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Novice nurses' transition to the clinical setting in the COVID-19 pandemic: A phenomenological hermeneutic study

Sara Fernández-Basanta^{a,*}, Carmen Espremáns-Cidón^b, María-Jesús Movilla-Fernández^a

^a Research Group GRINCAR, Department of Health Sciences, Faculty of Nursing and Podiatry, Ferrol Industrial Campus, University of A Coruña, Naturalista López Seoane s/n, 15471 Ferrol, Spain

^b Canary Islands Health Service, C/ Pérez de Rozas, 5 Planta 4ª 38071 - Santa Cruz de Tenerife, Spain

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ABSTRACT

Background: The COVID-19 pandemic both exposed and increased weaknesses in the healthcare system, so that novice nurses have become a more vulnerable group during this context.

Aim: This study sought to illuminate experience of novice nurses in providing care during the COVID-19 pandemic.

Method: It consists of a qualitative study conducted with data collected by means of semistructured interviews, audio recorded, transcribed, anonymised, and analysed in the light of the phenomenological hermeneutic approach. Fourteen registered novice nurses from two health areas in northwest of Spain, being twelve women and two men, who experienced the COVID-19 pandemic within their first five years of professional experience, were selected through a non-statistical snowball sampling.

Results: After analysing the narratives, we identified four main themes: "Transitioning to a hostile, unknown and uncertain clinical setting from inexperience," "Invisible wounds because of being on the front line," and "Healing to return to the front line."

Discussion: The uncertainty of an unknown illness and the lack of support during the COVID-19 pandemic has been affecting novice nurses, impacting their health conditions. At the same time, this context created opportunities for professional development. According to the interviewees, self-care and social support were elements to cope with exhaustion.

Conclusion: Our study investigates the experiences of a group barely approached in the literature, highlighting the reality and difficulties of these nurses in transitioning to the clinical setting and providing insights to managerial leaders and educators.

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Summary of relevance

Problem or Issue

- The highly demanding pandemic scenario and precarious working conditions made novice nurses a particularly vulnerable group.

What is already known?

- The COVID-19 pandemic has increased the demand for health professionals and the workload.
- Nurses are the main frontline COVID-19 professionals, being deeply affected, both physically and emotionally, by the pandemic.

What this paper adds

- The pandemic and the lack of experience of novice nurses led to a series of physical, psychological, and social impact on them.
- The uncertainty in the face of an unknown disease, the insufficient support from organisations, and the vulnerability of patients deeply affected novice nurses.
- Experiential and transformative teaching and learning approaches that promote moral resilience, well-being, self-care, and support of future nurses are required. Organizational involvement, nursing leaders, and educators are required.

1. Introduction

At the end of 2019, an outbreak of pneumonia of unknown aetiology resulting in severe respiratory distress syndrome was reported in Wuhan, China. Caused by the severe acute respi-

* Corresponding author at: Faculty of Nursing and Podiatry, University of A Coruña, Ferrol Industrial Campus, Naturalista López Seoane s/n, 15471 Ferrol, Spain
E-mail address: sara.fbasanta@udc.es (S. Fernández-Basanta).

ratory syndrome coronavirus 2 (SARS-CoV-2), the novel coronavirus disease was termed COVID-19 (World Health Organization (WHO), 2020), provoking mild to severe respiratory symptoms. After spreading to other countries in a fast rate, the WHO declared the COVID-19 outbreak a pandemic on March 11, 2020. By October 2021, more than 234.000.000 confirmed cases and 4.797.368 deaths from COVID-19 had been reported worldwide ((WHO), 2021).

The coronavirus spread has become a central issue all over the globe, affecting the everyday life and work of healthcare professionals – especially nursing staffs, who were deeply involved in the care of these patients (Di Tella, Romeo, Benfante, & Castelli, 2020; Galehdar, Kamran, Toulabi, & Heydari, 2020). Such situation contributed to the development of work-related acute stress, causing physical symptoms such as increased muscle tone and sleep disorders, and psychological symptoms such as irritability, anxiety, sadness, impotence, fear of being infected, and feelings of defeat (González-Rodríguez & Labad, 2020; Wang et al., 2020). Situations such as that posed by the COVID-19 pandemic are often faced by recalling strategies that have worked in previous contexts; however, for this specific situation, no related experiences were found in history (Ha, 2021).

