Universitat de Lleida

Expectativas y experiencias laborales de estudiantes y egresados/as del Grado de Enfermería

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Universitat de Lleida

TESI DOCTORAL

Expectativas y experiencias laborales de estudiantes y egresados/as del Grado de Enfermería

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Memoria presentada para optar al grado de Doctor por la Universidad de Lleida

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ABREVIATURAS

ATS: Ayudante Técnico Sanitario.

BOE: Boletín Oficial del estado.

CIE: Consejo Internacional de Enfermeras.

CIE: Consejo Internacional de Enfermeras.

EIR: Enfermero Interno Residente.

EPI: Equipo de Protección Oficial.

OCDE: Organización para la Cooperación y el Desarrollo Económico.

OMS: Organización Mundial de la Salud.

OIT: Organización Internacional del Trabajo.

SASRQ: The Stanford Acute Stress Reaction Questionnair.

SPSS: Statistical Package for Social Sciences.

STROBE: Strengthening the Reporting of Observational Studies in Epidemiology

TFG: Trabajo Fin de Grado

UE: Unión Europea

RESUMEN

La crisis financiera que tuvo lugar en España en 2008, provocó una reducción de los recursos humanos y materiales en el sistema sanitario, siendo el colectivo enfermero uno de los más castigados. Esto conllevó un aumento de la migración de egresados/as enfermeros/as a otros países, acentuando la falta de enfermeros/as en España. La pandemia del COVID-19 agravó dicha situación, siendo necesaria la incorporación prematura de estudiantes de Enfermería a la actividad asistencial.

Objetivos: El objetivo principal fue conocer las expectativas laborales de estudiantes del Grado de Enfermería de tres Universidades españolas (A Coruña, Lleida y Murcia) pre-COVID y las experiencias laborales de varias regiones españolas pre-COVID (Lleida, Galicia y Murcia) y post-COVID (Madrid, Lleida y País Vasco).

Metodología: Se realizaron tres estudios multicéntricos, dos de métodos mixtos y un estudio trasversal. Se calcularon estadísticas descriptivas mediante el programa SPSS. Se realizaron pruebas de comparación (ANOVA, Chi-cuadrado). Los datos cualitativos se codificaron y organizaron mediante el apoyo del softwares informáticos de análisis cualitativo.

Resultados: La mayoría de los/as estudiantes de Enfermería estaban preocupados/as por su futuro laboral, la incertidumbre de llegar a encontrar un trabajo como enfermero/a y las condiciones de empleo precarias previstas, eran las dos causas más citadas, Artículo 1. La mayoría de enfermeros/as egresados/as tenían contrato temporal y mostraban una alta tasa de burnout, altos niveles de fatiga emocional, despersonalización y falta de realización personal, Artículo 2. La situación del COVID-19 provocó la incorporación laboral de los/as estudiantes de Enfermería, mostrando niveles elevados de ansiedad y reacciones de estrés agudo, Artículo 3. Pero, a pesar de la crisis sanitaria, los/as estudiantes de Enfermería valoraron aspectos positivos de dicha situación, como adquirir experiencia y conocimientos, Artículo 4.

Conclusiones: Los/as estudiantes de Enfermería españoles/as se encuentran en una situación de gran incertidumbre cuando terminan el grado, visualizando un futuro con gran estrés y frustración, debido a la precariedad laboral y la falta de empleo. A este colectivo se suman los/as enfermeros/as egresados/as españoles/as, quienes presentan altos niveles de fatiga emocional, despersonalización y falta de realización personal, siendo la contratación temporal y la dificultad de realización profesional los principales motivos. La pandemia del COVID-19 agravó esta situación, poniendo de manifiesto la escasez de enfermeros/as en los hospitales españoles y la necesidad de incorporar estudiantes de Enfermería a la asistencia sanitaria.

ABSCTRACT

The financial crisis that took place in Spain in 2008 resulted in a reduction of human and material resources in the healthcare system, with the nursing profession being one of the most affected. This led to an increase in the migration of graduate nurses to other countries, exacerbating the shortage of nurses in Spain. The COVID-19 pandemic worsened this situation, requiring the premature incorporation of nursing students into healthcare activities.

Objectives: The main objective was to understand the employment expectations of nursing students from three Spanish universities (A Coruña, Lleida, and Murcia) pre-COVID, as well as the work experiences in several Spanish regions pre-COVID (Lleida, Galicia, and Murcia) and post-COVID (Madrid, Lleida, and the Basque Country).

Methodology: Three multicenter studies were conducted, two of which were mixed-methods studies, and one was a cross-sectional study. Descriptive statistics were calculated using the SPSS software. Comparative tests were performed (ANOVA, Chi-square). Qualitative data were coded and organised using qualitative analysis softwares.

Results: The majority of nursing students were concerned about their future employment prospects. The two most cited causes were the uncertainty of finding a nursing job and the anticipated precarious employment conditions, Article 1. Most graduate nurses had temporary contracts and showed high rates of burnout, emotional fatigue, depersonalization, and lack of personal fulfillment, Article 2. The COVID-19 situation led to the employment of nursing students, who exhibited high levels of anxiety and acute stress reactions, Article 3. However, despite the health crisis, nursing students valued positive aspects of the situation, such as gaining experience and knowledge, Article 4.

Conclusions: Spanish nursing students find themselves in a situation of great uncertainty upon graduation, envisioning a future with high stress and frustration due to job insecurity and lack of employment. This group is joined by Spanish graduate nurses, who experience high levels of emotional fatigue, depersonalization, and lack of personal fulfillment, with temporary contracts and professional fulfillment difficulties being the main reasons. The COVID-19 pandemic aggravated this situation, highlighting the shortage of nurses in Spanish hospitals and the need to incorporate nursing students into healthcare.

RESUM

La crisi financera que va tenir lloc a Espanya el 2008, va provocar una reducció dels recursos humans i materials en el sistema sanitari, sent el col·lectiu infermer un dels més castigats. Això va comportar un augment de la migració d'egressats/es infermers/es a altres països, accentuant la falta d'infermers/es a Espanya. La pandèmia de la COVID-19 va agreujar aquesta situació, sent necessària la incorporació prematura d'estudiants d'Infermeria a l'activitat assistencial.

Objectius: L'objectiu principal va ser conèixer les expectatives laborals dels estudiants del Grau d'Infermeria de tres universitats espanyoles (A Corunya, Lleida i Múrcia) pre-COVID i les experiències laborals de diverses regions espanyoles pre-COVID (Lleida, Galícia i Múrcia) i post-COVID (Madrid, Lleida i País Basc).

Metodologia: Es van realitzar tres estudis multicèntrics, dos de mètodes mixtes i un estudi transversal. Es van calcular estadístiques descriptives mitjançant el programa SPSS. Es van realitzar proves de comparació (ANOVA, chi-quadrat). Les dades qualitatives es van codificar i organitzar mitjançant el suport del programes informàtics d´anàlisi qualitativa.

Resultats: La majoria dels/des estudiants d'Infermeria estaven preocupats/des pel seu futur laboral, la incertesa d'aconseguir un treball com a infermer/a i les condicions d'ocupació precàries previstes eren les dues causes més citades, Article 1. La majoria dels/es infermers/es egresats/es tenien contracte temporal i mostraven una alta taxa de burnout, alts nivells de fatiga emocional, despersonalització i manca de realització personal, Article 2. La situació de la COVID-19 va provocar la incorporació laboral dels/es estudiants d'Infermeria, mostrant nivells elevats d'ansietat i reaccions d'estrès agut, Article 3. Però, malgrat la crisi sanitària, els/es estudiants d'Infermeria van valorar aspectes positius d'aquesta situació, com adquirir experiència i coneixements, Article 4.

Conclusions: Els/es estudiants d'Infermeria espanyols/es es troben en una situació de gran incertesa quan acaben el grau, visualitzant un futur amb gran estrès i frustració, a causa de la precarietat laboral i la manca d'ocupació. A aquest col·lectiu s'hi sumen els/es infermers/es egresats/es espanyols/es, els quals presenten alts nivells de fatiga emocional, despersonalització i manca de realització personal, sent la contractació temporal i la dificultat de realització professional els principals motius. La pandèmia de la COVID-19 va agreujar aquesta situació, posant de manifest l'escassetat d'infermers/es als hospitals espanyols i la necessitat d'incorporar estudiants d'Infermeria a l'assistència sanitària.

1. INTRODUCCIÓN

En España, 10.236 estudiantes de Grado finalizaron sus estudios en 2018-2019 (Ministerio de Educación y Ciencia, 2021) y la mayoría de los empleos que desempeñaron fueron contratos temporales. Esta tendencia se puso de manifiesto en los datos de 2018, que sugirieron que el 70,03% de los contratos en el ámbito de las ciencias de la salud son temporales (Ministerio de Educación y Ciencia, 2021). Esta situación afecta especialmente a los/as jóvenes menores de 25 años: más del 57% en el primer año después de la graduación y más del 49% después de cuatro años, tienen contratos temporales. En total, los/as recién graduados/as en Enfermería empleados con contratos temporales representan el 48% de todos los/as graduado/as (Ministerio de Ministerio de Ciencia, Innovación y Universidades, 2019).

Además, España también tiene una de los ratios de enfermeros/as por habitantes más bajas de la Unión Europea. Según la OCDE (Organización para la Cooperación y el Desarrollo Económico), la ratio en Europa es de 8,8 profesionales de Enfermería por cada 1000 habitantes, mientras que en España esta ratio es de 5,6 enfermeros/as (Montero, 2020) por cada 1000 habitantes. La Organización Mundial de la Salud (OMS) estima un déficit de 18 millones de trabajadores sanitarios para 2030, lo que impediría alcanzar los objetivos de desarrollo sostenible (OMS, 2020). Además, es necesario aumentar el número de graduados/as en Enfermería en un 8% en todos los países (OMS, 2020). Sin este aumento, se calcula que el 89% (5,3 millones) de la escasez de enfermeros/as, se concentrará en los países de renta baja y media-baja, donde el crecimiento del número de enfermeros/as apenas sigue el ritmo del crecimiento de la población, y se espera que las mayores diferencias se den en África, Asia sudoriental, el Mediterráneo Oriental y en algunos países de América Latina (OMS, 2020, Salami et al., 2014).

Entre 2010 y 2013, un total de 4.580 enfermeros/as españolas enviaron una solicitud a través del Ministerio de Educación para convalidar sus títulos de Enfermería para trabajar en otro país del Espacio Económico Europeo (Galbany y Nelson, 2016). Uno de los motivos que se plantearon para tomar esta decisión fue la gestión económica del Sistema Sanitario español, que provocó un aumento de desempleo y unas condiciones laborales precarias (OMS, 2018; Ruiz y Bayle, 2016).

La crisis financiera que tuvo lugar en España en 2008 llevó a la aplicación de políticas de austeridad y una reducción de los recursos humanos y materiales, afectando negativamente al sistema sanitario (OMS, 2018; Ruiz y Bayle, 2016). El impacto de la

crisis todavía se puede sentir hoy en día, dificultando la adaptación de los/as jóvenes al mercado laboral y aumentando la incertidumbre y la inseguridad respecto a su futuro inmediato (OMS, 2018).

