last decade, an increasing number of ESN positions have been developed in high vacancy areas with a view that ESNs will transition to new graduates in these settings, therefore the ESN roles function as both workforce development investments and operational supports. When ESN opportunities rely in part on vacant line funding, fiscal reductions at the HA level can disproportionately affect these positions, potentially weakening the recruitment and retention pipelines at a time when long-term workforce sustainability remains a provincial priority.

The ESN role is supernumerary, therefore its impact on nurse-patient ratios has not been explored; however, there are indications that it provides a positive contribution to the clinical workforce. Evidence from other jurisdictions shows that recruitment into these positions can be used to incentivize traditionally "tricky" areas to staff such as rural and remote settings and reduce staff shortages (Miller et al., 2025). ESNs are predominantly women resulting in genderized hiring practices; this is despite attempts to diversify the nursing workforce by increasing the pool of suitably qualified applicants from a heterogeneous population in terms of age, gender, and cultural background (Rusaanes et al., 2024; Salamonson & Andrew, 2006). While the distribution of nursing students by age group is not known across the province, we offer an example; approximately 35-40% of nursing students in the University of Northern British Columbia (UNBC) program are second career and mature-aged, often with dependents. This results in specific requests for ESN positions during their undergraduate educational trajectory. Other university programs are likely to have similar student

profiles. Evidence to inform successful ESN positions and generic retention rates post-graduation is limited (Wise et al., 2022). Evidence to support hiring ESNs into clinical "home community" settings to support longer-term retention is slowly emerging. Several studies suggest a strong correlation between the positive impacts of ESN programs and the factors contributing to better recruitment and retention (Cordon et al., 2025; A Kenny et al., 2021; Wise et al., 2022). However, there is a lack of definitive evidence to demonstrate a direct improvement in recruitment and retention rates or possible other benefits such as core baseline staffing retention or reenergizing of a workforce with the addition of the ESN to a unit. Further, the influence of the new graduate transition program (NGTP)[7] on hiring must also be considered, since how the ESN role and transition model work in tandem is unclear.

Across Canada and in B.C., it is well known that internationally educated nurses (IEN) wish to return to practice. With limited opportunities to access post-secondary re-entry education, IENs can quickly lose clinical skills, knowledge, and confidence. If we are to consider equity and inclusion, then including ESN positions within re-entry programs warrants consideration. There is scope to explore this as an opportunity to enhance IEN learning opportunities, explore IEN fit in units, and support IENs financially: all cited in the literature as key tenants of success (Sanders et al., 2025).

Additional challenges in the healthcare system have surfaced since the initial review of the ESN project in B.C., and these have also affected these positions. These include ESNs working in high acuity settings that have traditionally declined to employ ESNs, the increased use of advanced technology and telehealth, which highlights the need for ESNs to have an understanding of AI and technology in healthcare while demonstrating digital literacy (Erfani et al., 2025), and the need for preparation to work in rural and remote setting with Indigenous populations and marginalized communities, none of which have been examined within the ESN role. There has been a continued downward trend in available staffing, resulting in higher vacancy rates, which impacts opportunities for ESNs to be mentored and supervised in clinical contexts. During and after the COVID-19 pandemic, ESN positions, and similar positions for other cadres of health professional students, were implemented as a "surge" workforce with a role to support an evolving and continuing staffing crisis including a shift to allow work hours to count as clinical hours in formal programs (Baumann et al., 2024; Boggon et al., 2023; Cowley & White, 2021; Maas et al., 2021; Miller et al., 2025). While ESN roles expanded during COVID as part of broader workforce strategies, their ongoing value post-pandemic lies in strengthening transition-to-practice readiness, improving retention, and supporting rural recruitment.

Working in rural and remote contexts and with Indigenous populations provides an important opportunity for ESNs (Kenny et al., 2021). An Australian study highlighted how aligning educational curriculum with these opportunities could facilitate an extended, immersed placement experience

[7] The NGTP guarantees eligible new graduate nurses in B.C. a regular minimum 0.7 FTE position for at least six months, with streamlined hiring and structured mentorship support. The goal of this program is to stabilize workforce entry and strengthen retention across public health authorities.

(Algoso & Peters, 2012). The value of this has been demonstrated in the UNBC medical program which offers extended community-based placements to medical students (Winwood, 2023). With variations in nursing educational curricula, there are differing degrees of theoretical insight into primary and Indigenous health care, which is likely to influence ESN skills and opportunities in these areas (Bloomfield et al., 2015; Green et al., 2022). These variations, combined with the persistent narrative that acute care is the gold standard in the healthcare, leads to a situation where we can fail to encourage or prepare students for work in primary care, community care, and rural and remote settings should they choose this career path before, during, or post-graduation. Applying evidence and local experiences may open the door for the ESN role and clinical educational placements to be continuous, thereby providing an opportunity for ESNs to grow in confidence and skill, and deliver culturally competent and relational care in rural/remote or primary care contexts in a positive way. In addition, rural and remote clinical positions often include interprofessional relationships. This opens the opportunity to explore if and what a robust approach to supervising ESNs could look like for professions outside of nursing, where clinical and therapeutic skills overlap exists.

This project explores the current ESN role, and other employed healthcare student programming as it is implemented across B.C. and in other jurisdictions, to identify what changes may be necessary or beneficial to support a more robust and integrated program for the multiple partners associated with this career training resource. This work is to support and enhance B.C.'s *Health Human Resources Strategy, Create Accessible Career Pathways,* through its training objective: *Strengthen employer supported training models*, and specifically *Action 58, the HHR IPT Employed Student Nurse Program* (BC Ministry of Health, 2022). The identified knowledge gaps surrounding the ESN role, while varied, primarily focus on the need to develop a more robust, modern and innovative ESN program that could (re)align the relationships between the educational provider, employer, student employee, and regulator to liberate learning for ESNs, extend employment opportunities, and ensure viable and sustainable outcomes for all. This research can support discussion about early practice-readiness pathways for nurses and other health professions, including allied health.

4 RESEARCH OBJECTIVES

The aim of this research was to identify and examine the underlying principles and experiences that inform a robust ESN program, expose the social structures and mechanisms that shape these experiences, and identify possibilities for improvement and systems change. This work is designed to assist government, employers, educational institutions, and regulators to determine the direction and/or efficacy of actions that need to be undertaken to build quality, equitable, inclusive, and sustainable employed student experiences.

To achieve this aim, we had three research objectives:

1. To identify the architecture or structures that inform the employed healthcare student opportunities and placements across B.C., Canada, and internationally.
2. To understand the opportunities and challenges associated with employed student programs from the employer, regulator, union, and student lenses.
3. Propose draft changes or innovations that support a robust employed student program.

In pursuing these objectives, we remained cognizant of the broader political context surrounding the ESN program and gave careful consideration to the critical factors necessary for effective implementation in order to promote sustained success. We also acknowledged the inherent challenges associated with introducing change within complex environments.

This work was also designed to build on the original evaluative work undertaken following the introduction of the ESN role in 2001. In light of the findings from the original UVic research report (Gamroth & Lougheed, 2004), the limited evaluative work undertaken in the ensuing two decades, and the prevailing social narrative that ESNs have historically been used to address workforce gaps, we considered that it was important that we approach this work through a research paradigm that would allow us to examine power hierarchies. Starting from the primary evaluation, the analytical orientation was informed by critical theory (Morrow & Brown, 1994) since the ESN role sits within labour relations, regulatory governance, and publicly funded health systems. Early engagement with the UVic report data, associated papers, and the mapping of ESN or similar opportunities across Canada (Appendix 7) highlighted tensions around power, hierarchy, productivity norms, and vulnerability. Critical theory can provide a useful lens to surface these dynamics.

We followed a three-step approach with the first step informing the second, and then the findings from the second step being validated through an external advisory discussion. Firstly, we undertook an environmental scan and rapid review of existing peer reviewed and grey literature on employed student programs, including relevant policy and legislation, from nursing, midwifery, medicine, and allied health. As we progressed through this literature review, we began to question our initial assumptions and considered how our critical theory and methodological choices could create or limit space for alternative perspectives to emerge. As the literature analysis deepened, it became clear that the ESN role could not be adequately understood solely through a critique of power relations. As a team, we applied reflexivity because we wished to utilize this work as a genuine development opportunity. We agreed that we needed to explain and explore the health system structure, aware of the need to provide politically relevant and meaningfully informed workforce design and transition-to-practice reform in a constructive and system-oriented manner. To support this transitioning perspective, we (re)explored position, methodology, and methods, agreeing as a team to utilize narrative inquiry. Collecting ESN stories was the second phase to obtain employer, regulator, union, and student perspectives on employed student work. The use of narrative inquiry became central to how we generated and interpreted data, providing the empirical depth necessary for identifying

generative mechanisms. To strengthen our methodological coherence, we will briefly explain our shift towards critical realism.

Critical realism is used by many health science researchers to distinguish between what exists and is observable and how we come to know this, asserting that reality exists independently of our knowledge through the principle of intransitivity[8] (Archer et al., 2016; Reid, 2019). Therefore, our understanding of the ESN role at the individual and employer level is transitive, always partial, and shaped by social and operational, cultural and fiscal, and historical contexts (Danermark et al., 2019). Critical realism views events and systems in layers from what is observable (*empirical*), to what happens (or does not) (*actual*), enabling an understanding of the deeper mechanisms and structures that produce outcomes (*real*) (Danermark et al., 2019; Lawani, 2021; Reid, 2019). Critical realism assumes that while we can observe experiences and events, there are often hidden mechanisms and structures that shape what happens to generate or constrain care coordination. So, what it asks is what underlying structures and generative mechanisms produce the experiences we observed for ESNs and employers.

While we acknowledged the power structures and norms that exist with the ESN role, we were equally interested in identifying and understanding the generative mechanisms embedded within the role such as workforce pressure, regulatory ambiguity, and workplace socialization. Using critical realism allowed the study team to move beyond individual blame or ideological critique and instead identify the structural mechanisms that generate both the strengths and tensions of the ESN role. This then positions reform as a shared system redesign effort rather than an adversarial correction. Overall, our theoretical shift reflected a movement from interpretive critique toward explanatory system design. The shift strengthened methodological coherence and enhanced the practical relevance of the research while maintaining attention to issues of equity, vulnerability, and institutional power. Through this approach, we illuminate the systematic changes necessary to support ESNs, examine curriculum gaps, and explore the feasibility of work-based assessment methods that could be utilized when an RN, NP or RPN may not be consistently present in the clinical context. The role of PSIs, faculty, clinical supervisors and supportive technology is also discussed. Ethical approval for this research was obtained from the B.C. Harmonized Research Ethics Board, approval # H25-00669, and operational approval was obtained from all health authorities that agreed to participate.

Early investigations for this work involved a preliminary literature search utilizing Scopus, Cochrane and JBI (Joanna Briggs Institute for Evidence-based Healthcare) databases to identify any current or in-progress systematic or scoping reviews relating to the topic “employed nursing student”. Three reviews were found, all scoping reviews, one focused on pre-registration paid employment for nurses covering the period 1995 – 2013 (Phillips et al., 2016), a more recent review on the same topic but

[8] Intransitivity in critical realism refers to the idea that reality exists independent of our knowledge of it. In this study, the key point is that structures, mechanisms and causal power exist whether or not we observe them, while our interpretation does not create reality, we are trying to describe it.

only relating to the Australian context (Lindsay et al., 2023), and the third on models of practice education (Budgen & Gamroth, 2008). None of these were current enough or covered the breadth of the topic that was required for this study; however, these investigations noted that employed healthcare students can be referred to by many terms. Table 1 summarizes the terms used in different jurisdictions.

Table 1 Terms used for employed healthcare students

Term	Location
Employed Student Nurse (ESN) Previously known as Undergraduate Nurse (UGN) in the evaluation of original pilot study	British Columbia
Undergraduate Nurse Employee (UNE)	Alberta, Manitoba, Yukon
Continuing Care Assistant (CCA)	Saskatchewan
Clinical Extern (CE) Title can be used by nursing, physiotherapy and occupational therapy students	Ontario
Externat (Extern)	Quebec
Undergraduate Student Nurse (USN) Undergraduate Student Nurse/Midwife (USN/M)	Nova Scotia Australian Capital Territory (Canberra, Australia)
Undergraduate Student in Nursing/Midwifery (USiN/M)	Australia - Queensland
Assistant in Nursing/Midwifery (AIN/M)	Australia - New South Wales. South Australia, Western Australia,
Registered Undergraduate Student of Nursing/Midwifery (RUSON/M)	Australia - Victoria, Tasmania, Northern Territory
Healthcare Assistant (HCA)	New Zealand United Kingdom (UK)
Extern Apprentice	Some states in United States of America (USA)

Environmental Scan and Rapid Review of the Literature

An international environmental scan was completed to attain a snapshot of current ESN job descriptions, employment opportunities, and existing evaluation mechanisms. The focus of the rapid review of the literature was to identify what is currently known about the extent, challenges, and successes of healthcare student employment, in particular for nurses, and the implementation of these types of positions in rural, remote, and Indigenous contexts. Five research questions were developed to guide the environmental scan and rapid review of the literature.

1. What types and contexts of student employment programs, or similar pathways, exist domestically or internationally to provide opportunities for health professional students to work in healthcare settings to support practice readiness and enhance intentional recruitment and retention?
2. What challenges and supports (barriers and facilitators) are experienced in these employment programs from the perspectives of students/participants, employers, regulators, professional associations, governments, other partners (e.g. local communities, etc.)?
3. What role, if any, do educational providers/faculty have in relation to these programs?
4. What measures are used to determine the effectiveness of these employment programs and how successful are they?

5. What are the challenges and supports (barriers and facilitators) associated with rural, remote and Indigenous clinical placements? How would these impact on student employment programs?

Narrative Inquiry Interviews

The focus of the interviews was to obtain employer, regulator, union, and student perspectives on employed student work. Lists of critical areas for conversation with employers, ESNs, and regulator, and union representatives were developed from the literature review and circulated amongst the team members for input. Then through a narrative inquiry interview, participants were invited to describe their experiences with the role as *episodes*—with beginnings, turning points, and outcomes, and to express not only what happened, but what it meant to them.

Advisory Consultation Group

The advisory consultation group (ACG), comprised of purposely invited participants from each partner group, was designed to discuss and further explore perspectives on the ESN program, opportunities emerging from the findings of the interview study, and provide feedback and recommendations.

5 RESEARCH METHODOLOGY

5.1 ENVIRONMENTAL SCAN

The environmental scan was conducted using internet searches for employed student nurse/midwife[9] positions and associated regulatory requirements for jurisdictions in Australia, Canada, Ireland, New Zealand, Singapore, the UK, and the USA.

5.2 RAPID REVIEW OF LITERATURE

The rapid review of the literature was conducted following the PRISMA systematic review guidelines, modified and simplified to be more consistent with that recommended by the WHO *Rapid Reviews to Strengthen Health Policy and Systems: A Practical Guide* (Smela et al., 2023; Tricco et al., 2017). The inherent components of a rapid literature review identified by Smela et al. (2023) include shortened timeframe, usually no more than 12 weeks, clear research question, search protocol, simplified processes for study selection and data extraction, and quality assurance: all were followed in this review. A research protocol was developed based on the PICO framework (population, intervention, comparison, and outcome) with specific inclusion and exclusion criteria. Table 2 provides the PICO framework used for the rapid review.

Table 2 PICO Inclusion and Exclusion Criteria

	Include	Exclude
Population	• nursing, midwifery, allied health, medicine or dentistry students • not registered/licensed to practice without supervision	• professionals who are already regulated in a profession, e.g. students progressing from LPN to RN, EN to RN, RN to NP
Intervention	• must be paid for work time in clinical areas • position must be in field of professional study • positions can supernumerary and non-supernumerary • paid position can be regulated or not regulated (e.g. nursing or other profession assistant)	• clinical work time that is required by educational program, e.g. required practicums, however named (e.g. maybe called internship, residency, etc.), paid or unpaid • employment that is not in the field of professional study

[9] Australia offers three types of nursing/midwifery programs – Bachelor of Nursing (BN) - 3 years (has no maternity/midwifery education included), Bachelor of Midwifery (BM) – 3 years; BN/BM - combined nursing and midwifery program (4-years). Vast majority (95%) of midwives are not independent midwives as comparable to a Canadian or New Zealand educated midwife; they are employed in hospital-based maternity units in a role similar to an obstetrical nurse with on-site medical oversight.

Comparison	• Students who did not undertake an ESN role, e.g. did only minimum required general placements and practicums • Include concepts associated with employment of student professionals • Use of rural/remote clinical settings for employment • Determination of scope of professional activities that can be included role, including concept of entrustable professional activities (EPA)	• Mandatory clinical practicums
Outcome	• Descriptions of types & contexts of programs • Challenges/barriers, supports, measures of effectiveness and success from perspectives of participants, employers, regulators, professional associations, governments, other partners (e.g. communities) • role/responsibilities of educational facilities in programs	Does not address factors relating to success from any of the identified perspectives - student, employer, educational provider, regulator, government
Study Characteristics	• Literature published since 2000 • Literature from any country, English speaking or non-English speaking	• Literature published prior to 2000 • Literature not published in English
PICO Exclusion reasons	Wrong Population Is not an employed pre-registration healthcare student Wrong Intervention Is not paid work in a healthcare setting Wrong Comparison Is required clinical practicum or required work time only Wrong Outcome Does not address or include factors that impact success of the role	

Due to project time constraints the protocol was not published. The protocol was registered with Open Science Framework https://osf.io/4be5t .

Using the services of a health librarian, a search strategy was developed, then reviewed, and finalized by the research team. As per guideline recommendations the search strategy focused on population and intervention criteria from the PICO framework (Frandsen et al., 2020). The search terms utilized are provided in Appendix 2. The databases Cumulative Index to Nursing and Allied Health Literature

(CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), Educational Resources Information Centre (ERIC), and Cochrane Systematic Reviews were searched for primary research studies (qualitative, cross-sectional, case studies, systematic and scoping reviews, mixed methods, dissertations and narrative/opinion pieces) published between 2000 and 2025. Publications were limited to English language. Grey literature was located using website searching and reference lists of included papers were also searched for additional studies.

Following searching, all identified peer review citations were entered into *Covidence* systematic review software (Veritas Health Innovation, Melbourne, Australia www.covidence.org) where duplicates were removed, and titles and abstracts were screened by one of two reviewers (AR, LN) against the PICO framework inclusion criteria for the review. Potentially relevant studies were then retrieved in full and assessed in detail independently by two assessors (AR, LN) using an extraction template developed from Covidence Extraction Tool 2 (Appendix 3). The extraction template addressed publication metadata which described the basic attributes of the article, characteristics of the study and participants, and findings such as key problems and challenges, indicators of success, and recommendations. Any disagreements in data extraction that arose between the reviewers were resolved by discussion. Studies that did not meet inclusion criteria were excluded, reasons for exclusion are provided in the Findings section (See Figure 1 Search results and study inclusion process). A template for grey literature data extraction was developed from the Covidence Extraction Tool 2 and the data extracted by one assessor (AR).

All included peer reviewed studies were assessed for methodological quality by three assessors (AR, AT, LN) using JBI Critical Appraisal Checklists (JBI Global, 2024) specific to the study type. The critical appraisal checklists used included qualitative research, analytical cross-sectional studies, systematic reviews and research synthesis, case report, cohort studies, and textual evidence: expert opinion. All studies, regardless of the methodological quality were included in the findings of the rapid literature review. The findings of the quality review are presented in Appendix 4.

The data extracted from the peer reviewed and grey literature were then independently synthesized by two reviewers (AR, CS) into dominant themes based on the main headings in the data extraction framework. This was then reviewed by all members of the research team.

5.3 NARRATIVE INQUIRY INTERVIEWS

The purpose of a narrative inquiry interview is to explore and understand the individual's lived experience with a particular event or action including their personal challenges, relational dynamics, and the impact the experience had on their transformation and growth (Kartch, 2017; Muller, 1999). The interview focuses on eliciting *stories*, *sequenced events*, *meaning-making*, and *personal identity formation* by having the participant describe their experiences as episodes where they recount chronological stories ("When I first started… then I moved to…"), describe turning points ("That was

when my confidence changed…"), share critical incidents (e.g., first high-acuity patient, first night shift) and reflect on how they felt and what that meant to them in their educational and professional journey. Unlike other types of interviews, the interviewer undertakes a facilitation role, not a controlling one, deploying narrative principles that positioned them as a listener, meaning facilitator, and encourager of elaboration - using reflective probes, affirmation, and invitations to expand stories (Anderson & Kirkpatrick, 2015; Polkinghorne, 1995). Using this style of interview allowed the researchers to explore and identify how the ESN role impacted on the student's journey to becoming a nurse, and elicited the employer's responses and opinions in relation to the program.

Based on the findings from the environmental scan and the literature review, semi-structured questions for ESNs, employers, the regulator, and union representatives were developed. The questions were reviewed, refined, and agreed to by the research team members (See Appendix 5 for interview questions). The questions, study information, and consent form were shared with the participants a minimum of 72 hours before a scheduled interview. The interviews were undertaken using Microsoft Teams and Zoom videoconferencing software, including simultaneous recording and transcription. The ESN interviews lasted an average of 28 minutes with a range of 18 to 50 minutes, while the employer, BCCNM, and BCNU interviews lasted an average of 31 minutes with a range of 15 – 53 minutes.

The interviews followed a semi-structured approach with the interactional patterns, question framing, and participant responses aligned with narrative inquiry principles. The majority of the interviews were undertaken by one researcher (CS) with a few being undertaken by a second team member (TH). Transcripts of the interviews were reviewed and cleaned by one of two team members (CS, AR), then coding and thematic analysis was undertaken to identify the dominant key concepts, categories, and themes by one team member (AR). These findings were then reviewed and confirmed by the principal interviewer (CS).

The researchers conducted their analysis of the interview dataset using a critical realism lens to elucidate the experience of the ESN role at three distinct but interconnected layers: *empirical* or observed experiences, *actual* or what happened – observed or not, and *real* – the underlying generative mechanisms, structures and causal powers that explain why the patterns of events have happened. This was then utilized to explain how macro-level forces at the HA and PSI level shape micro-level experiences of the student and employer staff member (Lawani, 2021).

To recruit participants for the interviews, both ESN and employer, contact information for each of the seven HAs[10] and Providence Health Care's ESN programs[11] were obtained from the B.C. MoH, with one of the research partners also providing a list of contact names. Each HA's ESN program lead was emailed, and meetings were held to share information relating to this research, garner support, ensure local operational approval was correctly obtained, and ensure the researchers had the correct individuals to use to initiate the recruitment process. At this stage, seven of the eight HAs agreed to participate, with one declining because their ESN program was still under development with no employees yet, however they participated in other phases of this research.

Formal invitations to participate were sent to the seven HAs with two sets of follow up emails for those that did not reply within 2 weeks and 1 month. One research partner (RM) also attended the provincial ESN leadership meeting and advocated for participation in the study, which resulted in successful recruitment of all HAs. The interview questions were shared with the HAs and following their feedback both ESN program leaders and operational leaders were invited to participate in interviews to obtain multiple perspectives. This resulted in an increase from the original recruitment plan to include a minimum of one ESN program lead, one operational lead, and two ESNs from each HA. HAs then emailed study information to their operational leads and ESN employees who then responded directly to the research team to confirm their interest in participating.

At the same time as this research was being undertaken, BCCNM was conducting their own separate research on the ESN role. BCCNM sent an invitation to participate in their study to every ESN currently registered to practice who had opted to participate in ongoing research activities: their invitation also included a link to this research project with an invitation to participate. In addition, BCNU put an announcement and invitation to participate in their regular newsletter. Interested participants from either of these sources contacted the research team directly to participate.

Research team members who were faculty at educational institutions also provided information to students at their institutions about participating in the research project, however participation

[10] BC health care system is built around seven government HAs and the Denominational Health Association which operates Providence Health Care. The five of the seven HAs are based on geographical regions, and two provide provincial-wide services. The two provincial- wide service agencies are:

1. Provincial Health Services Authority which provides services such as cancer care, specialized obstetrical and pediatric services, correctional services, emergency response, specialized mental health and addictions, digital health records, and the provincial centre for disease control.
2. First Nations Health Authority - A specialized service for First Nations peoples focusing on primary care and mental health services that blends traditional healthcare with western medicine, is guided by Indigenous knowledge, and works towards a vision of healthy, self-determining, and vibrant First Nations communities.

Providence Health Care works in partnership with Vancouver Coastal Health and Provincial Health Services authorities to provided acute and long-term services in the Vancouver area.

[11] For simplicity in referring to the ESN employers in this report, the participating HAs and Providence Health Care will all be referred to just as health authorities (HAs).

information was not provided to all educational institutions as the response rate from the other recruitment processes had provided more than the required number of participants.

BCCNM and BCNU were contacted directly by the research team and representatives from each organization were interviewed relating to their involvement with the ESN role in the province.

5.4 ADVISORY CONSULTATION GROUP

The findings were then presented to the ACG for discussion, confirmation, and feedback. One meeting of this group was held with 14 purposively selected individuals invited representing ESN employers (HAs), PSIs, ESNs, BCCNM, BCNU, and the author of a graduate policy student report exploring aspects of the PSI/HA relationship as they relate to ESN roles and transition to practice[12]. At the same time, or just prior to this research, there were three other research programs focusing on the ESN program being undertaken in B.C. or Canada-wide in which B.C. respondents participated. These research programs included: 1) BCNU bargaining research[13] and a BCNU/CNSA student study[14]; 2) BCCNM research associated with the upcoming transition to the new Health Professions and Occupations Act (HPOA) and how this will impact on the ESN role; and 3) a B.C. MoH graduate policy student internship report exploring the current relationships between PSIs and HAs in relation to the ESN role and transition to practice. The very high-level findings from all this work, plus questions for discussion, ideas for consideration, and a request for feedback, were provided to the ACG members through a briefing report emailed one week prior to the meeting (See Appendix 6 – *Advisory Consultation Briefing Report*). The members were invited to respond both in writing to the research team and at the videoconferencing meeting held using Microsoft Teams.

The findings from all these phases are presented in the following sections: 6) environmental scan, 7) rapid review of the literature, and 8) narrative interviews and advisory consultation group. These findings were then used to identify opportunities for transformative reform at the system level presented in 9) discussion, 10) limitations of report, and 11) recommendations and conclusions.

[12] The HA and PSI invited participants were selected based on each HA having a voice twice in this project, either through this research or the policy student report, and all PSIs having a voice through these two projects.
[13] BCNU is currently in negotiations with HEABC for a new collective agreement for all nurses employed in the B.C. public health care system and this research was associated with their negotiation requirements.
[14] This is a nation-wide study of student nurses in relation to financial, employment, educational and wellbeing concerns.

6 FINDINGS – ENVIRONMENTAL SCAN

6.1 SEARCH RESULTS

Environmental scan internet searching was focused on the type and context of employed student nurse/midwife positions, requirements for these positions, whether they were a regular employee or supernumerary, requirements to be registered or licensed with the jurisdictional regulator, where the student could work, and the extent of the scope of the role. Only a small number of USA states were searched, limited information was found, and the findings are based on published studies and surveys. The searching yielded news items, position advertisements and descriptions, regulatory and/or governmental policies, and fact sheets.

6.2 KEY FINDINGS

The key findings from the environmental scan are listed below with the full findings of the scan presented in Appendix 7.

- All seven countries offered some form of employment position for students enrolled in nursing or midwifery pre-registration education. Some countries offered positions for other types of healthcare students.
- The majority of these positions have become available in the past five years with some in the USA dating back to the 1990's.
- Australia and most Canadian jurisdictions have specific educational requirements for employed students, e.g. must have completed a certain number of years of formal education before employment. Other jurisdictions do not state educational requirements.
- Australian jurisdictions hire students as either an *assistant/aide* or a *registered undergraduate student in nursing (or midwifery) (RUSON/RUSOM).* Both positions are governed by a position statement developed by the Australian Nursing & Midwifery Federation (union).
- Most Australian and Canadian positions are supernumerary; some aide roles are unclear.
- Only the Canadian provinces/territories of B.C., Quebec, and the Yukon require the student to be individually registered with their jurisdictional regulator.
- Depending on the jurisdiction, students may be employed in acute care, community or long-term care settings.
- The extent of the scope of the role or practice[15] varies with jurisdiction and employer, can range from aide duties only (most Australian jurisdictions) to being able to undertake restricted activities under supervision from an RN, RPN or NP (most Canadian jurisdictions).

[15] The term 'scope of practice' is used differently across the different jurisdictions. In Canadian jurisdictions the term officially refers to the jurisdictionally legislated scope of the professional role and is usually described through practice standards and specified legally restricted activities. E.g. ESNs have no scope of practice as they

- Ireland requires all students to undertake a 36-week paid final clinical internship as the 4th year of the educational program. These students are regular salaried members of staff and receive 80% of the first-year RN salary. Completion of this internship is a requirement for registration with the Nursing and Midwifery Board of Ireland.
- New Zealand, Singapore, and the UK offer positions as unregulated health care assistants.

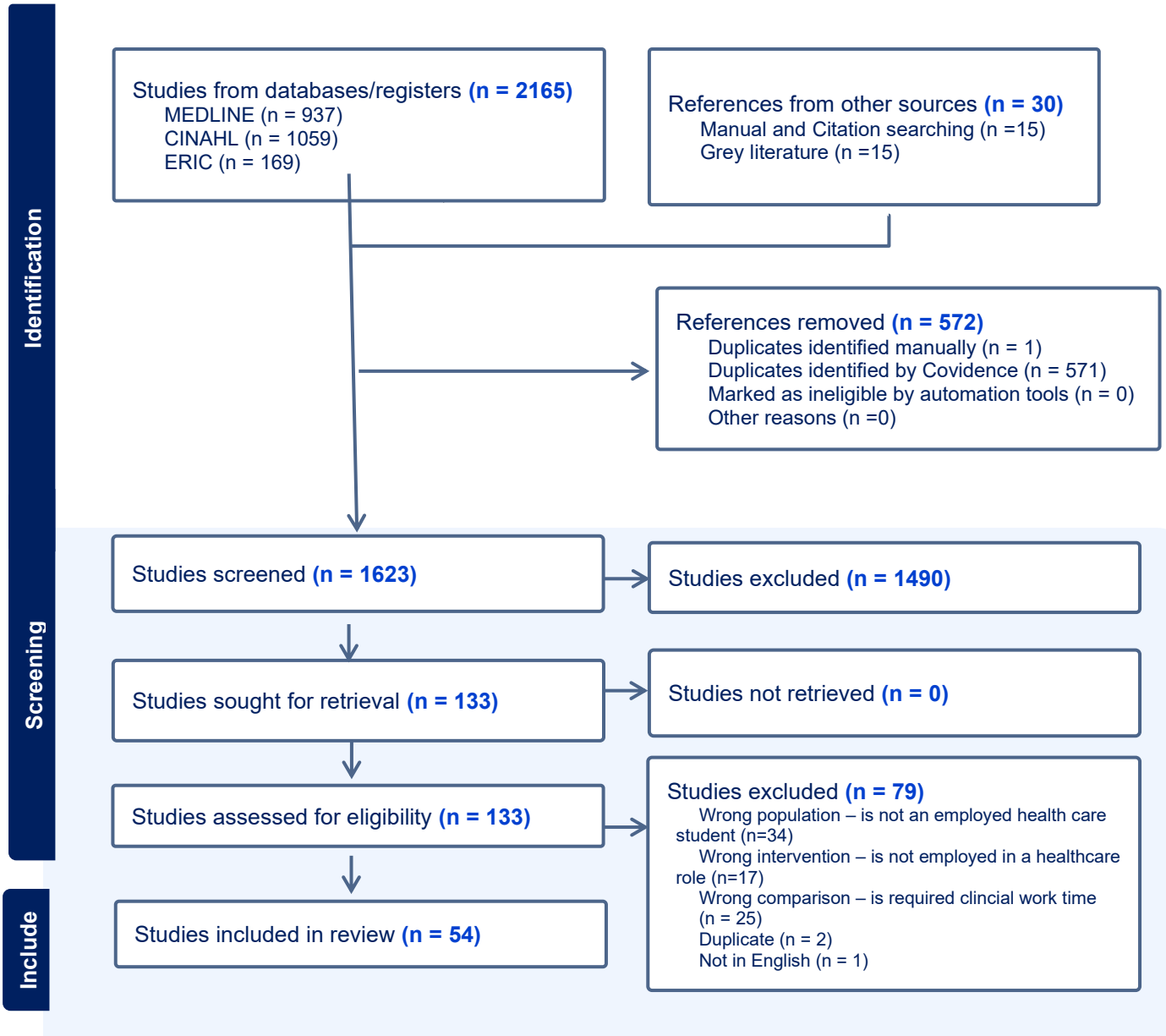
have no legal authority to practice without supervision. In Australian jurisdictions, scope of practice refers to what the practitioner is permitted to do within their position description and duties and exclusions list.
In this report we will use the term 'scope of practice' to refer to the **enacted role** undertaken by the employed student as this is the way it was routinely expressed in both the included literature and in the data obtained through the interviews. It is acknowledged that the use of the term in this manner is not consistent with its official use in BCCNM regulations, however, to protect the integrity of research data we will use the term in the manner in which the participants used it.