Thus, the conditions under which healthcare professionals have been facing this pandemic are far from ideal – especially when it comes for nursing staff. With the overcrowding of intensive care units, the shortage of key materials such as personal protective equipment (PPE) and ventilators, and the burden arising from the number of patients dying without their families at the bedside, these professionals are overloaded by care tasks. Moreover, being a disease of unknown evolution, the treatment protocols are constantly, and comprehensive care is hampered by social isolation.

According to Benner (1984), a novice nurse is one with limited work experience who may never have faced real-life problematic situations, including newly graduated nurses from the first and second year of clinical experience. However, previous literature has extended this classification to nurse professionals until the first five years of practice (Wallin, Gustavsson, Ehrenberg, & Rudman, 2012). Although novice nurses enter the labour market every year, 2020 was the first year in this century in which this process occurred amidst a pandemic.

The transition from nursing student to practising nurse is a complex process often described as the struggle to develop a new professional sense of self (Arrowsmith, Lau-Walker, Norman, & Maben, 2016; Björkström, Athlin, & Johansson, 2008; Duchscher & Cowin, 2004). Such a sense of self and, consequently, the new professional identity are associated with the lived experience of novice nurses in the clinical setting, where they face new challenges and responsibilities (Duchscher, 2009; Leong & Crossman, 2015). For Benner (1984, p. 22), “any nurse entering a clinical setting where she or he has no experience with patients may be limited to the novice level of performance if the goals and tools of patient care are unfamiliar.”

Novice nurses live many personal and environmental experiences during their early years of practice, suffering numerous changes as to physical, emotional, developmental, and intellectual aspects (Björkström et al., 2008; Duchscher, 2009). The transition process to become a staff nurse and provide care is often associated with feelings of confusion, uncertainty, and stress (Gardiner & Sheen, 2016). Moreover, when their performance at work is influenced by their personal lives and vice versa, these nurses are required to balance the demands of both (Ten Hoeve, Kunnen, Brouwer, & Roodbol, 2018).

Although nursing students are considered as professional nurses upon the completion of their bachelor's degree, the literature stipulates an adaptation period for such, in which nurses not only demonstrate and apply the knowledge, skills, and abilities ac-

quired during their studies into real situations, but also acquire and develop experience in real practice (Woo & Newman, 2020). During this period, professionals learn, for example, to manage anxiety and stress (Hussein, Everett, Ramjan, Hu, & Salamonson, 2017; Kaihlanen, Elovainio, Haavisto, Salminen, & Sinervo, 2020; Woo & Newman, 2020).

The transition to professional nurse often requires a period in which novice nurses can observe the work reality and become acquainted with the system. However, the pandemic hurried the transition process, incorporating novice nurses into the clinical environment without an observation period (Thang et al., 2019). The COVID-19 pandemic poses numerous challenges for novice nurses, such as changing tasks, the increasing number of patients per nurse, heavy workloads, ever-changing policies and procedures, and physical and psychological exposure risks (Ehrlich, McKenney, & Elkbuli, 2020; Fernandez et al., 2020; Maben & Bridges, 2020). The pandemic also had impacts on the theoretical-practical education of nursing students, with the interruption of student placements in clinical settings and the ensuing changes in education modality (Dewart, Corcoran, Thirsk, & Petrovic, 2020; Dos Santos, 2020). This measures led to a gap in practical knowledge, so that newly graduated nurses struggled to adapt to clinical workflows (Wong et al., 2018).

Although numerous studies address the transition of newly graduated nurses into clinical settings, studies investigating such a movement during the COVID-19 pandemic are rather scarce. In fact, previous literature addresses the experience of novice nurses in this situation (García-Martín et al., 2021; Naylor, Hadenfeldt, & Timmons, 2021), but our research was not restricted to a specific service or the care of COVID-19 patients, thus advancing knowledge on the theme. Our study focuses on the experience of novice nurses transitioning to the clinical setting amidst the pandemic – a context that could likewise impact the practical education of these nurses.

In the face of the novel COVID-19 pandemic, both nurses and novices are required to face this scenario without prior experience with similar situations. Add to that other previous issues, such as precarious employment contracts and feelings of anguish, stress, and anxiety in the clinical environment (OECD & Union, 2020). In response to the 2007 economic crisis, Spain experienced a decrease in public expenditure, reforms in the labour market, and transformations in the health system, which worsened the working conditions of Spanish nurses (Galbany-Estragués & Nelson, 2016) and led over 12,000 professionals to emigrate to other countries (Gea-Caballero et al., 2019). In recent years, the country has also gone through an increase in precarious contracts and a tightening of labour legislation (Esteban-Sepúlveda, Moreno-Casbas, Fuentesaz-Gallego, & Ruzafa-Martinez, 2019; Granero-Lázaro, Blanch-Ribas, Roldán-Merino, Torralbas-Ortega, & Escayola-Maranges, 2017), thus increasing the number of part-time and temporary contracts and decreasing salaries by 5%–10%, while increasing taxes and working hours (Esteban-Sepúlveda et al., 2019; Legido-Quigley et al., 2013).