1.1. Expectativas laborales

Según el Diccionario de la Real Academia Española, expectativa se define como la "esperanza de realizar o conseguir algo" (RAE, 2017). Las expectativas laborales hacen referencia al tipo de trabajo al que aspiramos y a las metas que nos gustaría alcanzar en nuestro trabajo (Escobar y Covarrubias, 2019). Las percepciones personales o expectativas de los/as estudiantes de Enfermería son aspectos que están relacionados con su futuro profesional y académico y este futuro, a su vez, influye en la propia motivación, trayectoria y logros (Ángel & Blanco, 2017.).

Es importante señalar que Enfermería es, tradicionalmente, una carrera universitaria con altas expectativas laborales. Si bien, las expectativas laborales pueden variar con el tiempo. De hecho, los/as jóvenes cuya socialización anticipatoria (en este caso mediante las prácticas) les haya permitido elaborar pensamientos respecto a determinados aspectos laborales, podrán prever las posibilidades de desarrollo del rol laboral y responder en consecuencia (Pinazo & Carrero, 2010).

Por otro lado, la incertidumbre es entendida como la forma en que una persona reacciona ante situaciones inciertas o ambiguas que pueden ser vividas como agotadoras bajo la creencia de que los eventos inesperados son negativos y deben de ser evitados y que un futuro incierto e injusto (González et al., 2006). Diversos autores/as han identificado esta experiencia como intolerancia a la incertidumbre y la describen como un continuo unidimensional en el que la persona con intolerancia a la ambigüedad experimenta el estrés como reacción o evitación de estos estímulos (González et al., 2006; López y Gago, 2013). La adaptación española de la Escala de Intolerancia hacia la Incertidumbre, la trata como una variable de vulnerabilidad cognitiva relacionada con la etiología y el mantenimiento de la preocupación excesiva e incontrolable (Herrera et al., 2006). Hace referencia "al modo en que una persona (o grupo) percibe y procesa la información sobre situaciones ambiguas cuando se enfrenta con una variedad de señales no familiares, complejas o incongruentes". La intolerancia hacia la ambigüedad se concibe a menudo como un continuo unidimensional en el que la persona con alta intolerancia hacia la ambigüedad experimenta estrés, reacciona prematuramente y evita estímulos ambiguos (Herrera et al., 2006). Según Gago Velasco (2013) la incertidumbre

respecto al futuro profesional afecta a los/as jóvenes enfermeros/as españoles/as y supone un grave factor de riesgo para la salud.

En Enfermería, nos encontramos ante una generación de jóvenes con ganas de trabajar y desarrollarse profesionalmente en el ámbito sanitario, que ven afectada su salud y planes futuros desde antes incluso del inicio de su vida laboral debido al estado actual en que se encuentra la situación laboral de este colectivo, fuertemente marcado por el desempleo (Ángel & Blanco, 2017).

1.2. Satisfacción laboral y burnout

La satisfacción laboral de los/as trabajadores/as tiene una influencia directa en la calidad de los servicios, la satisfacción de los/as pacientes y el desarrollo de la organización (Lu et al., 2019). La satisfacción laboral se entiende como una perspectiva favorable, con un equilibrio entre las expectativas laborales de las personas, las recompensas que ofrece, las relaciones interpersonales y el tipo de gestión (Fernández et al., 2019).

Los/as profesionales sanitarios/as insatisfechos tienden a sufrir más cambios de humor y diversas dolencias psicosomáticas, además de ser menos eficientes, y tener un mayor absentismo laboral y cambios de trabajo más frecuentes (Gandarillas González et al., 2014). Todas estas situaciones conducen a un alto riesgo de sufrir el "Síndrome de Burnout".

El burnout, clasificado por la Organización Mundial de la Salud (OMS) como enfermedad profesional, es una consecuencia del estrés crónico (Moreno et al., 1990; Pérula et al., 2016). Este síndrome tiene tres dimensiones: agotamiento emocional, despersonalización y sensación de baja realización personal (Maslach y Jackson, 1981) que provoca alteraciones emocionales, conductuales, psicosomáticas comportamiento, psicosomáticas y sociales, pérdida de eficiencia laboral y alteraciones en la vida familiar (Moreno et al., 1990; Pérula et al., 2016).

El Agotamiento Emocional (AE), se describe como "un sentimiento y sensación de vacío y agotamiento ante las exigencias de la tarea por la que no se siente atractivo alguno", puesto que crea relaciones emocionales independientes de los/as pacientes y minimiza los encuentros con ellos/as al mínimo requerido, fenómeno que puede convertirse en indiferencia y falta de interés por las necesidades del/a otro/a. Produce desgaste, cansancio y fatiga (Maslach y Jackson, 1981).

La despersonalización (DP), supone una conducta de rechazo hacia los/as pacientes: “el/la individuo/a presenta reacciones negativas hacia ellos, se niega a ser cortés, denigra e incluso desprecia al paciente”. Los sentimientos que pueden aparecer en el/la profesional son el cinismo, el desapego, irritabilidad, actitudes negativas y respuestas frías (Maslach y Jackson, 1981).

La falta de realización personal (PA), consiste “en una actitud negativa hacia uno mismo y hacia el trabajo, pérdida de interés por éste, irritabilidad, baja productividad y pobre autoestima”; el/la individuo/a siente un fracaso profesional y el colapso de su autoestima puede desembocar en una depresión (Maslach y Jackson, 1981).

El personal sanitario es especialmente susceptible de sufrir burnout (Chemali et al., 2019; Morse et al., 2012). En particular, los/as enfermeros/as tienen una prevalencia de burnout del 54%, a nivel mundial (Zhang et al., 2018). La profesión de Enfermería implica un alto estrés laboral debido a la implicación psicológica y emocional, ya que están en contacto directo con el sufrimiento, el dolor y la muerte de los/as pacientes, así como aspectos relacionados con la dicotomía entre la carga de trabajo y los recursos disponibles (Pérula et al., 2016).

Organizaciones internacionales como la Organización Mundial de la Salud (OMS), el Consejo Internacional de Enfermeras (CIE) y la Organización Internacional del Trabajo (OIT) han identificado las inadecuadas condiciones laborales que afectan a la población enfermera (Chen et al., 2019), entre las que se encuentran el aumento de la carga de trabajo, la falta de recursos humanos, contratos temporales que disminuyen la seguridad laboral, la falta de recursos para la prestación de servicios y los bajos salarios. Estos factores generan sobrecarga de trabajo, fatiga, agotamiento físico y mental y un alto nivel de estrés en esta profesión (Castillo Ávila et al., 2014). Además, los niveles de estrés mantenidos en el tiempo pueden provocar síntomas de depresión (Fernández-Sánchez et al., 2019). La tasas de prevalencia de depresión o síntomas depresivos entre los/as profesionales de Enfermería son superiores al 20% (da Silva et al., 2015), consideradas altas en comparación con la población general, ya que se considera que el 5% de los/as adultos/as sufren depresión en algún momento de su vida (OMS, 2023). Estudios internacionales identificaron que la depresión es un motivo de absentismo entre Enfermeros/as (Dos Santos Trettene et al., 2020; Méndez-Nieto et al., 2013; Vargas & Dias, 2011; Yun et al., 2010).

El tipo y la temporalidad de los contratos de trabajo contribuyen directamente a la satisfacción de los/as profesionales sanitarios/as (Herrera-Amaya & Manrique-Abril,

2008). En 2018, el 70,38% de los contratos de los/as profesionales en España eran temporales (Ministerio de Ciencia, Innovación, & Universidades, 2019). Esta elevada proporción se debe en parte a un cambio en la gestión del Sistema Nacional de Salud como consecuencia de la crisis económica que se inició en 2008, provocando una reducción de los recursos humanos, el aumento del desempleo y la precariedad laboral (Galbany-Estragués et al., 2019; Galbany-Estragués & Nelson, 2016). Estas condiciones contribuyeron a un flujo migratorio de profesionales de la Enfermería en busca de oportunidades de mejores salarios, mayor estabilidad y mejor calidad de vida. Así mismo, la precariedad laboral también lleva al abandono de la profesión Enfermera. De hecho, los/as enfermeros/as insatisfechos/as tienen un 65% más de posibilidades de abandonar la profesión, y la precariedad laboral en Enfermería, caracterizada por el paro y los contratos temporales y parciales han limitado el nivel de satisfacción de los/as profesionales (Paz et al.2014; Galbany-Estragués y Nelson, 2016; Salami et al., 2014).

La migración de los/as profesionales de Enfermería que se viene produciendo desde 2007 en nuestra afecta al sistema económico del país, que invierte en formar enfermeros/as que posteriormente se ven "forzadas" a migrar por las condiciones laborales y desempleo, favoreciendo la economía de otros países que se benefician de la formación de los/as enfermeros/as en España (Galbany-Estragués et al., 2019; Galbany-Estragués & Nelson, 2016).

La escasez de personal induce un aumento de la insatisfacción laboral y el agotamiento entre los/as profesionales, provocando un aumento de los errores de Enfermería que hacen que la calidad de los cuidados se vea afectada (Gandarillas González et al., 2014), además de aumentar el riesgo de mortalidad de los/as pacientes (Needleman et al., 2020).

El mercado laboral en el que se encuentran los/as enfermeros/as es en general de contratación temporal, ratios de pacientes/enfermeros/as muy elevados y escasez de continuidad en el puesto de trabajo. Todo ello pone de manifiesto el desconfort en el que se encuentran, afectando a su salud mental y a la calidad de la asistencial (Gandarillas González et al., 2014, Needleman et al., 2020).

1.3. El rol de Enfermería durante la pandemia COVID- 19

En marzo de 2020, la Organización mundial de la Salud (OMS) declaró el brote del nuevo coronavirus SARS-CoV-2 como pandemia. Asimismo, la presión ejercida sobre el sistema sanitario durante el brote de COVID-19 hizo imprescindible reordenar la actividad asistencial, incrementándose las unidades disponibles para atender a las personas infectadas y reducir, e incluso suspender, aquella considerada no esencial. La escasez de recursos materiales y humanos para atender las demandas de atención, llevó a la incorporación a la atención sanitaria de estudiantes y especialistas en formación de profesiones sanitarias, medida que fue finalmente adoptada también en distintos países, incluido Reino Unido (Swift et al., 2020).