7 FINDINGS – RAPID REVIEW OF LITERATURE

7.1 SEARCH RESULTS

The search strategy yielded a total of 2,165 articles from Medline, CINAHL and ERIC, plus 30 from grey literature and manual citation searching. Cochrane Systematic Reviews identified no literature. Following removal of duplicates, and the use of the PICO inclusion/exclusion criteria, 54 articles remained for inclusion in the rapid review. See Figure 1 for search results and study inclusion processes. Appendix 8 provides a full listing and summary of all 54 articles included in the review, including their study aim and key findings.

Figure 1 Search results and study inclusion processes



The included studies came predominantly from Australia (46%), followed by Canada, the USA, and the UK. Approximately 1/4 of all literature were either case studies or grey literature, with cross-sectional surveys, scoping and unspecified literature reviews, mixed methods, qualitative interviews, cohort studies, and narrative text and opinion pieces making up the remainder. The included grey literature was composed of six commissioned evaluation reports; five regulator policy directives and fact sheets; three duty, guidance, and implementation documents; and a master's thesis. Most of the included literature was quite recent with 2/3 published in the last 10 years and 54% in the last five years. Figures 2, 3, and 4 provide summaries of the source countries, study types, and year published for this literature.

Figure 2 Source countries of literature

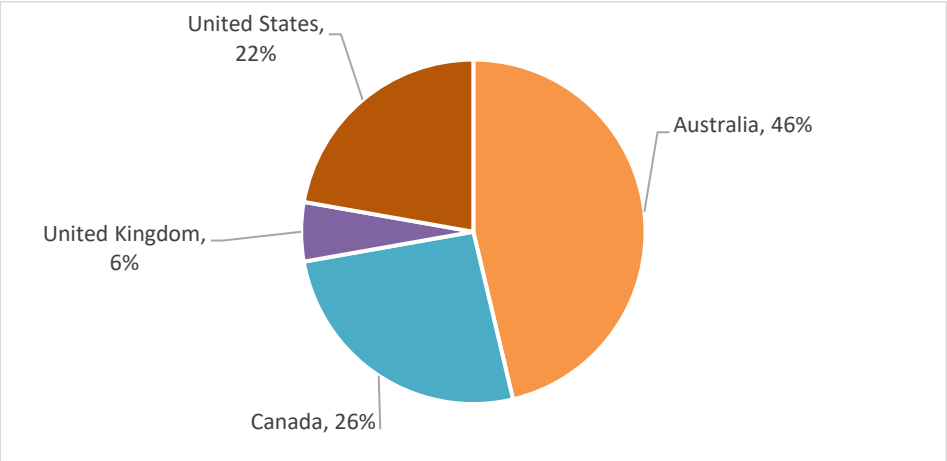


Figure 3 Study types of literature

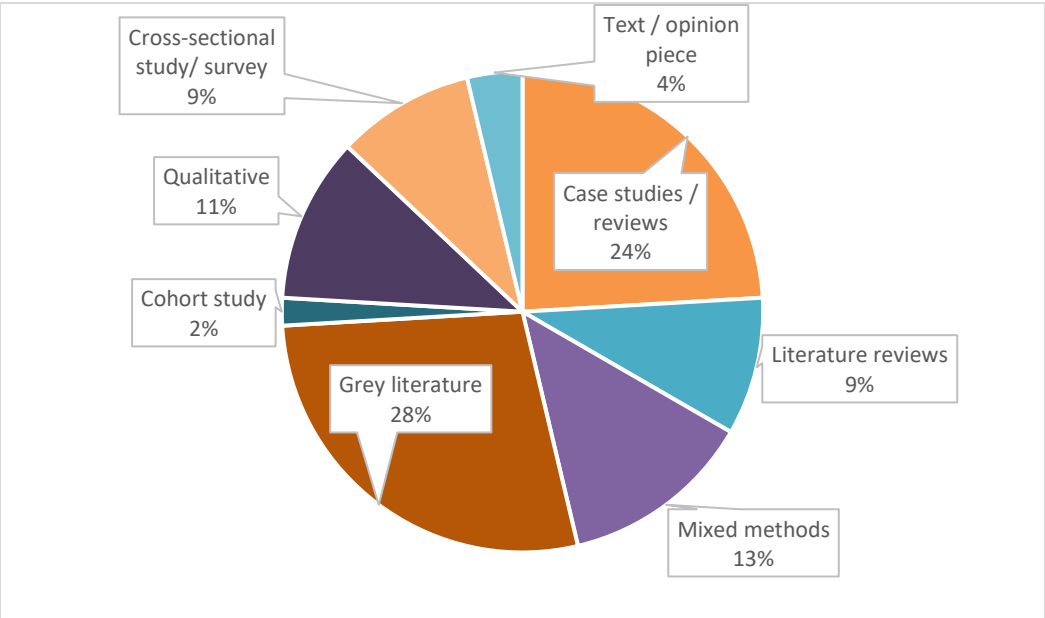
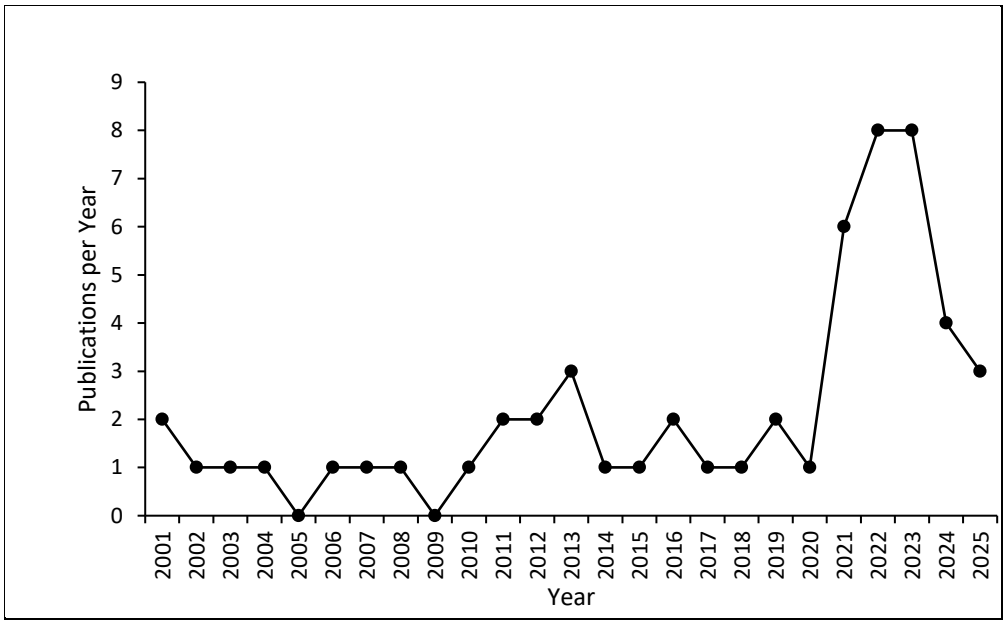


Figure 4 Articles published per year



All peer-reviewed studies were assessed for methodological quality using JBI critical appraisal tools (Appendix 4). The grey literature was not assessed for methodological quality. The findings from these methodological reviews showed that the majority of studies were of high quality with only a few criteria consistently missing. These missing criteria were:

- Qualitative research – In most cases there was no stated philosophical perspective, therefore it was not possible to determine congruity between this and chosen research methodology. In many cases there was no statement locating the researcher culturally or theoretically, and few studies addressed the influence of the researcher on the research or vice-versa.
- Cross-sectional studies – The cross-sectional studies were generally of high methodological quality. It was difficult to identify any confounding factors that would have influenced the study population and questions, as a result these quality questions were viewed as not applicable in this review.
- Case reports – The case report category was used for the published individual program reviews and evaluations. As a result, some of the standardized questions on this checklist did not apply to a program evaluation or in specific cases to financial evaluations of programs. In some cases, the evaluation methodology for determining the outcomes was not well described.
- Systematic reviews and research synthesis – In no cases was the likelihood of publication bias assessed in the studies' review processes.
- Cohort study – There was only one cohort study included in the rapid review. This was a prospective observational cohort study which made matching the methodological quality criteria to the study information difficult.

- Text/Expert opinion pieces – These pieces showed a high level of methodological quality across the expected criteria.

7.2 KEY FINDINGS

The analysis of the rapid literature review identified seven main themes with several sub-themes under some of the main themes. The main themes were:

- Motivations for employment;
- Benefits for students;
- Benefits for patients;
- Benefits for healthcare organizations;
- Challenges and limitations;
- Relationship with educational institutions; and
- Key factors for success.

These key findings under each of the themes are described below.

Motivation for employment

- Provided much needed financial assistance to students
  - More than 50% of students needed to work while in their student role, and engaging in healthcare employment was seen as more advantageous than other forms of employment such as hospitality and retail (Budgen & Gamroth, 2008; Hasson et al., 2013; Kee & Ryser, 2001; Kenny et al., 2021; Lokmic-Tomkins et al., 2021; Maas et al., 2021; McDermott & Lewis, 2025; Phillips et al., 2016).
- Provided increased clinical exposure (Algoso & Peters, 2012; Boggon et al., 2023; Kee & Ryser, 2001; Maas et al., 2021; Phillips et al., 2016; Wallace, 2016).
  - "… first time in my [profession] training that I have felt of value or that 100% of my time is being used to maximum efficiency. I am constantly learning and working within the team to ensure patient care is central" (Boggon et al., 2023 p.2).

Benefits for students

- Contributed to the development of knowledge, skills and confidence, and socialization to professional practice, role development, and standards (Ahern et al., 2023; Steen et al., 2011; Wallace, 2016).
  - Improved time management, management of deteriorating patient, management and care for pressure areas, basic observations and vital signs, effective communication, wound management, using aseptic technique, and more advanced technical skills (Algoso & Peters, 2012; Cordon et al., 2025;

Gamroth & Lougheed, 2004; King et al., 2022; Lokmic-Tomkins et al., 2021; McBrearty et al., 2024; Sweet et al., 2023; Wise et al., 2022).

- Developed a sense of 'belonging' (McLachlan et al., 2011; Muir, 2023; Mumford et al., 2023; Sweet et al., 2023; Willetts et al., 2022).
- Developed more respect, value, and autonomy (Algoso & Peters, 2012).
- Able to work as part of a healthcare team: Very different experience to being a student (Algoso & Peters, 2012; Burns et al., 2022; Cordon et al., 2025; Gamroth et al., 2006).
- Helped with transition to professional role (McDermott & Lewis, 2025; Roush et al., 2021).
- Provided exposure to other roles and practice options, e.g. research, leadership, education (Cepanec et al., 2013; Souder et al., 2012).

Benefits for patients

- Improved patient experience by providing direct care, more time, another pair of eyes (Ahern et al., 2023; Budgen & Gamroth, 2008; Cordon et al., 2025; Gamroth et al., 2006; McGillion et al., 2022; Mumford et al., 2023; Raffelt, 2018; Sweet et al., 2021, 2023).
- Substantially contributed to minimising harm to patients during COVID (Beccaria et al., 2024; Boggon et al., 2023).
- Strong evidence of patient/client satisfaction with the role (Kenny et al., 2019; Sweet et al., 2021).
- Significant impact on patient safety, particularly in rural health services (Kenny et al., 2019; Stout et al., 2015).

Benefits for healthcare organizations

- **Financial benefits**
  - Cost savings from reduced use of overtime (Amerine et al., 2017; Gillian et al., 2024).
  - Required less time for transition to practice, even when hired into speciality areas, e.g. emergency and intensive care (Gamroth & Lougheed, 2004; Gillian et al., 2024).
  - Eliminated the need for agency personnel (Gregory et al., 2014).
  - Reduced orientation time from 12-16 weeks to 10.5 weeks, net saving over 2 years $216,993 (Roush et al., 2021).
  - Reduced recruitment costs, e.g. saving $600,000 over 26 positions (Stout et al., 2015).
  - Program cost-effective with positive return on investment (Roush & Opsahl, 2023).

- **Staff benefits**
  - Enabled clinical staff to more effectively to manage heavy workloads, able to 'special' patients as needed (Ahern et al., 2023; Beccaria et al., 2024; Boggon et al., 2023; Chow & San Miguel, 2010; McGillion et al., 2022; Raffelt, 2018; Sweet et al., 2021, 2023).
  - Positive staff satisfaction, increased staff and unit morale (Amerine et al., 2017; Budgen & Gamroth, 2008; Gamroth et al., 2006; Mumford et al., 2023).
  - Enabled clinicians to refresh own practice (Budgen & Gamroth, 2008; Gamroth et al., 2006; McLachlan et al., 2011).
- **Transition to practice**
  - Facilitated and expedited transition to practice (Budgen & Gamroth, 2008; Cordon et al., 2025; Gamroth & Lougheed, 2004; Gillian et al., 2024; King et al., 2022; Maas et al., 2021; McBrearty et al., 2024; McGillion et al., 2022; Wise et al., 2022).
- **Recruitment**
  - Encouraged recruitment through being internal applicants (Cordon et al., 2025; Lokmic-Tomkins et al., 2021; McDermott & Lewis, 2025; Roush et al., 2021).
  - Facilitated recruitment into specialized/difficult to fill areas (Happell & Gough, 2007; McLachlan et al., 2011; Souder et al., 2012; Wise et al., 2022).
  - Key strategy for regional/rural recruitment (Kenny et al., 2019).
- **Retention**
  - Improved retention rates (Amerine et al., 2017; Kee & Ryser, 2001; Stout et al., 2015).
- **Career path development**
  - Created interest for students in new/different areas (Browne et al., 2013; Cepanec et al., 2013; Cordon et al., 2025; Happell & Gough, 2007; McDermott & Lewis, 2025; Souder et al., 2012; Wise et al., 2022).

Challenges and limitations

- **Scope of practice**
  - Role and scope of practice was inconsistent between different employers, wards and individual clinical staff (Ahern et al., 2023; Algoso & Peters, 2012; Burns et al., 2022; Lindsay et al., 2023; McBrearty et al., 2024; McGillion et al., 2022).
  - Work was often at level of aide or assistant, limiting learning and decreasing interest in future employment (Burns et al., 2022; Crevacore et al., 2019; Hasson et al., 2013; Lokmic-Tomkins et al., 2021; McBrearty et al., 2024).
  - Scope of practice needs to increase with progression through education program (Algoso & Peters, 2012; Amerine et al., 2017; Kenny et al., 2019; Mumford et al., 2023; Raffelt, 2018; Sweet et al., 2021).

    - Increased role clarity and expanding scope of practice leads to greater satisfaction with role (Amerine et al., 2017; Beccaria et al., 2024; Boggon et al., 2023; Sweet et al., 2021).
- **Skill / competency level**
    - No formal means of measuring or ensuring competency, need formal accreditation process to ensure quality and safety (Algoso & Peters, 2012; Gamroth & Lougheed, 2004).
- **Work/Study balance**
    - Challenges balancing clinical placements with study requirements (Boggon et al., 2023; Phillips et al., 2016; Wise et al., 2022).
    - More than 16 hours work per week leads to negative impact on academic performance (Phillips et al., 2016; Wise et al., 2022).
- **Supervision**
    - Concerns related to support and provision of supervision (Lindsay et al., 2023; Lokmic-Tomkins et al., 2021; Mumford et al., 2023).
- **Limited evaluation of the role** (Happell & Gough, 2007; Lindsay et al., 2023; Muir, 2023; Mumford et al., 2023).

Relationship with educational institutions

- Role needs to be developed in partnership and collaboration with the educational institutions (Ahern et al., 2023; Beccaria et al., 2024; Boggon et al., 2023; Crevacore et al., 2019; Gamroth & Lougheed, 2004; Gregory et al., 2014; Lindsay et al., 2023).
- Formal educational institution recognition of the role should be considered (Ahern et al., 2023; McDermott & Lewis, 2025).
- Position plays an important role in bridging the theory to practice gap (Algoso & Peters, 2012; Gregory et al., 2014; King et al., 2022; Phillips et al., 2016; Wallace, 2016).

Key factors for success

- Clarity of scope of practice important success factor (Beccaria et al., 2024).
- Requires commitment and support from whole healthcare team (Chow & San Miguel, 2010; Willetts et al., 2022).
- Need a formalized support person for position (Cordon et al., 2025; McGillion et al., 2022; Raffelt, 2018).
- Role ambiguity, e.g. dual roles as both student and employee, needs to be understood and supported (Hasson et al., 2013; Raffelt, 2018).

7.3 OUTCOMES AND THEMES

The key outcomes and themes from the rapid literature review findings were:

1. The position offered a range of benefits for all the main partners: Students, employers/staff, and patients.

2. The scope of practice associated with the position was the most significant and commonly identified challenge. The scope needs to be better understood and aligned to adjust to the progressing level of the student knowledge and skill.
3. For the majority of programs there was little to no involvement or relationship between the educational institution, student, and employer: This was identified as a problem and stronger collaboration and coordination are required to ensure better outcomes for all.
4. Despite the reasonably widespread uptake of the role, there has been limited fulsome evaluation of the role with almost no longitudinal data, and many studies being descriptions of individual programs with little evidence on the impacts on recruitment, retention and long-term sustainability.
5. The use of the program in rural and remote areas and with Indigenous populations needs to be further explored.

These outcomes and themes were then taken forward and integrated into the development of the interview study. The interview study findings are presented in the next section.

8 FINDINGS – NARRATIVE INTERVIEWS AND ADVISORY CONSULTATION GROUP

From the multiple sources of recruitment, a total of 43 interviews were undertaken with ESNs, and HA, BCCNM, and BCNU representatives.

8.1 INTERVIEW RESPONDENTS

8.1.1 ESNs

The original recruitment plan for ESNs included recruiting a minimum of two ESNs from each participating HA, therefore at least 14 ESNs across the province. However, we were very interested in obtaining information from as wide a variety as possible of employment contexts, so we continued accepting ESN respondents beyond the original 14 with a particular emphasis on community, and rural and remote role locations. Recruiting a wide variety of ESNs participants was more challenging than expected with the response rate from each of the different recruitment pathways being small. While we are not aware of exactly how many ESNs were invited to participate we do know that each HA emailed the invitation to their ESN employees, BCCNM included the invitation and link in their own email to all ESNs registrants whom had opted to be on their research related email list (estimated to be more than 700 persons), and BCNU included the invitation and link in their newsletter which is accessible to all employed ESNs. From these emails and invitations, a total of 29 ESNs responded indicating they were interested in participating in an interview. This small response rate is consistent with that experienced by HAs when they seek feedback relating to the ESN role, BCCNM in their survey of ESN experiences where they describe their sample size as fairly small, and BCNU when they conducted their 2024/25 bargaining survey of their members.

Of the 29 initial ESN respondents, six did not reply to the follow up email organizing the interview, one respondent was declined as there were already sufficient respondents from that particular work context, and one was a no-show at their interview time. In total 21 ESN interviews were conducted, 19 with students enrolled in Bachelor of Science in Nursing programs leading to RN registration and two with students enrolled in Bachelor of Science in Psychiatric Nursing leading to RPN registration. Table 3 summarises the settings and levels of care of the ESN interview respondents.

Table 3 Employment settings and care levels for ESN interview respondents*

Employment setting	Number of ESNs
Tertiary level hospitals (BC Women's & Children's, Royal Columbian Hospital, Royal Jubilee Hospital, St Pauls Hospital, Vancouver General Hospital)	5
Regional/Urban hospitals	8
Community/Rural hospitals	5
Community/Residential settings	4
Level of Care	**Number of ESNs**
Acute care facility	14
Long-term care within an acute care setting	2
Long-term or residential care in community	3
Sub-acute setting (Rehabilitation or palliative care)	2
Primary care	1

*1 ESN respondent had undertaken 2 ESN positions in different settings and care levels

Fifteen of the 21 ESNs respondents provided the number of hours that they had worked in their ESN role: This ranged from 36 – 1,200 hours, with a mean of 532 hours and median of 545 hours. There are currently 13 universities or colleges[16] in B.C. that provide undergraduate nursing education, with two of these universities also currently offering a condensed nursing program (2 years) for students who already have an undergraduate degree. The ESN respondents attended seven of the 13 B.C. universities or colleges, two were enrolled in a condensed nursing program, and three were students from a nursing program in another Canadian province/territory who had chosen to work as ESN in B.C.[17]. These students had worked in a variety of clinical areas including general medical/surgical, pediatrics, maternity, emergency departments, psychiatric services, correctional services, intensive care, rehabilitation, palliative care, cardiac surgery, long-term care, primary care, and family medicine.

Most students took ESN positions relatively close to their educational institution; however, some students choose to experience a completely different environment and accepted a position in another HA with a different type of setting either urban or more rural. Some students expressed that they wanted to use this opportunity to experience living and working in another community.

8.1.2 Employers, regulator, and union

The recruitment process for employer representatives involved a minimum of two representatives from each HA, representing both the leadership level and the manager/operational/educator level. A total of 22 interviews were conducted with HA representatives with nine respondents being at the leadership level, nine being clinical area managers, and four holding an education role. Because the

[16] This does not include all the different variations of college/university partnerships that exist between different post-secondary educational institutions recognised by BCCNM.

[17] BCCNM does not restrict ESN registration to B.C. nursing students, any nursing student enrolled in a nursing education program recognised by BCCNM is eligible to be an employed student registrant.

ESN role has been around for more than 20 years in B.C., several of the clinical area managers and educators had themselves worked as an ESN during their own time as a student nurse.

One representative each from BCCNM and BCNU participated in the interviews.

8.2 CONTEXT OF THE ESN ROLE

HAs reported employing between approximately 60 and 1,000 ESNs annually over the past few years with an average of approximately 350 employed. BCCNM's *2024 Annual Report* registrant statistics reported 1,850 registered ESNs, an increase of more than 400 from the previous year (BCCNM, 2025). Several HAs indicated that they would be reducing their employment of ESNs for the 2026/27 financial year due mostly to funding issues. It is expected that the number of ESNs employed per HA for 2026/27 will range from 100 – 500 depending on the size of the HA. Most HAs hire ESNs at multiple times throughout the year and try to coordinate this with the semester cycles of their local educational programs.

Nursing students can be hired as ESNs if they have completed their first instructor-led adult medical/surgical clinical placement. For most nursing education programs in B.C. this means that they must be nearing the end of their second year of the four-year program or three semesters into the condensed or accelerated programs. They normally begin work in the summer break between the second and third years of their program (referred to as second year students) and then work again in the break between third and fourth years of their program (third year students). Some students continue their work all year round, fitting it in between their educational program requirements.

ESNs are hired as supernumerary, casual employees and currently paid $32.13 per hour (85% of starting RN wage) (BCNU, 2022). HAs generally hire on an annual basis with the expectation that they can work 400 – 500 hours per year. Some students wanted to work more hours than this and managers indicated that they often used the hours from students that were not using their full allotted time to increase the available hours of other ESNs. Hence some ESN were able to work up to 1,200 hours over two years of employment. If an ESN becomes employed as a new graduate RN in the same HA, they can "port" their ESN hours into their seniority as a RN if they meet the requirements under the BCNU contract with HEABC (BCNU, 2022).

ESN positions were available in most clinical areas of all HAs including medical/surgical wards, maternity, mental health, critical care areas, emergency departments, outpatient services, cancer treatment, community services, and long-term care. In some HAs, second year students were restricted to areas such as medical wards, long-term care, rehabilitation and community services, while third year students generally had no restrictions on their placements. Depending on the HA, critical care areas could include intensive care units, high dependency units, pre- and post-anaesthetic care, as well as emergency departments. Several HAs wanted to increase the placement

options to include services such as public health, hospital in the home programs, and interventional radiology. Most HA did not allow students to work as an ESN in the same clinical area as they were or would be undertaking their required final preceptorship as this leads to role confusion for both the student and the staff; however, in some situations this scenario was unavoidable despite their best efforts to prevent it.

HA clinical area managers reported having a range of 3 – 19 ESNs working in their area. These students worked four, eight, and 12 hours shifts depending on their preference and the needs of the ward or unit, and they worked days, evenings, nights, and weekends as needed. Most HAs did not allow work on public holidays, and none were going to allow this going forward.

8.3 KEY FINDINGS - ESN

The ESN narrative interviews were designed to explore the student's experiences with the ESN role with specific focus on the following areas:

- Motivation to become an ESN;
- How did their actual experience compare with their expectations;
- Challenges experienced in the role and balancing this with academic commitments;
- Differences between the student and ESN role including role clarity and scope of practice;
- Support for the ESN role and recognition of its impact within their academic progression;
- Impact on professional identity and team integration; and
- Impact on transition to practice and future intentions.

Seven key findings emerged from these interviews:

1. Filling gaps in clinical placements
2. Developing a nursing identity
3. Career path development
4. Working in a supportive team environment
5. Different to being a student
6. Funding and administrative issues
7. Value of the role

8.3.1 Filling gaps in clinical placements

Students consistently noted that their educational program clinical placements often lack the necessary opportunities to allow them to engage in and sufficiently develop their nursing and procedural skills. The more independent practice embedded within the ESN role allowed them to accelerate their skill mastery and this was a transformative way to enhance their confidence and cement the competencies into applied nursing practice. This was consistently express by almost every interviewee.

"*Got to do a lot more in my role as an ESN than when I was in school in clinical". (Participant M)*

"ESN let me get the full experience, … you have a full rotation like a nurse would, so not just there 2 days a week, … Do the full 12-hour shifts, in clinical we only do 8 hours, so kind of got like the full experience, it was fantastic". (Participant J)

"The first time I actually did it fully on a person [assessment], it was actually as an ESN, not on a clinical rotation". (Participant P)

"You get a freedom to flourish with the ESN role that is somewhat constrained by a clinical instructor … I don't think it is anyone's fault, there isn't enough things to go around, so you have a lot of missed opportunities or I haven't done that [with a clinical instructor]. Like I had one friend who hadn't administered an IM injection her whole time, I only see IM injections so often, it doesn't come up much, there's so many things like that". (Participant G)

"[in clinical] I was just trying to gather the information so that I could get my assignment done as opposed to this is a human being, whose care is actually temporarily in my hands. I'm going to let that be my motivation, more person centred". (Participant S)

In addition, the ESN role functioned as a valuable extension, narrowing the distance between unavailable or over-stretched clinical-instructed opportunities. This helped students obtain the necessary experience to build confidence in core nursing tasks. They learned to be more confident, expanded their learning through observation and immersion, and improved skills with repetition and consolidation.

"I wasn't as confident when I was in clinical, because of the limited amount of hours that we get in the hospital. So, I know if I wanted to be as confident as I wanted to be as a new grad nurse, to increase my confidence, and get to do skills that I didn't really have time for to do in clinical [I needed the ESN]". (Participant M)

"I wanted a place where I could build confidence and get more experience, … it has definitely done that, I think our program [has] big gaps in clinical, [there is a] really big difference in performance for those who were ESNs and those who weren't. When we move, we have no clinical for four months and with those gaps [there is a] difference between a couple of clinical shifts and like real ESN clinical experiences. So, I really feel that ESN has benefitted me that way, … it has really filled in any gaps". (Participant D)

"Consolidated all my learning prior to preceptorship". (Participant R)

"ESN gives you real hands-on, … I'm more of a hands-on learner than book theory". (Participant G)

"There's a ton of gaps in the curriculum, which makes me sad because if I don't work as ESN [it is] going to be so much harder, … [ESN provides] opportunity to learn on the job". (Participant C)

8.3.2 Developing a nursing identity

The ESN respondents consistently linked the ESN role with developing their sense of self as a future nurse. Most respondents wanted to experience what it was like to be a real nurse.

> *"Makes me hopeful for when I graduate, because when I'm in clinical, I don't like it. I'm like, do I even want to be a nurse if I hate this? But then I go work at my job and I actually enjoy this. So that was a good experience because the first couple of years in the school, I was really concerned that I might have been picking the wrong career". (Participant B)*

> *"I remember starting my ESN, and that's when I really started loving nursing, I did not enjoy clinical at school. My ESN made me fall in love with it [nursing]. I was like, oh wow, I'm going to love being a nurse, even though it is stressful and hard, this feels like something I'm actually really excited to do now". (Participant F)*

> *I feel like I get a lot more sense of being more of a nurse than a student, because as a student, I'll just kind of stand there in the corner while watching". (Participant O)*

> *"It's been probably the most valuable learning experience of my entire degree so far, just kind of showing up every day and being, feeling independent, and having to really make decisions and think critically on your own intuition. It's made me a way better student. I think just because the real-world experience". (Participant S)*

> *"The experience was more than I expected, I think it was actually amazing". (Participant R)*

> *"Brings theory and practice together". (Participant J)*

8.3.3 Career path development

Students viewed their ESN position as crucial for shaping their long-term career pathways.

> *"Great opportunity for me to find out if I really do enjoy the population that I'm working with. I wanted to expand on what I already knew from class and wanted to see if I really would like to work in that field. I wasn't exposed to high acuity (specialty area) population in clinical. That was where my passion was when I started nursing. So, I really wanted to see if that is still where it lies. … the ESN position is what gave me the stepping stone to do that". (Participant A)*

> *"Don't wanna work in a hospital, so I wanted to find some other niche, and I have an interest in mental health and substance use, so it just kind of seemed like the perfect place for me to try out". (Participant B)*

> *I don't really know where I wanted to be as a nurse. OK, let's kind of dip my toe in this department and see if that works for me". (Participant R)*

> *"I always wanted to come back to this unit as an (specialty area) nurse (previously worked there as health care aide), when I heard about the ESN, this is perfect. It has been even more fulfilling, I am actually learning something, and I know that my future is going to be here and it has helped solidify the fact that I am going to be a (specialty area) nurse". (Participant Q)*

The ESN position also led to exposure in new environments and career paths that students had not previously considered or had the opportunity to be exposed to. This was particularly true for rural and remote areas and demonstrated the need for more placements in areas beyond acute care.

> *"Went there with the expectation of doing medicine or psychiatry, obstetrics was my last choice. ESN took me on an unexpected turn, and I ended up enjoying obstetrics, took me in a very good, unexpected turn, pushed me outside my comfort zone". (Participant J)*

> *"I wanted to learn more about rural health. I wanted to learn more about Indigenous health, so that is why I am here". (Participant H)*

> *'Really wanted a rural location, want to work rurally, in school don't get placed in rural". (Participant C)*

> *"Wanted to try rural, which is me now, now I think rural is really cool". (Participant L)*

> *"If I could do a community ESN, oh my god, if I could do a community ESN, that would have been so much better". (Participant K)*

8.3.4 Working in a team environment

Most students repeatedly emphasized the significance of working with supportive RNs, receiving responsive mentorship, inclusive unit environments, and developing relationships and trust within a team. These supportive relationships enabled deeper learning, created psychological safety, and drove ESN satisfaction, which in turn led to additional work shifts and future workforce retention.

8.3.4.1 Supervision and support

> *"I definitely was supervised, but it didn't feel quite as - like over your shoulder as a lot of clinical instructors [make you] feel". (Participant I)*

> *"I think there's more support, at least in this unit because I didn't have to fight eight other students for the attention of one. You're kind of spoilt in ESN where you have extra support because you're not in a class setting". (Participant R)*

> *"They want to help me, teach me, they want me to excel". (Participant C)*

However, some students worked evenings and weekends when the ESN support services were usually not available. In some cases, the work units were not appropriately prepared for their responsibilities associated with the ESN role, putting both the student and staff in difficult positions.

> *"Worked mostly evenings and weekends so no direct CNE[18] support, there is CNL[18] available, so experienced leadership, unit is staffed, oh gosh, probably at least 75% with travel nurses or new grads. Sometimes the new grads are travel nurses. So, in terms of,*

[18] Clinical Nurse Educator; Clinical Nurse Leader

really experienced nurses to learn from, there's not as many as maybe I would have hoped". (Participant D)

"They need to be like more aware of ESNs and just have a bit more compassion. I found myself asking lots of questions because I was, I still am, a baby". (Participant K)

"Support been ok, but not great. I didn't even see one [CNE] for the first 2 months that I worked there because I worked only weekends and evenings". (Participant E)

"Manager was so busy she did not have time". (Participant L)

"They were available but asked me to be more with the LPN and I didn't realise because the conversation happened prior to me showing up that that was what was happening. I probably would have just asked to reschedule my shift and gone home. That's kind of what they advise us to do, if it doesn't seem like they necessarily have capacity for a student that day, they'll organise rescheduling the shift and making sure that we get our hours another day instead of being put in an unsafe practice experience. They're usually really good about it, but I think you have to be confident as a student to advocate for that. And it can be hard if the sites are already short staffed and then you'd say that you're going". (Participant U)

8.3.4.2 Being a team member

Students had to learn to work effectively with different team members, roles, and workplace problems. This was different and more realistic than what they experienced in their student role.

"Really taught me how to gain trust with a team". (Participant P)

"When you are a student, you are in the way of people, [as an] employee – I am here to do my job, we are equal, they are a lot more open, they get to know me". (Participant M)

"I felt like I was genuinely a part of the team". (Participant H)

"The unit doesn't provide them with a care aide, so for them just having the second hand to help them complete their tasks, … they absolutely love me because they know I'm here as an extra hand for them, and for them it's more like it's a learning opportunity, they go out of their way, they make me feel important". (Participant Q)

"I was able to actually communicate more with the doctors". (Participant A)

"When you are in the class setting it's all theory, you are learning about the nursing role in a theory kind of way, but I have learned it is more than that, I've learned that some departments don't talk to each other, so you have to be the mediator between them". (Participant R)

"In the clinical setting, you have some say in advocating for your patients and the doctors take that into account". (Participant R)

8.3.4.3 Symbiotic benefit

The ESN role also brought additional benefits to the existing staff with new and updated knowledge, while providing workload assistance.