The epidemic peaks exacerbate the already-existing nursing shortage, including due the fact that nurses were infected by the virus (Organisation for Economic Co-operation and Development (OECD/European Union), 2020). In May 2020, Spain reported 30,663 cumulative confirmed COVID-19 cases among healthcare professionals – the highest rate worldwide, accounting for 20% of the confirmed cases. When compared with other healthcare professionals, nurses were the most affected group by COVID-19 worldwide, summing up 38.6% of infections (Bandyopadhyay et al., 2020). In this scenario, on March 15, 2020, the Ministry of Health of Spain recruited both final-year nursing students and retired nurses to work and help with the response to the COVID-19 crisis (Casafont et al., 2021). Apart from the pandemic scenario, the demand for nurses continues to increase due to the population

ageing and the nearly 500,000 nurses who are about to retire (Crismon, Mansfield, Hiatt, Christensen, & Cloyes, 2021; OECD & Union, 2020).

Besides the lack of professional experience, novice nurses also had to cope with a series of ethical dilemmas and conflicts ensuing from the pandemic. Together, these factors may lead to moral distress, moral damage, or post-traumatic stress disorder (Hossain & Clatty, 2021; Lesley, 2021). Thus, such a health crisis both introduced and exacerbated previous issues in the transition of novice nurses to the clinical setting. Considering the distinct features of this group, understanding their experiences can help designing a curriculum adapted to social and health challenges, thus providing future nurses with knowledge and skills beyond techniques performance. These findings may also guide managers and health professionals in the incorporation and support of novice nurses.

1.1. Aim

To illuminate the experiences of novice nurses in providing care during the COVID-19 pandemic.

2. Methods

2.1. Design

This is a qualitative study with a hermeneutical phenomenology approach (Lindseth & Norberg, 2004) – a method that holds that essential meaning is something with which human beings are familiar in life, and that such familiarity should be expressed through actions, narratives, reflections, and lifestyles. The movement between phenomenology and hermeneutics allows us to go beyond purity: focusing on these experiences not as something ‘factual’ that requires explanation, but rather on their understandable meaning.

2.2. Participants

Participants were selected via non-statistical snowball sampling, including registered nurses who experienced the COVID-19 pandemic during the first five years of professional experience. First, the research team sent an email to potential participants who met the inclusion criteria, and those who requested further information on the study were contacted via telephone. Initial informants were sourced through the list of students who completed their nursing studies during the 2019–2020 academic year, whose access was available to SFB and MJMF. Besides providing further information on the research, telephone contact also aimed to set a face-to-face or virtual appointment. These participants acted as recruiting agents, requesting peers whose situation met the inclusion criteria for their consent in sharing their contact details with the research group.

2.3. Data collection

Data were collected by means of face-to-face or virtual semistructured interviews, so that participants could share their experiences (Lindseth & Norberg, 2004). Most interviews were conducted by video call, and face-to-face interviews were conducted at an office in the Faculty of Nursing and Podiatry of the University of A Coruña. Interviews lasted 30 minutes on average, and a guide based on a literature review was used to conduct them. All interviews began with a general question about the impacts of the COVID-19 at a personal and social level, being followed by further questions to encourage participants to talk about their personal experiences (Table 1). To gather relevant information that was not collected during the interview, a final open question was

Table 1
Semistructured interview script.

Thematic field	Questions
Care provision	<ul style="list-style-type: none"> - What has been the hardest thing to work with during the pandemic? Why? How did you handle these difficulties? - What has been the hardest thing to deal with emotionally? Why? What strategies do/did you use to manage these emotional demands? - How would you describe your transition to the clinical setting? What would you need to ease this transition?
Personal impact	<ul style="list-style-type: none"> - What physical impacts did the pandemic had on you? Why? - What psychological impacts did the pandemic had on you? Why? - What impacts did the pandemic had on you at a social level? Why? - Have you received any support? From whom?

asked. Field notes were also used to enrich data. Interviews were conducted in Spanish, and were audio recorded, transcribed, and anonymised. The second author was responsible for these steps, and did not have a previous relationship with any of the participants. Therefore, power imbalance situations did not occur during the development of the study.