Esta crisis sanitaria que provocó el COVID-19, afecto a la salud mental de los/as profesionales sanitarios/as que trabajaron durante la pandemia. Varios estudios sobre los/as profesionales de la salud, mostraban niveles altos de estrés, agotamiento, ánimo depresivo y poca satisfacción (Zerbini et al.2020; Koksal et al. 2020; Wang et al.2020; Azoulay et al.,2020; Karabulut et al.,2021; Kounou et al.2020; Lasalvia et al.,2021; Cunill et al., 2020), miedo a estar infectados ellos/as mismos/as o infectar a sus familias (Zebinbi et al.2020; Koksal et al. 2020; Saracoglu et al., 2020), eventos relacionados con la pandemia potencialmente traumáticos y alteraciones del sueño (Azoulay et al.,2020; Karabulut et al.,2021; Lasalvia et al.,2021; Saracoglu et al., 2020; Haravuori et al., 2020), y otros síntomas como cefaleas asociadas a los equipos de protección individual (Ong et al., 2020), especialmente enfermeros/as (Zebinbi et al.2020;Wang et al.2020; Azoulay et al.,2020,Karabulut et al.,2021; Kounou et al.2020; Lasalvia et al.,2021; Cunil et al., 2020; Haravuori et al., 2020) y otros/as sanitarios/as trabajando con pacientes COVID-19 (Zebinbi et al.2020; Lasalvia et al.,2021), personas con alta carga de trabajo o enfermedades crónicas (Koksal et al. 202038, Lasalvia et al.,2021), etc.

Varios/as autores/as destacaron que el mayor impacto sobre la salud mental lo sufrieron los/as enfermeros/as y los/as profesionales que trabajaban en primera línea (Moreira et al., .2020; Du et al, 2020; Huang & Zhao, 2020), destacando la presencia de ansiedad, depresión y estrés y otros problemas como calidad del sueño. En estudios sobre profesionales enfermeros/as, se obtuvieron resultados con una prevalencia de ansiedad y depresión del 49% y el 25% respectivamente (Dal´Bosco et al, 2020), del que un 40% de los/as participantes refirió ansiedad entre moderada y severa

(Pouralizadeh et al., 2020), y riesgo de síntomas del trastorno de estrés post-traumático e insomnio (Cai et al., 2020).

Así mismo, la situación de emergencia sanitaria condujo también a la reestructuración de la actividad docente en los centros educativos, entre ellos las Universidades (Newell, 2020; Brand, 2020). Esta situación conllevó a que tanto los/as estudiantes de Enfermería como los/as docentes, se tuvieran que adaptar a un modo de educación semi-presencial en formato online, suponiendo un esfuerzo por no estar acostumbrados a esta modalidad (Jowsey et al., 2020). Además, en algunos casos se contaba con barreras tecnológicas que suponían un reto debido a los problemas técnicos o de accesibilidad, o por costes elevados de la conectividad, mala cobertura, etc (Alhassa, 2020; Cassum et al., 2020; Dewart et al., 2020).

Las prácticas clínicas del Grado de Enfermería fueron canceladas en la mayoría de las Universidades y de centros asistenciales, produciendo una preocupación por una posible falta de preparación de los/as estudiantes (Dewart et al., 2020). En algunos casos, los/as estudiantes tuvieron un sentimiento de presión al llevarlas a cabo y tener que atender a pacientes con COVID-19, ya que por el desconocimiento que en ese momento había de la enfermedad tenían miedo de ponerse en riesgo a ellos/as mismos y a sus familias (Dewart et al., 2020; Usher et al., 2020).

En ciertos países como Estados Unidos, Irlanda, e Italia dieron opción a una graduación más temprana en ciertas titulaciones sanitarias, para ayudar a descomprimir la sobrecarga asistencial y falta de personal en los centros sanitarios mediante la realización de exámenes tempranos (Rerford, 2020; O´Brien, 2020) o mediante las tareas de ayuda a los/as profesionales sanitarios (Cole, 2020).

En países como España (Monforte- Royo &Fuster, 2020; Collado et al., 2020), Reino Unido (Taylor et al., 2020), Estados Unidos (Koetter et al., 2020; Baheti et al., 2020; Gresh et al., 2020) y China (Xiao et al, 2019), se llevaron a cabo otra estrategias para liberar esta sobrecarga, como fue la contratación de los/as estudiantes de último curso de carreras de ciencias la salud, de forma voluntaria. En España, el gobierno de la nación aprobó la Orden SND/232/2020 de 15 de marzo, por la que se adoptaron medidas en materia de recursos humanos y medios para la gestión de la situación de crisis sanitaria ocasionada por el COVID-19, que posibilitaba la incorporación inmediata a los servicios de Salud de las diferentes comunidades autónomas de los/as estudiantes de último año de los Grados de Medicina y Enfermería (Gobierno de España, 2020). Conforme a la Orden, éstos serían contratados bajo la figura de Auxilio

Sanitario, debiendo desarrollar su actividad asistencial en calidad de apoyo y siempre bajo la supervisión de un/a profesional sanitario titulado. En las semanas siguientes, el estudiantado -principalmente de 4º curso- de Enfermería se incorporó de manera voluntaria a los servicios sanitarios de Comunidades Autónomas como Madrid, Cataluña**,** Eusckadi, Castilla y León**,** Castilla-La Mancha**,** la Rioja **y** Canarias, estableciéndose en diferentes recursos asistenciales, como hospitales, residencias y hoteles medicalizados (Cuesta-Santamaría, 2020; Gómez-Ibáñez et al., 2020); éstos tenían cursada toda la formación teórica a falta de terminar el Trabajo Fin de Grado (TFG) y su formación práctica (Aslan & Pekince, 2020).

Varios estudios han medido los niveles de estrés percibido (Ersin & Kartal, 2021) y de ansiedad (Cici &Yilmazel, 2021) en estudiantes de Enfermería durante los primeros meses de la pandemia del COVID-19, indicando que éstos se incrementaron durante la pandemia debido a la incertidumbre académica y también a la situación sanitaria vivida (Collado-Boira, 2020). En este estudio de Collado et al., (2020) se entrevistó a distintos/as estudiantes de Enfermería y Medicina de últimos cursos sobre sus experiencias trabajando en primera línea de la pandemia, los/as cuales manifestaron aspectos como miedo a infectarse y transmitirlo a sus familias, falta de equipos de protección, miedo a una insuficiente preparación para hacerse cargo de una situación vivida como la actual (tanto por conocimientos como por no estar preparados mentalmente), etc.

2. MARCO TEÓRICO

2.1. Principios de la Enfermería como titulación.

En España, la unificación de la medicina y la cirugía en 1843 dio origen a una nueva profesión, los "Prácticos en el arte de curar", sanitarios (enfermeras y enfermeros de la actualidad) que se instauraron en las zonas rurales donde la población no podía ser atendida por un médico-cirujano (Gómez et al., 2020).

La Ley de Bases para la Instrucción Pública (1857), conocida como Ley Moyano, reguló la formación teórico-práctica de las profesiones sanitarias existentes hasta el momento, incluyendo dentro de los practicantes a los sangradores, callistas, dentistas y asistentes a partos. Esta ley también creó el título de matrona, unificando en él a parteras, comadronas y profesoras en partos. Incluso, reconoció la necesidad de formación teórico-práctica para asistir a las mujeres en el momento del nacimiento de sus hijos. Sin embargo, la Ley Moyano no contempló el papel de los/as enfermeros/as, pues, su actividad no fue considerada profesión sanitaria, sino oficio (Gómez et al., 2020).

En 1896 se funda la primera escuela de Enfermería en España, es la Escuela de Santa Isabel de Hungría, por el Doctor Federico Rubio pero no es hasta 1915 cuando se crea el título de enfermera por primera vez en la historia. Se reconoce legalmente a los/as enfermeros/as y se institucionalizan los cuidados bajo tres denominaciones distintas: enfermeros/as, practicantes/as y matrones/as (Chaboyer et al., 2001).

Es la Ley de Salud Pública del 10 de agosto de 1904 la que permite a la mujer la adquisición del Título de Practicante (Chaboyer et al., 2001). En la Orden Ministerial de 21 de mayo de 1941 se establece que los estudios de Enfermería tendrán dos cursos académicos de duración y podrán realizarse en las Facultades de medicina o centros reconocidos (Coll-Vinent et al., 2010).

En agosto de 1953, en el plan de estudios, y poco después en el Real Decreto de 4 de diciembre de 1953, se unifican los estudios de enfermero/a, practicante/a y matrón/a en uno solo, el de ayudante técnico sanitario (ATS) (Drennan, 2010). Desaparece el término enfermero/a, bajo las siglas de ATS, desatendiendo así las recomendaciones de la Organización Mundial de la Salud, partidaria de la denominación enfermero/a.

Hasta 1977 los/as enfermeros/as estudiaban en las Escuelas de Asistentes Técnicos Sanitarios, compartían prácticas en los hospitales con otros/as profesionales con

titulación universitaria. Pero al terminar sus estudios no obtenían un título universitario (Romero, 2020).

Finalmente, en el Real Decreto 2128/77, de 23 de julio, se transforma las escuelas de ATS en escuelas Universitarias de Enfermería (Falcó-Pegueroles, 2009). El 31 de octubre, una orden ministerial establece las directrices para la elaboración de planes de estudios en dichas escuelas. Permitiendo la entrada de la disciplina enfermera en la universidad, se garantizaba su desarrollo y crecimiento competencia. Desde entonces, ha habido múltiples Reales Decretos, Órdenes ministeriales y Leyes destinados a marcar las directrices del profesional sanitario (Romero, 2020).

En el Real Decreto 1466/90, de 26 de octubre, se establecen las directrices generales de los planes de estudio del Diplomado en Enfermería, que posteriormente serán revisadas y modificadas en sucesivos planes de estudio (Galimany et al., 2011).

Un largo y complejo proceso en el que la perseverancia, la unión de toda la profesión y la normativa europea fueron claves para que la Enfermería alcanzase, por fin, el desarrollo académico que merecía (Romero, 2020). En los primeros tiempos la mayoría de los profesores eran médicos. Hasta entonces existían enfermeros/as profesores/as titulares de Escuela que habían sido nombrados por idoneidad. Esa situación se compensó en cierta manera gracias al esfuerzo de la propia profesión, que buscó otras vías. Así, por ejemplo, en octubre de 1999, la Organización Colegial de Enfermería firma el "Proyecto Amanecer" con la Universidad Católica San Antonio de Murcia. Gracias a este convenio, la Enfermería lograba acceder a la Licenciatura en Antropología Social y Cultural. De esta forma, los/as enfermeros/as podían acceder a los estudios de Tercer Ciclo y al Doctorado. Pero la lucha no finaliza aquí. En enero del año 2000 la Comisión Europea lleva al gobierno español ante el Tribunal de Justicia de la Unión Europea, tras la denuncia del Consejo General de Enfermería por el reiterado incumplimiento de la Directiva 77/453/CEE, que incluía una formación mínima de 4.600 horas que la Diplomatura no cumplía (Romero, 2020, Gómez et al.,2020).

El impulso definitivo llegaría de la mano del Plan Bolonia, por el que se crea el Espacio Europeo de Educación Superior, modificando todo el sistema universitario en la Unión Europea con la creación de los Grados. Así, el 27 de febrero de 2008, el Boletín Oficial del Estado (BOE, 2008) publicaba una breve resolución que, sin embargo, tenía una enorme trascendencia: las condiciones de los planes de estudios de Enfermería (Romero, 2020).