“It's kind of nice because I'll bring new evidence and I'll be - ‘we're supposed to do it that way now’ - and they're - ‘you're right, OK, we're gonna do that too’. They're gonna do it the proper way. So, I think, they like having a student there too, because sometimes they're - ‘what are they teaching you in school these days? What's the actual way to do it now?’ ”. (Participant B)

“Their workload becomes lighter because then we can share it. It also gives them more opportunity to teach me because their workloads lighter”. (Participant B)

“There's a lot of us nurses that want to work, ESNs/students that want to work, and it's perfect, it's a symbiotic relationship, it's great for the unit because they got an extra hand and it's great for us because even if I'm not assigned, I get to learn so much from them because they get to have somebody that they can pour knowledge into”. (Participant Q)

8.3.5 Different to being a student: Role scope, clarity, and learning

The ESN respondents were asked to consider how they navigated between the student and ESN role, what challenges and strains this created, and how the ESN role, employer, and educational program worked together. None of the respondents expressed concern relating to balancing the demands of the two roles, with the students indicating that they knew their academic responsibilities took precedence and the employers understood that. However, most of the students expressed some frustration with the differences between these two roles as they were not always consistent, co-ordinated, and did not necessarily complement each other.

Because the ESN role facilitated students to gain confidence and comfort in the clinical environment many respondents reported frustration with their subsequent instructor-led clinical experiences.

“I do find it frustrating now with clinical placements, now that I’m a lot more confident and comfortable and independent, I feel a lot more micromanaged in my clinical placements by my instructors”. (Participant E)

“They wanna take it away [ESN program] because they found people were missing school, which is inappropriate, but when you’re finding that you’re not being supported in a clinical setting and you’re finding that you’re learning more in the ESN, you might want to [do the] ESN more”. (Participant C)

“As an ESN, going back to school after doing my ESN, I felt like I was going backwards because I had that kind of, you know, ability to work more independently”. (Participant N)

Students also reported frustration with the lack of understanding and varying scope of their practice, based on having passed assessments in the post-secondary sector, between different HAs and different areas within a HA.

“[there are] lots of opportunities to practice - removing sutures, staples, taking out drains, NG tubes, urinary catheter insertions, IV insertions; but no NG insertion for some, but others were doing this, and IV push meds, blood administration. Can’t do everything we learned in school, it's roughly the LPN scope, there's a can and cannot document, but it's weirdly worded and it's quite vague. The student scope and the ESN scope is fairly

different for us. But yeah, it's really hard to figure out what I am, and I'm not, allowed to do. So, I tend to just do things that are within the LPN scope in our authority". (Participant D)

"Scope for the position as it is outlined is really unrealistic, needs to be codified a little bit better, would be easier for us, so that's kind of been my experience, just navigating that there are nuances like I can't give medications to a pregnant woman, but I can give medication to a postpartum woman". (Participant E)

"So many missed opportunities to gain and enhance skills". (Participant G)

Respondents wanted a better match of clinical skills between their academic learning progression and what is allowed by the employers for the ESN role, as well as to take advantage of the learning opportunities that the role brings.

"Especially 3rd year going into 4th year, you're almost graduating and you're almost a full RN. So, can you be doing that and all of these things as well? So, there was a lot of backpedalling and having to compare like the [university] policies with the ESN site policies and just make sure that I was kind of safe in my practice". (Participant U)

"There could be almost, like, a sliding scale of where you're at in your education, and what skills you're allowed to do. So, when you're in second year, obviously you're finishing second year, going into third year, constrained to certain skills, and then…third year, maybe when you hit fourth year and you're…done your clinical placement, and you've been actively doing more complex skills in your clinical placement". (Participant F)

"I think that there's a bit more of a capacity to sort of identify skill levels of students rather than just relying on independent kind of self-reporting. Like having level 1,2,3,4 ESNs, that should have roughly a similar scope, just to make it easier and also to have a little bit more flexibility in terms of being able to learn how to do certain skills with particular supports and safety mechanisms in place that weren't available through your undergraduate program". (Participant E)

"I wish we could be taught skills as well, obviously not skills that are like completely out of our scope, but [ones that] aren't necessarily taught in school". (Participant O)

"*They accept ESN placements in a lot of areas where it's very likely that you won't have done something in school, and a lot of those skills are not particularly complicated. I think you could gain a certain level of competence, or there could be structures in place to teach those things. I don't know how that would be done in collaboration with institutions or whatever, but I do think there's more capacity there to use it as a learning opportunity, because the reality is that's already happening. It's just kind of being done under the table and not only is that kind of unsafe for patients, the supervising nurses and the ESNs, but I also think if they're going to be doing that anyways why not use it as an opportunity to increase the educational opportunities that students have, particularly if they're lower risk activities or it's something that you can kind of develop particular curriculums or standards on, you've done the training that any staff member would do".* (Participant E)

8.3.6 Funding and administrative issues

8.3.6.1 Financial benefits and concerns

The ESN role provided obvious financial benefits to the students, as it is well known that the majority of students, 68%, needed to work and earn income while they were studying (Canadian Federation of Nurses Unions & Canadian Nursing Students Association, 2024). According to this CFNU/CNSA survey this number increases with student age and year of study with 22% of students aged 30+ working full time hours while studying. Approximately 1/3 of interview respondents acknowledged that earning an income was very important, and that the ESN role paid more than they could make as a healthcare assistant or in other retail/hospitality jobs.

> *"I'm a broke student, [if I could] I would have just kept it as my [job] because I've only got nine shifts, then I go back to being a part-time barista over Christmas because student or not, you need your gas, you need groceries, you need to eat. I've got bills. I live on my own and so I have to have some sort of income. It would be lovely to not have to go back to minimum wage and you know, doing an entry-level job, it would be great to keep the experience going, until I finish in April 2026". (Participant S)*

However, despite the need for this income, for many of the respondents this was not the main driving force behind taking the role.

The lack of security around the funding for these positions was a concern for many respondents.

> *"It was very sudden when they told my manager to stop allowing me to work. He pulled me aside and was very concerned about it and luckily, he advocated a lot for me to stay on and then they gave him permission to let me keep working. But it was a very stressful few weeks where I didn't really know what was happening. Always in the back of mind, how safe is the job, are they going to cut me off?". (Participant B)*

> *"I would love to still be working as an ESN but this year it sounds like we aren't allowed to get any more even if the site might want us". (HA reduced available hours for ESNs by 55%) (Participant U)*

8.3.6.2 Workplace orientation

The majority of respondents indicated that they had received a good orientation to the work environment and were provided with access to training and support. Many respondents also commented that they had many opportunities to learn things that may not have been available in post-secondary sectors. Such opportunities were often delivered face-to-face and in a hands-on manner, i.e. "the training class where I learned how to chart properly on Meditech, that was great" (Participant R), being able to do basic life support and fit testing as an employee, which was associated with no cost, and being able to attend staff training days.

However, this was not consistent for all ESNs with some having challenges with coordination of timing with their university schedule, and others feeling that they were having to teach themselves about the work environment.

> *"I feel like I needed an orientation shift. I kind of just started working right away. I would ask questions, but I would mainly be teaching myself, kind of getting familiar with the environment". (Participant M)*

> *"A lot of people in my program were finding it hard to do ESN. A lot of them wanted to do ESN, but they couldn't because the orientation dates were throughout the summer when we had classes and they had to keep passing on their orientation". (Participant K)*

> *"The ESN orientation that they did with us as a group, I think was good, but the individual site, I probably would have appreciated more orientation". (Participant U)*

8.3.7 Value of the role

The respondents consistently described that the ESN role had been of enormous value to them. Their narratives reflected the BCCNM professional standards, so while ESN opportunities were "hugely different to being on clinical practicum" (Participant B), the expectations of professional responsibility and accountability, knowledge-based practice, client-focused provision of service, and ethical practice were recognized and demonstrated as core principles in their authorised practice. ESNs believed that the opportunities in the program allowed them to demonstrate responsibility and accountability, which supported them to become a respected member of team. The supported exposure to clinical realities helped them to learn how to respond and cope in challenging and unexpected situations. Finally, the ESN opportunity prepared them significantly for their final practicum and transition to practice.

8.3.7.1 Final practicum and transition to practice

> *"I feel what I have learned in ESN is going to support me come January [final practicum]. I feel like I won't be like a chicken with its head cut off". (Participant J)*

> *"I'm gonna be ready to work as a new grad when I do hit that point, and I think that the ESN role has really helped me". (Participant F)*

> *"Even though I know the foundation of it [a skill learned in the classroom], it's very different to do it in person and see it in person and do the skill in person. The thing that we learned in school - it is kind of - just the basic and then you go out into the real world and it's all of these different things added on to it, and it was hard for me to navigate around". (Participant A)*

> *"I've heard people feel that the new grad program can be constraining if you've been somewhere as an ESN". (Participant B).*

> *"Going into the workforce as an RN, I don't quite have the same intimidation piece as I would [without the ESN]". (Participant I)*

"Makes the gap between student and new grad so much easier, already have all the baseline info and you can build off that". (Participant C)

8.3.7.2 Overall value and benefit

"I don't think that there's a negative thing that you can take away from it. Honestly, it's been amazing and it has definitely brought up my confidence 100%". (Participant C)

"Helped shape my future path, I can now recognize the value of consolidating for a bit before going to critical care". (Participant G)

"Got exposure to many things, surgery, medicine, substance use - patient overdosing in the hospital [from street drugs], great experience, how the nurses handled that". (Participant L)

"Working ESN has been so huge for my learning. Like it has been the best experience. I love it there. I'm actually excited to go to work". (Participant N)

"I think it's very, very valuable for students in the sense that a lot of the people that I am in the program with, it's their first time even walking into the hospital. So, for them taking an extra day off [school] to go work in the unit is so, so beneficial. A lot of them talk about how it's helped them grow confidence. … For me too, genuinely just help me so much to solidify my goals as an RN moving forward". (Participant Q)

"I've done ESN for about a year now and I feel I'm a lot stronger in my clinicals compared to some of my classmates that haven't done ESN. I feel there's quite a big gap between us". (Participant O)

"It really bridges the gap between your academic education in nursing and professional practice. It's like the most beautiful bridge between those two things. And I think that's a fear that a lot of new grads have". (Participant S)

"I would recommend it for everybody". (Participant U)

8.4 KEY FINDINGS – EMPLOYERS, REGULATOR AND UNION

The narrative inquiry interviews with employer, regulator, and union representatives were designed to explore their experiences with the ESN role, with a specific focus on the following areas:

- Understanding the local context of the role and their primary goals in utilizing the role;
- Challenges associated with the role;
- How support and supervision are provided to ESNs;
- Operational level experience with the role;
- Relationship with educational institutions; and
- Future plans, challenges and priorities for the role.

Six key findings emerged from these interviews:

1) Primary purpose: Recruitment, work experience, and increased patient support
2) Clinical challenges
    a. Restricted 'scope of practice' and learning opportunities
    b. Need for closer relationship with educational institutions[19]
    c. Managing supervision challenges
3) Management challenges
    a. Effective orientation
    b. Organizational buy-in
    c. Duplication of processes, poor information exchange
4) Value of the role; benefits both employees and students
5) Need for consistent and sustainable funding
6) Requirements for ongoing success

8.4.1 Primary purpose

Employers overwhelming saw the primary purpose of the ESN role as a pathway to recruitment of new graduate nurses. This was expressed by every HA leader and many of the operational managers interviewed.

> *"We see them as our new grads, they convert to our new grads". (Participant AA)*
>
> *"Overarching goal is to grow our future workforce". (Participant BB)*
>
> *"A pathway to hire. So it is about recruit, recruit, train, retain". (Participant FF)*
>
> *"As an employer we want to recruit them, want them to come back and work for us". (Participant NN)*
>
> *"We're hiring more, we're targeting more ESNs in their final year of preceptorship". (Participant SS)*
>
> *"In terms of a recruitment thing, we have a pathway that we try and involve our ESNs in, if they do so many hours in the emerg, then they're on the way". (Participant UU)*

The employers wanted to have the ESNs build their competence, confidence, and integrate into the workplace, so that "when they come back as a new grad, they have already built those connections, are well supported, know the unit flow, [this] decreases transition shock, some of that still exists, but they feel more comfortable stepping into the environment". (Participant MM)

The hands-on experience the role offered was also viewed as extremely important and a means to prepare them for transition to professional practice.

[19] Educational institutions in this report are referred to as post-secondary institutions (PSIs)

"Get hands on experience, you know, working with directly with RNs, RPNs and other staff, but then also additional direct patient care and have that work experience, which we think is super, super, super important because some folks haven't had a ton of general work experience". (Participant EE)

"[They] really understand workflow, really understand the environment, maybe some of the pressures and so forth, what is within the role of a nurse and then they have the opportunity to apply their skills and are seen as a valuable member of the team". (Participant KK)

"It's not just observation, it's doing. The ESNs that become new grads – it makes a world of difference". (Participant HH)

At the same time as preparing them for their future employment, the ESN role also provided support to the work unit and their presence improved patient safety.

"It's extra help for the unit as well. So, any help in the busy unit is good. It helps with patient safety; there's another person looking after things". (Participant AA)

"[It is an] opportunity to have an extra pair of hands and eyes for our patients and families". (Participant LL)

"They do add value to just the day-to-day work. I mean they are there; they're another nurse who can help". (Participant UU)

8.4.2 Challenges - clinical

While the employers were overwhelmingly positive about the importance of the role, there were challenges associated with it, from both a clinical and managerial perspective. The main clinical challenges were associated with what they saw as staying within the restrictions of the "scope of practice'; the "inability to teach" the student employee anything that they had not previously learned in their educational program; the lack of communication and coordination with the educational programs, lack of consistency with the different PSIs curricula; and supervision requirements and challenges. Respondents described these challenges as leading to frustration for both the student and the staff, as well as reducing the learning opportunities and benefits of the position.

8.4.2.1 Restrictions on "scope of practice"

Respondents described a need to increase the ESN's "scope of practice" to better match their level of education and how this evolves as the students move through their educational program, while aligning with any limitations set by the employer. Without a clear definition of what their "scope" is, the managerial and ward level staff had trouble understanding where the boundaries of the role were.

"Clearly defining the scope of practice for ESNs within your facility, it is a big challenge. Actually, not so much for the ESNs, but it's the RNs and the RPNs, building their understanding". (Participant EE)

"Biggest complaint is their scope – what can they do?" (Participant FF)

“Need very clear outlines as far as what is and is not within their scope”. (Participant II)

“[need] very, very clear parameters – about what they can and can't do, some of that is BCCNM and the health authorities. So BCCNM has the scope out here and the HA limits it like this, [part of this] it's the HA not catching up with what students can and cannot do, and PSIs not keeping people updated as to what's in the curriculum and what's happening, but do PSIs and HAs communicate well?” (Participant JJ)

8.4.2.2 Teaching and learning opportunities

The concern around teaching and learning new skills came up regularly in the interviews. Many respondents described this as a grey area, with difficulty in understanding what they could teach them because even just taking a position in a clinical area involved the student learning new things, and while the employer saw this as normal for any employee, they were unsure as to how to deal with this based on the restrictions associated with the ESN role.

“Can’t teach new skills/acquiring new knowledge– very grey area, what does this really mean? Practical implementation of this - very difficult in the workplace. [We want to] offer them more skills that they'll be able to consolidate, we find that it's so restrictive. There are only limited skills that they can do, they miss learning new things”. (Participant AA)

“We can't tell them that this is a requirement because then we're teaching them something more. But are we providing them with more information, more education? What is that? Should we tell them that is a requirement to work in [clinical area]? We asked them if they want to participate in [education] for their learning, but we are very well aware of the fact that we're not to be teaching them anything new. Which I feel like is a total barrier, cause it's kind of like, what does that mean? Because they might be coming from a health authority where they've used a different pump. So, am I teaching them something new then? Everybody wants to follow the rules. We all want to make sure we're doing the right things, but there's a lot of grey areas”. (Participant CC)

“Not only just missed opportunities for learning, but the result is some students get frustrated and check out. Some leaders will check out and go, oh my gosh, you know, if you can't do this, it's just quicker for a bedside nurse with her hair on fire to just get things done herself”. (Participant FF)

8.4.2.3 Relationship with educational institutions

The vast majority of respondents noted the need for a better and closer working relationship with the PSIs. They wanted more communication with the PSIs, along with more curricula consistency across the province. There was frustration that the timing of when skills were included in the curriculum differed across the university schools of nursing. This resulted in some proposing that there should be a “universal nursing graduate” so they could better understand what they should be expecting from an ESN and later a new nursing graduate.

“Would really like if we could work together with PSIs, because it feels so restricted, it feels so siloed. We meet their needs, one of the reasons why we have our August summer hiring is to be able to cater for condensed programs, so it would be nicer if they

could take our needs or ideas back, like a suggestion about safe patient handling … your ESN is going to long-term care, they will need to know how to use that equipment, … use of our equipment, we have to train them to use it. So, it's a collaboration, optimizing that opportunity that's there for them to learn. … [we] don't have input into curriculum, that's another avenue, we could say 'can we look into this'?" (Participant AA)

"There isn't information transfer between these two worlds currently. … Challenge being many of our candidates [ESNs] come from non-local PSIs, which would make that [education] piece inconsistent and very challenging to follow across the different PSIs that the candidates apply from". (Participant BB)

"It would be nice to have alignment [between PSIs and HA] because that way it doesn't cause confusion, because they come to me and they're like, well, my friends over at X HA can do this and this and this, or my friends at Y HA can't do that. … I've been told each HA bases their scope [ESN practice limitations] on the education of the local schools, which creates a challenge because an ESN could go from [this] HA and go and work in another HA". (Participant CC)

"It would be great if we could have more collaboration together in developing like the clinical stuff and the clinical readiness. That would be really great". (Participant EE).

"As an employer you have to know all the schools to know what they're up to and what they've [ESNs] learnt to be able to slot them in. And so that's a lot of work, because we don't have a universal nursing graduate". (Participant GG)

"it's a bit easier [in an area where] we have only a couple of nursing schools. In Vancouver, very, very different, where you've got, you know, many different schools of nursing that don't teach a universal curriculum. So, while the students that are at [university] might have learned that, the ones at [different university] haven't. So, I think in some cases that's why the HAs are saying no to some things, because you know, students want to be helpful and they might say they know how to do something because they've done it on a practice dummy, doesn't mean they are competent or good". (Participant JJ)

"When the workforce is wanting students to come in with this level of preparedness and the schools aren't offering it, there's a lot of opportunity there to learn back and forth from each other, what we need for them to be job ready for when they graduate, and where that gap is between what they're teaching them at school". (Participant NN)

"Why are we teaching different things at each PSI? It makes no [sense] it's beyond me. It's crazy". (Participant RR)

"Why is that support and education not being supplied in the educational system? We need nurses to be supported, trained, have great learning opportunities, and the ESN program allows that to happen. Especially seeing how they're not getting exposed to that amount of real-time old-school nursing education". (Participant KK)

8.4.2.4 Supervision and support challenges

Supervision was clearly one of the biggest challenges identified during the interviews. From the comments it was clear that ensuring RNs, particularly at the ward/unit level, understood what their

responsibilities were regarding BCCNM required ESN supervision was a continuous and taxing process. All employer representatives were aware of this challenge, with many addressing this through specific policies such as “students can only report to a max of two RNs per shift” (Participant NN). Some of the challenges also stemmed from the ESN program staff predominantly working Monday to Friday day shift while the ESNs often worked evenings, nights and weekends, which resulted in less supervisor support being available when it may be needed. Employers also reported that RNs did not always understand the difference between preceptoring a student, the ESN role, and supporting new graduates. RNs that came from an internationally educated background (IENs) often did not understand what an ESN was, or the ESN program, therefore expecting them to undertake the required regulatory supervision was a challenge.

> *“Number one challenge - not following the regulatory supervision. Sometimes it's just that lack of awareness and responsibility. The [main problem] is using ESNs as workload, that’s not across the board, a lot of places are really good about not, but recently we totally had that problem and again we had to go in and kind of re-educate. Have taken a more proactive approach, explaining regulatory supervision to the ESNs more than we ever have. We're using more ESNs than before. We're using BCNNM's visual to really explain to them, when they [ESNs] ask their RNs and RPNs, so that they understand that it is on them too and to advocate for that kind of standard”. (Participant EE)*

> *“Have that limits and conditions document that they can review, and they know what they can or cannot do and there's rationale in the document of those pieces as well too, so that helps our teams to know what regulatory supervision is about. It's very different than precepting a nursing student. It's very different to having a new grad. It is a very different role. …[ESNs] they're identified to work with one RN. It's very clear in our processes. They work with one regulatory RN. That RN sets those conditions. They have conversations, they collaborate throughout the shift. That ESN never takes an assignment”. (Participant LL)*

> *“[IENs] they've no exposure to the ESN programs and oh my gosh, to ask them to be understanding and having this regulatory supervision on their on their shoulders. It's asking a lot of them. It's pretty intense when they're just trying to get their feet wet practising”. (Participant EE)*

One of the reasons behind the lack of understanding about regulatory supervision was put down to a misunderstanding about what the term scope of practice “officially means”: This misunderstanding stems from the difference in how the term scope of practice is used by the regulator, in legal regulations, and how it was commonly used and understood by RNs:

> *“The nurse assumes, based on what the ESN has told them, [the skills and competencies they are permitted to do by the HA] is the ESN scope of practice, so they're only intervening when something appears to be outside the ESN scope of practice. I've never done this before or I need help with this, or hospital policy says ESN can't do that. So, they don’t necessarily see themselves day to-day supervising all of it, they just see them supervising that's outside scope, but ESNs technically don't have a scope of practice at all [in legal terms], and that's the gap”. (Participant PP)*

The use of travel and agency nurses by HAs was also a problem as they lacked the experience, support, confidence, and orientation to the work environment to be able to provide appropriate support to ESNs.

> *"It has nothing to do with regulatory supervision; it's about being confident in the practice environment. Some [travel nurses] do a few weeks, there's some that do a few months, not a lot longer. The burden of [staff] orientation is huge, like almost every day there's a new team". (Participant LL)*

> *"ESNs working with agency and travel nurses, only if absolutely necessary, isn't the best suited for an ESN, they do occasionally work with agency nurses, but we do try to minimize that happening as much as we can". (Participant MM)*

8.4.3 Challenges - managerial

The main managerial challenges were associated with orientation to the workplace, the need for consistent buy-in for the role across all levels of the organization, and the duplication of administrative processes both across and within HAs.

8.4.3.1 Need for effective workplace orientation and organizational buy-in

It was acknowledged by the interviewees that workplace orientation was variable, some HAs and individual units had robust orientation processes while others may not be providing as effective an orientation. While all HAs indicated they had mandatory education that all ESNs must attend before they were allowed to undertake their first shift on the ward, much of this was done using virtual sessions, and they "continually see gaps in this process because we don't even know if they're on the other side of the thumbnail in the virtual space" (Participant BB). Much of this orientation is focused on the unique nuances of the ESN role, with the goal to ensure there is an understanding of personal responsibility, professionalism, confidentiality, and regulatory supervision, but there were concerns raised about how effective this was and if there were better ways to do this.

Managers also spoke of the need to ensure there was organizational buy-in for the role across different levels of the organization, different regions, different departments, and different roles. They indicated that it can be difficult to ensure that there is consistency in the approach to the role and that work needed to be done to ensure that everyone embraced the importance of this opportunity, the return on investment it offers, and the impact that it can have on the long-term careers and workforce retention for both students and staff.

There was also a concern around the information exchange between the partners associated with the role: students, HAs, PSIs, the regulator, the union, and government ministries. They acknowledged there was a lack of sharing of information and services, and this led to misinformation, missed opportunities, and unnecessary duplication of processes.

8.4.3.2 Duplication of administrative processes

A significant number of the employer respondents noted that there was much duplication in the onboarding and administrative processes associated with the ESN role which wasted a lot of time, energy, and resources.

> *"There is a whole lot of stuff they have to do as an employee that is not different to being a student, and we are paying them for 11 hours just to do this onboarding, it is very repetitious with what they have to do as students. [They] have to do it again because we use a different system [but it is the same information]". (Participant RR)*

> *"Duplication between PSIs and HAs is huge, the amount of onboarding work". (Participant KK)*

> *We are a small organization at [HA], that [admin processes] takes up a lot of time and energy to work it all out". (Participant EE)*

Respondents thought that there could be significant improvements and cost savings made if the administrative processes could be reduced and streamlined, and the inconsistencies in the provincial structures addressed.

8.4.4 Importance and value of the ESN role

Overwhelmingly, the ESN role was seen as significantly importance and valuable. It was described as being extremely important for successful transition to practice, career establishment, development of career pathways, prevention of early career attrition, as well as having positive impacts on staff morale.

8.4.4.1 Successful transition to practice

> *"We are really feeling challenged by folks coming out of preceptorship, starting as new grads, and not being able to take on a full patient assignment with their expected buddy shifts, that is what I thought the point of preceptorship was. The new grads who have been ESNs are just doing better". (Participant EE)*

> *"It is like night and day, literally like night and day, the difference between new grads that have not been ESNs. The difference will be this person is gonna need tons of orientation, tons of support, gonna struggle as a new grad, versus this new grad is going to blossom and hit the ground running, is totally adaptable and able to do their work". (Participant KK)*

> *"They are formulating their nursing career; they are becoming so much a part of the team that they are involved in some ways that are front facing out of the hospital. They are the ambassadors for us; they are attracting people into healthcare careers". (Participant LL)*

> *"They feel like they are one of us, they want to belong, trust is built, trust is developed, and if you don't know what you're are doing, you are gonna to ask a good question, you are gonna find someone who will help you, so they are safe, that's the bonus". (Participant FF)*

8.4.4.2 Positive impacts on staff morale

The ESN role has resulted in unexpected and extremely positive influences on other staff, which has improved staff morale and retention.

> *"I've done this [job] for a long time, so looking back over the last few years, I think this is one of the best decisions I've made [bringing ESNs into the work unit]. The one thing I did not expect was the very, very positive influence the ESNs would have on my [specialty] nurses. They [staff nurses] are like, they're new, right? [The ESNs] - they're keen [to work and learn], they are selected, well selected, they are good communicators, they are very positive, they are happy. Oh yeah, there's an energy too, can I do it? If you've done this work for 20 years, it doesn't excite you, but to witness the excitement and the eagerness to learn and the willingness, they [ESNs] just absorb everything. They [specialty nurses] are eager to be a role model, to share the stories, and I think it does have an impact on reminding them why they chose this profession in the first place". (Respondent TT)*

> *"They are almost invaluable; they were so helpful in all the areas that we had them in". (Participant GG)*

> *"Usually you'll hear, we love our ESNs, that's the chorus, that's 80-85-90% of the time". (Participant FF)*

> *"They're not a lot of work. No, it's only a bit upfront maybe, but once they're established, you know, and they're working within their scope, they're helpful, really helpful". (Participant DD)*

8.4.5 ESNs in rural and remote settings

Very few of the HAs were using ESNs in rural and remote settings as there were challenges associated with these locations. However, for those that were doing this, the experience was very positive. It was acknowledged that people go to rural sites for a reason and once they are there, the retention rate is positive, they stay longer than in the more urban locations. Having local recruitment and retention ambassadors that can connect them with the local community, give them a more robust experience in addition to their work life, was viewed as very important. This connection allowed the ESNs to have a more fulsome and supported experience.

The challenges with the rural and remote settings included the need to provide subsidized housing for these students, and to subsidize the travel time to get to the setting. It was acknowledged that housing was difficult to come by, and you could not expect the student to pay for two sets of accommodation, at university and then somewhere rural for a few months. There was also the fear of the unknown and concerns around socialization. One HA was creating a series of videos, 'a day in the life of a rural nurse', 'rural med cert nurse'[20], 'rural emergency nurse', as ways to address these issues. The other concerning issue was how to provide regulatory supervision in these sites, some of

[20] A 'med cert' nurse is an RN who has obtained *Certified Practice: Prescribing* from BCCNM and is able to prescribe medications as per the BCCNM practice standards for certified practice.

which only have LPNs or a hybrid LPN/RN model, how can this be made to work with the current requirements for regulatory supervision?

8.4.6 Going forward – What needs to change?

There were two consistent responses to what needs to change and what the forward plan should look like:

1. There needs to be consistent and sustainable funding for the role, and
2. There needs to be sufficient positions for all students, as all students should undertake the ESN role.

"Grow them, grow that nurse, grow that nurse so that when they're a new grad, boom. So as long as the students have had ample opportunity to explore and think about what lights their fire, then yes, because we do need to consolidate that learning so they're not terrified and they don't go, I'm out". (Participant FF)

"Everyone should do an ESN, absolutely, every single nursing student that wants the opportunity should be afforded minimum 500 hours over the four years to get opportunities". (Participant LL)

"Need sustained funding, ESN has a place in education with PSIs – it is a missed opportunity". (Participant KK)

"We need to find a better way. We are causing harm. I'm going to say this; we're causing harm in the last 6 to 8 months of their program. We're then pushing them into an employment opportunity they're barely ready for and burden of financial is huge, and no wonder some of them defer the NCLEX and then they're not successful. I don't know any other profession that there's so much pressure, not even physicians. And they get paid. Sorry, those residents are getting paid. What could a co-op like residency look like? We don't care about the name of it, but how do we pay students in their final years? Need to connect ESN positions to some sort of government bursary". (Participant LL)

8.5 ADVISORY CONSULTATION GROUP

The ACG reviewed and discussed the documents provided, reporting no omissions in the findings. HA partners drew attention to dynamic changes that were happening due to more recent cross-provincial partnering about the ESN role. Issues relating to the Indigenous perspective were also raised. Areas of concern and for further discussion included:

- Internal administrative processes between the partners that were burdensome.
- Funding and resource inequity for ESN positions between the HAs, and between acute and community care positions.
- Need for more standardized processes to help support HAs to understand knowledge and skills development in the different PSI curricula, where students are on their learning trajectory, and the timing of learner readiness for the ESN program.
- The importance of working with ESNs to develop ensure appropriate career mapping and talent acquisition.

- Aligning the ESN Program and the NGTP to avoid duplicative, unnecessary and costly processes.
- Recognizing ESNs positions play a significant role in reducing student attrition, and workforce recruitment and retention, and that changes need to be carefully managed.
- Clearer supervision approaches are needed to provide clarity, including addressing knowledge gaps and inappropriate historical views.
- Addressing the gap between PSIs and HAs through the development of shared teams, knowledge, and resources that enhance clarity and learning.

Following the ACG meeting, a follow up interview was held with First Nations Health Authority (FNHA)[21]. FNHA indicated that they currently employ a small number of ESNs. These students have been placed in a range of settings as FNHA explores the feasibility of ESNs working in community-based practice environments and public health contexts. As part of its employment package, FNHA has been able provide ESNs with housing support and offer wages that are comparable to, or slightly higher than, those negotiated by BCNU. FNHA has also found that participation in community health fairs and related events provides opportunities to promote ESN roles and support recruitment efforts.

FNHA does not place ESNs on behalf of the other provincial health authorities. However, it is open to collaborating with self-determining First Nations and Bands that wish to explore the feasibility of employing ESNs within their communities. ESN opportunities can only be offered where adequate supervision can be assured. FNHA operates a diverse network of health centres, nursing stations, and primary care locations across the province, which may serve as potential learning environments.

Supporting First Nations' self-determination in developing sustainable and safe health services is a central FNHA goal. FNHA expressed interest in co-developing a pilot project that would create pathways for ESNs to be situated in "good ways" within self-determining First Nations communities. However, a key challenge relates to FNHA's funding structure, which limits its ability to attract and retain stable ESN support structures. Even with champions within the MoH, a need remains for renewed discussion on how FNHA can be equitably supported in comparison to regional HAs. For example, when temporary ("soft") funding was made available to support ESN mentors and coaches in HAs, FNHA did not receive similar equitable funding. This created a missed opportunity, slowing the implementation of ESN placements within FNHA and limiting exploration of meaningful supervision and support models within First Nations communities.

[21] It is acknowledged that the FNHA occupies a distinct role, mandate, and service delivery model within the health care system of B.C. Consequently, engagement with the FNHA for this report was conducted using an approach tailored to its unique position, differing from the methods used with other HAs in the province. Given these circumstances, anonymity could not be ensured; therefore, consent was obtained from the interview participant to reference the FNHA identifier when summarizing consultation findings for this report.

It is also worth noting that many self-determining Nations operating their own health services, such as Carrier Sekani Family Services, may have the internal infrastructure, including RNs, to support ESN placements. To date, this has not been fully explored, but there is clear potential to collaborate with FNHA and interested Nations to expand local workforce development opportunities.

FNHA was generous in explaining to the study team how union representation functions within their organization. ESNs and nursing staff fall under the Professional Institute of the Public Service of Canada (PIPSC), an important consideration for any future work aimed at supporting equitable ESN employment structures within FNHA.