2.4. Ethical considerations

All participants received oral and written information about the research, voluntarily agreeing to participate upon the provision of an informed consent form. Participants were also assured of confidentiality and the right to suspend the interview at any time if they wished so. After transcription, all audio recordings were erased.

This study was approved by the Research and Teaching Ethics Committee of the University of A Coruña on February 2021 (number 2021-0003).

2.5. Data analysis

Data were analysed using a three-step hermeneutic phenomenological method (Lindseth & Norberg, 2004). In the first step, the research team captured the general meaning of the interviews through a naïve reading, via reading and rereading the texts. The naïve understanding of the text is considered as a first conjecture and requires validation or invalidation by subsequent structural analysis. Then followed the structural analysis. This is the methodical example of interpretation, which was based on a thematic analysis, whereby the text related to the experience of novice nurses was divided into units, with each unit being described in terms of what was communicated and what the text was about. Meaning units were condensed and summarised to create preliminary themes and subthemes, which were compared with the naïve reading for validation. Finally, a comprehensive understanding emerged from the naïve understanding, structural analysis, study context, researchers’ pre-understandings, and theoretical perspectives. Participants were offered the possibility of recognising and commenting findings by sending the results via email, validating the results in the first instance.

To avoid distortion in data interpretation, all analytical phases were discussed in group sessions with all authors until reaching agreement. The phenomenological characteristic of bracketing was performed during data collection and analysis, holding our judgments about the facts in abeyance to open ourselves to the experience and its implicit understandable meaning. During the inter-

view, only clarifying questions and those that would facilitate the narration of forgotten or important facts that could be lost were asked, enabling the participant to recount their experience without judging, not in pursuit of what was reported to be considered correct or incorrect but rather making the interviewer participate in their story (Lindseth & Norberg, 2004). Another method of bracketing was to write memos throughout data collection and analysis, facilitating review and reflection on the researcher's engagement with the data. In addition, team sessions enabled critical reflection to review (Cutcliffe, 2003; Tufford & Newman, 2012), broaden, and deepen our awareness, recognising the aspects inherent to our pre-understandings. The analysis also relied on grids created for this purpose.

2.6. Trustworthiness

This study was conducted based on the criteria outlined by Lincoln and Guba (Lincoln, 1985), including credibility, transferability, dependability, and confirmability. The research was performed maintaining consistency and a theoretical-epistemological adaptation. We ensured credibility by presenting data according to the authors' interpretations, triangulation, and validation of the results by participants. Structural analysis was provided by the dialectical movement between explanations, while understanding ensured rigor and transparency. Transferability was enabled by the description of the context and participants. To enhance dependability, we also described the study sample, data collection process, data analysis and interpretation, and study limitations. Finally, the criterion of confirmability was addressed by the researchers' reflections on their own positions on the topic.

The data collection and analysis were carried out in Spanish. The entire research team participated in the translation into English of the quotations incorporated in the manuscript, and two language reviewers, with experience in Spanish and English, supervised and examined the translation to preserve the original meaning, maintaining a dialectical process between the research team and the reviewers.

Our research team consisted of two nursing professors and a final-year nursing student, whose training in the clinical setting was affected by the pandemic, thus providing a deep knowledge of the field and the basis for their pre-understanding. Two authors were also trained qualitative researchers with previous experience in research on the transition to graduate nurses. Authors' pre-understandings were based on the fact that people demanding care constitute a whole – that is, an indivisible entity that includes body, soul, and spirit. The purpose of caring is to alleviate suffering and to promote health and life, thus employing a notion of care that goes beyond the physical approach. On the other hand, providing comprehensive care can be emotionally demanding for nurses, who require support on the part of the organisation and leadership.

3. Results

Interviews were conducted with 14 novice nurses from two health areas in northwest of Spain, comprising 12 women and two men aged between 22 and 28 years. Participants had between five months to two years of experience in the field, and practical training during nursing studies of seven participants was affected by the pandemic. Almost all of the nurses interviewed worked directly with patients diagnosed with COVID-19, either in the COVID-19 ward, intensive care units (ICU), or conducting polymerase chain reaction (PCR) tests (Table 2). No nurses refused to participate or withdrew from the study. Participants are identified with an alphanumeric code composed of N (for nurse), a number, and a symbol indicating the sex of the participant.