Entre las nuevas condiciones del título de Graduado en Enfermería destacaba que el plan de estudios dejaba de ser una Diplomatura de tres años y pasaba a convertirse, finalmente, en un Grado de cuatro años y 240 créditos académicos. Ello suponía la equiparación de los estudios universitarios de Enfermería al resto de titulaciones históricas como Derecho, Historia, Biología, etc. (Romero, 2020) con el correspondiente acceso a estudios de postgrado de Master y Doctorado.

2.2. Teoría de la adquisición de destrezas de Patricia Benner

Patricia Benner fue una teórica de Enfermería que estableció los niveles de adquisición de destrezas en la práctica de la Enfermería en la obra *From Novice to Expert: Excelence and Power in Clinical Nursing Practice* (Benner, 1984).

Según Benner, la experiencia aumenta cuando se integra la memoria al reconocimiento de patrones basándose en conocimiento racional y analítico (Acebedo, 2012; Becker et al., 2012), experiencia que no depende del tiempo que lleve la persona realizando la actividad, sino de la cantidad de situaciones reales que le brindan herramientas para utilizarlas posteriormente, y hacen que el/a estudiante pase de observador/a imparcial a participante implicado (Carrillo 2018), por medio de estrategias que le permiten asumir la responsabilidad individual, desarrollar herramientas que lo llevan a encargarse de su propio aprendizaje y garantizan que los graduandos cumplan las competencias predeterminadas (Cónsul & Medina, 2014).

Benner utilizó descripciones sistemáticas de cinco etapas: principiante, principiante avanzado, competente, eficiente y experto (Carrillo, 2018):

Nivel I principiante

No tiene experiencia al enfrentarse a una nueva situación, se encuentran los/as estudiantes de Enfermería y también a profesionales que al ser expertos/as en un servicio pasa a realizar actividades nuevas en otro servicio.

Nivel II principiante avanzado.

En este nivel se encuentran los/as estudiantes que a lo largo de su práctica clínica hayan enfrentado situaciones reales y resuelven aspectos de la situación después de haber sido guiados por un/a tutor/a quien proporciona directrices para el reconocimiento de aspectos clínicos relevantes.

Nivel III competente.

Presenta seguridad en su actuar, ha experimentado situaciones que le permiten actuar con argumento, basándose en reglas normas y protocolos. Se caracteriza por su planificación y determinación de situaciones actuales y futuras.

Nivel IV eficiente.

Genera habilidad innata en sus actividades, tiene la capacidad de tomar decisiones asertivas, ya que diferencia lo correcto de lo incorrecto, se basa en las experiencias e información previa que conoce para proceder a su actuación.

Nivel V experto.

Muestra dominio en su actuación, se guía por experiencias vividas, el conocimiento teórico practico y por su memoria, no necesita recurrir a un instructivo a menos que sea una experiencia nueva para ella. Demuestra capacidad analítica e intuitiva.

La teoría de formación de Patricia Benner es una explicación acerca de cómo el/a estudiante adquiere progresivamente habilidades y mejoras con las experiencias de la práctica clínica y los diferentes niveles (Carrillo 2018).

El personal de Enfermería se forma con teoría sólida que aplica en la práctica, inicialmente guiado por docentes, dependiendo de las experiencias reales a las cuales tiene acceso durante ésta fase, el/la futuro profesional adquiere las competencias necesarias para su desempeño laboral, inicialmente se encontrará según Benner en el nivel de aprendizaje, en la medida que adquiere competencias genéricas especialmente la de aprender a aprender simultáneamente irá desarrollando las específicas que le permiten ubicarse en un nivel superior. Existen aspectos que el/la estudiante aprende por imitación de los/as profesionales de Enfermería expertos/as, por tanto la institución formadora y el escenario de práctica deben garantizar la selección de personal competente, que sean modelos a seguir (Carrillo 2018).

3. JUSTIFICACIÓN

La crisis financiera que tuvo lugar en España en 2008 llevó a la aplicación de políticas de austeridad y una reducción de los recursos humanos y materiales (OMS, 2018; Ruiz y Bayle, 2016). Este impacto se puede sentir hoy en día, dificultando la adaptación de los/as jóvenes al mercado laboral y aumentando la incertidumbre y la inseguridad respecto a su futuro inmediato (OMS, 2018). Resulta del máximo interés disponer de información sobre si los/as estudiantes universitarios de Enfermería son plenamente conscientes de estas realidades del mercado laboral y si han tomado la decisión de cursar estudios universitarios siendo conocedores de dicha situación.

La Enfermería se considera como una profesión particularmente estresante, que afecta tanto la salud y el bienestar personal como la satisfacción laboral y colectiva. Posee altos niveles de responsabilidad, relaciones interpersonales y exigencias sociales. En ese sentido, se considera que la contingencia de resolver problemas que surgen de improviso, la escasez de personal con la consabida sobrecarga laboral, la inestabilidad en el puesto de trabajo, los conflictos, la ambigüedad de rol por no existir especificidad de funciones y tareas, la falta de autonomía y autoridad para la toma de decisiones, los rápidos cambios tecnológicos, las malas relaciones interpersonales y la superposición familia trabajo contribuyen a aumentar las tensiones específicas del quehacer asistencial, produciendo estrés laboral crónico (Malagón-Aguilera et al, 2012).

Así pues, con los datos encontrados en la literatura científica, se pone de manifiesto la necesidad de realizar esta tesis, para conocer qué es lo que piensan nuestros/as estudiantes enfermeros/as sobre la situación laboral a la que se van a enfrentar y el conocer la situación laboral que se encuentran los/as egresados/as enfermeros/as cuando terminan sus estudios. Todo ello nos permite realizar un análisis de la situación actual de dicho colectivo y hacer un diagnóstico actual de la situación laboral, para la petición y creación de políticas basadas en estudios científicos que incidan en la mejora de las condiciones laborales y precariedad enfermera en distintas Comunidades Españolas.

Durante el desarrollo de este estudio, en marzo de 2020, la Organización Mundial de la Salud (OMS) declaró el brote del nuevo coronavirus SARS-CoV-2 como pandemia. Las presiones ejercidas sobre el sistema sanitario por el brote de COVID-19 obligaron a reorganizar la actividad sanitaria para disponer de más unidades para tratar a las personas infectadas y a reducir o incluso suspender las actividades consideradas no esenciales. Esta crisis sanitaria supuso por una parte, un gran impacto sobre la salud mental de los/as profesionales enfermeros/as que trabajaron en primera línea, y una

reestructuración de los planes académicos de los/as estudiantes de Enfermería que no se había vivido hasta el momento. Por lo que se plantearon dos estudios paralelos que permitieran conocer los niveles de ansiedad y las reacciones al estrés agudo de los/as estudiantes de Enfermería durante la primera oleada de la pandemia COVID-19, tanto de aquellos/as que se incorporaron a la actividad asistencial como de los que no lo hicieron.

4. OBJETIVOS

4.1 Objetivo general

Conocer las expectativas laborales de los/as estudiantes del Grado de Enfermería de Universidades Españolas (A Coruña, Lleida y Murcia) pre-COVID y las experiencias laborales de varias Regiones Españolas pre-COVID (Lleida, Galicia y Murcia) y post-COVID (Madrid, Lleida y País Vasco).

4.2. Objetivos específicos

1. Identificar las expectativas laborales y la intolerancia a la incertidumbre de los/as estudiantes del último curso de tres Universidades Españolas y evaluar la diferencia entre ellas (artículo 1)

2. Determinar los niveles de satisfacción laboral y Síndrome de Burnout y los factores relacionados entre los/as enfermeros/as de tres Regiones Españolas (artículo 2)

3. Comparar los niveles de ansiedad y estrés agudo entre los/as estudiantes de Enfermería que se incorporaron al trabajo durante la primera oleada de la pandemia COVID-19 y los que no lo hicieron (artículo 3)

4. Describir las experiencias de los/as estudiantes de Enfermería y sus niveles de ansiedad y estrés agudo al incorporarse al trabajo durante la primera oleada de la pandemia COVID-19 (mayo-junio de 2020) (artículo 4).

5. METODOLOGÍA

5.1. Artículo 1

5.1.2. Diseño

Estudio descriptivo y multicéntrico, que incluyó tres Universidades Españolas (Universidad de Lleida, Universidad de A Coruña y Universidad de Murcia). Se aplicó un diseño secuencial de métodos mixtos, se estableció una fase cuantitativa seguida de una fase cualitativa (Roslyn, 2009). En concreto, este estudio combinó datos cuantitativos a través de cuestionarios con datos cualitativos a través de entrevistas en profundidad.

La duración de este estudio fue de dos años, correspondientes a dos cursos académicos (2017-2018 y 2018-2019).

5.1.3. Aspectos éticos

El proyecto fue revisado y recibió la autorización ética a través del Comité de Investigación de la Universidad de Murcia (anexo 1) y además fue autorizado por todos los centros participantes. En consecuencia, los datos cuantitativos y cualitativos se recogieron solo después de que los/as estudiantes firmaran el consentimiento informado y los datos se anonimizar para garantizar la confidencialidad.

5.1.4. Participantes

Participaron los/as estudiantes matriculados en el cuarto y último curso del Grado de Enfermería correspondientes a dos cursos académicos (2017-2018 y 2018-2019), de las Universidades de Lleida, A Coruña y Murcia. El criterio de inclusión fue estar matriculado en el cuarto año o último curso del Grado de Enfermería en una de las tres Universidades participantes.

5.1.5. Recogida de datos.

En primer lugar, se elaboró un cuestionario ad hoc que incluía datos sociodemográficos, basados en un estudio similar (Paz et al., 2014). También se incluyeron otras variables para caracterizar específicamente a la población de estudio: número de hijos/as, idiomas, rotación externa o movilidad y universidad en la que estudiaban al tratarse de un estudio multicéntrico (anexo 2).

Además, se utilizó un Cuestionario de Expectativas Laborales específicamente desarrollado para medir las expectativas laborales y la empleabilidad de los/as estudiantes de Enfermería y Psicología (Paz et al., 2014). Este instrumento muestra una fiabilidad de 0,844 para la escala de valoración del puesto de trabajo y 0,864 para la contribución del empleado a la empresa, medida por Alfa de Cronbach (Paz et al., 2014) (anexo 3).

Se empleó la Escala de Intolerancia a la Incertidumbre (IUS) (Freeston et al, 1994), que fue previamente validada en población española (González et al., 2006), que se utilizó para evaluar la tendencia a reaccionar negativamente ante situaciones y acontecimientos inciertos a nivel emocional, cognitivo emocional, cognitivo y conductual (anexo 4). La puntuación total se basa en 27 ítems y oscila entre un mínimo de 27 puntos y un máximo de 135 (escala Likert de 1 a 5, a mayor puntuación, mayor es la intolerancia a la incertidumbre). En el cuestionario se incluyó una última pregunta abierta, en la que se invitaba a los/as estudiantes a participar en la fase cualitativa.