9 DISCUSSION

This research has provided important knowledge and perspectives regarding how the ESN role is currently implemented and utilized within B.C. HAs. The findings demonstrated that the role has developed into an extremely valuable opportunity for both students and employers, while at the same time there are misalignments and missed opportunities that could invite collaboration. The interview findings were first analyzed through a critical reasoning lens within each group, ESN and employer, to develop key themes. These two sets of key themes were then combined into a single set of overarching themes. This consolidated set of themes was further analyzed to deepen understanding and explore how the layers of observed experiences and subsequent events interact, thereby shaping underlying structures and causal mechanisms. This approach provided valuable insights into the benefits afforded by the ESNs/employer dynamic, while highlighting the systemic misalignments that contribute to missed opportunities and structural challenges which can impact workforce sustainability, career transitions, and retention of recent graduates. This was then used to identify opportunities for transformative reform at the system level. These themes, challenges, and opportunities are discussed below.

9.1 KEY THEMES

The key themes that emerged from the findings of the two groups, ESNs and employers, are summarised below in Table 4. Within this table, sub-themes relating to each key theme are identified with an explanation/example of what was observed or demonstrated.

Table 4 Key themes from ESN and employer findings

ESNs		
Themes	**Sub- themes**	**Explanation**
Growing confidence	Autonomy Decision-making	ESNs gain independence, clinical assurance, and confidence.
Supportive culture	Mentorship Psychological safety	Unit culture, RN values and principles shape ESN learning.
Skill consolidation	Practice repetition Acuity exposure	Allows ESNs to strengthen foundational competencies.
Emotional strain	Workload Ethical tensions Isolation	Challenges vary depending on work unit and staffing structures.
Career Pathway	Specialty exploration Recruitment and retention	ESN work experience shapes career decisions and creates employer loyalty.
Symbiotic relationship	Staff support Mutual value	ESNs help unit and staff workload. Units and staff create learning opportunities for ESNs.
Employers		
Themes	**Sub- themes**	**Explanation**
Structural solution	Workload relief Future employees	ESNs provide tangible labour assistance in contexts with

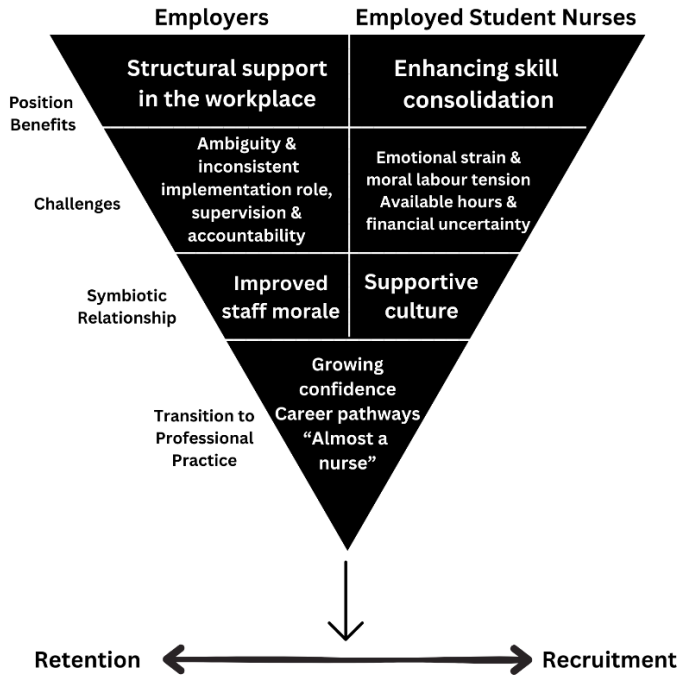
		overcapacity utilization, chronic understaffing, and high acuity. ESN paid employment is also seen as necessary to secure future employees.
Ambiguity and inconsistency	Supervision Orientation Variable support roles Differing enactment of role, responsibilities, and delegation	Employers have variability in the available orientation, day to day support, supervision, and expectations for enactment of the ESN role.
ESNs “almost nurses”	Liminal professional identity Future employable commodity	Employers value the knowledge and skills of ESNs, employees while still being learners. Both beneficial and anxiety-provoking with limited support structuring.
Emotional and moral labour	Pathway to recruitment Insufficient and precarious nature of position funding	Employers investing in future employee without guarantee. ESNs – precarious nature of positions.
Supportive culture Improved staff morale	Ease transition to practice Confidence building Improves team integration and communication Improves recruitment and retention	Positions reinvigorate existing staff and team dynamics while providing significant learning and support opportunities

These two sets of key themes were then combined into four overarching themes addressing benefits, challenges, the development of a symbiotic relationship, and transition to professional practice:

- Structural support and skill consolidation;
- Ambiguity and inconsistency/Emotional strain/Moral labour;
- Supportive culture/Improved staff morale; and
- Growing confidence/Career pathways/Professional identity development – “Almost a nurse”.

Together these themes lead to the desired and common goal of recruitment, retention and successful transition to professional practice. Figure 5 provides a visual representation of these overarching themes.

Figure 5 Overarching themes



By analyzing these themes through the layers of critical realism the mechanisms and structures that create the role's strengths, tensions, and outcomes become visible, and the areas for targeted reform become clearer.

9.1.1 Benefits

The ESN position provides a structural response in the workplace for employers while enhancing skills consolidation for students.

These benefits were immediately visible and observable for both parties. The ESN role allowed for repetition and acuity exposure that is at times absent in other learning contexts, resulting in students being able to strengthen their foundational competencies, and gain independence and clinical assurance. Active ESN exposure resulted in enhanced skill consolidation and confidence in the workplace. At the same time, employers benefited through tangible labour assistance in an environment known for overcapacity utilization, chronic understaffing, and high acuity (Health Workforce Canada, 2024). This was a resounding finding of this study, the importance of which cannot be underestimated in the current healthcare context. While the employer side of this issue is well recognized and accepted, the importance of this for the student must be acknowledged. The role that the ESN position can play in strengthening foundational competencies and enhancing skill consolidation is of paramount importance in an environment where there is an emerging acknowledgement of a deficit in student nurse preparation for independent practice as a graduate RN (Jamaludin et al., 2025; McGarity et al., 2023). This theme spans many countries with McGarity

(2023) summarizing: “The reality is that although most nursing graduates may possess basic nursing knowledge, they need to increase in critical thinking competencies, as well as the commitment, confidence, and professionalism required to be practice-ready” (p.1). Since 2010, the percentage of new graduate RNs exhibiting an adequate level of competency for novice practitioners has steadily decreased. By 2020, less than 10% of graduates demonstrated this standard (Kavanagh & Sharpnack, 2021). The reasons for this decline are multifaceted and can include: 1) steadily increasing seat numbers in nursing programs, which limit placement duration and availability (McTier et al., 2023); 2) reduced opportunities to witness the full range of patients in clinical placement; 3) limited education that helps students to build digital literacy and utilize digital solutions (Pearce et al., 2022); and 4) the delay in modernizing nursing systems to adopt emerging translational mechanisms between education and practice i.e., entrustable professional activities[22] (EPAs) and precision education[23] progression. These are complex, “wicked” problems comprising factors that affect every partner, limited resources, political sensitivities, and deeply rooted structures, making them impossible to solve with a single approach. The ESN role can be used to address these issues without causing instability as the position acts as both an interactive mechanism and a lever for change. In short, B.C. has created a model that contributes to the solution; the ESN role serves as a practice-ready accelerator that helps bridge gaps in our current nurse education system.

In addition to the clinical experience and labour benefits the position afforded, the role helped ESNs build their professional identity and gain exposure to new practice areas and career options and pathways. This is illustrated in the narrative exemplar created from an ESN’s journey ‘*Rural Emergency Practice’* (Appendix 9) and in a recent HA news item (Island Health, 2026, January 7). The position also acted as a bridge between the academic world and real-work practice, addressing the well acknowledged theory/practice gap (Tambunan, 2024) by providing a more realistic nursing experience in a context where students are afforded a safer space in which to demonstrate competencies that support more independent and responsible practice than a student on an educational practicum. The nature of ESN supervision offers a level of budding autonomy while the learner is supernumerary because it allows for “in the moment” mentorship in the workplace. The ESN role has evolved into a workforce development mechanism that operates simultaneously as an educational bridge, labour support structure, and recruitment pipeline.

9.1.2 Challenges

However, the position is also challenged by ambiguity and inconsistency resulting in emotional strain and tension for both ESNs and employers.

[22] EPAs are a shared framework of clearly articulated standards that define discrete, observable units of clinical work that can be progressively delegated to the learner. They are designed to bridge the gap between competency-based education and workplace practice and reshape from informal trust to structured defensible entrustment. Section 9.2.2 addresses the use of EPAs.

[23] Precision education applies competency-based progression, performance measures and its individualized so has a strong overlap with EPAs.

This ambiguity and emotional strain are the direct consequences of the observable variations in scope of practice, which is more appropriately referred to as role enactment, supervision and accountability issues, as well as the uncertainties around work scheduling and financial security for students. This structural gap with lack of communication, coordination, and limited information and knowledge sharing was also acknowledge in the recent report on collaboration between B.C. PSIs and HAs in relation to student to new graduate transition (Blanchard, 2025). Role enactment discrepancies were observed both within and between HAs, with students reporting inconsistent opportunities and restrictions on what they could do. Employers and ESNs noted tensions arising because, despite not being expected or permitted to learn in the workplace, the students inevitably did learn through their day-to-day exposure, and interactions with motivated nurses or teams who wanted to teach. This learning was neither recognized in their educational environment nor officially allowed in the employer context to support skill advancement. The variable timing and focus of the educational curricula of the different PSIs has led to ESNs having inconsistent skills and preparation. This posed difficulties for employers in understanding what they should expect from ESNs. The educational (PSIs) and employment (HAs) systems operate in what could be described as parallel spaces, rather than in collaboration, leading to systemic friction between them.

Regulator required supervision and accountability was another source of tension. When students are working as ESNs they are not under the auspices of their educational institution; their workplace practice is officially overseen through their regulatory requirement for membership with BCCNM. The BCCNM standards that govern the ESN role state:

> they may only perform restricted activities when they are under regulatory supervision from a practising NP, RN, or RPN and have gained competence for that activity in an entry-level nursing or psychiatric nursing education program recognized by BCCNM (this competence is usually achieved by learning the theory, practising in the lab, and being observed performing the activity to the satisfaction of the education program faculty).(British Columbia College of Nurses and Midwives, 2025)

This statement delineates what an ESN is officially allowed to do in the workplace; however, it was a source of uncertainty and anxiety in the workplace for both supervising nurses and ESNs. The ESN role differs from that of a student participating in an educational practicum supervised by a PSI clinical instructor or in a formal preceptorship with an RN before graduation. This has led to confusion regarding RN supervisory responsibilities. Supervising RNs and employers did not always know what skills and competencies ESNs had mastered in their educational program, what the scope of their role or enacted practice should be, and had no means of confirming this except through ESN self-disclosure and self-advocacy. As previously mentioned, variations in educational curricula, student's experiences and background, and their level of progression through their program resulted in students with differing abilities and knowledge. This was further complicated by supervising nurses and employment locations having differing requirements and expectations for knowledge and skills, which at times varied from those learned through the educational program. This is attributed to the ESN role

reflecting a more real-world and complex environment, with different patients, conditions, equipment, and supplies than can be provided for in the educational setting. While it was acknowledged that a significant amount of work had been directed at developing a better understanding of the responsibilities and accountabilities of both the ESN and the supervising nurse, tensions remained and new approaches to resolving these are needed.

The availability of ESN work hours, and the resulting financial insecurity and stress when work hours were unavailable, created another source of pressure and emotional strain for students. In the current world, almost all students need to work while they are studying to earn sufficient income to pay tuition and living expenses, with a significant number now holding both a full-time employed position and being a full-time student (Canadian Federation of Nurses Unions & Canadian Nursing Students Association, 2024). This was one of the reasons for the creation of the ESN role in 2001 (Gamroth & Lougheed, 2004), and this need has become more pressing over the last two decades. The inconsistency of funding for ESN positions and reported current reduction in the number of available positions has exacerbated this situation with both students and employers feeling these pressures. These pressures are increased with the impacts of the Employment Standards Act Regulation 33 that prohibits payment to nursing students for educational clinical practicum time. This issue is the source of controversy and changing perspectives across Canada and other countries with several jurisdictions moving to, or having already moved, to paid clinical practicums (See Appendix 1 for more information) (Australian Government, 2025; Dihn, 2026). Employers acknowledged that they rely heavily on ESN positions to facilitate recruitment to often harder to fill positions and locations (HR Analytics Department, 2026; Island Health, 2026, January 7), that students recruited through these positions have longer retention (HR Analytics Department, 2026; Stout et al., 2015), and that this can reduce the utilization of more expensive and less appropriate agency and travel nurses (Almost, 2024; Failla & Dubose, 2025; Gregory et al., 2014).

9.1.3 Symbiotic relationship

The ESN program offers symbiotic benefits for both parties, a supportive culture for the student, and improvements in staff morale and possibly retention for employees.

Despite the challenges, the ESN program was acknowledged by all to have created a beneficial symbiotic relationship between the ESN and the employer. This symbiotic relationship exhibits itself as supportive mentorship for the student and improved staff morale and teamwork for the employer which may lead to improved staff retention, though this has not been empirically confirmed. This is illustrated in the narrative exemplar created from an employer's experience with the ESN role "*They Changed My Unit More Than I Expected"* (Appendix 10). Contrary to what was often the prevailing narrative, the ESN role was not seen as a substitute workforce by either the employers or the ESNs, and the supernumerary status afforded the position was real. Both ESNs and employers reported that if the student found themselves in a situation where they were asked to fill a workforce void, or could not be appropriately supervised, they were to decline the shift and go home instead of working. This

situation was reported as infrequent, which is remarkable with the current workforce shortages, and demonstrates the level of support, value, and teamwork that has become a fundamental part of the position in most locations. RNs and unit managers consistently described ESNs as valued team members, a sentiment echoed by the ESNs.

Supportive mentorship of nursing students is extremely important with burnout, and other mental and emotional health challenges, becoming increasingly common and leading to adverse patient outcomes, decreased productivity, and increased turnover (Li et al., 2024). The 2025 Canadian nurses survey showed that early career nurses (one – five years' experience) were the most likely to experience anxiety, depression, and burnout with greater than 1/3 of nurses reporting these events, and one in three reporting they were considering leaving their current job within the year (Canadian Federation of Nurses Unions (CFNU), 2025). A recent study highlighted the need for students to be prepared with "a more realistic portrayal of the nursing profession, including education on systemic issues like moral distress, incivility, and organizational dysfunction, as well as preparation for the pace and complexity of bedside care. These findings support calls for better alignment between academic preparation and real-world practice" (Stubin, 2026 p.71) and the establishment of "co-created placement models that are pedagogically rich, student-centred, and responsive to the realities of contemporary healthcare by taking a strengths-based reflection of these models and engaging in genuine collaboration between universities and clinical services" (Crowfoot, 2025 p.418).

This symbiotic relationship has resulted in the ESN role being viewed as existing in a liminal space between student and employee, where they are more accountable than a student but with less authority and responsibility than a nurse. This space allows the ESN to accelerate their confidence, learning, and professional growth and development, but can also make them vulnerable to exploitation, emotional labour, and increased stress leading to burnout if the support mechanisms are not adequate. Working in units with a supportive culture leads to psychological safety, identity affirmation, deeper learning, and ultimately retention loyalty, while an unsupportive culture creates feelings of incompetence, isolation, and ultimately disengagement with the profession.

9.1.4 Transition to professional practice

Both students and employers see the role as facilitating and growing confidence and career pathways, with the student being viewed as "almost a nurse" which enhances and supports professional identity development and transition to professional practice.

The goal and desired outcome of the ESN program, from both employer and ESN perspectives, was to enhance recruitment, retention, and successful transition to professional practice. The students saw the role as a stepping stone to cementing their future career, exploring and creating possible career options and pathways, and strengthening the formation of their professional identity – almost a nurse as described in this video https://www.youtube.com/watch?v=_GghOfZn6Ms (*Jill Sader, Employed Student Nurse Program, Smithers BC*, 2022). Employers wanted to recruit and retain ESNs

as new graduate employees because they brought with them a level of confidence and experience not available with non-ESN new graduates, particularly when they were hired into the same clinical areas as they had previously worked as ESNs (Island Health, 2026, January 7; Kehle, 2025). This was the bonus, the payback for the investment they had made in this supernumerary position. These outcomes are demonstrated in recent publications from Island Health Authority where they state more than 84% of ESNs transition to RNs in Island Health, and 87% continue to work in the same clinical areas where they were an ESN (Island Health, 2026, January 7). Another B.C. HA had five-year employment and retention data that showed 82% of ESNs were retained as RNs within the HA, and 72% remained in their original community of ESN hiring (HR Analytics Department, 2026). A third HA reported current employment conversion rates of 70%, with a target retention of 90% (Participant SS).

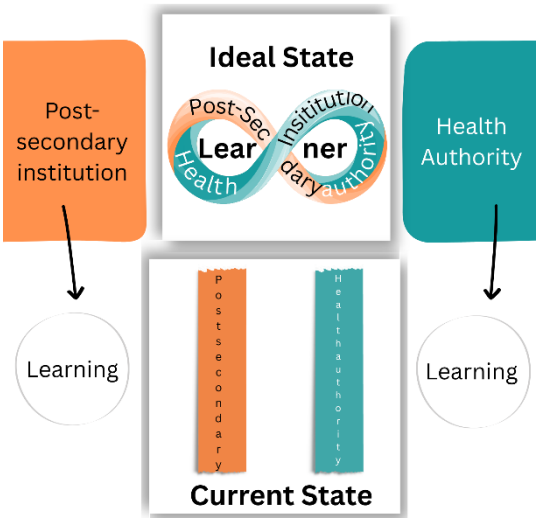
The ESN role is not just an employment opportunity; it functions as a transitional space between student and professional. ESN opportunities can dampen the transition shock commonly reported in the literature (https://nursingthefuture.ca/transition-support) by acting as a buffering mechanism, gradually allowing the exploration of autonomous practice while being supernumerary and under supervision and mentorship. A positive ESN experience leads to a smoother transition to RN, reduced orientation burden, and stronger integration as a new graduate.

9.2 UNDERSTANDING THE ESN/EMPLOYER DYNAMIC

The overarching themes identified in the ESN program have illuminated both the experiences of students and employers, as well as the underlying structural and cultural factors that influence the program's strengths, limitations, and challenges. Understanding the ESN/employer dynamic through this layered framework allowed a shift from viewing the ESN role at its individual level to recognizing the structural mechanistic causations of these challenges, and highlighted the need for systemic, mechanism targeted reforms.

This dynamic emphasizes the change in the employer's role; they are no longer just service providers, they are now functioning as a shaper of practice readiness, and an essential component of the educational system for students. This highlights and forefronts the educational-practice gap: Real nursing happens in the ESN role, and identity formation occurs in this work role rather than through the educational institution. This is made more visible by the perceived and reported regression of the student when they return to PSI facilitated clinical experiences. However, this transition is accidental and fragmented and comes with clinical risks and missed opportunities. To prevent these risks and capture these opportunities, this enhanced role must come under the umbrella of a shared space with the PSI and employer as co-partners in developing and growing the workforce. The parallel universes of PSI and HA need to change to become a continuous, collaborative event with the shared goal of educating and supporting the learner: the future employee. This transition is illustrated in Figure 6 – The PSI -Learner-HA triad.

Figure 6 The PSI–Learner–HA Triad



9.2.1 Bridging the PSI – HA gap

A shared mechanism between the PSIs and the HAs leads to shared accountability for practice readiness, captures and takes advantage of the currently missed learning opportunities afforded by the ESN role, allows for creation and alignment of joint calendars and work schedules, and clearly outlines the process for transition from student to ESN to new graduate employee. This leads to integrated learning progression; addresses curriculum gaps; facilitates the removal of costly duplicative processes for both the PSI and HA, such as onboarding and other administrative, orientation and overlapping processes; and encourages the utilization of educational and career supporting/learning tools such as EPAs and common digital technological platforms. Addressing this current structural division not only mitigates the tendency toward assigning blame, which can consume valuable resources, but also formalizes shared responsibilities and promotes cohesive integration. This approach moves away from dependence on disjointed communication and promotes more effective collaborative networks.

In addition to the educational-practice gap, there is also a disparity in the regulatory mechanisms with curriculum variability, uncertainty and lack of clarity around the extent of role enactment, confusion around competencies taught, and tensions about the necessary regulatory supervision. This ambiguity leads to both students and RNs having to navigate with poor role clarity, unclear scope boundaries, and reliance on student self-reporting and self-advocacy of educational learning and competency, thereby creating uncertainty in responsibility, supervision challenges, and missed learning opportunities. The introduction and utilization of *entrustable professional activities* (EPAs) across nursing education and the practice setting is a potential means to address these challenges.

9.2.2 Entrustable professional activities

The concept of EPAs was first introduced in medicine in 2005 by ten Cate (ten Cate, 2005) and they are now used extensively in both undergraduate and graduate medical education and other health professions with 100s of publications now referring to them and many countries incorporating them into their health educational programming (ten Cate, 2018; Wilbur, 2017; Zainuldin & Yang Tan, 2023). Regarded as an effective means to bridge the gap between competency-based education and actual clinical tasks in the workplace (ten Cate, 2018; Wagner et al., 2018), they provide a complementary framework by defining discrete, observable units of clinical work that can be progressively entrusted to learner. In nursing education, EPA development started in the late 2010s with both RN and NP programs in a number of countries now incorporating the concept into their educational programs (Al-Moteri et al., 2021; Moore et al., 2024; Pietsch et al., 2025; Surjadi et al., 2019; Tiang Lau et al., 2020a, 2020b). The American Association of Colleges of Nursing has recommended the use of EPAs in nursing education to standardize core competencies and assessment tools for evaluating nurses (American Association of Colleges of Nursing, 2015). This recommendation also noted that EPAs use a common taxonomy of competency domains, and shared language “that may assist in promoting the understanding necessary for effective collaborative practice” (p.23). In 2017, Singapore's Ministry of Health introduced a national framework for healthcare services to tackle rising costs, increasing chronic diseases, and an aging population. This initiative required all healthcare professional education programs to incorporate EPAs, leading to their integration into nursing, medicine, and six allied health entry-level curriculums (Tiang Lau et al., 2020a, 2020b; Zainuldin & Yang Tan, 2023). EPAs are used in the Canadian context in all medical schools and are mandated by the Association of Faculties of Medicine in Canada (AFMC) and the Royal College of Physicians and Surgeons as the measure of readiness for independent practice (AFMC EPA Working Group, 2019). The University of Waterloo, one of two pharmacy schools in North America which incorporates a co-op model with paid work terms alternating with in-class academic learning, introduced EPAs in 2024 as part of their assessment process for students on co-op placement: EPAs were perceived to be valuable in assessing student autonomy and readiness for unsupervised practice while on clinical rotations (Syed et al., 2026).

EPAs can be used to link everyday role enactment in the workplace with structured, intentional learning, supervision, and assessment, enabling alignment between lived practice and educational design. The use of EPAs as a means to structure ESN practice in the workplace would provide numerous benefits to all partners. From the regulatory perspective it would provide clarity in the provision of restricted activities, reduce the hidden and informal role expansion, decrease RN and employer anxiety over supervision, and reduce the burden for student self-policing. Sharing of EPAs between employer workspaces and PSI learning spaces would provide an opportunity for enriched learning and give authenticity in the experiential spaces while helping to develop and evolve the clinical instructor role to meet the demands of a modern nursing program. It could also provide a structure to support and liberate RNs when they are working with and mentoring ESNs. Their use

would also help enhance and enable ESN movement between HAs while appropriately situating learning and accountability.

9.2.3 Learner-based digital platforms

The goals and effectiveness of the ESN role are maximized when all stakeholders, ESN, employers, and the student's PSI, are consistently updated with the student's current knowledge, skills, abilities, and mastery of competencies. The use of a learner-based digital platform[24] for tracking, recording evidence, and supporting learning across all these partners is the most efficient and effective means to do this. A learner-based digital platform allows for individualized understanding of the student employee's level of knowledge, skills and competence, supporting more appropriate understanding of their supervisory requirements. Integrating this technology with EPAs would significantly improve clarity for both the ESN and the RN supervisor of the expected responsibilities of the ESN, as well as identifying areas where additional supervision or clearer role boundaries may be necessary. These platforms also allow for experiential learning from the workplace to be understood by the PSI, potentially allowing for formalized acknowledgement and recognition of this learning.

9.2.4 Improved provincial wide centralised administrative processes

These findings highlighted duplicative administrative processes, both across different HAs and between PSIs and HAs. Currently students must undertake repetitive administrative processes to be a student and then an ESN in the same HA, as well as requiring duplicate IT access accounts and processes for each of these categories. There are human and financial costs associated with these repetitive processes for both the PSI and the HA, and both the ESNs/students and employer managers could not understand the need for this. There were also repetitious processes if an ESN chose to move from one HA to another. It would also be proposed, though not confirmed, that similar duplicative administrative processes were likely to be in place if a PSI had their students on clinical placement with more than one HA, a situation that is quite feasible particularly in the Vancouver/lower mainland area of B.C. where there are at least four, and possibly five, different HAs providing service provision. These issues were acknowledged from the HA perspective, where they indicated they can be dealing with students from 10 different PSIs in the recent report into PSI/HA collaboration (Blanchard, 2025). There were also duplicative processes for recruitment into graduate nurse positions and when being orientated to the HA. Utilizing different systems for these processes, which lead to inconsistencies and discrepancies across provincial structures, results in inefficient use of resources, especially when all types of resources are currently scarce. It was proposed that many of these processes could be centralized, shared, and better use could be made of newer technologies to facilitate this.

[24] Learner-based platforms include products such as "PebblePad" – an e-portfolio and learning platform currently utilized by many university and college nursing programs across B.C., Canada, the UK, Australia, New Zealand and the USA. This platform provides both a life-long learning tool and an e-portfolio documenting practical skills and professional development. It is controlled by the learner and can be shared with both employers and educational programs. Other similar products used in healthcare education include Mahara, PARE, and LiftUpp.

9.2.5 Investing in the future through the ESN program

The ESN program was clearly shown to provide important benefits to both the student and the employer. The value and need for the program as a part of practice readiness, transition to professional practice, recruitment, and retention was recognised by both partners. However, there were concerns with there not being a consistent funding model for the program and whether sufficient funding could be attached to this program for every student nurse to experience the ESN role. The ESN program and role should be viewed as a necessary part of a sustainable workforce strategy, providing the connection between academia and the workplace, and the career bridge from student to graduate: Without the role, retention of new graduates becomes fragile and the early career attrition problem will only become worse (Canadian Federation of Nurses Unions (CFNU), 2025; Stubin, 2026). Significant resources are already being spent on educating new nurses, if we then fail to provide them with the necessary bridge to success through appropriate partnerships between academia and the workplace then this money is effectively being wasted, and the problems of retention and ongoing shortages of nurses will only worsen.

9.2.6 Rural and remote context

There were calls for more positions to be made available in differing contexts beyond traditional acute care settings to provide both expanded career experiences and options, and offer the structural support benefits the role affords to the full range of locations. One of the areas identified for potential expansion was rural, remote, and Indigenous settings.

Based on the 2021 Canadian census, approximately 18% of the Canadian population live in a rural or remote location, while at the same time the Canadian Institute of Health Information identified that only 10% of employed nurses worked in a rural or remote location creating chronic staffing shortages. There is also a chronic lack of other health care providers, limited technology support, as well as geography, isolation and weather impacts that create an expanded set of challenges for rural health service provision when compared to more urban settings (Canadian Association for Rural and Remote Nursing (CARRN), 2020). Rural and remote nurses undertake a more generalist role with a broader range of responsibilities and activities that would more commonly be done by other healthcare workers including laboratory technologists and pharmacists (MacLeod, Stewart, & Kulig, 2019), and work in small teams often with interprofessional cross over (Canadian Association for Rural and Remote Nursing (CARRN), 2020). These workplace structures and mechanisms create both a valuable opportunity and a challenging environment in terms of supervision, role clarity, and educational capacity in which to embed the ESN role.

This research highlighted several locations where the ESN role was successfully being utilized in rural community hospitals but was unable to confirm any utilization of the role in rural community or primary care settings. The challenges associated with these placements were also acknowledged with housing, travel, and transportation costs, financial concerns with siloed funding streams, and support

and supervision issues being raised. In addition, educational issues relating to limited to no prior exposure to rural specific learning and work environments as students, role clarity, and scope of practice drift – particularly with acknowledgement that 10% of rural RNs work beyond their official scope of practice – have been raised as potential concerns (Blanchard, 2025; Canadian Association for Rural and Remote Nursing (CARRN), 2020; MacLeod, Stewart, Kosteniuk, et al., 2019). However, despite these concerns, the value of these positions was acknowledged by both ESNs and employers. This was clearly articulated in the Blanchard report (2025) where the potential for ESN placements in FNHA health centres was clearly supported, however the need for additional work to achieve this remains: “It is essential that First Nations communities agree, feel safe and embrace the [ESN] concept” (p.11). It was anecdotally acknowledged in this research project that the ESN role is a stepping stone to rural practice, and that once they get there the retention is better than in urban areas: “People go to rural sites for a reason, and they stay in those sites longer” (Participant BB). This has been well acknowledged in the literature with student rural placements shown to lead to intention to practice rurally, better rural recruitment, and an improved understanding of interprofessional practice (Crossley et al., 2023; A Kenny et al., 2021; Walsh et al., 2023; Winwood, 2023). Longer and more expanded placements allow students to tailor and contextualize their practice, navigate complex inequities, understand and develop cultural awareness, establish a sense of belonging, and develop a more rural-ready nursing workforce (Jones et al., 2022).

Access to the necessary supervision in these sites has been raised as an issue with onsite staff often unfamiliar with the ESN role or not experienced with the requirements and responsibilities for supervision. However, it was also acknowledged that this could be addressed with more appropriate training for staff, the utilization of EPAs providing both clarity and confidence to supervision models, and the potential for hybrid models.

10 LIMITATIONS TO THE REPORT

Despite the study demonstrating the extremely valuable opportunities of the ESN role for both students and employers, there are a few factors that need to be considered when reviewing the findings and recommendations from this study

- The literature included in this study came from a rapid review, which has limitations by the nature of its processes and timeframe. Literature searching was limited by the simplified processes used during the search protocol, study selection, and data extraction. As a result of this, research and grey literature included in this study may have missed articles and papers which should have been included and could have impacted on the findings from the literature review.
- Almost half of the literature included in the rapid review addressed the Australian context of the ESN role which is different to the B.C. role in scope of practice, role enactment, and how the role is used as a skill consolidation, transition to professional practice, and new graduate recruitment tool. The B.C. ESN scope of practice is more expansive than possibly all of what is described in the remaining literature except that relating to the original evaluation of the B.C. ESN in role in 2004. Despite this, the findings from the rapid literature review were generally consistent with the key themes and issues found in the interview phase of this study.
- While quality analysis was undertaken on all peer-reviewed literature included in the rapid review, and the majority of literature was deemed to be high quality, not all included literature met all quality requirements and bias or other deficiencies may have impact on the results.
- The recruitment response rate for interviews yielded a small sample compared to the size of the ESN pool. This is a consistent finding with the other ESN research undertaken at the same time as this research and is also consistent with the response rate experienced by employers when they have conducted research and information gathering on the ESN role from ESN students.
- The time frame for the study was also limited and as such there was a limited time period to conduct the interviews. Attempts were made to increase the number of ESN and employer respondents from different work settings, and with different educational and HA backgrounds, but not every type of work setting and educational background was able to be represented. This was attempted to be addressed in the ACG with purposeful sampling used to create the meeting invitation list, but some gaps still remained across all possible sectors.

11 RECOMMENDATIONS AND CONCLUSIONS

From the findings of this research the following recommendations are proposed. In making these recommendations, we remained cognizant of the broader multifaceted context surrounding the ESN program and have given careful consideration to the critical factors necessary for effective implementation to promote sustained success. We also acknowledged the inherent challenges associated with introducing change within complex environments with multiple partners.

Recommendations:

1. The ESN program needs to be continued and enhanced with embedded ministry funding and specified budget lines. This should include:
    - Provide sufficient funding for 80% of 1) regular second- and third-year RN and RPN students, 2) condensed and accelerated program RN students, and 3) IEN re-entry program students to be able to work a minimum of 600 hrs as an ESN over the course of their pre-registration program. The cost of this would currently equate to $19,278 per eligible student.
    - These minimum hours could be increased if able to be supported by individual HAs.
    - This should ideally be increased to 100% of students over the next few years.
    - Require that all ESNs work a minimum of 300 hours to prevent the inappropriate use and cost to the program associated with students who are only interested in very short-term work.
    - Provide the funding through a province-wide/student allocation, rather than to individual HAs, to ensure all locations and students have as equal as possible access to the program.

Alignment of provincial programming

2. Conduct a review of the goals and outcomes of the ESN program and NGTP. Explore the feasibility of integrating both programs into a single, two-phase structure—pre- and post-registration—while considering a reduction in the length and scope of the NGTP. This integrated approach has the potential to enhance the transition to practice for new graduates, streamline program delivery, and optimize both human and financial resources by minimizing redundancy between programs with similar objectives.

3. Create a provincial ESN working group with key HA and PSI players to investigate and create tools to support the implementation of the ESN program in HAs. Areas for this group to work on would include:
    - Collating a province-wide guide to PSI curricula and teaching timelines for core subjects and skills to help HA education and clinical units understand the expected knowledge and skills of ESNs.