3.1. Naïve understanding

Next, the result of the naïve understanding is shown, which was later validated by the structural analysis. Although novice nurses perceived the immediate transitioning to clinical settings and the high demand for health professionals as an opportunity, this also meant the proposal of rather short-term employment contracts. For these workers hardly ever enjoyed days off and suffered from anxiety due to constant changes, such a situation contributed to fatigue. Along with their lack of experience within the clinical environment, the pandemic had a considerable physical, psychological, and social impact on the lives of novice nurses. Besides fearing being infected or infecting their relatives, interviewees also reported feeling sadness in having to witness lonely patients who were suffering or at the end of their lives. Those who treated COVID-19 patients expressed difficulty and lack of training to communicate with them, which, together with the helplessness of the organisation, contributed to provoking feelings of abandonment and uselessness. To cope with the emotional demands arising from such a situation, nurses often relied on the support from their peers or adopted behaviours of avoidance.

3.2. Structural analysis

Structural analysis indicated four main themes among narratives: "Transitioning to a hostile, unknown, and uncertain clinical setting from inexperience," "Invisible wounds because of being on the front line," and "Healing to return to the front line."

3.2.1. Transitioning to a hostile, unknown, and uncertain clinical setting from inexperience

For the majority of novice nurses, the transition to the clinical environment was marked by the lack of protection from the organisation having transitioned with a lack of practical training due to the pandemic and a lack of experience and training with the disease.

The workload of healthcare personnel increased dramatically during the pandemic, resulting in many nurses anticipating that they would receive more support from the organisation. Such a lack of support evoked feelings of insecurity and undervaluation, some of which were related to the inability of performing the PCR tests on themselves despite having been in contact with infected colleagues. Hence, workers felt unsafe and feared the possibility of infecting family members and patients.

During the pandemic, final year nursing students were approved to work as healthcare professionals under a relief contract. However, many graduate nurses were unemployed at the time of the hiring of nursing students, leading to several participants criticising this measure, as reported by the following participant:

'It was very frustrating to be at home, receiving no calls, seeing how the media or hospitals were looking for people to basically do the work for free. This was one of the things that bothered me the most in the pandemic - that [the health service] did not value us.' (RN11♀)

There was a lack of knowledge of who or what organisation would be responsible for such a lack of care towards health personnel, with some nurses expressing the need for receiving psychological support from the system:

'I think that for this part, we were not taken care of [psychologically]. It is true that we did not receive any kind of help or tools from the hospital. (...) Sometimes, you feel a little abandoned' (RN8♀).

The final year practical training of participants who graduated during the 2019–2020 academic year was affected, making them

Table 2
Participant demographics.

ID	Gender	Age	Time of professional experience	Professional experience services	Impact of the pandemic on undergraduate training
RN1♀	F	23	1Y8m	Hospital - Various specialties - COVID ward	✗
RN2♂	M	23	7m	PCR test Hospital - Internal medicine ward - Emergency service - COVID ward - Consulting room - Primary healthcare - Cardiology	✓
RN3♀	F	24	1Y8m	Hospital - Emergency service - ICU and COVID-ICU - Various specialties - COVID ward	✗
RN4♀	F	28	5m	Hospital - Internal medicine ward - Cardiology ward - Emergency service - COVID ward	✓
RN5♀	F	23	7m	Hospital - Emergency service - Various specialties - COVID ward	✓
RN6♀	F	24	7m	Primary healthcare consulting room Hospital - ICU and COVID-ICU - Coronary care unit	✓
RN7♀	F	22	5m	Hospital - Gynaecology ward	✓
RN8♀	F	22	8m	Primary healthcare consulting room Hospital - Various specialties - COVID ward	✓
RN9♂	M	23	1Y	Hospital - Internal medicine ward - COVID ward - Emergency service	✗
RN10♀	F	24	10m	Primary healthcare emergency service Hospital - Various specialties - ICU	✓
RN11♀	F	25	1Y6m	COVID team Hospital - Internal medicine ward - COVID ward - NICU	✗
RN12♀	F	24	1Y6m	Hospital - COVID-ICU - Psychiatric ward	✗
RN13♀	F	23	8m	Hospital - Emergency service	✗
RN14♀	F	25	2Y8m	Primary healthcare consulting room Hospital - Internal medicine ward - COVID ward - ICU Primary healthcare consulting room	✗

Abbreviations: Female (F), Male (M), Year (Y), months (m), Neonatal Intensive Care Unit (NICU), Intensive Care Unit (ICU), No (✗), Yes (✓).

feel little prepared to provide care in clinical settings. Specifically, they reported difficulties in addressing sensitive issues, such as witnessing patient death, providing information to patients and relatives in the follow-up of chronic diseases, or communicating difficult situations or death.