La fase cualitativa consistía en una entrevista en profundidad con preguntas abiertas centradas en: (1) las expectativas de empleo; (2) las condiciones de trabajo (3) la incertidumbre laboral; y (4) la continuación de la formación tras finalizar el Grado de Enfermería (anexo 5). También se recogieron datos sociodemográficos. Fueron realizadas por uno de los autores (MPB) cara a cara en lugares privados (como aulas Universitarias vacías) durante 30-60 minutos. Se procedió a la grabación y la transcripción literal, y se tomaron notas de campo durante y al final de cada entrevista.

Se envió un enlace a la cuenta personal de todos los/as participantes a través de Survey Monkey.

5.1.5. Análisis

Los datos cuantitativos del cuestionario se analizaron mediante estadística descriptiva utilizando IBM SPSS Statistics 24.0. La media, la desviación estándar desviación estándar (DE), frecuencias (n), porcentajes (%) y ANOVA para las variables continuas. Se utilizaron tablas de contingencias segmentadas y la prueba de chi-cuadrado para las variables categóricas.

Los datos cualitativos se analizaron mediante un análisis de contenido cualitativo con el apoyo del software Atlas.Ti-7 para codificar y organizar la información. Los códigos abiertos que surgieron de las transcripciones se asignaron a frases o párrafos y, a continuación, los códigos se agruparon en categorías según su similitud. Las

categorías se refinaron, se discutieron y negociaron entre el equipo de investigación hasta que se decidieron los temas.

Tras analizar cada fuente de datos por separado según sus de acuerdo con sus respectivos paradigmas metodológicos, los resultados cuantitativos y cualitativos se integraron para complementar el análisis (Paz et al., 2014).

Los datos cuantitativos y cualitativos se integraron para comprender mejor las expectativas de futuro y la intolerancia a la incertidumbre de los/as estudiantes del Grado de Enfermería en tres Universidades Españolas. Como parte del enfoque de fusión, la información se integró en la base, para favorecer una mayor coherencia entre los resultados cualitativos y cuantitativos, que se evaluó mediante la organización de los resultados por temas. Los resultados cuantitativos se alinearon con los temas cualitativos de forma que los datos de las entrevistas apoyaran los resultados cuantitativos, lo que ayudó al lector a comprender cómo se complementan los datos cuantitativos y cualitativos entre sí (Guetterman et al., 2015).

5.2. Artículo 2

5.2.1. Diseño

Se realizó un estudio descriptivo transversal multicéntrico en el que participaron tres Regiones Españolas (Murcia, Lleida y Galicia). Se desarrolló entre abril del 2019 y febrero del 2020. Se obtuvieron datos cuantitativos a través de los cuestionarios ad hoc, el Cuestionario de Satisfacción laboral S20/23 (Meilá y Peiró, 1989) y el Inventario de Maslach Burnout (Maslach & Jackson, 1981), validado en español (Gil, monte&Peiró, 2000).

5.2.2. Aspectos éticos

El proyecto fue revisado y recibió la autorización ética a través del Comité de Investigación de la Universidad de Murcia (anexo 1) y además fue autorizado por todos los centros participantes. En consecuencia, los datos cuantitativos y cualitativos se recogieron solo después de que los/as estudiantes firmaran el consentimiento informado y los datos se anonimizar para garantizar la confidencialidad.

5.2.3. Participantes

Participaron los/as egresados/as enfermeros/as que estaban inscritos en los Colegios de Enfermería en las provincias de A Coruña, Murcia y Lleida, también participaron las/os enfermeros/as graduadas del año anterior en la Universidad de Murcia y A Coruña, así como los/as enfermeros/as de dos hospitales públicos de la Región de Murcia. El periodo de estudio fue entre abril del 2019 y febrero del 2020.

5.2.4. Recogida de datos

Los datos se recogieron entre abril de 2019 y febrero de 2020 en tres Regiones Españolas (Murcia, Lleida y Galicia). En julio de 2019 se envió un correo electrónico a los/as colegiados/as enfermeros/as pertenecientes a tres Colegios profesionales (Murcia, Lleida y Galicia), también a los alumnos/as que habían finalizado sus estudios de Enfermería en el 2018 en Murcia y A Coruña y se entregaron/ recogieron de manera presencial los cuestionarios en los hospitales de la Región de Murcia.

Se recogieron datos sobre variables sociodemográficas, formación, situación laboral, migración (anexo 6) y utilizaron los siguientes cuestionarios:

(1) el Cuestionario de Satisfacción Laboral con el trabajo S20/23 (Meliá y Peiró, 1989), que consta de 23 ítems, con el que se obtiene una media global de satisfacción y la descripción de cinco factores: satisfacción con la supervisión (6 ítems), satisfacción con el entorno físico (5 ítems), satisfacción con los beneficios recibidos (5 ítems), satisfacción intrínseca con el trabajo (4 ítems) y satisfacción con la participación (3 ítems). Cada ítem tiene una escala Likert de 1 a 7, donde 1 = muy insatisfecho y 7 = muy satisfecho. Se obtiene un máximo de 160 puntos y un mínimo de 22 puntos (anexo 7).

(2) el Maslach Burnout Inventory (Maslach & Jackson, 1981), validado en español (Gil-Monte& Peiró, 2000) (anexo 8), consta de 22 ítems con una escala Likert de 0 a 6, donde O = nunca y 6 = todos los días; mide los 3 aspectos del síndrome: agotamiento emocional, despersonalización y realización personal (Tabla 1). Las puntuaciones inferiores a 34 se consideran bajas.

Las puntuaciones altas en las subescalas de agotamiento emocional (>27) y despersonalización (>10) y puntuaciones bajas en realización personal (<33) permiten diagnosticar el síndrome.

Tabla 1: Subescalas del cuestionario Maslach Burnout Inventory (Maslach & Jackson, 1981)

	Nivel bajo	Nivel medio	Nivel alto
Cansancio emocional	≤19	19-26	≥27
Despersonalización	≤6	6-9	≥10
Realización personal	≤33	34-39	≥40

5.2.5. Análisis

Los datos se analizaron mediante métodos estadísticos descriptivos empleando el programa SPSS. Los porcentajes, las medidas de tendencia central tendencia central (frecuencia y media-M) y dispersión (desviación estándar desviación estándar-SD) y se crearon tablas de contingencia para analizar las para analizar las frecuencias de las distintas variables cruzadas.

5.3. Artículo 3

5.3.1. Diseño

Se trata de un estudio descriptivo transversal multicéntrico en el que participaron tres Universidades (Universidad Autónoma de Madrid, Universidad del País Vasco y Universidad de Lleida). Se aplicaron los cuestionarios y escalas validadas para la obtención de datos entre Abril y Junio del 2020. Para el desarrollo de este estudio se siguió la declaración de fortalecimiento de la notificación de estudios observacionales en epidemiología (STROBE) (anexo 9).

5.3.2. Aspectos éticos

Se obtuvo el permiso de las tres universidades, con la aprobación del Comité de ética de la Universidad de Madrid (anexo 10). Tras la recogida de datos, se asignó un código numérico a cada participante para garantizar el anonimato durante el proceso de análisis. Los/as participantes en la fase cualitativa firmaron un consentimiento informado enviado mediante correo electrónico previamente a comenzar la entrevista.

Del mismo modo, se les pidió permiso para utilizar el grabador de voz. Tras la transcripción, los audios fueron destruidos y las transcripciones anonimizadas.

5.3.3. Participantes

La población del estudio estuvo formada por estudiantes de Enfermería de la Universidad Autónoma de Madrid, Universidad de Lleida y la Universidad del País Vasco. Los criterios de inclusión fueron que los/as estudiantes debían estar en el tercer o cuarto año del Grado de Enfermería con posibilidad de incorporarse al trabajo durante la primera ola de la pandemia. El periodo de estudio fue de Abril a Junio del 2020.

5.3.4. Recogida de datos

La recogida de datos se realizó en Abril-Junio de 2020, distribuyendo un formulario online a través del correo virtual e institucional de cada universidad participante. Se utilizó una página de bienvenida con información sobre el estudio y el consentimiento informado. Sólo pudieron acceder y completar el cuestionario los/as estudiantes que previamente habían leído y entendido las condiciones y accedieron voluntariamente a participar en el estudio, a través de un formulario inicial con información sobre el estudio que se envió junto con la encuesta.

Se recogieron los datos de las variables: género, año de la titulación de Enfermería (tercero-cuarto), Universidad de procedencia, incorporación al puesto de trabajo (sí/no) y características de esta incorporación en cuanto a tiempo transcurrido desde la incorporación, modalidad contractual, servicio de incorporación, duración de la jornada laboral, responsabilidad sobre las personas atendidas y atención o no a pacientes con COVID-19 (anexo 11).

Las variables dependientes fueron las puntuaciones obtenidas por los alumnos en la Escala de Autoevaluación de la Ansiedad de Zung (Zung, 1971) (anexo 12) y en el Cuestionario de Reacción al Estrés Agudo de Stanford (SASRQ) (Cardeña et al., 1991, 2000) (anexo 13).

La Escala de Autoevaluación de la Ansiedad de Zung -validada en población hispanohablante con buenas propiedades psicométricas (Hernández-Pozo et al., 2008)- consta de 20 ítems referidos a diferentes síntomas de ansiedad psicológica y somática. Las respuestas se puntúan según una escala de cuatro puntos, con 1 = nunca o casi nunca y 4 = siempre o casi siempre. El rango de puntuación es de 20-80, y el nivel de ansiedad se clasifica como: sin ansiedad (< 45), ansiedad moderada (45-59), ansiedad

grave (60-74) y ansiedad clínicamente significativa (≥ 75) (Dunstan et al., 2020). Se pidió a los participantes que respondieran a cada ítem en función de su experiencia en el último mes.

El SASRQ (Cardeña et al., 1991, 2000) fue desarrollado para medir la ansiedad y los síntomas disociativos en personas que han experimentado eventos traumáticos, según los criterios del DSM-IV para el trastorno por estrés agudo. El/a administrador/a fija un período de tiempo durante el cual pueden haber ocurrido eventos estresantes y se le pide a la persona que describa el evento más perturbador y el grado de perturbación que le causó. A continuación, teniendo en cuenta este acontecimiento, la persona puntúa los 30 ítems del cuestionario según la frecuencia con la que lo ha experimentado. Por último, se pide a la persona que identifique en cuántos días del período establecido ha experimentado la angustia. A partir de la suma de los ítems se puede obtener una puntuación total o diagnosticar un trastorno de estrés agudo si se consideran los ítems de forma dicotómica (Bados, 2015). Este cuestionario ha sido adaptado y traducido al español por Cardeña y Maldonado (2001). Se pidió a los/as estudiantes que recordaran eventos estresantes ocurridos durante el mes anterior de su vida y que puntuaran cada ítem del cuestionario en función del grado en que describía su experiencia durante y/o después del evento previamente descrito.

5.3.5. Análisis

Se utilizaron métodos estadísticos descriptivos básicos para el análisis de los datos mediante el programa SPSS 23.0 para Windows. La comparación entre grupos (género, año, universidad y empleo o no empleo) se realizó mediante la prueba de chi-cuadrado y la prueba t de Student o ANOVA según las características de las variables. La significación estadística se fijó en $p < 0,05$.