- Develop common supervision standards and guidelines, and educational tools about the ESN role for consistent use across HAs. This should include developing standards and guidelines for equity of educational support and resourcing across the different health service agencies of the province (Blanchard, 2025).
- Explore the use of learner-based digital portfolio and learning platforms that could bridge between employer and PSI to track, record evidence, and supporting learning.
- Explore the development of additional ESN positions in non-traditional clinical areas such as community placements, tele and digital health, and public health sites.

4. Develop a province-wide centralized approach to PSI/HA administrative processes for students to reduce duplication in student placement, hiring, and onboarding requirements.
    - Develop a centralized provincial-wide portal for position advertising. This portal should include information on available positions, locations, and any specific conditions, as applicable. While advertising for positions would be centralized, the processes of recruitment and selection should continue to reside with individual HAs.
    - Review, streamline, and align the processes required for student placement and ESN to reduce duplication and facilitate movement and portability between HAs.
    - Ensure the ESN program is appropriately embedded within provincial career pathways and pipelines for new graduate recruitment.
    - Investigate with BCNU and PIPSC (union for FNHA employees) the potential for ESN hours to be portable between provincial HAs, not just the same HA as is the current situation.

Entrustable Professional Activities

5. Investigate the potential to develop a provincial EPA framework for RN/RPN education to link expected core competencies to professional activities in the workplace. This would require representation from education and clinical practice to investigate developing core EPAs, and EPAs specific to common conditions and problems inclusive of acute, community, and public health settings.

Rural, Remote and Indigenous placements

6. Create dedicated funding for the rural and remote sector, and for FNHA, to develop appropriate ESN positions. This funding needs to account for rural and remote realities, community needs, and historical funding inequities (Blanchard, 2025).
    - Recommended that a minimum of 10% of ESN positions be dedicated to rural, remote and Indigenous locations.
    - Explore how to support:
        a. ESNs within FNHA and associated union (PIPSC) mechanisms, and
        b. Self-governing First Nations to support local ESN recruitment and retention opportunities while ensuring safe and appropriately supervision, oversight, and education opportunities.

- Clinical placements in rural locations should be combined with an ESN component to provide an extended, immersion experience, similar to what is undertaken by the UNBC medical program and recommended in the rural studies (Algoso & Peters, 2012; Kenny et al., 2021; Winwood, 2023).
- Work with rural health service providers and communities to ensure provision of appropriate housing and social supports, as required. Identify locations where supported rural ESN employment is working well, (e.g. locations in Northern, Interior, and Island Health) and determine what can be done to replicate these sites.
- Explore with BCCNM the inclusion in the *RN/NP Program Review Guidelines*, *Curriculum Standard,* of a minimum requirement for community and rural nursing courses to support community and rural and remote ESN and new graduate employment.
- Provide specific supervision education and support to RN/RPNs in rural and Indigenous settings. The use of EPAs and learner-based digital platforms would provide clarity and increased confidence to supervision requirements and strengthen the learner's experience while reducing clinical risk and uncertainty.

Data, evaluation and outcomes

7. Develop a common evaluation framework for the ESN program to be used across all HAs. This should have both short- and long-term measures and include mandated data from all key partners, including all publicly funded HAs, PSIs, and anonymized data from BCCNM. The need for this was also acknowledged in the Blanchard report (Blanchard, 2025).
    - This framework should track recruitment, retention, and career movement over a minimum of a five-year period post-graduation.
    - Explore with BCCNM the potential to embed workforce data collection relating to transition to practice, recruitment, retention, and career progression into the annual registration processes.
    - Data should be stored in a common repository in a manner accessible to all partners.
    - This framework would align with the recommendations of the *B.C. Student Practice Education Capacity Building* project (Diamond et al., 2023) and the monitoring and evaluation component of the health human resources strategy (BC Ministry of Health, 2022).

Conclusion

The ESN role is not just an employment opportunity; it functions as a transitional space and developmental bridge between undergraduate education and full professional accountability. By providing a buffering mechanism, ESN opportunities help alleviate transition shock, enabling individuals to gradually develop autonomy while operating under supervision and mentorship. Through progressive autonomy, the ESN role supports skill consolidation, effective negotiation of team dynamics, and early identity formation before registration. This incremental exposure has been

shown to reduce aspects of transition shock and foster a more seamless integration into new graduate positions.

The buffering effect of the ESN role is significantly influenced by supervision quality, clarity of scope, and stability of funding. When structured effectively, ESNs function not simply as supplementary workforce members but as essential components of an infrastructure that facilitates a successful transition to professional practice. Engagement within supportive and culturally responsive units does more than improve ESN well-being; it activates mechanisms that enhance competence, foster identity formation, and contribute to long-term retention. Identity formation plays a crucial role, as supportive environments can cultivate resilience, promote relational practice, and bolster confidence; all factors which may reduce early career burnout, support a sense of belonging, and mitigate risks such as moral injury. A positive ESN experience contributes to a smoother transition to RN status, decreases the orientation burden, and strengthens the integration of new graduates.

12 REFERENCES

AFMC EPA Working Group. (2019). *AFMC Entrustable Professional Activities for the Transition from Medical School to Residency*. https://www.afmc.ca/wp-content/uploads/2022/10/AFMC_Entrustable-Professional-Activities_EN_Final.pdf

Ahern, T. A., Pardon, M. K., Lindsay, D. J., & McAuliffe, M. T. (2023). Linking student in nursing/student in midwifery employment to Australian professional standards: A cross-sectional study. *Collegian*, *30*, 498-505. https://doi.org/https://doi.org/10.1016/j.colegn.2023.02.003

Al-Moteri, M., Youssef, H., AbdElbagy, A., Elryah, I., Yaseen, R., Begum, F., Abdelgadir, W., & Malki, M. (2021). Development of undergraduate nursing entrustable professional activities through using a participatory design approach. *Journal of professional nursing: official journal of the American Association of Colleges of Nursing*, *37*(4), 741-748. https://doi.org/https://doi.org/10.1016/j.profnurs.2021.04.009

Algoso, M., & Peters, K. (2012). The experiences of undergraduate assistants in nursing (AIN). *Nurse Education Today*, *32*, 197-202. https://doi.org/10.1016/j.nedt.2011.08.002

Almost, J. (2024). *Opening the black box: Unpacking the use of nursing agencies in Canada*. https://nursesunions.ca/research/opening-the-black-box/

American Association of Colleges of Nursing. (2015). *White Paper: Re-envisioning the clinical education of advanced practice registered nurses.* https://www.aacnnursing.org/Portals/0/PDFs/White-Papers/APRN-Clinical-Education.pdf

Amerine, L. B., Valgus, J. M., Moore, J. D., Arnall, J. R., & Savage, S. W. (2017). Implementation of a longitudinal early immersion student pharmacist health system internship program. *Currents in pharmacy teaching & learning*, *9*(3), 421-426. https://doi.org/https://dx.doi.org/10.1016/j.cptl.2017.01.011

Anderson, C., & Kirkpatrick, S. (2015). Narrative interviewing *International Journal of Clinical Pharmocology*. https://doi.org/DOI10.1007/s11096-015-0222-0

Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., & Vandenberghe, F. (2016). What is critical realism. *Perspectives: A newsletter of the theory section. American Sociological Association.* http://www.asatheory.org/current-newsletter-online/what-is-critical-realism

Australian Government. (2025). *Commonwealth Prac Payment for students*. Canberra: Government of Australia Retrieved from https://www.education.gov.au/commonwealth-prac-payment-cpp/students

Baumann, A., Smith, V., & Crea-Arsenio, M. (2024). Innovative nursing employment initiatives to strengthen and sustain the health workforce in Canada. *Healthcare Management Forum*, *37*(4), 251-257. https://doi.org/doi:10.1177/08404704241232668

BC Ministry of Health. (2022). *B.C.'s Health Human Resources Strategy: Putting People First*. https://news.gov.bc.ca/files/BCHealthHumanResourcesStrategy-Sept2022.pdf

BCCNM. (2025). *Annual Report 2024*. https://www.bccnm.ca/Documents/governance/annual_reports/BCCNM_2024_Annual_Report.pdf

BCNU. (2022). *2022-2025 Provincial Collective Agreement between HEABC and Nurses Bargaining Association*. https://www.bcnu.org/Contracts-Bargaining/Documents/nba-pca_2022_2025.pdf

Beccaria, L., Hoey, H., Towler, H., Rees, S., Brazier, R., Gordon, K., Neville, C., & Knight, B. (2024). Employment of undergraduate nursing students for specialling of people with cognitive impairment: A pilot study. *Collegian*, *31*(2), 84-91.https://doi.org/10.1016/j.colegn.2023.12.002

Blanchard, S. (2025). *Strengthing the Transition from Nursing Student/Employed Student Nurse to New Graduate Nurse: Enhancing Collaboration between Post-secondary Institutions and Health Authorities*. BC Ministry of Health, Unpublished report.

Bloomfield, J. G., Gordon, C. J., Williams, A. M., & Aggar, C. (2015). Nursing students' intentions to enter primary health care as a career option: Findings from a national survey. *Collegian*, *22*(2), 161-167.

Boggon, A., Poole, A., Smith, S., Burns, A., & Dilworth, P. (2023). Medical students as health workers during the COVID-19 pandemic. *BMJ leader*, *7*(2), 149-151. https://doi.org/https://dx.doi.org/10.1136/leader-2022-000597

British Columbia College of Nurses and Midwives. (2025). *Practice Standard - Employed Student Nurses*. https://www.bccnm.ca/RN/PracticeStandards/Pages/employedstudents.aspx

Browne, G., Cashin, A., Graham, I., & Shaw, W. (2013). Addressing the mental health nurse shortage: Undergraduate nursing studentsworking as assistants in nursing in inpatient mental health settings. *International Journal of Nursing Practice*, *19*, 539-545. https://doi.org/10.1111/ijn.12090

Budgen, C., & Gamroth, L. (2008). An overview of practice education models. *Nurse Education Today*, *28*(3), 273-283. https://doi.org/https://dx.doi.org/10.1016/j.nedt.2007.05.005

Burns, E., Triandafilidis, Z., Hargreaves, A., Keedle, H., Hitchick, M., Campbell, O., & Elmir, R. (2022). Hospital-based assistant in midwifery role for undergraduate midwifery students: A survey exploration. *Midwifery*, *110*(8510930, mwf), 103319. https://doi.org/https://dx.doi.org/10.1016/j.midw.2022.103319

Canadian Association for Rural and Remote Nursing (CARRN). (2020). *Rural and Remote Nursing Practice in Canada: An Updated Discussion Paper.* https://www.carrn.com/images/pdf/CARRN_RR_discussion_doc_final_LR-2.pdf

Canadian Federation of Nurses Unions & Canadian Nursing Students Association. (2024). *Canadian Nursing Students Survey Results.* Canadian Nursing-Student-Survey-Report-January-2025.pdf

Canadian Federation of Nurses Unions (CFNU). (2025). *CFNU National Nurses Survey*. https://nursesunions.ca/wp-content/uploads/2025/03/CFNU-Member-Survey-Report_March-25_final-65.pdf

Cepanec, D., Clarke, D., Plohman, J., & Gerard, J. (2013). Engaging undergraduate nursing students in research: the students' experience of a summer internship program pilot project. *The Journal of nursing education*, *52*(8), 466-469. https://doi.org/https://dx.doi.org/10.3928/01484834-20130718-03

Chow, J., & San Miguel, S. (2010). Evaluation of the implementation of assistant in nursing workforce in haemodialysis units. *International Journal of Nursing Practice*, *16*, 484-491. https://doi.org/10.1111/j.1440-172X.2010.01873.x

Cordon, C., Norman, D., Fox-Robochaud, A., Perazzo, J., Marzilli, N., Alvi, M., Blakely, C., & Aliaszon, M. A. (2025). Exploring the impact of a clinical extern progam on readiness to practice. *Healthcare Management Forum*, *38*(3), 216-220.

Cowley, S., & White, G. (2021). Healthcare support worker assistantships should form a mandatory part of medical school curricula: A perspective from UK medical students. *Medical Teacher*, *43*(9), 1092-1093. https://doi.org/https://doi.org/10.1080/0142159X.2020.1817351

Crevacore, C. A., Duffield, C. M., & Twigg, D. E. (2019). Undergraduate registered nursing students working as assistants in nursing within the acute care environment: Program development and discussion. *Collegian*, *26*(2), 256-261. https://doi.org/10.1016/j.colegn.2018.07.012

Crossley, C., Collett, M., & Thompson, S. C. (2023). Tracks to postgraduate rural practice: Longitudinal qualitative follow-up of nursing students who undertook a rural placement in Western Australia. *International Journal of Environmental Research and Public Health*, *20*(6). https://doi.org/https://dx.doi.org/10.3390/ijerph20065113

Crowfoot, G. (2025). Co-designing the future of nursing education: Integrating tradition and innovation. *Contemporary Nurse*, *61*(5). https://doi.org/https://doi.org/10.1080/10376178.2025.2532884

Danermark, B., Ekstrom, M., & Karlsson, J. (2019). *Explaining Society: Critical Realism in the Social Sciences* (2nd ed.). Routledge.

Diamond, C., Wereley, N., & Hutchison, F. (2023). *Student Practice Education Capacity Building*. HHR Action # 70, BC's Health Human Resources Strategy.

Dihn, K. (2026). An urgent call for paid nursing clinical placements. *Canadian Nurse*. https://www.canadian-nurse.com/blogs/cn-content/2026/01/05/paid-nursing-clinical-placements

Erfani, G., McCready, J., Gibson, B., Nichol, B., Unsworth, J., Jarva, E., Mikkonen, K., & Tomietto, M. (2025). Factors influencing digital health competence among healthcare professionals: A cross-sectional study. *Applied Nursing Research*, *82*. https://doi.org/doi:10.1016/j.apnr.2025.151922. Epub 2025 Feb 8.

Failla, K. R., & Dubose, B. M. (2025). Reducing reliance on travel nurses through recruitment process improvement. *Nurse Leader*, *Article 102513*. https://doi.org/https://doi.org/10.1016/j.mnl.2025.102513

Frandsen, T. F., Nielsen, M. F. B., Lindhardt, C. L., & Eriksen, M. B. (2020). Using the full PICO model as a search tool for systematic reviews resulted in lower recall for some PICO elements. *Journal of Clinical Epidemiology*, *127*, 69-75. https://doi.org/https://doi.org/10.1016/j.jclinepi.2020.07.005

Gamroth, L., Budgen, C., & Lougheed, M. J. (2006). Feasibility and outcomes of paid undergraduate student nurse positions. *Nursing Leadership*, *Online Exclusive - September 2006*.

Gamroth, L., & Lougheed, M. J. (2004). *Nurse transitions to professional practice: Feasbility and outcomes of paid undergraduate student positions: Final Report*.

Gillian, C., Magliozzi, A., Savelli, L., & Cornacchione, P. (2024). Early engagement: The role of MRT student externs in mitigating health human resources shortages. *Journal of Medical Imaging & Radiation Sciences*, *55*, S2-S16.

Green, E., Quilliam, C., Sheepway, L., Hays, C. A., Moore, L., Rasiah , R. L., Bailie, J., Howard, C., Hyde, S., Inyang, I., Matthews, K., Ferns, J., Brown, L., Jones, S., & Collett, M. (2022). Identifying features of quality in rural placements for health students: Scoping review. *BMJ Open*, *12*(4). https://doi.org/https://doi.org/10.1136/bmjopen-2021-057074

Gregory, S., Bolling, D. R., & Langston, N. F. (2014). Partnerships and new learning models to create the future perioperative nursing workforce. *AORN journal*, *99*(1), 96-105. https://doi.org/https://dx.doi.org/10.1016/j.aorn.2013.10.012

Happell, B., & Gough, K. (2007). Employment through residency programs: A strategy to address the workforce crisis in psychiatric nursing. *Archives of Psychiatric Nursing*, *21*(3), 126-131. https://doi.org/https://dx.doi.org/10.1016/j.apnu.2007.01.002

Hasson, F., McKenna, H. P., & Keeney, S. (2013). A qualitative study exploring the impact of student nurses working part time as a health care assistant. *Nursing Education Today*, *33*, 873-879. https://doi.org/http://dx.doi.org/10.1016/j.nedt.2012.09.014

Health Workforce Canada. (2024). *Canada's health systems over capacity, marked by job vacancies, millions of hours in overtime*. https://healthworkforce.ca/canadas-health-systems-over-capacity-marked-by-job-vacancies-millions-of-hours-in-overtime/

HR Analytics Department. (2026). *ESN-RN Retention Report: 2020 to 2026 YTS Hires.* [Unpublished internal report, Northern Health].

Island Health. (2026, January 7). From student to staff: Island Health program launches nursing careers close to home. *My Island Health Stories*. https://www.islandhealth.ca/news/stories/student-staff-island-health-program-launches-nursing-careers-close-home

Jamaludin, T. S. S., Ilias, D., Nurumal, M. S., Hasan, M., Kamil Che, Kyu, K. W., & Ariyanto, H. (2025). The readiness of final-year nursing students' clinical competency and intention to work in clinical setting: A systematic review. *INTERNATIONAL JOURNAL OF CARE SCHOLARS*, *8*(2), 161-196. https://doi.org/DOI:10.31436/ijcs.v8i2.454

Jill Sader, Employed Student Nurse Program, Smithers BC. (2022). Northern Health; https://www.youtube.com/watch?v=_GghOfZn6Ms

Jones, D., Randall, S., Williams, A., Waters, D., White, D., Haddadan, G., Erlandsen, A., Hanniver, J., Smith, R., & Parr, S. (2022). Strength of cross-sector collaborations in co-designing an extended rural and remote nursing placement innovation: Focusing on student learning in preference to student churning. *Australian Journal of Rural Health*, *30*(6), 801-808. https://doi.org/https://doi.org/10.1111/ajr.12880

Kartch, F. (2017). Narrative Interviewing. In M. Allen (Ed.), *The SAGE Encyclopedia of Communication Research Methods*. https://doi.org/https://doi.org/10.4135/9781483381411.n369

Kavanagh, J., & Sharpnack, P. (2021). Crisis in competency: A defining moment in nursing education. *The Online Journal of Issues in Nursing*, *26*(1). https://doi.org/https://doi.org/10.3912/OJIN.Vol26No01Man02

Kee, G., & Ryser, F. (2001). Work-study-scholarship program for undergraduate nursing students: A win-win service education partnership. *Nursing Admin Quarterly*, *26*(1), 29-34. https://doi.org/10.1097/00006216-200110000-0001210.1097/00006216-200110000-00012

Kehle, A. (2025). Celebrating National Nursing Week with employed student nurses. *Northern Health Stories*. https://stories.northernhealth.ca/stories/celebrating-national-nursing-week-employed-student-nurses

Kenny, A., Dickson-Swift, V., DeVecchi, N., Phillips, C., Hodge, B., & Masood, Y. (2021). Evaluation of a rural undergraduate nursing student employment model. *Collegian*, *28*(2), 197-205. https://doi.org/10.1016/j.colegn.2020.07.003

Kenny, A., Dickson-Swift, V., Phillips, C., DeVecchi, N., Masood, Y., & Hodge, B. (2019). *FINAL REPORT: Evaluation of Registered Undergraduate Student of Nursing (RUSON) Pilot Program*.

King, S., Cieslowski, B., Pope, D., & Winkfield, D. (2022). Outcomes of an innovative best practice clinical immersion framework: A pilot study. *Nurse Educator*, *47*(6), E140-E144. https://doi.org/https://dx.doi.org/10.1097/NNE.0000000000001219

Lawani, A. (2021). Critical realism: What you should know and how to apply it. *Qualitative research journal*, *21*(3), 320-333. https://doi.org/https://doi.org/10.1108/QRJ-08-2020-0101

Li, I. Z., Yang, P., Singer, S. J., Pfeffer, J., Mathur, M. B., & Shanafelt, T. (2024). Nurse burnout and patient safety, satisfaction, and quality of care. *JAMA Network Open*, *7*(11). https://doi.org/doi:10.1001/jamanetworkopen.2024.43059

Lindsay, D. J., Ahern, T. A., Pardon, M. K., McAuliffe, M., & Rannard, S. G. (2023). Student employment models for undergraduate nurses and midwives in Australia: A scoping review. *Sage Open Nursing*, *9*(9). https://doi.org/DOI:10.1177/23779608231186026

Lokmic-Tomkins, Z., Khor, M. K. Y., Matthews, K. A., Martin, J.-A., & McGillion, A. (2021). Improving the health assistant in nursing employment model through entry to practice nursing student perceptions: A cross-sectional study. *Contemporary Nurse*, *57*(6), 472-481. https://doi.org/https://dx.doi.org/10.1080/10376178.2022.2049615

Lydon, C., O Brien, F., & Mooney, M. (2024). Newly qualified general nurses' experiences of pre-registration internship: A Republic of Ireland cross-sectional study. *Heliyon*, *10*(e39427). https://doi.org/https://doi.org/10.1016/j.heliyon.2024.e39427

Maas, K., Wassef, M., Kulkarni, M., & Bowker, L. (2021). Employment of medical and physician associate students in an NHS trust during the COVID-19 pandemic. *Future healthcare journal*, *8*(1), e146-e149. https://doi.org/https://dx.doi.org/10.7861/fhj.2020-0174

MacLeod, M., Stewart, N., Kosteniuk, J. G., Penz, K., Olynick, J., Karunanayake, C. P., Kilpatrick, K., Kulig, J., Martin-Misener, R., Koren, I., Zimmer, L. V., Van Pelt, L., & Garraway, L. (2019). Rural and remote Registered Nurses' perception of working beyond their legislated scope of practice. *Nursing Leadership*, *32*(1), 20-29. https://doi.org/https://doi.org/10.12927/cjnl.2019.25851

MacLeod, M., Stewart, N., & Kulig, J. (2019). Lessons from 20 years of research on nursing practice in rural and remote Canada. *Canadian Nurse*, *115*(3). https://www.canadian-nurse.com/en/articles/issues/2019/may-2019/lessons-from-20-years-of-research-on-nursingpractice-in-rural-and-remote-canada

McBrearty, K., Zordan, R., McInnes, E., Murphy, J., Riddell, K., Walker, V., & Jacob, E. (2024). Introduction of a registered undergraduate student of nursing workforce: A qualitative study of student and registered nurses. *Journal of Advanced Nursing*, *80*(9), 3745-3756. https://doi.org/https://dx.doi.org/10.1111/jan.16046

McDermott, C., & Lewis, A. S. (2025). An academic-practice partnership to support transition to practice. *Nursing Administration Quarterly*, *49*(2), 87-93. https://doi.org/https://dx.doi.org/10.1097/NAQ.0000000000000681

McGarity, T., Monahan, I., Acker, K., & Pollock, W. (2023). Nursing graduates' preparedness for practice: Substantiating the call for competency-evaluated nursing education. *Behavioural Sciences*, *13*(7). https://doi.org/https://doi.org/10.3390/bs13070553

McGillion, A., Tureman, M., & Mill, D. (2022). *An Evaluation of the RUSON Pilot at Western Health*. Western Health, Melbourne, Victoria, Australia.

McLachlan, H. L., Forster, D. A., Ford, R. L., & Farrell, T. (2011). Addressing the midwifery workforce crisis: Evaluating an employment model for undergraduate midwifery students at a tertiary maternity hospital in Melbourne, Australia. *Women & Birth*, *24*(4), 173-179. https://doi.org/10.1016/j.wombi.2010.12.004

McTier, L., Phillips, N. M., & Duke, M. (2023). Factors influencing nursing student learning during clinical placements: A modified Delphi study. *Journal of Nursing Education*, *62*(6), 333-341. https://doi.org/doi:10.3928/01484834-20230404-01

Miller, K., Paananen, T., McIntyre, S., & Shelast, Y. (2025). Being paid to be a student: Risks and rewards - An Exploratory mixed-methods study. *Quality Advancement in Nursing Education*, *11*(1, Article 5). https://doi.org/https://doi.org/10.17483/2368-6669.1516

Mitchell, J. (2020). Juggling employment and studies: Nursing students' perceptions of the influence of paid employment on their success. *Nurse Education Tody*, *92*(104429). https://doi.org/https://doi.org/10.1016/j.nedt.2020.104429

Moore, J., Chan, T., Doucette, J., Lipps, T., & Slager, D. (2024). Defining nurse practitioner core entrustable professional cctivities. *Nurse Educator*, *49*(5), 235-240. https://doi.org/DOI:10.1097/NNE.0000000000001673

Morrow, R. A., & Brown, D. D. (1994). *Critical Theory and Methodology* (Vol. 3). Sage Publications, Inc.

Muir, E. (2023). *Becoming a Nurse: A Mixed Methods Study of Student Nurse Employment and Graduate Nurse Experience.* Master's Thesis, University of Melbourne. Melbourne, Australia.

Muller, J. (1999). Narrative approaches to qualitative research in primary care. In B. C. W. Miller (Ed.), *Doing Qualitative Research* (2nd ed., pp. 221-238). SAGE.

Mumford, S., Newton, M., Benzie, C., Forster, D., Matthews, R., Hyde, R., Llewelyn, F., & McLachlan, H. (2023). Supporting the midwifery workforce: An evaluation of an undergraduate midwifery student employment model at a large tertiary maternity service in Victoria, Australia. *Women and birth : journal of the Australian College of Midwives*, *36*(1), e65-e77. https://doi.org/https://dx.doi.org/10.1016/j.wombi.2022.04.012

Pearce, R., Topping, A., & Willis, C. (2022). Enhancing healthcare students' clinical placement experiences. *Nursing Standard*. https://doi.org/doi: 10.7748/ns.2022.e11887

Phillips, C., Kenny, A., & Esterman, A. (2016). Pre-registration paid employment practices of undergraduate nursing students: A scoping review. *Collegian (Royal College of Nursing, Australia)*, *23*(1), 115-127. https://doi.org/https://dx.doi.org/10.1016/j.colegn.2014.09.012

Pietsch, J., Maaz, A., & Kottner, J. (2025). Entrustable professional activities in nursing education: A scoping review. *BMJ Open*, *15*(5). https://doi.org/DOI: 10.1136/bmjopen-2024-094609

Polkinghorne, D. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education 8*(1), 5 - 23. https://doi.org/https://doi.org/10.1080/0951839950080103

Raffelt, A. (2018). Incorporating an Undergraduate Student in Nursing program into the workforce: a prospective observational study. *Australian Journal of Advanced Nursing*, *35*(4), 17-23. https://doi.org/10.37464/2018.354.1496

Reid, S. (2019). The rural determinants of health: Using critical realism as a theoretical framework. *Rural and Remote Health*, *19*(3), 1-11. https://doi.org/https://doi.org/10.22605/RRH5184

Roush, K., & Opsahl, A. (2023). Internship program receives return on investment from nurse professional development efforts. *Journal for Nurses in Professional Development*, *39*(5), 261-266. https://doi.org/https://dx.doi.org/10.1097/NND.0000000000000867

Roush, K., Opsahl, A., & Ferren, M. (2021). Developing an internship program to support nursing student transition to clinical setting. *Journal of Professional Nursing : Official Journal of the American Association of Colleges of Nursing*, *37*(4), 696-701. https://doi.org/https://dx.doi.org/10.1016/j.profnurs.2021.04.001

Rusaanes, V., Eide, H., Brembo, E. A., Gladhus, L., Oswald, B. M., & Heyn, L. G. (2024). Educating nursing students for sustainable future rural health-care services: An umbrella review. *International Journal of Nursing Studies*, *151*(104688).

Salamonson, Y., & Andrew, S. (2006). Academic performance in nursing students: Influence of part-time employment, age and ethnicity. *Journal of Advanced Nursing*, *55*(3), 342-349.

Sanders, C., Roots, A., Hoot, T., Haggarty, D., Howell, M., Clyne, C., Vostanis, A., Agoston, I., Huynh, N., Bell, A., & Sokolowski, V. (2025). *Nurse Bridging Education: Optimization, Innovation, and Sustainability.* Report for the B.C. Ministry of Health, Victoria, B.C. Canada

Smela, B., Toumi, M., Swierk, K., Francois, C., Biernikiewicz, M., Clay, E., & Boyer, L. (2023). Rapid literaure review: Definition and methodology. *Journal of Market Access & Health Policy*, *11*(2241234). https://doi.org/https://doi.org/10.1080/20016689.2023.2241234

Souder, E., Beverly, C., Kitch, S., & Lubin, S. (2012). Early exposure to geriatric nursing through an externship program. *Nursing Education Perspectives*, *33*(3), 166-169.

Steen, J. E., Gould, E. W., Raingruber, B., & Hill, J. (2011). Effect of student nurse intern position on ease of transition from student nurse to registered nurse. *Journal for Nurses in Staff Development : JNSD : Official Journal of the National Nursing Staff Development Organization*, *27*(4), 181-186. https://doi.org/https://dx.doi.org/10.1097/NND.0b013e3181a68acc

Stout, C., Short, N., Aldrich, K., Cintron, R. J., & Provencio-Vasquez, E. (2015). Meeting the future of nursing report recommendations: A successful practice-academic partnership. *Nursing economic$*, *33*(3), 161-166. https://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med12&AN=26259340https://unbc.on.worldcat.org/atoztitles/link?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rfr_id=info:sid/Ovid:med12&rft.genre=article&rft_id=info:doi/&

Stubin, C. (2026). A study of nursing graduates' transition to practice and implications for curriculum development. *Nurse Educator*, *51*(2), 68-73. https://doi.org/doi:10.1097/NNE.0000000000002049

Surjadi, M., Stringari-Murray, S., & Saxe, J. (2019). Entrustable professional activities in nurse practitioner education. *The Journal for Nurse Practitioners*, *15*(5), e97-e102. https://doi.org/https://doi.org/10.1016/j.nurpra.2018.12.030

Sweet, L., Vasilevski, V., & Sweeney, S. (2021). *The introduction of RUSOM staff at Western Health: Experiences of staff, supervisors, and women.* Report for Western Health, Melbourne, Victoria, Australia.

Sweet, L., Vasilevski, V., & Sweeney, S. (2023). The introduction of registered undergraduate students of midwifery in a tertiary hospital: Experiences of staff, supervisors, and women. *Women and birth : journal of the Australian College of Midwives*, *36*(1), e44-e56. https://doi.org/https://dx.doi.org/10.1016/j.wombi.2022.04.010

Syed, A., Pereira, J., Manson, K., Miller, A., Houle, S., & Waite, N. (2026). Entrustable professional activities (EPAs) for pharmacy students during experiential education: A comparative analysis. *Currents in Pharmacy Teaching and Learning*, *18*(5). https://doi.org/https://doi.org/10.1016/j.cptl.2026.102601

Tambunan, E. (2024). Theory-practice gap during clinical learning: A descriptive qualitative study of nursing students' experiences and perceptions. *Journal of Caring Science*, *13*(2), 74-81. https://doi.org/doi:10.34172/jcs.33251

ten Cate, O. (2005). Entrustability of professional activities and competency-based training. *Medical Education*, *39*(12), 1176-1177. https://doi.org/https://doi.org/10.1111/j.1365-2929.2005.02341.x

ten Cate, O. (2018). A primer on entrustable professional activities. *Korean Journal of Medical Education*, *30*(1), 1 - 10. https://doi.org/doi:10.3946/kjme.2018.76. Epub 2018 Feb 28

Tiang Lau, S., Ang, E., Samarasekera, D., & Shorey, S. (2020a). Development of undergraduate nursing entrustable professional activities to enhance clinical care and practice. *Nursing Education Today*, *87*. https://doi.org/DOI:10.1016/j.nedt.2020.104347

Tiang Lau, S., Ang, E., Samarasekera, D., & Shorey, S. (2020b). Evaluation of an undergraduate nursing entrustable professional activities framework: An exploratory qualitative research. *Nursing Education Today*, *87*. https://doi.org/https://doi.org/10.1016/j.nedt.2020.104343

Tricco, A. C., Langlois, E. V., Straus, S. E., & editors. (2017). *Rapid reviews to strenghten health policy and systems: a practical guide.* https://iris.who.int/bitstream/handle/10665/258698/9789241512763-eng.pdf?sequence=1

Wagner, L., Dolansky, M., & Englander, R. (2018). Entrustable professional activities for quality and patient safety. *Nursing Outlook*, *66*(3), 237-243. https://doi.org/doi:10.1016/j.outlook.2017.11.001. Epub 2017 Nov 22

Wallace, J. (2016). Nursing student work-study internship program: An academic partnership. *The Journal of Nursing Education*, *55*(6), 357-359. https://doi.org/https://dx.doi.org/10.3928/01484834-20160516-11

Walsh, S. M., Versace, V., Thompson, S. C., Browne, L. J., Knight, S., Lyle, D. M., Argus, G., & Jones, M. (2023). Supporting nursing and allied health student placements in rural and remote Australia: A narrative review of publications by university departments of rural health. *Medical Journal of Australia*, *219*(3 Supplement). https://doi.org/doi.org/10.5694/mja2.52032

Wilbur, K. (2017). Entrustable professional activities: A primer for Canadian pharmacy preceptors. *Innovations in Pharmacy Practice: Pharmacy Education*, *70*(6), 450-455.