'I'm sure everyone at some point had to think: 'What do I do now? I mean I have no idea, I don't have the tools to handle this situation [to communicate bad news], I don't have knowledge, I don't have anything'. I mean, it happened to me a thousand times with deaths, newly diagnosed diseases...' (RN8♀)

Likewise, participants who cared for patients diagnosed with COVID-19 struggled in initiating care due to the lack of experience and training with this disease. Starting on a new service was, in general, difficult to cope with, becoming more acute in this pandemic situation, as the participants often did not know what to do and how to provide the appropriate care to these patients.

'In the middle of the morning, patients [diagnosed] with COVID-19 began to arrive, without knowing what it was, or knowing how to wear PPE.' (RN9♂)

3.2.2. Invisible wounds because of being on the front line

Invisible wounds refers to the impact that the transition to the clinical environment during the pandemic had on novice nurses. The lack of experience and knowledge about the disease had a great impact on the psychological health of participants, being deeply affected by the workload, fatigue, and stress.

'I remember that during the first day, I came home crying and shaking, with tremendous anxiety. I always thought I had coronavirus, because I had pressure in my chest and a feeling of shortness of breath ... and all of that was anxiety.' (RN14♀)

This situation functioned as a trigger for the resurgence of health problems that had been previously treated, as expressed by this participant:

'I live with my partner, so not seeing my parents or my family, together with the risk of what we were exposed to, resulted in anxiety and insomnia again ... Well, now I have an adjustment disorder, which I had a while ago. I was already without medication and had to start again.' (RN4♀)

Due to the large amount of work and the high demand for personnel, participants faced long working hours and hardly had any days off, leading to exhaustion. At the time of the interview, several participants felt more apathetic.

'You could tell that with the passing of the months, the desire was starting to fade. People were already very burned out and very tired.' (RN13♀)

Working on a ward designed for attending patients diagnosed with COVID-19 provoked fear, for these nurses were foreign to the mechanics of these health services and the care of those patients. Their main fear was related to the possibility of infecting their relatives, which led them to avoid any contact with their family and friends and to perform an exhaustive sequence of actions before entering the house, so as not to put anyone at risk.

'Therefore, I attempted to sanitise everything as much as possible once I got home from work. At home I was more relaxed, but if I came from work, everything was separate. I disinfected the mobile and carried it encased. Everything [was] very, very thorough, and very careful that [her things] did not touch anything.' (RN14♀)

Apart from dealing with the uncertainty of the pandemic and the new disease, novice nurses also had to face challenges inherent to their transition, for in many cases, the only practical experi-

ence they had were the tutored practices as a student. Thus, they were required to learn rapidly within a very short time, resulting in the inability to solve problems that did not live up to their expectations and insecurity concerning their performance and training, making them question their worth.

'You finish the shift 3,000 hours later [metaphorically] and a few patients have died, and you didn't even notice. You feel as if you couldn't do anything.' (RN9♂)

The mandatory use of PPE to treat patients hampered physical contact and weakened verbal and non-verbal communication. Moreover, shortening the time spent with patients as a self-protection measure also affected their relationship of trust:

'[The patients] don't recognise you. You attempted to talk to them, tell them your name, but it doesn't matter, because you're covered from head to toe.' (RN8♀)

The circumstances in which patients were admitted or died was emotionally intense for participants, comprising an additional burden. Patients were admitted to hospitals alone and kept isolated, and were often uninformed about their own evolution. In many cases, patients died without saying goodbye to their loved ones.

'On a professional level, [the hardest thing] is the emotional charge. The emotional charge of being there. You are alive and you have to observe people dying alone.' (RN8♀)

3.2.3. Healing to return to the front line

This theme represents the mechanisms of self-care, the support of others, and the process of observing difficulties as opportunities, which the novice nurses used to face this situation.

The demands of such care, imposition of social isolation measures, and great involvement on the part of novice nurses to compensate their lack of experience resulting in them having to cope with emotional demands to which they had not been previously exposed, nor were provided with their usual resources. In this scenario, many participants expressed the importance of self-care to deal with the exhaustion arising from the pandemic.