5.4. Artículo 4

5.4.1. Diseño

Es un estudio secuencial de métodos mixtos, multicéntrico, en el que participaron tres Universidades de diferentes Regiones Españolas (Universidad Autónoma de Madrid, la Universidad de Lleida y la Universidad del País Vasco) y exploratorio en dos fases: (1) estudio descriptivo observacional aplicando un cuestionario con preguntas

abiertas y preguntas cerradas y (2) estudio cualitativo fenomenológico con preguntas semiestructuradas. Se desarrolló durante los meses de Abril-Junio del 2020.

4.4.2. Aspectos éticos

Se obtuvo el permiso de las tres Universidades, con la aprobación del Comité de ética de la Universidad de Madrid (anexo 10). Tras la recogida de datos, se asignó un código numérico a cada participante para garantizar el anonimato durante el proceso de análisis. Los/as participantes en la fase cualitativa firmaron un consentimiento informado enviado mediante correo electrónico previamente a comenzar la entrevista. Del mismo modo, se les pidió permiso para utilizar el grabador de voz. Tras la transcripción, los audios fueron destruidos y las transcripciones anonimizadas.

5.4.3. Participantes

Participaron estudiantes de 3º y 4º curso de Enfermería matriculados en las Universidades de Lleida, Madrid y País Vasco. Los criterios de inclusión que se aplicaron fueron: ser estudiante de Enfermería y haber trabajado como auxiliar sanitario durante la primera oleada del COVID-19

En la fase cuantitativa, se utilizó un muestreo de conveniencia para seleccionar la muestra durante mayo del 2020.

En la fase cualitativa, se utilizó un muestreo intencional para seleccionar a los/as participantes durante mayo de 2020. El único criterio de inclusión adicional fue proporcionar información de contacto al final del cuestionario en la fase cuantitativa para indicar la voluntad de participar.

5.4.4. Recogida de datos

La recogida de datos se realizó en Abril-Junio de 2020, distribuyendo un formulario online a través del correo virtual e institucional de cada Universidad participante. Se utilizó una página de bienvenida con información sobre el estudio y el consentimiento informado. Sólo pudieron acceder y completar el cuestionario los/as estudiantes que previamente habían leído y entendido las condiciones y accedieron voluntariamente a participar en el estudio, a través de un formulario inicial con información sobre el estudio que se envió junto con la encuesta.

Se recogieron los datos de las variables: género, año de la titulación de enfermería (tercero-cuarto), Universidad de procedencia, incorporación al puesto de trabajo (sí/no)

y características de esta incorporación en cuanto a tiempo transcurrido desde la incorporación, modalidad contractual, servicio de incorporación, duración de la jornada laboral, responsabilidad sobre las personas atendidas y atención o no a pacientes con COVID-19 (anexo 11).

Las variables dependientes fueron las puntuaciones obtenidas por los/as alumnos/as en la Escala de Autoevaluación de la Ansiedad de Zung (Zung, 1971) (anexo 12) y en el Cuestionario de Reacción al Estrés Agudo de Stanford (SASRQ) (Cardeña et al., 1991, 2000) (anexo 13).

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El SASRQ (Cardeña et al., 1991, 2000) fue desarrollado para medir la ansiedad y los síntomas disociativos en personas que han experimentado eventos traumáticos, según los criterios del DSM-IV para el trastorno por estrés agudo. El/a administrador/a fija un período de tiempo durante el cual pueden haber ocurrido eventos estresantes y se le pide a la persona que describa el evento más perturbador y el grado de perturbación que le causó. A continuación, teniendo en cuenta este acontecimiento, la persona puntúa los 30 ítems del cuestionario según la frecuencia con la que lo ha experimentado. Por último, se pide a la persona que identifique en cuántos días del período establecido ha experimentado la angustia. A partir de la suma de los ítems se puede obtener una puntuación total o diagnosticar un trastorno de estrés agudo si se consideran los ítems de forma dicotómica (Bados, 2015). Este cuestionario ha sido adaptado y traducido al español por Cardeña y Maldonado (2001). Se pidió a los/as estudiantes que recordaran eventos estresantes ocurridos durante el mes anterior de su vida y que puntuaran cada ítem del cuestionario en función del grado en que describía su experiencia durante y/o después del evento previamente descrito.

En la fase cualitativa se realizaron 18 entrevistas semiestructuradas a través de videoconferencia debido a las restricciones de la pandemia. Se siguió un guion de

preguntas abiertas previamente elaborado (anexo 14) que permitiese abordar en profundidad y explicar las cuestiones previamente formuladas en la fase cuantitativa. La duración media de las entrevistas fue de 50 minutos. Las entrevistadoras se adaptaron al horario y día escogido por los/as participantes promoviendo un ambiente de confidencialidad y comodidad. Las entrevistas fueron realizadas en el idioma escogido por los/as participantes (castellano o catalán), se grabaron en audio y se transcribieron para su posterior análisis. También se recogieron notas de campo durante y al final de las entrevistas.

5.4.5. Análisis

Para el análisis de los datos cuantitativos se emplearon métodos descriptivos básicos según universidad. El análisis estadístico se realizó con el programa SPSS 23.0 para Windows. Las preguntas abiertas fueron codificadas por pares de forma manual obteniendo un listado final de códigos y grupos de códigos que complementan el análisis cuantitativo.

Las transcripciones literales de las entrevistas se importaron a los softwares de análisis cualitativo empleados por las investigadoras (Open Code, Nvivo y Atlas ti). El análisis se realizó conforme a la propuesta Braun y Clarke (2006) de análisis temático. A partir del guion de entrevista y siguiendo los objetivos del estudio, los/as autores/as elaboraron un árbol de códigos preliminares para guiar la identificación de las unidades de significado, o aquellas partes del texto que versaban sobre un mismo aspecto. A continuación, se asignaron códigos abiertos resumiendo el contenido. La lista de códigos resultante fue puesta en común en un documento Excel y organizada en grupos de códigos hasta identificar las categorías finales.

Tras el análisis de los datos cuantitativos y cualitativos, se realizó una integración de los resultados. La codificación se realizó por pares y los/as investigadores/as que crearon los códigos se reunieron para discutir las diferencias y resolver posibles discrepancias. Así mismo, la coherencia de los datos y categorías creadas se discutió entre todo el equipo investigador. Los/as investigadores/as encargados/as del proceso de recogida y análisis de datos cualitativos tienen una amplia experiencia en el uso de la metodología cualitativa. Así mismo se realizó una triangulación de datos recabando información procedente de estudiantes de Enfermería de distintas Universidades y zonas geográficas y una triangulación metodológica comparando y contrastando los resultados obtenidos mediante instrumentos cuantitativos y cualitativos.

6. RESULTADOS

Esta tesis se distribuye en cuatro artículos que se describen y adjuntan a continuación:

- **Artículo 1:** Lorena Acea López, María del Mar Pastor Bravo, Esther Rubinat Arnaldo, Filip Bellon, Joan Blanco-Blanco, Montserrat Gea Sanchez, Erica Briones Vozmediano. Job expectations and intolerance to uncertainty of nursing students: Results from a multicentre, mixed-methods study in Spain. *Nurse Education in Practice*. 2022; 62:103337. Q1. Factor de impacto: 3.43. https://doi.org/10.1016/j.nepr.2022.103337

- **Artículo 2:** Lorena Acea López, María del Mar Pastor Bravo, Esther Rubinat Arnaldo, Filip Bellon, Joan Blanco-Blanco, Montserrat Gea Sanchez, Erica Briones Vozmediano.Burnout and job satisfaction among nurses in three Spanishre regions. *Journal of Nursing Management*. 2021; 00:1-8.Q1.Factor de impacto: 4.68. https://doi.org/10.1111/jonm.13376

- **Artículo 3:** Juana Robledo Martín, Lorena Acea López, María Teresa Alcolea Cosín, Iratxe Pérez Urdiales, Filip Bellon, Cristina Oter Quintana, Joan Blanco Blanco, Esther Rubinat Arnaldo, María del Mar Pastor Bravo, Erica Briones Vozmediano. Stress and anxiety in nursing students during the first wave of the COVID-19 pandemic. *Archivos de Prevención de Riesgos Laborales*. 2023. Q4. Factor de impacto*:* 0.116. *[En revisión.]*.

- **Artículo 4:** Juana Robledo Martín, Lorena Acea López, María Teresa Alcolea Cosín, Iratxe Pérez Urdiales, Filip Bellon, Cristina Oter Quintana, Joan Blanco Blanco, Esther Rubinat Arnaldo, María del Mar Pastor Bravo, Erica Briones Vozmediano. From students to nurses under pressure: Incorporation of nursing students into care activity during the first wave of COVID-19 in Spain. *Journal of Clinical Nursing*. 2023. Q1.Factor de impacto: 4.423. https://doi.org/10.1111/jocn.16800.

Artículo 1

Job expectations and intolerance to uncertainty of nursing students: Results from a multicentre, mixed-methods study in Spain.

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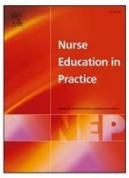

Job expectations and intolerance to uncertainty of nursing students: Results from a multicentre, mixed-methods study in Spain

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ABSTRACT

Aim: To identify the job expectations and intolerance to uncertainty in final-year nursing students from three Spanish universities and evaluate the differences between them.
Design: Multicentre, mixed-methods study.
Methodology: We included nursing students from three universities in Spain (Lleida, A Coruña and Murcia). Questionnaires were used to collect data on sociodemographic variables, job expectations and intolerance to uncertainty. In addition, in-depth personal interviews were conducted to complement quantitative data. Descriptive statistics were calculated and comparison tests (ANOVA, chi-square) were performed to analyse the differences between universities and a content analysis was carried out for qualitative data.
Results: The sample included 305 final-year nursing students enrolled in the 2017–2018 and 2018–2019 courses, of which 21 participants were interviewed for the qualitative phase. Findings were reported based on four main themes: Expected employment conditions, perceptions of working conditions, job uncertainty and increased chances of getting a job by continuing education after finishing the nursing degree. Results showed that 92.13% of the students were concerned about their future employment. Analysis of the in-depth interviews highlighted the uncertainty of finding a job as a nurse and the anticipated precarious employment conditions (i.e. lack of stability stemming from daily or weekly temporary contracts) in case they managed to find work. Moreover, it was shown that these perceptions affect their health, leading to situations of anxiety, stress and negativity during their time as nursing students. Overall, 65.57% considered migrating outside their town/region to increase their job opportunities and 97.0% wanted to continue their education after finishing their degree, motivated by their vocation, professional aspirations and to increase their possibilities of finding work.
Conclusion: Nursing students find themselves in a situation of great uncertainty before finishing their studies, anticipating a future with great stress and even frustration as a result of unemployment and job insecurity. They even consider the possibility of migrating when they finish their degree to increase their job opportunities. Therefore, it is necessary to improve the recruitment process of nurses in Spain through increased security and stability and thus contribute to reducing the stress and frustration of future nurses.