Willetts, G., Nieuwoudt, L., Olasoji, M., Sadoughi, N., & Garvey, L. (2022). Implementation of a registered undergraduate student of nursing (RUSON) program: The nurses' perspective. *Collegian*, *29*, 70-77. https://doi.org/https://doi.org/10.1016/j.colegn.2021.04.006

Winwood, D. P. (2023, April 27). Northern Health Stories: *Maintaining quality education in the Northern Medical Program.* https://stories.northernhealth.ca/stories/qualitycast-north-maintaining-quality-education-northern-medical-program-dr-paul-winwood

Wise, M., Ossenberg, C., & Hendersen, A. (2022). The contribution of paid employment for students during their pre-registration nursing studies: An integrative review. *Nurse Education Today*, *111*, 105296. https://doi.org/https://doi.org/10.1016/j.nedt.2022.105296

Zainuldin, R., & Yang Tan, H. (2023). Entrustable professional activities developed for allied health entry-level programs across a national level training standards framework in Singapore. *Journal of Allied Health*, *52*(2), 104-112. https://www.ingentaconnect.com/contentone/asahp/jah/2023/00000052/00000002/art00004

13 APPENDICES

Appendix 1 Employment Standards Act as pertains to nursing students

Appendix 2 Search Strategy for Rapid Literature Review –

Appendix 3 - Covidence Data Extraction Template

Appendix 4 Methodological Quality of Included Articles

Appendix 5 Narrative Interview Questions

Appendix 6 ACG Briefing Report

Appendix 7 Environmental Scan

Appendix 8 Articles included in Rapid Review of Literature

Appendix 9 Narrative Exemplar – ESN

Appendix 10 Narrative Exemplar - Employer

13.1 EMPLOYMENT STANDARDS ACT AS PERTAINS TO NURSING STUDENTS

Student nurses in B.C. are currently prohibited from being paid while on required educational placements or practicum under the Employment Standards Act and Regulations, specifically Regulations, Part 7, Section 33.

The following is from the B.C. government website
https://www2.gov.bc.ca/gov/content/employment-business/employment-standards-advice/employment-standards/forms-resources/igm

Guide to the Employment Standards Act and Regulation
Last updated on November 28, 2025

This guide is an interpretation of the B.C. Employment Standards Act and Regulation to help provide a clear understanding of the law. It is not a legal document and should not be used as a substitute for legal counsel.

Exclusions from Parts of the Act & This Regulation - Regulation Part 7, Section 33
Last updated on February 19, 2025

Summary
This section identifies certain types of employees who are excluded from Part 2 and Parts 4 to 8 of the Act and Part 4 of this Regulation.

Text of Legislation
33.(1) Part 2, section 16 and Parts 4 to 8 of the Act do not apply to any of the following:
(a)subject to paragraph (b), a student in an academic or technical program recognized under the bylaws of the British Columbia College of Nurses and Midwives as meeting a standard of academic or technical achievement required
(i)for registration as a member of that college, and
(ii)to practise the designated health profession of nursing, practical nursing or psychiatric nursing;
(b) a student in training to be a practical nurse, as defined in the Nurses (Licensed Practical) Regulation, at a hospital as defined in the *Hospital Act;*
(c) an auxiliary or volunteer fire fighter employed by a fire department that is organized by a municipality or regional district for the protection of the public.

Policy Interpretation
1. Student nurses including:

- a student in a school of nursing recognized by the College of Registered Nurses of British Columbia; or
- a student in training to be a practical nurse, under the Nurses (Licensed Practical) Act, at a hospital as defined in the Hospital Act; and

2. Auxiliary or volunteer fire fighters employed by a fire department, organized by a municipal or regional district fire department, for public protection.

are excluded from the following provisions:
Employment Standards Act
Part 2 – ***Hiring Employees***
Part 4 – ***Hours of Work and Overtime***
Part 5 – ***Statutory Holidays***
Part 6 – ***Leaves and Jury Duty***
Part 7 – ***Annual Vacations***
Part 8 – ***Termination of Employment***

The above employees are entitled to all the provisions of Part 3 of the Act, **Wages, Special Clothing and Records**, with the exception of s.16 **Employers required to pay minimum wage**.

Related Information
Related sections of the Act or Regulation
ESA

- s.1, Definition, “employee”
- Part 2 – Hiring Employees
- Part 3 - Wages, Special Clothing and Records
- Part 4 – Hours of Work and Overtime
- Part 5 – Statutory Holidays
- Part 6 – Leaves and Jury Duty
- Part 7 – Annual Vacations
- Part 8 – Termination of Employment

ESR

- Part 4 – Minimum Wages

Other
Nurses (Registered) Act
Nurses (Licensed Practical) Act
Hospital Act

This regulation section has obviously been in existent for a long time as many of the references in the regulation are outdated. As examples:

- The College of Registered Nurses of BC ceased to exist in 2018,
- The *Nurses (Registered) Act* was repealed in 2006,
- Licensed practical nurse training moved to colleges in the early 1990’s,
- The *Nurses (Licensed Practical) Act* was repealed in 2008,
- The *Hospital Act* makes no mention of nurse training, the sections relating to this regulation must have been repealed at an unknown time in the past. The only training requirements mentioned in *the Hospital Act* relates to medical students.

Our best estimate is that this regulation was formulated and implemented in the mid-1980s, as student nurses continued to receive financial compensation during their education programs up to at least 1982. Although the University of British Columbia introduced university-level nursing education in 1919, other universities in B.C. did not establish their nursing programs until the mid to late 1980s. We understand that this regulation was implemented during this period as part of the broader reform of nursing education, in order to ensure dedicated learning time and prevent students from being used as workforce. Notably, nursing students remain the only group of professional students exempt from remuneration under the Employment Standards Act.

Changing perspectives and circumstances

The economic circumstances for students have shifted significantly since the 1980s, with numerous other countries and professions now offering financial support to students undertaking mandatory education practicums.

The Australian Commonwealth Government has recently recognised this issue in an effort to address "placement poverty”. Effective from 1 July 2025, nursing, midwifery, teacher, and social work students on required educational practicums of more than 30 hours per week will be paid the *Commonwealth*

Prac Payment of $319.50–$338.60 per week. The amount will be adjusted each year using the same formula applied to all government payments. Payments are available for a maximum of 12 to 26 weeks throughout an individual's education, with nursing students currently eligible to receive up to 20 weeks of payments. This payment is additional to any payments made under the *Aus Study* or *Youth Start* government payment schemes for student study at higher educational institutions. https://www.education.gov.au/commonwealth-prac-payment-cpp/students

Since 2023, some educational providers in New Zealand have started paying nurses while on required clinical placements up to $500 per week, and the government has proposed paying all nursing students, but this has not been finalized. https://www.aut.ac.nz/news/stories/new-program-to-financially-boost-nursing-students#:~:text=In%20addition%20to%20the%20$500,of%20our%20future%20healthcare%20workforce.%E2%80%9D

In the UK, since 2020 all nursing students receive a payment of a minimum of £5,000 per year. This may be increased by a further £3,000 per year depending on location and circumstances. (https://www.gov.uk/government/news/nursing-students-to-receive-5-000-payment-a-year#:~:text=News%20story,for%20eligible%20students%2C%20including%20for)

In addition, nursing students are paid, either while on required clinical placements or by month salary in Germany, France, and Ireland, and in 2023 the European Union parliament voted in favour of banning unpaid training internships. Work is currently underway to determine how this will be implemented across the EU. https://youthforeurope.eu/unpaid-internship-what-the-european-parliament-decided/

13.2 SEARCH STRATEGY FOR RAPID LITERATURE REVIEW

Search term summary –
Medline, CINAHL, ERIC & Cochrane Systematic Reviews

Query:

1. *Health student employment search*

   ((nurs* or health* or midwife* or midwive* or "physical therap*" or "occupational therap*" or physiotherap*) N2 student*)

   AND

   ((job* or employ* or work*) N2 (program* or pathway* or model*)) OR (apprentice* or residency or residencies or internship*)

2. *Rural placement*

   ((nurs* or health* or midwife* or midwive* or "physical therap*" or "occupational therap*" or physiotherap*) N2 student*)
   AND
   (Placement* or practicum* or residencies or residency or apprentice* or preceptorship* or preceptee* or intern*)
   AND
   (Rural or remote or northern or nonmetropolitan)

Cochrane Systematic Reviews search produced no results

13.3 COVIDENCE DATA EXTRACTION TEMPLATE

General information

Study ID #

Title

Title of paper / abstract / report that data are extracted from

Lead author contact details

Country(s) in which the study was conducted

1. United States
2. UK
3. Canada
4. Australia
5. New Zealand
6. Nordic Countries
7. Other European
8. Asian countries
9. Other

Notes

Characteristics of included studies

Methods

Aim of study

Study design

1. Scoping review
2. Cross-sectional study / survey
3. Qualitative systematic review
4. Mixed methods study
5. Qualitative interview study
6. Case study
7. Economic evaluation
8. Text and opinion piece
9. Other

Start date

End date

Study funding sources

Possible conflicts of interest for study authors

Participants

Profession

1. Nursing
2. Midwifery
3. Pharmacy
4. Physiotherapy
5. Paramedic
6. Medicine / Physician assistant
7. Medical laboratory science
8. Medical radiological technology
9. Respiratory therapy
10. Diagnostic medical sonography
11. Other – specify

Total number of participants / studies included

Types of participants

	Number
Students (not yet registered)	
Graduates / Mentors / Supervisors	
Employer – Management	
Regulators	
Other	

Findings

Case study or description of employment model

Purpose of the employment program

Is there a SOP or job description?

Is position laddered to student progression, e.g. does it change with the progression of student learning?

Position regulated or unregulated?

Position supernumerary / not?

Supervised by?

Is position linked to an academic partnership or developed with a relationship to educational institution?

Outcomes from the position

Pt care outcomes

Improvement in patient experience / safety

Employer / Institutional outcomes

Recruitment

Retention

Cost effectiveness

Other outcomes?

How are the outcomes measured?

Recommendations / Conclusions

Reviews – Scoping or systematic review

Purpose of review

Key findings

Outcomes

Recommendations / Conclusions

13.4 METHODOLOGICAL QUALITY OF INCLUDED ARTICLES

Critical Appraisal of Qualitative Studies
JBI critical appraisal checklist for qualitative research

Author	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Algoso & Peters 2012	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Beccaria 2024	U	Y	Y	Y	Y	Y	U	Y	Y	Y
Burns 2022	U	Y	Y	Y	Y	Y	N	Y	U	Y
Cepanec 2013	U	Y	Y	Y	Y	N	N	Y	U	Y
Cordon 2025	U	Y	Y	Y	Y	N	N	Y	Y	Y
Gamroth 2006	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hasson 2013	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Kenny 2021	Y	Y	Y	Y	Y	N	N	Y	Y	Y
McBrearty et al 2024	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
McDermott 2025	Y	Y	Y	Y	Y	N	N	Y	U	Y
McLachlan 2011	U	Y	Y	Y	Y	N	N	Y	Y	Y
Sweet 2023	U	Y	Y	Y	Y	N	U	Y	Y	Y
Willetts 2022	U	Y	Y	Y	Y	N	Y	Y	Y	Y
% of studies	**46**	**100**	**100**	**100**	**100**	**38**	**23**	**100**	**77**	**100**

Y – yes, N - no, U – unclear, N/A – not applicable
Q1 = Is there congruity between the stated philosophical perspective and the research methodology?
Q2 = Is there congruity between the research methodology and the research question or objectives?
Q3 = Is there congruity between the research methodology and the methods used to collect data?
Q4 = Is there congruity between the research methodology and the representation and analysis of data?
Q5 = Is there congruity between the research methodology and the interpretation of results?
Q6 = Is there a statement locating the researcher culturally or theoretically?
Q7 = Is the influence of the researcher on the research, and vice-versa, addressed?
Q8 = Are participants, and their voices, adequately represented?
Q9 = Is the research ethical according to current criteria or, for recent studies, is there evidence of ethical approval by an appropriate body?
Q10 = Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Critical Appraisal of Analytical Cross Sectional Studies
JBI critical appraisal checklist for analytical cross-sectional studies

Author	Q1	Q2	Q3	Q4	Q5	Q6	*Q7*	Q8
Ahern et al 2023	Y	Y	Y	Y	N/A	N/A	Y	Y
Chow 2010	Y	Y	Y	Y	N/A	N/A	Y	Y
King 2022	Y	Y	Y	Y	N/A	N/A	Y	Y
Lokmic-Tomkins 2021	Y	Y	Y	Y	N/A	N/A	Y	Y
Mumford 2023	Y	Y	Y	Y	N/A	N/A	Y	Y
% of studies	**100**	**100**	**100**	**100**			**100**	**100**

Y – yes, N - no, U – unclear, N/A – not applicable
Q1 = Were the criteria for inclusion in the study clearly defined?
Q2 = Were the study subjects and the setting described in detail?
Q3 = Was the exposed measured in a valid and reliable way?
Q4 = Were objective, standard criteria used for the measurement of the condition?
Q5 = Were confounding factors identified? (no confounding factors were identified)
Q6 = Were strategies to deal with confounding factors stated?
Q7 = Were outcomes measured in a valid and reliable way?
Q8 = Was appropriate statistical analysis used?

Critical Appraisal of Case Reports
JBI critical appraisal checklist for case reports

Author	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Amerine et al. 2017	Y	Y	N/A	Y	Y	Y	Y	Y
Boggon 2022	Y	Y	N/A	U	Y	Y	Y	Y
Crevacore 2019	Y	Y	N/A	Y	Y	N	N	Y
Gillian 2024	Y	U	N/A	N	U	Y	U	Y
Gregory et al. 2014	Y	Y	N/A	U	Y	Y	N	Y
Maas 2021	Y	Y	N/A	Y	Y	U	U	Y
Olson 2001	Y	Y	N/A	Y	U	N	U	Y
Roush 2021	Y	Y	N/A	Y	Y	Y	U	Y
Roush 2023	Y	Y	N/A	Y	Y	N/A	NA	Y
Souder 2012	Y	Y	N/A	U	Y	Y	U	Y
Steen 2011	Y	Y	N/A	Y	Y	Y	U	Y
Stout 2015	Y	Y	N/A	Y	Y	Y	N/A	Y
Wallace 2016	Y	Y	N/A	N	Y	U	U	U
% of studies	**100**	**92**		**62**	**85**	**62**	**15**	**92**

Y – yes, N - no, U – unclear, N/A – not applicable
Q1 = Were the patient's* demographic characteristics clearly described? (*Employed student programs were used in the place of patient)
Q2 = Was the patient's [programs] history clearly describe and presented as a timeline?
Q3 = Was the current clinical condition of the patient on presentation clearly described? (Not applicable to this situation)
Q4 = Were diagnostic tests or assessment method* and results clearly described? (*assessment / evaluation of program were used in place of diagnostic tests)
Q5 = Was the intervention(s) or treatment procedure(s)* clearly described? (*program components and inclusions were used)
Q6 = Was the post-intervention clinical condition clearly described? Framed in the context of students working in ESN programs.
Q7 = Were adverse events (harms) or unanticipated events* identified and described? (*limitations of the program / role)
Q8 = Does the case report provide takeaway lessons?

Critical Appraisal of Systematic Reviews and Research Synthesis
JBI critical appraisal checklist for systematic reviews and research synthesis

Author	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11
Budgen & Gamroth 2008	Y	Y	Y	Y	Y	U	U	Y	N	Y	Y
Happell 2007	N	N	N	N	U	U	U	U	N	Y	Y
Lindsay et al 2023	Y	Y	Y	Y	Y	Y	Y	Y	U	Y	Y
Phillips 2016	Y	Y	Y	Y	Y	Y	U	U	N	Y	Y
Wise 2022	Y	Y	Y	Y	Y	Y	Y	Y	U	Y	Y
% of studies	**80**	**80**	**80**	**80**	**80**	**60**	**40**	**60**	**0**	**100**	**100**

Y – yes, N - no, U – unclear, N/A – not applicable
Q1 = Is the review question clearly and explicitly stated?
Q2 = Were the inclusion criteria appropriate for the review question?
Q3 = Was the search strategy appropriate?
Q4 = Were the sources and resources used to search for studies adequate?
Q5 = Were the criteria for appraising studies appropriate?
Q6 = Was critical appraisal conducted by two or more reviewers independently?
Q7 = Were there methods to minimize errors in data extraction?
Q8 = Were the methods used to combine studies appropriate?
Q9 = Was the likelihood of publication bias assessed?
Q10 = Were recommendations for policy and/or practice supported by the reported data?
Q11 = Were the specific directives for new research appropriate?

Critical Appraisal of Textual Evidence: Expert Opinion
JBI critical appraisal checklist for textual evidence: expert opinion

Author	Q1	Q2	Q3	Q4	Q5	Q6
Browne 2013	Y	Y	Y	Y	Y	N/A
Kee &Ryser 2001	Y	Y	Y	Y	N	N/A
% of studies	**100**	**100**	**100**	**100**	**50**	

Y – yes, N- no, U – unclear, N/A – not applicable
Q1 = Is the source of the opinion clearly identified?
Q2 = Does the source of the opinion have standing in the field of expertise?
Q3 = Are the interests of the relevant population the central focus of the opinion?
Q4 = Does the opinion demonstrate a logically defended arguments to support the conclusions drawn?
Q5 = Is there reference to the extant literature?
Q6 = Is any incongruence with the literature/sources logically defended?

Critical Appraisal of Textual Evidence: Expert Opinion
JBI critical appraisal checklist for cohort studies

Author	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11
Raffelt et al. 2018	Y	Y	Y	N	U	Y	Y	Y	Y	N/A	U
% of studies	**100**	**100**	**100**			**100**	**100**	**100**	**100**		

Y – yes, N- no, U – unclear, N/A – not applicable

1. Were the two groups similar and recruited from the same population?
2. Were the exposures measured similarly to assign people to both exposed and unexposed groups?
3. Was the exposure measured in a valid and reliable way?
4. Were confounding factors identified?
5. Were strategies to deal with confounding factors stated?
6. Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)?
7. Were the outcomes measured in a valid and reliable way?
8. Was the follow up time reported and sufficient to be long enough for outcomes to occur?
9. Was follow up complete, and if not, were the reasons to loss to follow up described and explored?
10. Were strategies to address incomplete follow up utilized?
11. Was appropriate statistical analysis used?

13.5 NARRATIVE INTERVIEW QUESTIONS

Questions for Employers/ ESN support roles	
Understanding Local Context	How is your ESN program structured, and what are its primary goals for both the students and the healthcare service? **Follow up:** How is success in the ESN program measured short and longer term? Please share where your ESNs work and what data is collected and collated at the HA level about ESNs? How are ESN placements determined? How many hours/ contracts do ESNs work in your HA? In what specific ways does the program contribute to students' clinical skills, confidence, and readiness for professional practice, and how are these outcomes measured?
Supportive Approaches	From your perspective as an employer or supervisor, or ESN program lead, what are the primary challenges or considerations in clearly defining and maintaining the scope of practice for ESNs within your facility, and how do you navigate these issues? **Follow up:** What challenges have you/your teams experienced with supervising ESNs generally? And in specific areas such as acute care/community care etc. Do you offer ESN positions in rural and remote settings? Based on your experience/knowledge, what do you consider important about establishing these types of ESN opportunities? What kind of support and mentorship is provided to students and the staff working with them, and how do you ensure clear understanding of roles and responsibilities? Do ESNs work with or have supervision from other HC team members i.e., SW, OT etc. What common challenges have arisen in the program (e.g., scope of practice ambiguity, scheduling, balancing academics), and how are they addressed? In what ways do you see the employment of student nurses impacting your organization financially, and how do you ensure their role is primarily focused on skill consolidation rather than just addressing staffing shortages?
Building the Future Workforce	What sort of feedback do you receive from ward level staff relating to the ESN role? **Follow-up** as example to help conversation: Bridging the theory – practice gap?

	How does this program contribute to the recruitment and retention of nurses within your organization short and longer term, and what are the observed long-term benefits? How do you support and celebrate the ESN role within your organization? **Follow up:** Are ESNs at risk of stress and burnout? What strategies do you have in place to limit this? Based on the data you collect about ESNs has this helped to shape supporting ESNs? What approaches do you have in place that support a learning pathway from ESN to career in healthcare? Based on your observations, how has the presence of ESNs impacted patient care, patient safety, or overall patient experience in your department?
Partnership working	Describe the collaboration between your organization and educational institutions in developing students nursing skills, is there any formal or informal program support. Are the students given any recognition of their learning from practice? **Follow up:** If there is no PSI – HA collaboration focused on ESN or skills learning, no credit for hours etc. is this a missed opportunity?
Moving Forward	What are the plans for this program, including potential expansion, funding, and integration into broader workforce strategies? Considering the overall experience of having ESNs , what do you see as the most significant benefits and challenges for your organization, and what aspects would you prioritize for future improvement? What wider challenges do you see for the ESN position in the changing healthcare landscape and funding limitations in health?

Questions for ESNs	
Theme	Question
Motivations and Expectations	What motivated you to apply for an ESN role, and how did your actual experience compare to your initial expectations? **Follow up:** Does the ESN work help with financial support and gain practical experience?
Balancing Demand	What have been the challenges you've faced in balancing your paid employment shifts with your academic commitments, clinical placements, and personal study? How do these competing demands impact your well-being or academic performance?

Role Clarity and Scope of Practice	How do you navigate the difference between your student role (e.g., on clinical placement) and your ESN role? What are the differences between these two roles? Have you felt pressured to perform skills outside of the activities you have been adequately educated and mastered at university? Or take on the HCA role to fill staffing gaps versus supporting nurses' work. Have you been taught additional skills, beyond those included in your education program, in your ESN role? Are these recognized by your employer and your educational program; if yes, how is this done?
Employment, Skill development and learning	What information did you receive when you started as an ESN? Can you describe the orientation you received? Do you think your orientation was adequate? In what specific ways has your ESN role contributed to the improvement of your clinical skills, confidence, practice of cultural safety and inclusion, and overall competence to practice? Can you provide examples of how this role has helped you to apply university-acquired knowledge and bridge the theory-practice gap? **Follow-up:** Is there a gap between what you learn in university and the skills/tools you use in your ESN role? Do you think the ESN role should be available in remote communities? How could this role help students to work in these communities? **Follow up:** Can you think of any barriers/ challenges or opportunities for ESNs working in rural and remote settings?
Support and Recognition	How well do you feel supported in your ESN role by your supervisors, nurses, managers or educators? – Tell me a little more about supervision? **Follow up:** Who provides, and how often, do you get feedback about your ESN work/role? What is most helpful? Do you believe the knowledge and learning you acquire in the workplace are formally recognized by your university? **Follow up:** How could your university help support you in your ESN position?
Professional Identity and Team Integration	How has working as an ESN facilitated your fit in with the healthcare setting? - Does it support communication with other professional teams? Has being an ESN helped in the formation of your professional identity?

	Do you feel like a valued part of the team and gain a sense of belonging? **Follow up:** If you have worked on more than one unit as an ESN have you noticed any differences in experiences? (think about orientation or scheduling, welcome environment)
Realistic Practice Understanding	How has your ESN experience shaped your understanding of the nurse's role and the realities of nursing practice, particularly in comparison to what you learn during traditional clinical placements?
Transition to Practice and Future Intentions	Did you get an ESN position in the clinical area you wanted? If you did, how did your ESN position help you decide on a nursing pathway i.e. ED or maternity? Were you successful in securing this pathway, did your ESN position help in this process? How do you anticipate your ESN experience will impact your transition into a new graduate role, including potentially reducing your orientation time? Does your experience in this role influence your intentions to seek future employment with your current health service post-graduation? Based on your experiences, what recommendations would you make to improve the ESN program for future students and the healthcare system?

Advisory Consultation Briefing Report *Strengthening the Employed Student Nurse (ESN) Role as a Provincial Workforce Development Strategy*

Advisory meeting 9th February 2026

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Invitations
BCCNM – one representative
BCNU - one representative
ESNs – four representatives
Graduate student & author - Ministry of Health (MoH) report – one representative

Health Authorities – Representatives from four health authorities (HAs). These representatives were determined based on ensuring each HA has a voice twice in this project, either through the Interior University Research Coalition (IURC) grant, or the MoH graduate student led work.

Post Secondary Institutions (PSI) – Representatives from three PSIs. These representatives were determined based on ensuring each PSI has a voice in this project, either through the IURC grant, the MoH graduate student led work, or is member of the study team.

Purpose
This session aims to draw together the four pillars of work completed in 2025 to discuss overlaps and explore perspectives to inform recommendations focused on the current employed student nurse ESN program and emerging opportunities.

Executive Summary
This report synthesizes findings from ESN and employer interviews, PSI and HA collaboration findings, as well as regulatory and system partner insights to inform strategic decisions regarding the future direction of the ESN role in British Columbia (B.C.). Evidence indicates that the ESN role operates as a reciprocal workforce development strategy that strengthens both student learning and organizational capacity, but is constrained by inconsistency, variable resourcing, and limited shared data infrastructure.

Preparing for the Meeting
Before attending the Advisory Consultation meeting on February 9th, please review the Terms of Reference (TOR) and the questions in the discussion guide Appendix A. After reviewing these items, add brief notes or responses to the space provided, including specific/focused feedback suggestions whenever possible, to ensure we make the most of our time together.

We ask that you complete this digitally so all notes can be compiled easily. While this activity is **optional**, it serves as a helpful guide for the meeting and allows you to reflect on your responses in advance and discuss them with your colleagues. Please be mindful that this report is not yet complete and is the property of the MoH.

If you prefer not to provide feedback during the discussion, this guide offers an alternative way to share your thoughts. Thank you for your time and involvement in this advisory consultation.

Four pillars of work focused on employed student nurses in B.C.

The ESN position has been in use in B.C. for more than 20 years, with no formal review or evaluation since the initial introduction. The number and extent of these positions have grown over the past decade, with employers exploring new skill mix solutions and changes in opportunities for utilizing ESNs. However, little is known about how these positions function and support students.

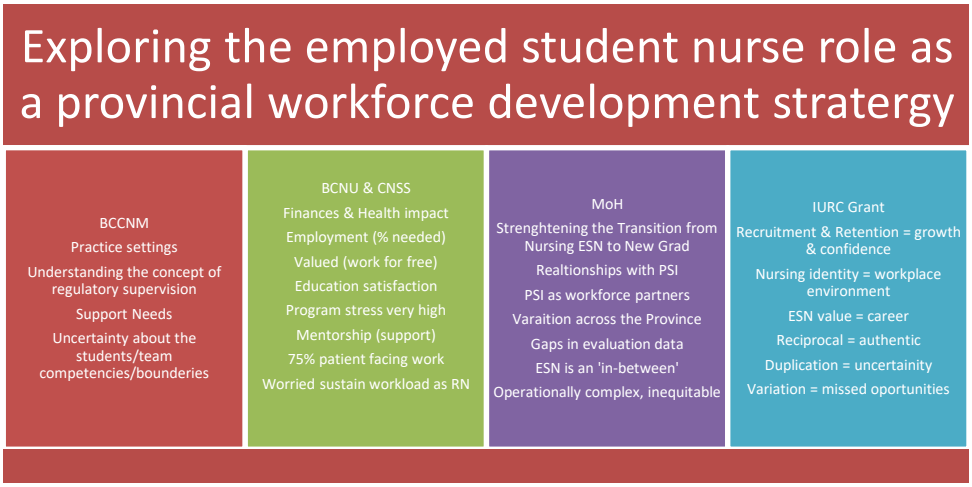


Figure 1. The four pillars of work focused on ESN under review

Our IURC study aimed to identify and examine the experiences and underlying principles that inform a robust ESN program, expose the social structures that shape these experiences, and identify possibilities for improvement and systems change.

This work is designed to assist government, employers, educational institutions, and regulators in determining the direction and/or efficacy of actions that need to be undertaken to build quality, equitable, inclusive, and sustainable employed student experiences.

We were not alone in focusing on ESNs in 2025: The ESN program is also under consideration through BCNU bargaining, BCCNM is working on the HPOA requirements, and the MoH report: *Strengthening the Transition from Nursing Student/Employed Student Nurse to New Graduate Nurse: Enhancing Collaboration between PSIs and HAs*.

The IURC study completed the following activities between March 2025 and December 2025.

1. An international environmental scan of employed healthcare student opportunities including all Canadian provinces, Australia, Ireland, New Zealand, Singapore, the UK and the USA;
2. Completion of a rapid review of the literature relating to employed student programs and relevant policy and regulation from nursing, midwifery, medicine and allied health; and
3. A narrative interview study with 43 respondents from BC, including ESNs, employers, regulators, and union representatives.

Findings

The key findings are presented in Appendix A Table 1 (ESNs) and Appendix B Table 2 (Employers). To aid discussion, we have formulated several guiding questions to open discussion in this advisory consultation exercise. The report is in draft and due for primary review with the MoH in 2 weeks, with final changes in March 2026.

Employed Student Nurses: The ESN role is highly valued, beneficial for consolidating and exposing learners to clinical opportunities that can be missing from instructor-led models. This enriches students' learning, offering authentic clinical exposure that supports the development of confidence in core nursing tasks/competencies/skills. Immersion in practice, guided observation, and opportunities for repetition enabled students to consolidate knowledge and translate learning into skilled, independent performance activities. Elevating confidence can, at one end of the spectrum, result in the learners loving nursing and deciding to stay in education programs. For others, the ESN

opportunity sits within a broader training pathway, feeding into recruitment and retention, and for some specialist pathways.

We believe the ESN role is most effective when understood as a shared learning–service space where both students and organizations grow capacity together. We noticed an absence or, at times, tension from the post-secondary sector in the ESN accounts. Such absence has a significant impact on the dynamic within the ESN learning space and missed opportunities between the employer-PSI interface. We acknowledge that relational practices do exist, but they are not consistent across HAs and levels of leadership and operations.

Employers, leadership, educators and clinical leadership: Employers have a critical role in the ESN program because they are not simply hosting ESNs, they are actively shaping the next generation of nurses, and the quality of that experience directly determines professional identity, recruitment, readiness, and retention outcomes.

We believe that the evidence across all data sources indicates that the ESN role is no longer simply a nice-to-have work opportunity that occurs alongside education. It has become a core site of learning, professional identity formation, and workforce transition.

As a result, employers are now functioning as co-educators and primary shapers of practice readiness, while PSIs remain responsible for foundational preparation but have limited visibility into what happens once students enter employment. If ESNs are to achieve their full potential as a workforce strategy, employers and PSIs must move from parallel roles using authentic partnership mechanisms that support and sustain education-workforce development.

Guiding questions for discussion at the advisory consultation

1. Do you agree with these high-level findings (themes)? What have we missed?
2. Addressing role ambiguity, inconsistency, emotional strain, and moral labour.
    a. How can we deal this?
    b. Who needs to take the lead on this?
    c. How do we develop buy in?
3. Appetite for combining PSI-based education with ESN, transition to practice, and career pathways?
    a. Would/wouldn't this work?
    b. What could be gained/lost by doing this?
    c. Could point 4, below, offer a solution?
4. Is there scope to consider a supervision model for ESNs that draws from the approach used in medicine, entrustable professional activities (EPAs). This would be a structured practice-based approach that reflects BCCNM competencies, task-focused, can be applied in a job description and has transparency. EPAs are defined as discrete professional tasks that reflect the essential work of a health professional and that can be *entrusted* to a learner once they demonstrate competence in integrating knowledge, skills, and professional behaviours across clear domains. For ESNs, the EPA model supports supervisors to calibrate levels of supervision, which we recognize from our data is a 'grey' area. Supervision ranges from observation to indirect practice based on demonstrated ability rather than time or subjective judgment. This approach can further enhance trust and facilitate growth between the learner and clinical teams, which strengthens recruitment potential. The EPA promotes consistent assessment and facilitates trustworthy entrustment decisions. It bridges the gap between educational competencies and practical workplace responsibilities, making supervision more transparent, work-aligned, and focused on real-world readiness.
5. Can students be both learners and workers concurrently? (Irish model below as an example, see attached papers for more information).

Learnings from the Irish model

a) A nationalized (provincial) structured approach to preparing supernumerary students for transition to practice (internship) can be developed.
b) The reality of the nurse's role was recognized only after the student transitioned from the supernumerary role.
c) 'Independent' preceptorship avoided the reality shock reported by newly qualified nurse in other studies.
d) 96% of respondents felt preceptorship was extremely valuable in transitioning from student to new graduate. The Irish regulatory standards require new graduates at the time of registration to be at the 'competent' level; as defined in Benner's framework, not 'advanced beginner' level, which is more frequently used to describe the level of a new graduate nurses in BC.
e) Hours in the Irish model = 1,280, we have gathered data on hours, and there is variation, but even with the current median approx. 500 hours if final preceptorship was included and funded with a 10-20% increase in hours, the ESN and a final paid practicum accelerate the learner to be more ready for practice, which raises the question of how the transition to practice model fits here.

Questions for consideration: Is there scope to examine costing models? Is there a provincial new graduate/employer perspective on the transition model? Has the transition model been taken up universally? Is it fit for purpose with evidence of retention when there are limited positions in the areas where graduates complete their transition to practice?

Next Steps

Discussion and feedback are welcome to shape the final stages of this report.

Please use **Appendix A and B** to share your thoughts and feedback.

Please review **Appendix C**: Emerging logic model and provide comments

Please review **Appendix D**: As a knowledge translation approach we are keen to explore in the final report. We propose using stories that reflect and celebrate the ESN, as with over 1000 pages of data we have a responsibility to ensure that the narratives are front and centre in the work we wish to share.