Despite trying to escape the pandemic by avoiding news and social media, their everyday life was permeated inevitably by this global crisis, resulting in its absorption. Talking to their family or friends, or even with other nurses who were in an identical situation enabled them to express their feelings.

'Crying was good for me and talking to my parents also helped. However, I had nothing to avoid those horrible days.' (RN1♀)

Many of the interviewees reported having forged greater bonds with their co-workers during the pandemic. Despite having received support from family and friends, most participants agreed that the support offered by their colleagues was even more essential, for they experienced the same situation and could, therefore, understand their experiences.

"Sharing experiences with peers, with people in the same situation as myself (...), what other person could potentially put themselves in my place than a person who is exactly in the same situation?" (RN2♂)

Working under these circumstances fostered teamwork, making novice nurses feel more integrated with other professionals – a key support for them to gain self-confidence, especially in a context, such as the pandemic.

Despite the obstacles posed by the health crisis, many participants saw this situation as an opportunity to grow and continue learning in the clinical environment. Before the pandemic, job opportunities in the public health system were restricted mostly to vacation periods; however, the COVID-19 outbreak led to a dra-

matic increase in job offers, thus contributing to their professional experience.

'Newly undergraduate nurses ... Having a one-year contract in the public health system was beneficial for everyone, because we learned a lot more and worked a whole year.' (RN3♀)

Having worked in the course of a pandemic implied the development of skills within a short time to face the growing healthcare demands, as expressed by this participant: *'I believe that if I had not lived what I experienced here, in the hospital, right now I wouldn't be as decisive as I am, you know?'* (RN8♀)

4. DISCUSSION

This study focused on the experiences of novice nurses in providing care during the COVID-19 pandemic, a context marked by uncertainty and unfamiliarity with the disease, demanding actions without support and resources. According to the literature, the guides and rules provided in theory are essential for professionals in this stage to overcome unknown situations (Benner, 1984; Escobar-Castellanos & Jara-Concha, 2019). Our results indicate that the lack of skills evoked feelings of insecurity, as well as fear of facing the unknown, making mistakes, and initiating care. As newly graduated nurses lack work experience, sharing the work shift with more expert nurses contributing to making them feel more secure (Benner, 1984). Given that novice nurses lacked enough support to deal with the difficulties arising from their inexperience or from the pandemic itself, the pandemic context hampered these professionals' transition process. The uncertainty, fear, and workload increased the personal cost of providing caring under such circumstances.

For assuming an increased responsibility for patients – which they sometimes do not accept due to their inexperience, – novice nurses are at a higher risk of suffering from burnout, depression, or abandoning work (Rudman, Arborelius, Dahlgren, Finnes, & Gustavsson, 2020). Our findings show the emotional repercussions of this situation and their consequences, which may be addressed upon the enrolment in courses that promote emotional management, recognition, and the valorisation of their work by colleagues and leaders (Di Tella et al., 2020; Galehdar et al., 2020). However, the participants interviewed in our study encountered a situation in which the support provided by the organisation was insufficient, causing a feeling of abandonment.

Constituting one of the essential pillars of health and accounting for 59% of health professionals, nursing personnel became highly important during the pandemic. Despite the relevance of this profession, several nurses have denounced their precarious employment situation over the years (Guerrero Flores, Timón Andrada, & Conde Caballero, 2018). In 2018, the European Union relied on an average of 8.2 nurses per 1,000 inhabitants, a rate that drops to 5.9 in Spain (OECD & Union, 2020). When assigning these workers to a given service, health organisations often disregard their training or experience, besides penalising them in the eventual lack of response to telephone calls for job offers from the public health system. During the early years of professional practice, newly graduated nurses face constantly changing shifts and units, as well as contracts offered without advance notice or even on the same day, so that in after a year they may add up hundreds of contracts. As a result, nurses face great instability in the employment contract and insecurity in their work (Guerrero Flores et al., 2018; Martín, 2015).

Besides these challenging factors, the pandemic significantly affected care provision. Our results indicate that nurses experienced moral distress, manifested in their speeches addressing the non-provision of care according to their expectations. Patients diagnosed with COVID-19 died alone, and even those who were ad-

mitted into the hospital for other reasons were affected by the social distancing measures, which restricted visits. In many cases, the nurses were the mediators between patients and their families and their only social contact. According to the literature, the COVID-19 pandemic caused moral distress at the individual, relational, organisational, and systemic levels of clinical practice (Silverman, Kheirbek, Moscou-Jackson, & Day, 2021).