1. Introduction

The financial crisis that took place in Spain in 2008 lead to the implementation of austerity policies and a reduction of human and material resources, negatively affecting the health system (WHO, 2018; Ruiz and Bayle, 2016). The impact of the crisis can still be felt today,

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making it difficult for young people to adapt to the labour market and increasing uncertainty and insecurity regarding their immediate future (González et al., 2006). Job expectations make reference to the type of job we strive for and the goals that we would like to accomplish in our work (Escobar and Covarrubias, 2019). On the other hand, ambiguity is understood as the way a person reacts to uncertain or ambiguous situations that can be experienced as exhausting and disturbing under the belief that unexpected events are negative and should be avoided and that an uncertain future is unfair (González et al., 2006). Various authors have identified this experience as intolerance to uncertainty and described it as a one-dimensional continuum where the person with intolerance to ambiguity experiences stress as a reaction or avoidance of these stimuli (González et al., 2006; Lopez and Gago, 2013).

In Spain, 10,236 undergraduate students completed their nursing studies in 2018–2019 (Spanish Ministry of Education and Science, 2021) and, of these, most will be employed on temporary contracts when they graduate. This trend was shown by data from 2018, which suggested that 70.03% of contracts in the field of health sciences are temporary. This situation particularly affects young people under 25: over 57% in the first year after graduation and over 49% after four years, have temporary contracts. In total, recent nursing graduates employed on temporary contracts represent 48% of all graduates. In terms of distribution according to gender, the percentage of permanent contracts is higher among men in both public and private universities (Spanish Ministry of Science, Innovation and Universities, 2019).

Spain also has one of the lowest ratios of nurses per inhabitants in the European Union. According to the OECD, the ratio in Europe is 8.8 nursing professionals per 1000 inhabitants, while in Spain this ratio is 5.6 nurses (Montero, 2020) per 1000 inhabitants. A recent study indicated that at least 87,890 nurses need to be incorporated into the Spanish Public Health System to provide care to the population, 15,514 of which are needed to strengthen primary healthcare (Salami et al., 2014). The current policies in the public health system result in a shortage of nursing professionals (Fernández and Lázaro, 2016), which translates into a precarious labour market for future nurses. The World Health Organization (WHO) estimates a deficit of 18 million health workers by 2030, which would prevent the achievement of sustainable development goals (WHO, 2020). Moreover, it is required to increase the number of nursing graduates by 8% in all countries. Without this increase, it is estimated that 5.3 million (89%) of the nursing shortage will be concentrated in low- and lower-middle-income countries, where the growth in the number of nurses is barely keeping pace with population growth, with the greatest differences expected to be in Africa, South-East Asia and Eastern Mediterranean regions and in some Latin American countries, Eastern Mediterranean and in some Latin American countries. (WHO, 2020; Salami et al., 2014).

Between 2010 and 2013, a total of 4580 Spanish nurses sent an application through the Ministry of Education to validate their nursing qualifications to work in another country in the European Economic Area (Galbany and Nelson, 2016). One of the reasons behind the decision of nurses to move abroad was the economic management of the Spanish Health System, which led to increased unemployment and precarious employment conditions (WHO, 2018; Ruiz and Bayle, 2016).

The Spanish health system is decentralized among 17 Autonomous Regions. Health services are publicly funded, meaning that they are universal and free of charge. The ratio of doctors per 100,000 inhabitants in 2015 was 380, slightly above the EU average of 350 that year. However, for nursing services there were 534 nurses per 100,000 inhabitants, which is below the EU average of 864, with a nurse to doctor ratio of 1.4 (Bernal et al., 2018).

The nursing degree in Spain lasts four years and allows graduates to enter the labour market directly. Graduates can also continue their training through a Master's degree or a 2-year specialization in nursing (also known as the RIN program) to specialize in the nursing-related areas of geriatrics, midwifery, pediatrics, mental health, occupational health and community health. Both the specialization program and the Master's degree allow the possibility of completing doctoral studies later on (Spanish Government Official State, 2003).

Therefore, given the employment situation of nurses in Spain, the main objective of this study was to identify the job expectations and intolerance to job uncertainty among final-year nursing students from three Spanish Universities and consider if there were differences between them.

2. Methodology

2.1. Design and ethical considerations

This study was a descriptive, multicentre study, including three Spanish universities (University of Lleida, University of A Coruña and University of Murcia). A sequential mixed methods design was applied, whereby an initial quantitative phase was followed by a qualitative phase (Roslyn, 2009). Specifically, this study combined quantitative data through questionnaires with qualitative data through in-depth interviews.

The duration of this study was of 2 years, corresponding to two academic courses (2017–2018 and 2018–2019).

The project was reviewed by and received ethics clearance through the Research Committee of the University of Murcia and was further authorized by all participating centers. Accordingly, quantitative and qualitative data were collected only after the students signed the informed consent form and the data were anonymized to ensure confidentiality.

2.2. Quantitative phase

2.2.1. Participants

All students (n = 564) enrolled in the fourth -and last- year of the nursing degree in the Universities of Lleida, A Coruña and Murcia were invited to participate. The only inclusion criteria was to be enrolled in the fourth year of nursing at one of the three participating universities.

2.3. Data collection

Firstly, an ad hoc questionnaire was developed including sociodemographic data based on a similar study (Paz et al., 2014). Other variables were also included to specifically characterise the study population: number of children, languages, external rotation or mobility and university where they were studying as it was a multicentre study (The complete questionnaire can be consulted in supplementary material 1).

In addition, a job expectation questionnaire that was specifically developed in Spain was used to measure job expectations and employability of nursing and psychology students (Paz et al., 2014). This instrument shows a reliability of 0.844 for the job evaluation scale and 0.864 for the employee's contribution to the company, as measured by Cronbach's Alpha (Paz et al., 2014) (Supplemental material 2).

Moreover, the Intolerance of Uncertainty Scale (IUS) (Freeston et al., 1994), which was previously validated in a Spanish population (González et al., 2006), was used to evaluate the tendency to react negatively to uncertain situations and events on an emotional, cognitive and behavioural level (supplemental material 3). The total score is based on 27 items and ranges from a minimum of 27 points and a maximum of 135 (Likert scale from 1 to 5, the higher the score, the greater the intolerance to uncertainty) (supplementary material 3). A final open question was included in the questionnaire inviting students to participate in the qualitative phase, which was an in-depth interview with open questions focused on: (1) employment expectations; (2) working conditions; (3) job uncertainty; and (4) continuing education after finishing the nursing degree (supplemental material 4). Sociodemographic data were also collected.

A link to all questionnaires was sent online to each student's personal

academic email account through Survey Monkey.

2.4. Analysis

Quantitative data from the questionnaire was analysed through descriptive statistics using IBM SPSS Statistics 24.0. Mean, standard deviation (SD), frequencies (n), percentages (%) and ANOVA were calculated for continuous variables. Segmented contingency tables and chi-square test were used for categorical variables.

2.5. Qualitative phase

2.5.1. Participants

Nursing students (14 women and 7 men) participated in the qualitative phase.

2.5.2. Data collection

In-depth interviews were conducted by one of the authors (MPB) face-to-face in private locations (such as empty university classrooms) for 30–60 min. The interviews were recorded and transcribed literally, and field notes were taken during as well as at the end of each interview.

2.5.3. Analysis

The qualitative data were analysed using a qualitative content analysis with the support of the software Atlas.Ti-7 to code and organise the information. Open codes emerging from the transcripts were assigned to sentences or paragraphs and then the codes were grouped into categories according to their similarity. Categories were refined, discussed and negotiated among the research team until the final themes were decided (Graneheim and Lundman, 2004).

After analysing each data source separately according to their respective methodological paradigms, the quantitative and qualitative results were integrated to complement the analysis (Paz et al., 2014). Quantitative and qualitative results were merged to better understand the future expectations and intolerance to uncertainty of final-year students of the nursing degree at three Spanish Universities. As part of the merging approach, the information was integrated based on the consistency between qualitative and quantitative results, which was assessed by organising results according to themes. Quantitative results were aligned with qualitative themes in a way that the interview data supported quantitative findings, helping the reader to understand how quantitative and qualitative data complement one another (Guetterman et al., 2015).

3. Results

Quantitative and qualitative results were combined and integrated in the four main themes identified in the qualitative phase: Expected employment conditions, perceptions of working conditions, job uncertainty and increasing the chances of getting a job by continuing education after finishing the nursing degree. These themes reflect the patterns found in the qualitative data and are presented below in relation to the corresponding quantitative data. In each theme, we firstly present the quantitative data, which is then contrasted with the corresponding qualitative information.

The survey was completed by 305 students and 21 of them were interviewed in the qualitative phase to deepen the understanding of quantitative results. Response rate was 54.1%.

The socio-demographic profile of participants in the first quantitative phase is shown in Table 1. Of the 305 students (56 men and 249 women) who completed the survey, 117 were from the University of Lleida, 122 from the University of Murcia and 66 from the University of A Coruña. The overall average age was 23.61 ± 4.93. Most (88.52%) of the students were single, 95.74% had no children, 63.93% lived with their parents and 66.23% did not work.

Table 1
Socio-demographic profile of fourth-degree nursing students (n = 305).

Variable	Category	N	%
Marital Status	Single	270	88.52
	Common law couple	22	7.21
	Married	12	3.93
	Divorced	1	0.33
Children	With children	13	4.26
	No children	292	95.74
Coexistence nucleus	family	195	63.93
	Flatmates	74	24.26
	Couple	28	9.18
	Couple and child	2	0.66
	Only	6	1.97
Dependents	Yes	19	6.23
	No	286	93.77
Work	Yes	103	33.77
	No	202	66.23
Fluent in foreign language	Yes	213	69.84
	No	92	30.16
Erasmus[a] or hospital/academic rotation abroad	If you were a foreigner/ rotation	33	10.82
		272	89.18
Age average	No erasmus[a]/foreign rotation	23.61	

A total of 21 fourth-year nursing students aged 21–36 (mean 22.9) were included in the second qualitative phase, of which 66,67% were female, 95,24% were single and without dependent family members, 71,43% lived with their parents and 42,86% worked while studying.

[a] **Erasmus:** European Region Action Scheme for the Mobility of University Student.

3.1. Expected employment conditions

This section describes the employment conditions that students expect to find when they finish their studies and they are ready to enter the labour market.

Overall, 77.38% of the total study sample expected that it would be difficult or very difficult to find a well-paid job (Table 2). Concerns about future employment were reported by 92.13% of the students and 69.74% considered urgent to seek employment. The participating nursing students indicated that the most important conditions for a good job were: to continue developing their professional life (99.02%), to continue studying (93.44%), to have responsibilities and to be held accountable for what they do (86.23%), to work together with others (76.72%) and to have time off even if the salary is not as good (73.77%) (Supplementary material 5).