Thank you for your participation. We will send a more formal acknowledgement and update after the Ministry of Health provides its preliminary feedback.

With gratitude,

The ESN Study teams: Dr Sanders, Dr Roots, Dr Hoot, Dr Newton, Dr Vostanis, Ms. Thorneloe

Thanks to the Ministry Team for their ongoing support: Patrick Jobe, Rajin Parmar, Marie Duperreaul

Terms of Reference

The Advisory Group will support and represent the interests of the ESN's work across BC.

The ESN Advisory Group will operate as an oversight and quality assurance mechanism through collaboration with the ESN project team, which comprises of researchers from UNBC (Dr Sanders), TRU (Dr Hoot), UVic (Dr Newton) & Dr Roots.

The ESN Advisory Group will follow the principles of respectful communication, inclusivity, and responsibility. All members will be responsible for ensuring that the space is safe, confidential, and welcoming.

The ESN Advisory Group will be drawn upon to offer advice and recommendations that are culturally safe and culturally relevant. The ESN Advisory Group will apply anti-racist principles and values in their work.

1. Background and Purpose

This research project aims to explore the experiences of ESNs, focusing on

- Identifying and examining the underlying principles that inform a robust ESN program, and
- Exploring how these could translate to rural and remote opportunities for ESNs.

The Advisory Group will play a key role in ensuring that the research is relevant, inclusive, and ethically grounded. The Advisory Group ensures that diverse perspectives, particularly those of student nurses and key partners, are integrated throughout the research process.

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2. Objectives of the Advisory Group

The Advisory Group will:

- Support ethical and culturally appropriate research practices.
- Offer insights into the interpretation and contextualization of findings.
- Guide knowledge mobilization efforts to ensure findings are shared effectively with relevant audiences (e.g., student nurses, educators, employers, policy makers).
- Identify potential risks, gaps, or biases in the research process and offer mitigation strategies.
- Guide future research direction and review recommendations.

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3. Membership

The Advisory Group will consist of approximately **8–12 members**, including:

- ESNs (current & recent) [3]
- Nurse educators, ESN lead from Health Authorities [2]
- Clinical placement supervisors or preceptors [2]
- Representatives from professional nursing organizations (i.e., BCCNM and unions)[2]
- Researchers with relevant expertise (e.g., workforce, student experiences, health equity) [2]
- Other key partners as appropriate

Efforts will be made to ensure representation across diverse backgrounds, including race, gender identity, geographic region, and type of employment setting.

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4. Roles and Responsibilities

Advisory Group Members will:

- Attend and participate in scheduled meetings over the course of the project – Feb - March 2026
- Review project materials and provide feedback
- Share knowledge and lived experiences relevant to the project aims
- Maintain confidentiality of discussions and project data
- Act as ambassadors for the project within their respective networks, where appropriate

The Research Team will:

- Provide meeting agendas, background materials, and minutes
- Ensure meetings are accessible and inclusive
- Incorporate feedback from the Advisory Group into project decisions
- Compensate Advisory Group members for their time and expertise, where applicable

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5. Meeting Frequency and Format

- The Advisory Group will meet once in February 2026
- Meeting will be held virtually and will last for approximately 50 minutes.
- Additional communication (e.g., emails, surveys) may be used to seek input between meetings.

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6. Term and Duration

Membership of the Advisory Group is for the duration of the research project, expected to run from February- March 2026. Members may withdraw at any time by notifying the project lead, Dr Sanders.

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7. Confidentiality and Ethics

All members are expected to maintain confidentiality regarding any unpublished data, participant information, or sensitive issues discussed during meetings. The project operates under ethical approval from [Institutional REB/Ethics Board], and all Advisory Group activities will align with these standards.

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8. Honoraria/Compensation

In recognition of their time and contributions, Advisory Group members who are not salaried or participating as part of a paid role will be offered an honorarium of $20.00 as an e-voucher, in accordance with institutional guidelines.

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9. Contact Information

For questions about the Advisory Group or the project, please contact:

Dr Caroline Sanders Email: caroline.sanders@unbc.ca Study email: esnproject@unbc.ca

Appendix A

Topic/Area/Theme	Notes/Responses/Feedback
Employed Student Nurses (seven themes)	
Meaningful, accessible, engaging clinical placements = *skills consolidation*	
Maturation in self and nursing identity = *growing confidence*	
Future career dreaming = *pathways and career planning*	
Presence and meaning in the work environment = *supportive team dynamics, positive symbiotic benefit*	
Difference in 'student' roles ESN vs. PSI learner = *emotional strain*	
Funding, finance, and visibility as an employee = *emotional strain*	
Personal and professional value = *reciprocity, mutual benefit*	
Additional Notes about Appendix C and D can be included here	

Appendix B

Topic/Area/Theme	Notes/Responses/Feedback
Employers (six themes)	
Recruitment, work experience, and increased patient support = *shapes professional identity*	
Clinical constraints and challenges (i.e., restriction, uncertainty PSI, supervision challenges and clarity) = *emotional strain for all parties*	
Management tensions (i.e., orientation, organizational/local buy-in, duplication, PSI-HA gaps) = *ambiguity and inconsistency, system burden, limits curriculum advancement*	
Value, acceptance, belonging, shared benefits = *professional identity formation, influences retention, and career ambition*	
Need for a consistent funding model, shared orientation approach, reduction of duplication (PSI/HA onboarding) and promote equity = *builds a sustainable mechanism, shared evaluation and clear metrics of success, accountability and responsive curriculum*	
Success linked to sustainability, financial accountability and redesign competing to complementary systems = *structured consistent opportunities, reduction in emotional strain which can support recruitment, retention and bridge careers*	
Additional Notes about Appendix C and D can be included here	

Appendix C Logic Model (draft)

Inputs	Activities / Processes	Immediate Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Impact
ESN positions	Clinical shifts	# ESN hours worked	Increased confidence	Clinical competence & confidence	Practice-ready graduates
Preceptor/mentor/ supervisor	Observation & shadowing & checking in/ EPA model (adapt and apply)	# supervised encounters	Skill consolidation	Reduced transition shock	Safer care
Unit teams	Supported participation in care	# skills practiced	Familiarity with workflow & IPT	Proportional greater independence & confidence	Workforce stability
Post-secondary *(potential as not currently involved in ESN)*	Practice learning synergy	Reduction learners stress	Application learning to practice	Applied curriculum standardization	Enriched educational workforce (sessional, preceptors)
Organizational infrastructure	Repetition & immersion	Exposure to varied cases	Comfort in clinical settings	Employment readiness	Sustainable staffing pipeline

Appendix D

This is an example of an ESN story. Please share your thoughts on this with the team as a KT approach. Your thoughts on how we may narrate, present or add imagery would be welcome.

“I Built My Own Place Here” — An ESN Story

When people ask me why I became an Employed Student Nurse, I usually laugh a little, because the truth is—it didn’t really exist where I worked.

I made it happen.

Well, I knew the role existed in other hospitals. I’d heard about ESNs working in bigger hospitals, getting experience, getting paid, learning in real time. But in our small rural emergency department, we didn’t have one. I already worked there as a healthcare aide. I knew the hallways, the smell of the disinfectant, which stretchers squeaked, which nurses liked their coffee strong.

So, when second year was ending, I went to my manager and educator and said, “Why not here?”

Part of it was practical. I didn’t want to drive an hour for work. I have kids. Life is busy. But it was also something deeper. I could see what this place could be for a student like me. I wanted to grow here, not somewhere anonymous.

So, we built the role together.

Looking back, that feels like the first moment I started seeing myself not just as a student, but as someone who belonged in nursing.

Our hospital is small. Rural. Two trauma bays, a handful of beds, always too many patients. We serve everyone from tiny towns to the highway, and beyond – to the mountains and remote spaces. Some days it feels quiet, and then suddenly three ambulances show up and everything explodes into motion.

I like that about emergency.

It’s alive.

As an ESN, I slip into this strange in-between space. I’m not “just” a student, but I’m not fully a nurse either. At first, I thought that would feel awkward. Instead, it feels like freedom.

In clinical, there’s always someone watching. Checking boxes. Timelines. Tasks. “Did you do this? Did you chart that?” It can feel like performing nursing instead of learning it.

But here, paired one-to-one with a nurse, it’s different. Quieter. More relational.

They explain their thinking out loud.

“Here’s why we’re ordering this.”

“Watch how this patient is compensating.”

“See that subtle change? That’s what you look for.”

It’s like being let in on the secrets.

Sometimes they send me off to observe a trauma just because they know I’ll learn something. No pressure. No evaluation sheet. Just-Go-Watch.

That trust changes you.

I get to practice real skills too—IVs, catheters, assessments. Things some of my classmates haven’t touched yet. It’s not glamorous work, but it’s repetition. Muscle memory. Confidence. My hands don’t shake the way they used to.

There are limits, of course. No IV push, no blood, no narcotics. Sometimes it feels like we’re trusted—but not fully trusted. Like there’s this invisible ceiling. I understand safety, but I can’t help wondering about the missed opportunities.

Still, what I gain feels bigger than what I can’t do.

I get time.

Time to think. Time to ask why. Time to look something up without feeling rushed. In clinical, everything is task, task, task. Here, learning feels slower and deeper. I remember the first time I saw cardiogenic shock—not just reading about it, but watching it unfold in a person’s body. That sticks with you in a way textbooks never do.

And then there's the team.
Emergency works because everyone knows their role. When a trauma rolls in, people move like choreography. Someone grabs the airway cart. Someone draws meds. Someone documents. I learned quickly when to step in—and when stepping back helps more.
That was an "aha" moment for me. Realizing I'm still supernumerary, new – but keen. Still learning. Watching nurses who've done this for twenty years anticipate everything before it happens.
They're not rushed. They're steady.
It made me rethink my own path.
I used to think I'd graduate and jump straight into emergency nursing. Now I'm not so sure. Now I see the value of consolidating first, building a foundation. The department isn't going anywhere. I don't have to rush to prove myself.
That realization feels like maturity.
Like becoming.
I also notice how I'm starting to sound like them when I talk to patients—simplifying language, explaining gently, choosing words carefully. Little phrases I've borrowed. Tiny pieces of other nurses stitched into who I'm becoming.
School teaches theory. Perfect scenarios.
Work teaches humanity.
How to sit beside someone scared.
How to talk to families.
How to stay calm when everything feels loud.
That's the nursing identity I'm building.
Sometimes I think about how this all started—with me asking, "Why not here?" Now there are three more ESNs after me. A laminated scope sheet on the wall. An actual process. Something that didn't exist before.
That makes me weirdly proud.
Like I didn't just fit into the system—I shaped it a little.
If someone asked me now whether being an ESN matters, I wouldn't hesitate to SHOUT YES.
It's where everything clicked.
It's where I stopped feeling like a student pretending to be a nurse and started feeling like a nurse in progress.
It's where I built my own place.
And honestly?
I think that's exactly what nursing is—finding where you belong and then helping build it for the next person who comes after you.

13.7 ENVIRONMENTAL SCAN

Models of employment for student nurses/midwives
Australia, Canada, Ireland, New Zealand, Singapore, UK, and USA

Country / Jurisdiction	Name used	Commencement date	Requirements	Supernumerary or Regular employee	Must be Registered / Licensed with Jurisdictional Authority	Where they can work	Scope of Practice
Australia – All nursing & midwifery students are required by the National Law to be registered as students with Nursing and Midwifery Board of Australia (NMBA), however only some states have formal positions for students. Three types of nursing/midwifery programs exist – Bachelor of Nursing (BN) - 3 years (has no maternity/midwifery education included), Bachelor of Midwifery (BM) – 3 years; BN/BM - combined nursing and midwifery program (4-years). Vast majority of midwives are not independent midwives as comparable to a Canadian or New Zealand educated midwife.[25]							
Queensland	Undergraduate Student in Nursing/ Midwifery (USiN/M)	? 2018	Must be in 2nd year of program	Supernumerary workforce – cannot be used as substitute for RN or Midwife	Considered regulated as available only to registered students[26]	Acute care, Community, Long term care	Determined by employer
New South Wales	Assistant in Nursing/ Midwifery (AIN/M)	? 2005	Must have completed 1st year of nursing/ midwifery program	Unclear from position description – seems to depend on position. Cannot be used as substitute for RN or Midwife	No Hired as unregulated aid	Acute care, Community, Long term care	HCA duties, Dependent on employer
Victoria	Registered Undergraduate Student of Nursing (RUSON)/Midwifery RUSOM)	2017	Must have completed min 12 months BN program or 24 months if BN/BM program	Supernumerary workforce – cannot be used as substitute for RN or Midwife	Considered regulated as available only to registered students	Acute care, Community, Long term care	Duty statement provided by Victoria Department of Health, includes inclusions and exclusions

[25] Midwives can only work independently of a GP or Obstetrician if they hold a post-graduate 'endorsement' issued by NMBA. Less than 5% of registered midwives hold this endorsement. This endorsement requires a post-graduate course (approx. 1 year) offered by 4 universities: allows them to prescribe some medications, order diagnostic tests and procedures, and independently attend a birth. Approximately 95% of midwives are employed by hospital-based maternity units, role similar to obstetrical nurse, with on-site medical supervision.

[26] All health professional students are registered with their specific regulatory board as being enrolled in their educational program, students are not individually registered and limited information is provided to AHPRA, they are not on a publicly available register.

Country / Jurisdiction	Name used	Commencement date	Requirements	Supernumerary or Regular employee	Must be Registered / Licensed with Jurisdictional Authority	Where they can work	Scope of Practice
Tasmania	Registered Undergraduate Student of Nursing/ Midwifery	2025	Must have completed first year clinical placement	Supernumerary workforce – cannot be used as substitute for RN or Midwife	Considered regulated as available only to registered students	Acute care, Community, Long term care	Role and guiding documents provided by Department of Health
South Australia	Assistant in Nursing/ Midwifery (AIN/M)	?	Must be in 2nd or 3rd year of Bachelor of Nursing/ Midwifery	Supernumerary workforce – cannot be used as substitute for RN or Midwife	No Hired as unregulated aid	Acute care, Community, Long term care	HCA duties, Dependent on employer
Western Australia	Assistant in Nursing/ Midwifery (AIN/M)	2018	Must have completed 50% of Bachelor of Nursing/Midwifery or dual Nursing/Midwifery program	Supernumerary workforce – cannot be used as substitute for RN or Midwife	No Hired as unregulated aid	Aged care Maternity Acute care	Duty statement prescribed by Department of Health
Northern Territory	Registered Undergraduate Student of Nursing (RUSON)/Midwifery RUSOM)	?2023	2 levels – 2nd year students 3rd year students	Supernumerary workforce – cannot be used as substitute for RN or Midwife	Considered regulated as available only to registered students	Acute & primary care	Job description provided by Northern Territory Department of Health
Australian Capital Territory	Undergraduate Student Nurse/ Midwife (USN/M)	? 2023	Must have completed 1st year of educational program and have a clinical supervisor provide a referee report	Supernumerary workforce – cannot be used as substitute for RN or Midwife	Considered regulated as available only to registered students	Acute care, Community, Long term care	Job description provided by Canberra Health Services
Canada							
British Columbia	Employed Student Nurse (ESN)	2000	May be 2nd or 3rd year depending on HA and position	Supernumerary	Yes	Determined by Health Authorities	Provided by individual health authorities

Country / Jurisdiction	Name used	Commencement date	Requirements	Supernumerary or Regular employee	Must be Registered / Licensed with Jurisdictional Authority	Where they can work	Scope of Practice
Alberta	Undergraduate Nursing Employee (UNE) UNE/Student Hybrid role – created during COVID pandemic, combination of clinical placement and paid role (300-388 hrs and replaces final clinical preceptorship)	?2002-3 2022	Must be in 3rd or final year of educational program Must have minimum of 600 hours clinical practice in approved program Hybrid role – must be in final clinical preceptorship, Still continuing in some parts of province – hard to fill locations / positions	Supernumerary	No	Alberta Health care facilities	Standardized provincial job description provided by Alberta Health Services May perform restricted activities under supervision
Saskatchewan	Continuing Care Assistant (CCA) Previously had senior assistant nurse role for 3rd /4th year students – discontinued number years ago – don't know reason	?	Must have completed 2nd year of nursing program	Regular employee	No	Mostly long-term care, home care Some acute care positions	Employer provided job description
Manitoba	Undergraduate Nursing Employee (UNE)	2021	3rd / 4th year nursing students IEN applicants who meet certain requirements	Supernumerary	No CRNM has a position statement on role, & supervision practice directive	Acute care, Community, Long term care	Employer provided job description UNEs can perform reserved acts, authorized by CRNM regulations, only with RN or RPN supervision. Varies with level of knowledge and skill

Country / Jurisdiction	Name used	Commencement date	Requirements	Supernumerary or Regular employee	Must be Registered / Licensed with Jurisdictional Authority	Where they can work	Scope of Practice
Ontario	Clinical Extern	? 2021	Must be ½ way through education program	Supernumerary	No Hired as unregulated worker	Acute care, Community, Long term care	Employer provided job description with range of included and excluded care activities, more than basic nursing care
Quebec	Externat (Extern)	Prior to 2013	2nd year or later in educational program Each educational program as specific requirements for when students are eligible to be externs.	Unclear	Yes - must register with OIIQ for each employer. Educational institution and employers must also be registered with OIIQ	Acute care, Community, Long term care	May carry out the professional activities as per OIIQ regulations, unless patient's health condition is in a critical phase or requires frequent adjustments
New Brunswick	Unregulated Care Provider (UCP)	?	No specific requirements Hired as aide	Regular employee	No, Hired as unregulated aid	Acute care, Community, Long term care	Employer developed
Nova Scotia	Undergraduate Student Nurse (USN)	?2023	Must have completed 440 hours clinical placement	Supernumerary	No	Acute care, Community, Long term care	Employer developed Can be individually developed
Prince Edward Island	Nursing Student Summer Employment	?2023	Completed 1st year nursing program – Resident Care Worker Completed 3rd year of nursing program – Nursing Student Summer Employment Program	Supernumerary	No	Acute care, Public health, Long term care, Community care	Unable to find information
Newfoundland	Unable to find any information						

Country / Jurisdiction	Name used	Commencement date	Requirements	Supernumerary or Regular employee	Must be Registered / Licensed with Jurisdictional Authority	Where they can work	Scope of Practice
Yukon	Undergraduate Nursing Employee (UNE) Patient Care Assistant (PCA) Part of Student Training and Employment Program	?2023	UNE – 3rd & 4th year students PCA – 1st & 2nd year students	Supernumerary	Yes Must be registered with YRNA - Student licence	Acute care	Must practice under direct supervision
Northwest Territories / Nunavut	Unable to find any information						
Ireland	Beginning in 2002, all nursing and midwifery students are required to complete a 36-week paid final clinical internship as the 4th year of the degree program. Are considered regular salaried members of staff within the clinical staffing complement at their assigned location. Internship is mandatory to graduate from university and become registered with Nursing and Midwifery Board of Ireland. Receive salary equivalent to 80% of first year RN salary. Clinical placements prior to 4th year are not paid.						
New Zealand	Healthcare Assistant (HCA) • 50% Nursing students parttime employed (Mitchell 2020) • Most common position identified in study	Not known	No specific requirements	Regular employee	No Hired as unregulated aid	Acute care, Community, Long term care	HCA duties, Dependent on employer
Singapore	Auxiliary nurse (very little information available)	Not known	No specific requirements	Regular employee	No Unregulated position	Acute care, Community, Long term care	HCA duties, Dependent on employer

Country / Jurisdiction	Name used	Commencement date	Requirements	Supernumerary or Regular employee	Must be Registered / Licensed with Jurisdictional Authority	Where they can work	Scope of Practice
United Kingdom	Healthcare Assistant (HCA) • >60% nursing students parttime employed (Mitchell 2020) • Most common position identified in study	Not known	No specific requirements	Regular employee	No Hired as unregulated aid	Acute care, Community, Long term care	HCA duties, Dependent on employer
United States • Varies by state • Employment models exist in many states, increasing since Covid	Extern / Apprentice	Some states began in 1990's Increased since IOM report – Future of Nursing (2011) – this report recommended apprenticeship roles to improve transition to practice	No specific requirements	Variable depending on position. Determined by employer	Varies according to state. Some - unregulated positions as care aides During Covid some state regulators developed special student register – often called *Student nurse apprentices* – these categories have continued post Covid (INRC Temporary Authority to Practice Survey 2023)	Acute care, Community, Long term care	Dependent on employer. Often used to develop interest and recruit to hard to fill positions (Geriatrics, Paediatrics, Oncology, etc.) May be tied to specific learning pathways.

13.8 ARTICLES INCLUDED IN RAPID LITERATURE REVIEW

Study & date	Study aim	Country(s)	Methods	Profession / sample size	Key findings
Ahern 2023	Investigate links between undergraduate employment roles and professional standards for practice. Determine if there were any differences in the scopes of practice of these roles across North Queensland hospitals.	Australia	Cross-sectional study Survey students employed in public and private hospitals	Nursing / Midwifery 56 students	Provide benefit to patient experience by providing direct care and freed up time for RNs to be able to effectively manage their heavy workloads. Improved time management, management of deteriorating patient, management and care for pressure areas, basic observations and vital signs, effective communication, working alongside other health professionals, wound management, using aseptic technique. Paid work contributes to the development of knowledge, skills, confidence and socialisation to professional practice and standards. Management of this workforce operates inconsistently across Australia, student roles and their scopes of practice(SoP) differ across jurisdictions or may be open to some interpretation depending upon where the position is located. Relationship between university study and learning during paid employment in clinical environments is required. University recognition of those undertaking these roles should also be considered.
Algoso 2012	Explore and describe experiences of undergraduate nurses working as AINs in the nursing workforce.	Australia	Qualitative interview study	Nursing 6 students – 3 in aged care, 1 each in pediatrics, mental health and surgery	Perform basic nursing care such as bed making and assisting patients with activities of daily living, and ideally their role expands in accordance with their progression at university. Very different experience to clinical placement. On clinical practicum students perceived a decreased sense of responsibility and experienced an increased sense of security due to the support that was readily available from either clinical facilitators or the RNs they were working with. This is a barrier in that it prevents students from experiencing the realities of the nursing workforce by being behind the student veneer. Undergraduate AINs work as part of a health care team, use skills they learned at university without the pressure of being assessed or constantly supervised. More respect / valued from other nurses. More autonomy. AINs may in some way address the lack of work readiness resulting from limited clinical exposure, which has been blamed as a cause for new nurse attrition. In times of staff shortages pressured to work beyond SoP. SoP varies between institutions, wards, and even individual RNs. Needs to be more standardized. No formal means of measuring their competency prior to them performing a task, particularly higher-level tasks that require a sound knowledge base. For undergraduate AINs to expand their clinical skills, there must first be a formal training and accreditation process in place to ensure that quality patient care is retained.

Amerine 2017	Program for student pharmacists to enhance the quality of their education with practical experience by immersing them early in their careers within the healthcare system.	United States	Single case review	Pharmacy 4 students over 4 years	2-year program: Year 1 - work as pharmacy technician + additional duties Year 2 - pharmacy extenders Some shifts supernumerary, some are replacement for pharmacy technician Second year student interns able to counsel patients on anticoagulation therapies, helped Hematology/Oncology service meet goal of counselling >90% of patients discharged on anticoagulation therapy. Internship associated with 100% retention, areas without internship associated with 6 to 12% turnover rate. Cost savings due to reduced use of overtime - $7,236 annually (after paying students) Overall satisfaction from staff very positive due to the support interns give the operational areas and active participation in direct patient care and longitudinal projects. Positive feedback from pharmacists, technicians, and other leaders. Program viewed positively by students and staff.
Australian Nursing and Midwifery Federation 2023 (Union)	Employing nursing and midwifery undergraduates position statement	Australia	Grey literature Position statement	Nursing and Midwifery	Covers the definition, context, industrial and professional arrangements relating to the employment of student nurses and midwives across all states and territories in Australia as either an Assistant in Nursing or Midwifery, or as a Registered Undergraduate Student of Nursing or Midwifery with or without a formal qualification as required by the state or territory polices and employer requirements.
Beccaria 2024	Upskilling undergraduate students in nursing (USiNs) to care for people with cognitive impairment, such as dementia and/or delirium, during an acute care hospital admission.	Australia	Mixed methods study	Nursing Participants- 42 surveys, 15 student interviews, 11 graduate interviews, 10 chart audits	Covid – surge workforce, provided 10,000 hours of additional labour. Position developed in partnership with university School of Nursing, recruitment done in partnership with university, 2nd & 3rd year students only Substantially contributed to minimising harm to patients during COVID. Were considered valuable in specialling, and in the general ward workload. Were able to expand on their university education, but not all employed students felt their education had adequately prepared them to care for a patient with a cognitive impairment. Providing clarity about SoP was found to be an important success factor in helping RNs to understand the unique contribution of the employed student role. This was achieved by providing a defined SoP and a specific Clinical Development Pathway. Knowledge of the SoP is important for both delegating RNs and students to achieve alignment on what they can and cannot do.
Boggon 2022	Experiences of medical students working as surge workforce during COVID	United Kingdom	Single case review	Medicine 189 Medical students	Medical student workers eased the burden on hospital nursing teams Worked in ICU, general medicine, renal, dialysis unit and emergency. Developed specific role description with 40 responsibilities and tasks, developed in partnership with medical school. Students helped with many aspects of patient care from washing and repositioning patients to monitoring observations and helping to prepare medications.

				1 program, approx. 400 participants	Students assisted with monitoring patients under the supervision of experienced nurses. While students were employed at band 3 level, their clinical skillset enabled them to perform additional tasks such as venepuncture, cannulation and arterial blood gas sampling. Acknowledged to have substantially contributed to minimising harm to patients during COVID. Biggest challenges were balancing 12-hour shift with clinical placements and personal study. 'It is the first time in my medical training that I have felt of value or that 100% of my time is being used to maximum efficiency. I am constantly learning and working within the team to ensure patient care is central exactly what I joined med school for". Hospitals should consider the use of medical students in paid roles in the event of future pandemics or major incidents, and potentially also under more normal circumstances. Many medical students already work in part-time jobs alongside their degrees, often in roles which do not directly compliment their education. Hospitals may seek to create bespoke job plans for medical students for skill development, and to the benefit of patients and clinical services.
Browne 2013	Case for nursing students to work as Assistants in Nursing (AIN) in inpatient mental health units to address shortage of mental health nurses.	Australia	Text / opinion piece	Nursing 52 Research articles	Difficult to attract graduate nurses to mental health nursing, mostly because undergraduates do not regard mental health favourably. With the correct balance of RNs to AINs, the safety of consumers is not compromised. Nursing students who have exposure to positive experiences during their clinical experience can be attracted to mental health nursing as a career. The introduction of AINs into mental health needs to be explored and evaluated to make sure the changes in skill mix does not adversely affect the care to consumers.
Budgen 2008	Review of different types of practice education models - 10 types identified, 1 model ESN	Canada	Scoping review	Nursing	ESN model showed • Students increase practice knowledge and skills, and multidisciplinary teamwork. • Financial assistance for students • Clinicians refresh their own practice • Unit morale, workload and patient care improves • Transition to post graduate practice facilitated
Burns 2022	Explore the experiences and SoP of Assistant in Midwifery (AIM) in New South Wales (NSW), Australia.	Australia	Mixed methods study	Midwifery 13 position descriptions, 128 online survey participants	57% had unclear scope of practice. More than half staff did not understand AIM scope and responsibilities. No guidelines at the time of this publication, some are working beyond designated scope. **Benefits of position** : improved confidence; additional clinical experience; developing time management skills; participating in care escalation procedures; and becoming job ready. Feeling useful and an important part of the healthcare team strong benefit of role. Most workplaces supportive, some places - over-worked, poorly supported, and underappreciated. **Challenges** - Lack of clear job description leads to different expectations by staff, everything from being the cleaner to beyond knowledge level and SoP.

					Advantages of role AIM, when transitioning to graduate practice, includes increased confidence and enhanced skill development because of the additional clinical exposure.
Cepanec 2013	Summer program to facilitate participation of nursing students in faculty research and increase interest and utilization of research.	Canada	Mixed methods study	Nursing 5 students	Allowed students to be gainfully employed in student learning, scientific inquiry, and research mentorships through faculty/student research collaborations. Exposed to a wide variety of research activities through MCNHR research support services. Program lead to: Improvements in research, communication, information literacy, computer, qualitative data management, and analysis knowledge and skills. Increased understanding of nursing research, using research in clinical practice, and the research process in a much better way than a course could teach. Generally positive outcomes, need good, advanced planning of projects, requirements of internship program conflicted with research priorities at end of term, need better distribution of workload.
Chow 2010	Evaluate the introduction of AINs into haemodialysis units in Sydney, Australia.	Australia	Cross sectional study / review, Pre / post survey, data from incident reports	Nursing Midwifery 52 pre survey respondents, 33 post survey	AIN introduction was in response to shortage of specialized (RN) nursing workforce. Evaluated nurses' attitudes and satisfaction with care, changes in patient adverse outcomes, and work-related injuries. AINs were well received by nursing staff without increasing their workload but could not rule out that this might also have been due to other contributing factors such as the increase in nursing staff in the dialysis units over the same period of time. Success of the project was a result of commitment and support from the whole health-care team including administrators, medical, nursing and allied health staff. Project outcomes are applicable and transferable to other facilities and clinical services.
British Columbia College of Nurse and Midwives 2025 (Regulator)	Employed Students	Canada	Grey literature Practice Standard and Learning Resources		Official standards for employed students and supervision requirements for RNs or NPs.
College of Registered Nurses of Manitoba 2022 (Regulator)	Practice Direction: Supervision of Undergraduate Nurse Employees	Canada	Grey literature Practice Directive		Covers: • principles of supervision, • professional communication, • supervision of reserved acts, • practice expectations, • guidance for employers, • collaborative care when nursing in team environment • Factors to consider when assessing risk to the client

College of Registered Nurses of Manitoba 2024 (Regulator)	Creation of the undergraduate nurse employee position: Benefits and Opportunities	Canada	Grey literature Statement		News item describing the role, players and responsibilities.
Cordon 2025	Explore the outcomes of the clinical extern (CE) program in Ontario. What was the experience of the CE program participants?	Canada	Mixed methods study	Nursing 56 participants	Better relationships with patients, prioritization of care and workload. Improvements shown in ability to manage technical skills such as peripheral vascular access, admission swabs, oxygen therapy, and urinary catheter care and maintenance. Better communication skills, seen as part of the team, provides more experience than normal clinical placement. Great for recruitment, CEs can apply as internal applicants. Opportunity to explore and experience different clinical areas, building confidence and clinical decision making. CE program can support practice readiness, recruitment of staff, and better transition to practice, recommend hospital leaders implement the program within their clinical setting. Recommend having CECs (clinical extern coordinators) to support CEs in their roles. Balancing the supports provided to CEs with clinical operations is important for success.
Crevacore 2019	Program for RN students to complete AIN qualification through recognition of prior learning to work as AINs in acute care hospitals.	Australia	Single case study / review Program description	Nursing 828 students completed	University partnered with training provider to have 1st year BN program align with requirements for the qualification - Certificate 3 - Health services assistant - acute care, and the certificate is awarded by the VET provider. Students can then work as AINs. All work is at AIN level, significantly below that of RN education after 1st year. Program has been very successful and in 2017 was recognised by the university Vice Chancellor as enhancing and encouraging student learning. Workload to develop program significant, should be discussions with stakeholders about how this can be accommodated in workload allocations. Requires remapping every time new version of AIN course or university course is reaccredited, workload is significant. Timing of these two processes may not align with one another.
Gamroth 2002	Feasibility and outcomes of paid undergraduate student positions for designated health service areas in BC: Year one final report	Canada	Grey literature Commissioned evaluation report Mixed methods	Nursing 4 locations 123 Students 462 RNs 6 Employer reps 42 faculty	• Year 1 - 42 FTEs were funded, 87 positions created, 90 UGN participated in the program. • Positions - 60 acute care, 20 long-term care, 7 in facilities providing both acute and long-term care. UGN hired part-time (.25 - .5) as casual employees *Key findings*- • Collaboration – collaboration between the partners (union, nurses, students, schools, regulators and employers) was the 'window of opportunity ' that made this possible. Common interest and working together made this happen. • UGNs – improved patient care, helped with workload, improved morale, refreshed one's practice and helped with student learning. • Each Health service area implemented role differently

					Challenges • Need role clarity – clearer about what they can and cannot do, - • use of competencies was confusing, • level of experience within a competency also a challenge • Concerns raised about having UGNs outside of acute care settings, (e.g. long-term and community settings) – who would they be responsible to, how are they to remain supernumerary, not many RNs around so no one to supervise them, most settings would not use them in those settings.
Gamroth 2003	Feasibility and outcomes of paid undergraduate student positions for designated health service areas in BC: Year two final report	Canada	Grey literature Commissioned evaluation report Mixed methods	Nursing 4 locations 123 Students 462 RNs 6 Employer reps 42 faculty	• Year 2 – 30 FTEs funded, 103 UGNs participated in the program. • Positions available only in acute care, LTC facilities stopped due to regulatory supervision requirements not being met and concerns with supernumerary status. • All UGNs hired as casuals, 3 months over summer and then in some places, positions continued until Dec 02 when funding ran out. • program seen as a significant success in acute care, but not expanded beyond acute care. Spread quickly to non-pilot sites due to success of the project. "People wanted more of it", main issue was funding. • Role clarity improved considerably in 2nd year of the pilot.
Gamroth 2004	Nurse transitions to professional practice: Feasibility and outcomes of paid undergraduate student positions: Final report	Canada	Grey literature Commissioned evaluation report Mixed methods	Nursing 4 locations 123 Students 462 RNs 6 Employer reps 42 faculty	UGNs had an easier and quicker transition to professional practice than non-employed students • UGNs reported requiring 2 weeks less time for transition to practice than other groups, even when hired into speciality areas such as emergency and intensive care. • UGN described by workplace reps as more job ready: familiar with the routine; organized, skilful and confident; less guidance required from nursing colleagues; different orientation needed Conclusion of the evaluation, 3 years after project started, • 4 additional health authorities had implemented the UGN position, considered a success, and to be continued. • Overwhelming support and economic rationale to continue the program. • National interest in the project – Saskatchewan, Manitoba and Alberta all interested, and Canadian Nurses Association wants more information to move the position nationally
Gamroth 2006	Evaluation of the pilot project of paid undergraduate student nurse positions (UGN).	Canada	Mixed methods study	Nursing 4 locations 123 Students 462 RNs 6 Employer reps 42 faculty	Overall results indicate that the UGN was well received as an innovation to support the workplace and nursing students. Findings were remarkably consistent across groups of participants (i.e., students, graduates, workplace nurses, faculty and key stakeholders). UGN learning outcomes were increased confidence, improved organizational ability, expanded competency and greater ability to work with a team, plus positive effects on the workplace.