These factors suggest that one should focus on the causes of moral distress rather than on its affective symptoms (Thomas & McCullough, 2017). This situation could be prevented by including moral resilience development on the training of nursing students, based on an ethical education that facilitates processing and reflecting on distressing events, building skills in ethical decision-making, being realistic about their own limitations, and learning to share experiences (Rushton, 2016). Such an approach could be complemented through a training aimed at promoting well-being, self-care, and support of future nurses, as well as through the development of programs that facilitate the transition of novice nurses into the clinical practice (Jarden et al., 2021; Mills, 2021). In this respect, the figure of a nursing leader of the units where novice nurses are working has a fundamental role in the cohesion of the work team, supervision, and facilitation of the transition of these nurses. The nursing leader can function as a liaison between the novice nurse and senior nurses. For example, helping senior nurses identify and understand the impact effects of transition to effectively identify issues and help graduates with the transition (Graf, Jacob, Twigg, & Nattabi, 2020).

Whereas other healthcare contexts institute policies aimed at promoting health and resilience within clinical settings, fostering compassionate leadership (Mills, Sullivan, & Ross, 2021), ours still require a paradigm shift capable of challenging the social assumption that regards self-care as selfish in favour of one that normalises it as a necessary part of daily professional practice (Mills et al., 2021; Mills, Wand, & Fraser, 2015). In this sense, educators play a key role in implementing and promoting preventive self-care programs that train students to develop and maintain well-being, resilience, and self-compassion (Barnett, Barnett, Borgueta, Moreno, & Watson, 2021; Cusack et al., 2016; Fernandez, Heidi, Moxham, Middleton, & Halcomb, 2021; Jarden et al., 2021). This justifies the need for prioritising learning and teaching approaches that are both experiential and transformative, thus transcending the mere acquisition of knowledge about health and well-being (Mills et al., 2021).

4.1. Strengths and limitations

We understand the proximity of the research team with the experience of novice nurses as a strength that enhanced data collection and analysis. We investigated a heterogeneity of health services, which contributes to the fact that the experiences presented in the results are not limited to a specific service, thus facilitating transferability. However, the lack of male participants can be seen as a limitation. The participants provided feedback on this study results, ensuring its credibility and enabling their generalisation to other settings. Our results may be also beneficial both for the educational field and for managers of health organisations.

5. Conclusion

Our results indicate that the care provided by novice nurses during the COVID-19 pandemic was characterised by uncertainty and by the lack of organisational support. Besides these factors, these professionals also had to deal with the challenges inherent to their transition to the clinical environment – which were exacerbated by the pandemic. Although some participants understood

the labour demand arising from this context as a learning opportunity, it affected the health of participants, especially before the vulnerability of the patients. To cope with exhaustion, novice nurses performed self-care activities and relied on their social network, mainly on their co-workers.

For addressing a group that is poorly studied, these findings are considered a novelty and their applicability can be divided into four axes: contextualisation, care provision, management, and education. We conducted this study in an unusual context, such as the pandemic, revealing the real situation of nurses, who face greater difficulties during the first years of professional development, as well as the experiences and needs related to care provision. The findings highlight the need for strategies, mechanisms, and tools that address the emotional care of nurses, especially newly graduated ones, as the demand for communication training and preparation in COVID-19 care provision has increased recently. Accordingly, teaching and learning approaches that are experiential and transformative are required. A paradigm shift must also be encouraged that challenges the social assumption that considers self-care as selfish. In addition, training should be directed towards the development of moral resilience through ethical education. Finally, these findings may also be beneficial for management and education leaders, as they describe the experiences, needs, and deficiencies manifested by novice nurses under this current scenario. These results can form the basis for the development of programs that facilitate the transition of novice nurses to clinical practice. In addition, the lead nurse can facilitate the transition of novice nurses by providing support and guidance to senior nurses. As novice nurses enter the labour market every year, and considering that the pandemic is not over yet, deepening their experiences from different perspectives is essential to enable their transition into the clinical environment.

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Conflict of interest

The authors have no conflicts of interest to disclose.

CRediT authorship contribution statement

Sara Fernández-Basanta: Conceptualization, Methodology, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision. **Carmen Espremáns-Cidón:** Conceptualization, Formal analysis, Investigation, Data curation, Writing – review & editing, Visualization. **María-Jesús Movilla-Fernández:** Conceptualization, Methodology, Formal analysis, Investigation, Resources, Writing – review & editing, Visualization, Supervision.

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