					Workplace participants reported increased unit morale, helped with workload, improved patient care and enabled refreshment of RNs practice. Positive impact on the nursing workforce, other workplace participants, and quality of patient care. Provided opportunities for graduates to become more job-ready and eased their transition to the RN role in comparison with other graduates. Lead to expansion UGN position across the province.
Gillian 2024	Pilot study to bridge academic learning with practical clinical support, engage with future workforce in a safe and meaningful way.	Canada	Evaluative case study	Radiation therapist, Molecular imaging and Nuclear medicine students 34 employed students	Decreased staff overtime, quicker transition as a new grad
Gregory 2014	Description of a pipeline program for perioperative nurses through collaboration and teamwork between employer and School of Nursing.	United States	Single case study / review	Nursing 120 employed students	45% Operating room ambulatory care nurses and 70% Operating room critical care nurses have completed this program. Program has eliminated the need for agency personnel. Developed greater links with faculty in understanding specialty needs. School of Nursing has been able to expand enrolment. Collaborative partnerships between nursing school and employment services has resulted in significant positive outcomes, not originally envisioned by either party.
Happell 2007	Explore the literature concerning residency programs for psychiatric nursing students.	Australia	Literature review	# articles not specified , appears to be approximately 14	Available literature is limited. Suggests potential benefits from residency program include improvements in competency and confidence, reduced need for lengthy orientation for new graduates and overall improvements in recruitment and retention rates for psychiatric nurses. Recommendation: Residency programs for undergraduate nursing students could provide a useful strategy to improve the image of psychiatric nursing and attract new graduates.
Hasson 2013	Examine the extent and implications of student nurses'	United Kingdom – Northern Ireland	Qualitative stage of mixed methods study	Nursing 45 students	60% students were in paid nursing related employment, mostly as health care assistants. Most participants - advantageous to enhancing confidence, skills and time spent in the clinical setting. Small number of participants - detrimental to subsequent learning resulting in role confusion, influencing placement behaviour, and preferences for future nursing practice.

	work experience on learning and training.			32 participated in focus groups, 13 individual interviews	Student with no prior work experience believed this placed them at a disadvantage, negatively influencing their learning, ability to fit in, and adjustment on placement. Student participants desire more recognition of the experience and skills they have gained from their employment. Policy makers, educators and health service providers need to be aware of the students who operate within the dual roles of student and health care worker so as to provide guidance and appropriate direction.
Kee 2001	Commentary on paid internship partnership between academia and 5 medical centres/ community hospitals.	United States	Text / Opinion piece	Nursing 40 students / year	60% of students enrolled in the paid internship were recruited for staff nurse positions after graduation. 100% retention rates at 6- and 18-months post hire in institution after graduation Financial assistance and increased clinical exposure have made this program very attractive to students. Recruitment, employment, and retention rates have made the program desirable and cost-effective for the health care agencies. Increased collaboration with the healthcare agencies has improved scholarly activity of the involved faculty and helped to keep the curriculum relevant and meaningful. Program expanded from 1 - 5 hospitals over 4 years.
Kenny 2019	Evaluation of Registered Undergraduate Student of Nursing (RUSON) Pilot Program	Australia	Grey literature Commissioned evaluation report Mixed methods	Nursing 12 health services, 21 RUSONs, 286 RNs, 80 patients	Evaluation of 10-month pilot project in regional / rural Victoria Conclusions: • RUSON role did improve access to appropriate and accessible services. • Staff saw great potential in the role and the benefits appear to indicate that the RUSON model is a cost-effective workforce strategy for rural health services. • However, the issue of how ongoing funding can be sourced to build a sustainable model is a major question. • There was much conjecture within data collected about the scope of the RUSON role and limitations associated with no change to scope as the student progressed through their course. • Overwhelming agreement that the RUSON role increases intention for rural practice. • Qualitative data indicated that the RUSON role impacted positively on patient/client safety, but there was no significant evidence of changes in quantifiable patient/client outcomes. • However, it should be noted that a longitudinal study might yield different results. • There is strong evidence of patient/client satisfaction with the role.
Kenny 2021	Evaluate the Registered undergraduate student of nursing (RUSON) pilot	Australia	Mixed methods study	Nursing 12 health services, 21 RUSONs, 286 RNs,	Role was implemented differently in pilot sites, overall value-added position that improved client experience of healthcare. **Staff** - value of the role centred on risk management in relation to falls, patient deterioration and de-escalation, extra pair of hands or eyes, highlighting the impact they had on patient safety within a rural health service. 100% of staff indicated that the patients/client were happy with the care delivered by the RUSON.

	project in regional Victoria.			80 patients	Key strategy to address rural recruitment - 99% students had increased intention to practice in regional/rural areas following graduation. **Students** - engaging in healthcare employment was seen as more advantageous than other forms of employment, such as hospitality and retail. Access to longer work times (months), compared to the very short required clinical placements (2 weeks) was a strength of the role, and having a support nurse available to help them deal with role problems with other team members, Supported transition to rural practice, much more confident about making the transition to RNs as a result of their RUSON role and that they were work ready **Patients/clients** rated the model highly. **Significant challenges** with balancing university commitments with service requirements, issues related to scope of the role, and concerns around ongoing funding of the model
King 2022	Description / evaluation of practice-based internships designed to expose students to the practice environment, address practice gaps, and improve readiness to practice.	United States	Cross sectional study Pre / Post survey	Nursing 48 employed students, 16 participated in evaluation	**Intervention:** Practice / academic best practice clinical immersion framework developed designed to expose students to the practice environment, address practice gaps, and improve readiness to practice. Framework had shared syllabus and e-learning platform, was approved by regulator, and students received academic credit and were paid for internship clinical hours. **Outcomes:** **Students** - increased confidence in communicating with patients, documenting in medical record, more opportunities to practice skills and tasks, reduced anxiety
Lindsay 2023	Review to identify and synthesize evidence related to nursing and/or midwifery students employed in regulated and unregulated clinical roles in Australia	Australia	Scoping review	Nursing & Midwifery 23 studies (2011-2023)	Only two Australian states appear to have dedicated employment roles for undergraduate students of nursing and midwifery: the RUSON and RUSOM roles in Victoria and the USiN and USiM roles in Queensland. USiN role (1 study) reported that their introduction at a large tertiary pediatric hospital had an overwhelmingly positive affect [sic] for parents and children. USiN role had no supporting framework These student-only roles have not been explicitly developed in partnership with the student's university, and there is no formal relationship between their employment and their respective undergraduate program. The university also does not contribute to the selection, supervision, or evaluation of students in such roles. Roles are not to be substitutive, only act as support workers for RNs, ENs, midwives. The number of unlicensed 'nurses' has grown substantially during the past 2 decades - with impacts of patient safety and myriad on complexities associated with integration and supervision.

					All students are registered with AHPRA therefore subject to relevant provisions irrespective of the position employed into, non-students working in assistant roles are unregulated and have no standard educational requirements. Recommended that they should have minimum required education, English language etc... Victoria - RUSOM students are not supernumerary. RUSON students are, why the difference?? both have specific role descriptions, used as a surge workforce during Covid for immunizations. NSW / WA - predominately work as PCW /AIN - unregulated roles, various scopes of practice, pay levels vary, dissimilar educational preparation. SA, ACT, NT – at time of article no identified roles Tasmania - started RUSON role 2025. While the employment of students in these ancillary roles has demonstrated positive outcomes for both the student and the facility, their clinical supervision by an already stressed workforce has implications for the safety and sustainability of such roles. There has been limited to no evaluation of these roles. More consistent national approach needed Significant governance concerns, so far unable to be addressed by employers and professional bodies.
Lokmic-Tomkins 2021	Perceived benefits of being employed as a Health Assistant in Nursing (HAN) for graduate entry to practice nursing students.	Australia	Cross sectional study	Nursing 38 students	80% respondents said working as HAN was better alternative than other paid employment. 79% HAN model was good for patients (no reason as to why provided) Most felt they did not get sufficient hours. Only 47% agreed that they received enough support and supervision during their employment as HANs. Study suggested that the scope of HAN practice be expanded to that of the entry to practice nursing student scope of practice, under registered nurse supervision. Failure to incorporate students' suggestions to address the existing HAN scope of practice for nursing students, as opposed to HANs from non-nursing backgrounds, may lead to nursing students thinking that the tasks within their scope of practice as a HAN are unrewarding and limiting to their learning. Negative experiences as a HAN decreased interest in future employment with the organisation. Overall: graduate entry to practice students feel that HAN employment improves their clinical competencies, gives recruitment advantage over other graduates and is a way of being exposed to the responsibilities of registered nurses, support the positive benefits of the HAN employment model.
Maas 2021	Understand the medical and physician	United Kingdom	Single Case Study / Review	Medicine, Physician Assistants	Surge workforce during COVID.

	associate students working within our NHS tertiary trust during COVID.			Satisfaction survey (students only, no employers or patients)	Responsibilities varied with different facilities and level of student - included clerking patients, assisting on ward rounds, performing practical skills, writing discharge summaries and communicating with patients' family. Overwhelmingly positive response from clinical staff and students. Raises possibility of future considerations to introduce similar voluntary roles nationwide, irrespective of the pandemic, aimed at flexibly supporting NHS staffing while benefiting students learning and financial position. Overall - healthcare professional student recruitment to increase the COVID-19 workforce was positive and can be adapted if future need arises. Model of combining flexible arrangements, an overseeing team, and student enthusiasm and professionalism, contributed most significantly to success of the role.
McBrearty 2024	Explore the benefits and challenges of RUSON workforce from the perspective of employers, RNs and students.	Australia	Qualitative interview study	Nursing Interviews / focus groups 11 students 10 RNs 5 employer reps	Used to absorb the really time-consuming jobs. Limited SoP, problems understanding SoP, quite restrictive, needed to be clarified. Feeling a part of the team - important - belongingness, work satisfaction, helpful junior staff, not like being a student. Employed RUSONs reported improved confidence, skills, and felt like they started clinical placement at an advantage, ready to step up and learn the Registered Nurse scope of practice. Develop and consolidate their current skills and knowledge whilst working as part of the nursing team.
McDermott 2025	Apprenticeship program for accelerating readiness for practice and support workforce pipeline.	United States	Qualitative survey study	Nursing 14 students at 2 hospitals	Student nurses received a salary; program is an elective course - receive academic credit. Program is in addition to regular clinical practicums. Expected to work 180 hours over 3 semesters. Serves as a recruiting strategy for the hospitals. Outcomes on success of recruitment strategy not available at time of publication Benefits included additional hours of clinical without the pressure of an instructor supervised practicum. Students practice skills under supervision of the mentor, focus on role of the nurse within the team. Students wanted wider variety of placement options - e.g. critical care areas. Employer - difficulty accommodating
McGillion 2022	An evaluation of the RUSON pilot at Western Health	Australia	Grey literature	6 wards 49 RUSONs	1 year pilot study **Key findings** • role enabled others to better manage acuity and access demands • role released more time to spend with patients and was viewed as an essential role by peers • contributed to risk prevention and could be described as the 'gatekeeper' of the patient experience through their engagement and presence • Tighter and more consistent governance over the role is required, particularly in terms of structured induction processes and scope of practice guidance **Key recommendations**

			Commissioned evaluation report Mixed methods		• Expand the RUSON workforce across all wards at Western Health in 2022 • Improve governance structures, ensuring the Nurse Unit Managers have consistent and standard tools to maximise the benefits of the RUSON role • Provide Nursing and Midwifery Directorate support for this key role by facilitating the success of our RUSONs 'through' appropriate support of our Nurse Unit Managers • Maximise the RUSON 'pipeline' to funnel into Fellowship Programs and graduate employment at Western Health, maximising their gained knowledge of systems and processes. Provide mentoring for them to encourage them to successfully transition through these time points. A successful pipeline may successfully shape the type and length of graduate support needed.
McLachlan 2011	Evaluation of midwifery students employed as enrolled nurses (practical nurse) in post-natal ward.	Australia	Qualitative Interview study	Midwifery 5 students 47 RM	100% students wanted position at hospital, positive long-term investment for hospital. Sense of belonging to organisation, strengthened partnership between university and hospital, improved teaching and learning culture at hospital, helped change practices at the hospital, "keep us up to date". Provided short- and long-term advantages for midwifery, at the same time meeting the needs of managers under pressure to locate suitable staff to work in the maternity setting.
Muir 2023	Becoming a nurse: a mixed methods study of student nurse employment and graduate nurse experience.	Australia	Grey literature Master's Thesis	Nursing 534 surveys	**Aim:** To explore the ways in which student employment impacts student learning and preparation for practice, and investigate how employment influences transition experience. **Participants** - RNs currently employed in Victoria Transition to Practice program, 65% had worked as RUSONs during undergraduate education. **Conclusion**: Graduate nurse transition is influenced by engagement in the paid employment as a student. This influence is perceived to be most beneficial where employment provides the student with the opportunity to work in clinical areas with more direct care and nursing experience, particularly when the employment is part of a nursing team. This provides the student with informal but important work integrated learning that could be better utilised. The increased connection to nursing and the workplace may also serve to increase opportunities for graduate nurse recruitment and retention. research found that **Implications:** RUSON model can strengthen the graduate nurse experience and support workforce development. The influence of different student RN employment models on the graduate RN workforce requires further exploration. Further research scoping the models over a longer period of time is required to measure the impact on graduate nurse preparedness for work, practice based learning, and graduate nurse recruitment and retention.
Mumford 2023	To evaluate the RUSOM model implemented in	Australia	Cross sectional study	Midwifery 20 students	Provided time for post-natal and breastfeeding education and support, made a positive difference to women. Improved quality of care for women / families and babies. Increased satisfaction of RMs, eased load of midwives, may impact on staff retention

	a tertiary maternity service in Australia.		Evaluation 4 months after implementation	110 RM	Students felt part of the team, valued and appreciated, increased confidence and competence to practise. Role could be expanded to include more skills, should be closer to a student on placement. Same applies to RUSON role, duties should increase as progression through course and learning. Need more collaboration between stakeholders to improve the role and its implementation. Need to better identify what students / RUSOM/Ns are able to do Should be able to work all shifts across the week. Need for more formal support and supervision for the RUSOM role, and education of the staff. Need a different title, confusing for families and women as to who they are and what their role is. Need a long-term, larger evaluation to look at sustainability, recruitment and retention.
Nurses Association of New Brunswick 2021 (Regulator)	Fact Sheet: Student nurses and student nurse employees	Canada	Grey literature Regulatory fact sheet	Nursing	Provides information on: • role, • supervision, • practice guidelines, and • working with unregulated care providers
Olson 2001	Describes residency program for students as transition to staff nurse in an acute-care setting.	United States	Single case study / review	Nursing 14 students 20 preceptors	900-hour residency program for senior baccalaureate nursing students Retention figures provided at 2 years, but no significant difference to non-program students. Program discontinued after 1 year at 1 hospital due to no recruitment benefits seen and no shortage of new graduates
Ordre des infirmières et infirmiers du Québec (Quebec nursing regulator) 2023	Student externs (parcours-etudiant / extern)	Canada	Grey literature Policy directive	Nursing	Includes: • requirements for extern role, • where they can work, • how to apply for registration, • employer requirements
Phillips 2016	Highlight what is known about pre-registration paid employment practices of undergraduate	Australia	Scoping review	Nursing 40 studies	**Reasons for paid employment:** Most students reason - economic survival. Work in health services, retail and hospitality > 16 hours / week employment has detrimental impact on academic performance. **Benefits:** Paid employment within a health service provided insight into realities of nursing practice and preparation for future roles. Assisted in the development of a professional identity, increased confidence, work exposure, skill acquisition, securing future employment.

	nursing students.			23 US 10 Australia 4 UK 3 Canada	Limited understanding of benefits of role. Employers appear more interested in-service provision Many different models exist - lists some of them, but confusion around names, and what they mean, variation between models made comparison difficult,
Raffelt 2018	Description of introduction of USiN in pediatric hospital.	Australia	Cohort study – pre / post implementation	Nursing 169 nurses (AINs, ENs, RNs, NUMs, Nurse Educators, no students included)	Risk mitigation strategy, initial USiN practice scope was conservative, well below mapped levels of academic theoretical preparation. Role included rounding, spending time with patients, playing and tidying in patient areas. These simple tasks contribute substantially to the parent and patient experience. 87% perceived patient safety had substantially increased. Parent and child satisfaction improved, more than initially anticipated. RNs - workload improved; good understanding of SoP, 85% role met expectations, 88% positive change. Added benefit of allowing RN time to practice to top of licence. Pivotal to success was dedicated Clinical Nurse Facilitator who supported role, addressed issues and role ambiguity with staff in the clinical areas. Evaluation results indicated that a review of the SoP may be warranted. Staff suggested a range of skills that could be added to SoP to better aligned with their academic progression.
Roush 2021	Description of internship program to support nursing student transition to clinical setting.	United States	Case study / description	Nursing 25 students	Recruitment strategy for hospital Worked as patient care interns (PCI) (non-licensed assistant personnel) prior to transitioning to RNs. Students selected on merit. Implies 100% students recruited and 50 - 82% of students were retained at 2 years into RN positions. Reduced orientation time from 12-16 weeks to 10.5 weeks Hospital experienced net saving of $216,993 over 2 years of program 100% students agreed that the participating increased role satisfaction with their transition to RN.
Roush 2023	Financial analysis of internship program (above)	United States	Case study / description	Nursing 25 students	**Financial analysis:** 64% of program students were retained at 1 year post graduation Program was cost-effective; ROI of 61 - 76% 2 years of the program had benefit - cost ratios of 1.76 & 1.61, anything > 1 shows a positive impact for the organization and an efficient investment. Sample- very small, limited generalisation due to stringent entry requirements, model not easily replicated. PCI replaced normal recruitment, on boarding / orientation costs for new hires. One of the few financial reviews done of employed students.
Souder 2012	Description of summer externship program to	United States	Case study / description	Nursing 24 students	Had a positive effect on recruitment into geriatric nursing. Exposed students to practice, research, education and leadership in geriatrics Successful in introducing and increasing interest in specialty areas which are harder to recruit to.

	recruit students to gerontological nursing and expand the workforce.				
Steen 2011	Impact of student intern program on transition from student nurse to registered nurse.	United States	Case study / description	Nursing 50 students	Student internship program to gain clinical experience, earn course credits, and get paid for hours worked. **Student outcomes:** internship program increased their confidence in performing nursing tasks, caring for more acute patients, and interacting with patients and their families. Nurse managers should be made aware of the many benefits of internship programs and their contributions to hiring and orienting new graduate RNs, retaining employees, and training new nurses.
Stout 2015	Evaluation of a practice-academic partnership involving additional paid hours of work.	United States	Case study / description	Nursing 26 students	Program was 260 hours additional to their required clinical practicum hours. 4 goals - • increase # of BSN prepared RNs • asses if decreased recruitment / orientation time costs compared to normal processes • improved the speed of acquiring competencies for safe and high-quality patient care • Satisfaction achieved by interns and preceptors. Was deemed successful for improving patient safe and achieving required competencies faster than normal new graduates. Reduction in medication errors all interns were recruited (was a condition on employment or had to pay back stipends provided for employment). Early indications show 100% retention at 2 years $600,000 cost savings in recruitment cost for 26 interns
Sweet 2021	The introduction of RUSOM staff at Western Health: Experiences of staff, supervisors, and women	Australia	Grey literature Commissioned evaluation report for health service	Midwifery 14 students 6 months post-implementation on postnatal wards.	**Key findings** • The RUSOM role was beneficial for the daily workflow in the health service. • Women and midwives valued the care provided by the RUSOM. • The RUSOM valued the ability to work autonomously, to build their clinical skills and professional identity. • No RUSOM worked outside of their scope of practice and no incidences were reported during the evaluation period. • There were no clinical incidences as a result of RUSOM care. **Key recommendations** • Review the task list of care RUSOM can provide • Consider extending the hours RUSOM are employed • Consider extending the locations in the health service in which the RUSOM can work • Maintain the support for the RUSOM by allocating them a specific team and manager • Supply dedicated phone for RUSOM only to avoid the use of personal devices.

Sweet 2023	Evaluate acceptability of RUSOM role.	Australia	Mixed methods study; focus groups / surveys	Midwifery 135 RUSOMs, midwives, medical staff, patients	RUSOM were not allocated specific patients, were a roving assistant able to provide care to any woman or assist any midwife throughout the shift. Needs of women and families were met in a timelier fashion since their introduction to the wards. Midwives considered the provision of support from a RUSOM was a fabulous asset to the health service, ensuring that women received timely and quality care. RUSOMs – • 90% participants had more skills than they could apply to their position. • All strongly agreed that the work was enjoyable, majority indicated was stimulating. • 90% benefit to their midwifery education. • 80% instilled a greater sense of belonging, and reduced isolation within the team. Midwives – • 90% increased their job satisfaction. • 75% introduction of RUSOM made their work more interesting. • >50% allowed them to demonstrate their worth at work, increased their enthusiasm, and made their work more meaningful. • Allowed them to function better on a busy ward, more time to focus on clinical work, clinical problems, and delivering care
Toronto Academic Health Science Network 2023	Enhanced Extern Program Working Group: Toolkit & Orientation Handbook	Canada	Grey literature Toolkit and Orientation handbook	Nursing Physiotherapy Occupational Therapy	Guiding principles and standardization (with flexibility) for the SoP and utilization of clinical externs across Toronto area hospitals.
Victoria Department of Health 2020	RUSON employment and implementation guide	Australia	Grey literature Duties & Exclusions list	Nursing	Includes: • Role and scope of activities • Getting started – governance, management, planning, etc. • Scoping: assessing need and capacity • Establishing delegation and supervision requirements • Recruitment, orientation and employment • Reviewing outcomes • Bargaining agreement • Generic job description
Wallace 2016	Review of paid precepted internships to supplement academic	United States	Case study / description	Nursing 80 students	Paid precepted internship that supplements academic clinical experiences, enables mastery of learned skills and better understand the realities of the clinical practice environment. Allowed to perform nursing care and take on clinical responsibilities for which they have received instruction and demonstrated competence- e.g. conduct physical assessments, provide health teaching, medication administration, and intravenous management.

	clinical experiences.				Program developed in conjunction with university and state regulator, but not regulated Student nurses are paid 3 shifts per week for 10 weeks = 240 hours Funded by the health system community benefit fund and managed by the academic relations team. **Benefits:** Strengthens existing academic practice partnerships. Nursing programs and students benefit from additional clinical hours. Practice environment benefits from an infusion of new nursing knowledge and energy.
Willets 2022	Exploration of RUSON program from the nurse leader's perspective	Australia	Qualitative interview study	Nursing 6 nurse leaders from 1 hospital	Two key themes were identified from the analysis, i) Establishing the RUSON; with sub-themes: Who are RUSONs? - understanding their SOP and role, ii) You are not on clinical placement - you're an employee and a professional here The importance of inclusivity - being a part of the team. For successful implementation - collaboration with the nursing leadership team is important
Wise 2022	Explores potential associations between paid student employment and development of workplace capabilities.	Australia	Integrative review	Nursing 14 studies	**Students:** Contributed to preparation of professional nursing including: • developing a sense of maturity and self-awareness that improved interactions not only with nursing staff, but also the multidisciplinary heath care team. • learning professional values and behaviours including interpersonal skills and codes of conduct. • gain insights into running of the ward routines, how heath care systems function. • assisted in the development of skills helpful in effectively dealing with people who exhibited difficult behaviours and interacting with the general community. • personal growth and development - intrapersonal ability, emotional literacy, resilience. • improves clinical capability, technical knowledge, and complex care including time management. • organisational capability including knowledge of the workplace, communication and teamwork. • paid employment over 16 h per week leads to negative impact on academic performance **Employers:** • recruitment and retention of nursing workforce • growing your own workforce e.g. creating specific types of workforces for hard to fill positions. **Educators:** • this employment can assist to support and inform undergraduate nursing curriculum

13.9 NARRATIVE EXEMPLAR - ESN

“I Built My Own Place Here” — An ESN Story

When people ask me why I became an Employed Student Nurse, I usually laugh a little, because the truth is—it didn’t really exist where I worked.

I made it happen.

Well, I knew the role existed in other hospitals. I’d heard about ESNs working in bigger hospitals, getting experience, getting paid, learning in real time. But in our small rural emergency department, we didn’t have one. I already worked there as a healthcare aide. I knew the hallways, the smell of the disinfectant, which stretchers squeaked, which nurses liked their coffee strong.

So when second year was ending, I went to my manager and educator and said, “Why not here?”

Part of it was practical. I didn’t want to drive an hour for work. I have kids. Life is busy. But it was also something deeper. I could see what this place could be for a student like me. I wanted to grow here, not somewhere anonymous.

So we built the role together.

Looking back, that feels like the first moment I started seeing myself not just as a student, but as someone who belonged in nursing.

Our hospital is small. Rural. Two trauma bays, a handful of beds, always too many patients. We serve everyone from tiny towns to the highway, and beyond – to the mountains and remote spaces. Some days it feels quiet, and then suddenly three ambulances show up and everything explodes into motion.

I like that about emergency.

It’s alive.

As an ESN, I slip into this strange in-between space. I’m not “just” a student, but I’m not fully a nurse either. At first, I thought that would feel awkward. Instead, it feels like freedom.

In clinical, there’s always someone watching. Checking boxes. Timelines. Tasks. “Did you do this? Did you chart that?” It can feel like performing nursing instead of learning it.

But here, paired one-to-one with a nurse, it’s different. Quieter. More relational.

They explain their thinking out loud.
“Here’s why we’re ordering this.”
“Watch how this patient is compensating.”
“See that subtle change? That’s what you look for.”

It’s like being let in on the secrets.

Sometimes they send me off to observe a trauma just because they know I’ll learn something. No pressure. No evaluation sheet. Just-Go-Watch.

That trust changes you.

I get to practice real skills too—IVs, catheters, assessments. Things some of my classmates haven't touched yet. It's not glamorous work, but it's repetition. Muscle memory. Confidence. My hands don't shake the way they used to.

There are limits, of course. No IV push, no blood, no narcotics. Sometimes it feels like we're trusted—but not fully trusted. Like there's this invisible ceiling. I understand safety, but I can't help wondering about the missed opportunities.

Still, what I gain feels bigger than what I can't do.

I get time.

Time to think. Time to ask why. Time to look something up without feeling rushed. In clinical, everything is task, task, task. Here, learning feels slower and deeper. I remember the first time I saw cardiogenic shock—not just reading about it, but watching it unfold in a person's body. That sticks with you in a way textbooks never do.

And then there's the team.

Emergency works because everyone knows their role. When a trauma rolls in, people move like choreography. Someone grabs the airway cart. Someone draws meds. Someone documents. I learned quickly when to step in—and when stepping back helps more.

That was an "aha" moment for me. Realizing I'm still supernumerary, new – but keen. Still learning. Watching nurses who've done this for twenty years anticipate everything before it happens.

They're not rushed. They're steady.

It made me rethink my own path.

I used to think I'd graduate and jump straight into emergency nursing. Now I'm not so sure. Now I see the value of consolidating first, building a foundation. The department isn't going anywhere. I don't have to rush to prove myself.

That realization feels like maturity.

Like becoming.

I also notice how I'm starting to sound like them when I talk to patients—simplifying language, explaining gently, choosing words carefully. Little phrases I've borrowed. Tiny pieces of other nurses stitched into who I'm becoming.

School teaches theory. Perfect scenarios.

Work teaches humanity.

How to sit beside someone scared.
How to talk to families.
How to stay calm when everything feels loud.

That's the nursing identity I'm building.

Sometimes I think about how this all started—with me asking, "Why not here?" Now there are three more ESNs after me. A laminated scope sheet on the wall. An actual process. Something that didn't exist before.

That makes me weirdly proud.

Like I didn’t just fit into the system—I shaped it a little.

If someone asked me now whether being an ESN matters, I wouldn’t hesitate to SHOUT YES.

It’s where everything clicked.

It’s where I stopped feeling like a student pretending to be a nurse and started feeling like a nurse in progress.

It’s where I built my own place.

And honestly?

I think that’s exactly what nursing is—finding where you belong, and then helping build it for the next person who comes after you.

“They Changed My Unit More Than I Expected” — An Employer Story of ESNs (Anonymous Site)

If you had asked me a few years ago whether student nurses belonged in the ICU, I would have said no without hesitation. Our patients are too complex, too sick; it’s a scary place to be when you are learning.

That was my script. It’s not gentle work.

So for years, I told myself students should come later. After they’d “earned it.” After a couple years on a medical floor. After they were seasoned.

I thought I was protecting them.

Looking back, I think I was protecting us, because students slow you down. And in critical care, slowing down feels dangerous.

That was my thinking—old school, I’ll admit.

Then a few years ago, we started hearing more about Employed Student Nurses. Other sites were doing it. People kept saying, “Just try it”. I remember sitting with my leadership team, arms crossed a little, saying, “I don’t know… this might be too much for them”.

But eventually we said, “Fine. Let’s be open. Let’s try two”.

I still remember the day the first two ESNs walked onto the unit. I was watching closely. Probably too closely.

They weren’t what I expected.

They weren’t fragile. They weren’t overwhelmed. They weren’t asking to be rescued.

They were steady. Curious. Happy to just be there.

And that was the first crack in my assumptions.

In the past, when students came through for short clinical rotations, we’d feel pressure. We’d try to cram everything in. “You must see this, you must do that”. It was frantic, like trying to see the entire ICU in three weeks.

But ESNs were different.

They weren’t there to master everything. They were there to experience.

They’d stand at the bedside for a central line dressing change and look at it like it was magic.

“Wow,” they’d say.

And I’d think, really? This old thing?

But then I’d remember—this was once magic to me too.

Something shifted.

We stopped rushing them. We stopped performing education. We just let them be in the environment.

And oddly enough, that’s when the learning felt most real.

They helped with small tasks. Observed. Asked thoughtful questions. They knew their limits. They didn’t pretend.

There was no ego.

And then something happened that I didn’t anticipate at all.

It wasn’t what the ESNs gained.

It was what unit nurses gained.

I started noticing it on the floor.

A senior nurse—twenty years in—showing an ESN how to set up a line, explaining every step like it mattered. Another nurse staying late to debrief a case with them. Someone volunteering to teach. That doesn’t always happen in a busy ICU.

But these students were eager. Wide-eyed. Absorbing everything. Every procedure felt exciting to them.

And the nurses saw themselves in that. I could almost see the memory flicker across their faces. “Oh yeah. I used to feel like that.” It softened people. Reminded them why they chose this job.

I hadn’t expected ESNs to change the culture, but they did.

They brought energy into a space that can get heavy. Critical care can harden you if you’re not careful. But they would say things like, “Can I watch?” or “That was amazing,” and suddenly the seasoned staff were telling stories again, teaching again, finding time to see the next generation of nurses who may want careers with us, or just to stay a little longer in nursing after they graduate.

I realized something uncomfortable then: maybe students weren’t slowing us down.

Maybe they were waking us up.

One of my favourite moments came during an annual education open house. Normally, it’s managers like me at booths, talking to people. This time, we invited a couple of ESNs to join us.

They stole the show.

Other students flocked to them. Not to me.

“Tell me what it’s like.”
“Are they supportive?”
“Is ICU scary?”

And they spoke with this honesty and warmth I could never replicate.

They were ambassadors—for our unit, for our culture, for nursing.

Now, when I look back, bringing ESNs into our ICU is one of the best decisions I’ve made as a manager.

Yes, they learn. Yes, they build skills.

But that’s only half the story.

They remind us who we are. They reconnect senior nurses with purpose. They change the tone of the unit. They humanize a high-tech space. They create a pipeline of future staff who already feel like they belong.

If you ask me today whether students belong in critical care, I won’t hesitate. They absolutely do.

Not because they’re ready to do everything. But because their presence changes everything.

And sometimes, the value of a learner isn’t in what they can do yet.

It’s in what they help the rest of us remember.