Moreover, 88.2% considered it certain and probable to find work related to their profession. Students indicated their most probable work situations within five years after finishing their studies as: working in the healthcare area (66.23%), working outside their town/region (65.57%), a monthly salary over 1500 euros (59.34%) (in a maximum of 10 years), a full-time job (58.69%) and a temporary contract (54.75%). Half of the students saw themselves working in the public health system (53.44%) and in an urban region (50.82%) (supplementary material 6).

The qualitative data showed that students were uncertain about finding job as nurses and were concerned that job opportunities would be precarious. They projected the difficulty of having a permanent job or an assigned position, without shift changes and that was stable over time:

> *"The contracts are much more precarious. and yes, they're much more precarious, one day, two days, one week, now I'm sending you here, now I'm sending you there, I'm sending you to a place you've never been"...(E 21)."I don't understand why a nurse has to be worth less in a private company than in a public one, they're taking advantage of the precarious work situation to have cheap labour, you should be worth the same everywhere and that should be stipulated somehow. Needless to say, you have no option to be promoted" (E 12).*

Table 2
Expected difficulty to find a well-paid job (n = 305).

	No difficulty		Not very difficult		Difficult		Moderately difficult		Very difficult		Overall total	
University	N	%	N	%	N	%	N	%	N	%	N	%
A Coruña		0.00	10	3.28	35	11.48	17	5.57	4	1.31	66	21.64
Murcia	1	0.33	2	0.66	48	15.74	43	14.10	28	9.18	122	40.00
Lleida	23	7.54	33	10.82	41	13.44	14	4.59	6	1.97	117	38.36
Overall total	**24**	**7.87**	**45**	**14.75**	**124**	**40.66**	**74**	**24.26**	**38**	**12.46**	**305**	**100.00**

In addition, in the event of finding another job due to unemployment and the temporary nature of nursing contracts, they stated that it would be very difficult for that job to be health-related:

> *"There's very little work and the work that there is right now for young graduates are terrible hours, because that's the way it is, you get the worst of it, you get the last of it all and maybe I work a twelve-hour shift, the next day again, or even five nights in a row.apart from that it also affects our health. Anxiety, stress, the rubbish contracts they give us." (E 18)."In the public administration, what I find interesting is that there have been many cut backs on staff and that we're seeing the negative consequences in terms of a lack in resources, that patients arrive to A&E and are in the corridors of the hospital. I experienced a lot of it in 2011 when I was hired by the Murcia Health Service for a year and the crisis arrived and all of us who had fewer points were fired" (E 13).*

3.2. Expected working conditions

This section describes the working conditions that students expect to find and provides insights into what conditions are more valued by nursing students.

The students expected their working conditions to be precarious, with temporary contracts for just days or weeks instead of contracts that provide job stability. They are aware of the current situation of nurses, which presents high levels of unemployment as well as an increase of care burden among the hired nurses. They highlighted the precariousness of work in private institutions, considering that working conditions have become much worse and unworthy and they felt that private companies were taking advantage of the situation resulting from the global financial crisis of 2008, leading to worse working conditions and salaries for nurses. Some consider that the unions should guarantee minimum conditions, but they know that because there are so many unemployed people, companies would find professionals willing to work for those conditions. They considered that the recent graduates are the ones who suffer the most, obtaining fewer contracts and worse conditions. They also considered that working conditions had worsened, especially in nursing because it was not well valued. Among the causes they identified that had led to the current working conditions, they indicated the large number of graduates per year, especially from private universities, as well as the cuts in both personnel and materials as a result of the economic crisis:

> *"I see people looking for work and not finding anything. Not finding a job in three or four years and being unemployed, I'm worried in case I can't find a job" (E 04)."The cuts in healthcare have meant that fewer healthcare professionals are being hired, so this means that having fewer professionals and many patients means that the care will be less personal and more automated and you'll not be able to stop to talk to your patient, so I believe that the service will then be of a lower quality" (E 07).*

3.3. Valued working conditions

The conditions most valued by students in a job were: a good working environment, an interesting work, balance between personal and professional life, security, the possibility of development, the possibility of promotion and a good salary (Table 3). The interviews reflected that the working conditions they valued the most were primarily job stability, as well as good working hours and a job that allows them to be close to family and not to move far away.

> *"Bad because you realise that there are many professionals who have been working for many years who don't have a permanent contract. which doesn't give much hope of having a secure job and a fixed salary in the short term" (E 07).*

3.3.1. Job uncertainty

This section covers the students' ability to cope with uncertain events (i.e. intolerance to uncertainty) and whether this has an impact on their health. It also explores their expectations around migration and the reasons behind them.

3.4. Intolerance to uncertainty

The overall mean score of intolerance to uncertainty was 65.39, corresponding to a low intolerance to uncertainty. Specifically, 54.5% of the students were classified as having a low intolerance to uncertaintity, allowing them to better tolerate uncertainty; while 45.6% had high values of intolerance to uncertainty, making it harder for them to manage uncertain situations. Differences between universities were not significant (p = 0563). (Table 4).

The interviews revealed that there were different aspects contributing to students' uncertainty, such as not knowing what their next step was going to be, which and where their first job as a nursing professional was going to be, as well as how long it was going to take them to achieve job stability to be independent:

> *" /…/ because I know that I'll find a way one way or another if not here somewhere else, but I'd be uncertain because I don't know where and how. Especially during the first years when you're at the expense of your work, you don't know the schedule, you don't know the place, you don't know the time, you don't know anything, then it comes back to uncertainty" (E01)."Total uncertainty. Because I don't have economic stability. Because I can't support myself. I worry about everything. Wherever I work. I worry about the colleagues I have. I also worry about the salary because that's an important part of our work and that's why we also work to have economic support; In that respect I have no uncertainty. I'm quite clear. My idea is to go abroad. In fact. I want to do the RIN. but I'm not going to do it just now. I'm going to do it in four or five years' time when I get a bit of experience because I want to go abroad. That's my idea and I want to stay young. In other words. I want to have the experience and when I do a specialisation. with all the points I've earned abroad and the points from the RIN, masters or publications or whatever. I hope to be working regularly (E 15).*

3.5. Migration expectations

When faced with unemployment and precarious working conditions, 65.57% students chose to migrate to other regions where they had more opportunities or in some cases they even moved to another country. Their decision to work abroad led the interviewees feeling less anxious

Table 3
Answers to Job Expectations Questionnaire (III) (Paz et al., 2014) (n = 305).

Most valued conditions when selecting an employment	University of Murcia		University of Lleida		University of A Coruña		Overall total	
	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
The possibility of development	8.06	1.65	8.97	1.41	7.98	1.60	8.39	1.62
Interesting work, learning and training	8.87	1.30	9.32	1.13	8.91	1.25	9.05	1.21
Balance between personal and professional life	8.93	1.64	9.23	1.22	8.68	1.78	8.99	1.54
Good working environment	9.12	1.26	9.45	0.98	8.76	1.81	9.17	1.33
Promotion	8.07	1.75	8.23	1.91	8.11	1.35	8.74	1.76
Good salary	8.64	1.47	8.74	1.18	8.59	1.30	8.67	1.33
Security	8.86	1.64	9.16	1.07	8.77	1.39	8.95	1.39
Comfortable schedule	7.98	2.02	8.30	1.76	7.82	2.05	8.07	1.94
Projection	8.04	1.54	8.09	1.65	7.80	1.64	8.01	1.61
Prestige	7.10	2.36	7.22	2.34	7.29	1.74	7.19	2.23
Proximity to home	7.16	2.46	7.68	2.21	6.91	2.14	7.30	2.31

*The mean and standard deviation were calculated based on a Likert scale from 1 to 10.

Table 4
Intolerance to uncertainty of Nursing Students (n = 305).

Values	Low (27–68)		High (69–110)		Mean	Standard deviation	Range	P
University	N	%	N	%				
A Coruña	38	12.5	28	9.2	63.05	20.07	(31–104)	
Murcia	71	23.3	51	16.7	65.98	22.54	(27–128)	
Lleida	57	18.7	60	19.7	66.10	17.34	(27–123)	
Total	**166**	**54.5**	**139**	**45.6**	**65.39**	**20.11**		0.565

and more certain about their future as nurses as they felt in control about having made the decision, similar to those who already had jobs as auxiliaries or technicians and had stable circumstances prior to graduating:

> *Now I'm really thinking about going abroad. and I wouldn't mind spending 2. 3 or 4 months working as an assistant until I get my language qualification (E 05).Well. from other people's experience. I know that in other regions. in the north and so. I know that healthcare is better. They tend to have longer contracts. they also get paid much better and they're also committed to training. For example. in the Basque Country. they have a kind of retraining programme. which. when you don't have a contract. they offer you a retraining course. You don't get anything in return. but then you are prioritised over other people who haven't done that training. because they already know that you know how to do it. So. I think it's great that they invest in that (E 18).*

Some even anticipated that they would choose to adapt to other work options and leave the profession. This situation generates feelings of injustice, helplessness and contributes to the undervaluation of their profession in Spain. Students indicated feeling sad for having to exercise their profession in another country while they received their training in Spain and, if working conditions were different, they would have wished to remain. Interviewees were also concerned about the impact of staff cuts and job insecurity on the quality of care, professional performance and patient safety:

> *"It makes me sad. I'm worried about having to go abroad. I'm a grant holder. thanks to the grant I've been given I haven't paid anything and having to give my knowledge away to another country where you're not even recognised as having a university degree would seem disrespectful to my country "(E10).*

3.6. Health consequences

The uncertainty experienced by the students has an impact on their health in the form of anxiety, stress and negativity. They reported that the uncertain working conditions affected their future life planning in areas such as independence from their parental home, raising a family, continuing with postgraduate training, buying a car or house or even developing interhuman relationships:

> *It overwhelms me. Nervousness. uncertainty. it causes me a bit of restlessness. I have some anxiety and insecurity about what will happen to me in X time (E 05).What will I do with my life. you can't make plans for the future if you don't know if you're going to have a job. it's the never-ending circle. how am I going to make plans if I don't know if I'm going to have a job. when you don't have money. without money you're not going anywhere (E 08).*

3.7. Increasing the chances of getting a job by continuing education after finishing the nursing degree

This section includes information regarding the intention of final-year nursing students of studying another degree, a Master, or enrolling in the specialization nursing program after finishing the nursing degree.

When finishing their degree, 97.0% of the students wanted to continue their education, 81.4% of whom were women. There was a statistically significant difference between the universities regarding studying another degree ($P < 0.01$). The percentage of students wanting to study another degree was highest in the University of Murcia and lowest in the University of Lleida. Specializing in the Resident Internal Nurse (RIN) programme was considered by an average of 58.3% of the total students, with statistically significant differences ($P < 0.01$) between Universities: 96.5% at the University of Murcia, 81.5% at the University of A Coruña and 33% at the University of Lleida. Regarding interest in continuing education by enrolling in a master's degree, an overall average of 43.6% considered this option and there were also statistically significant differences ($P < 0.01$) between universities: 57% of the students in Lleida considered enrolment in a Master's degree, which was the highest, followed by 45.8% of the students from Murcia and 17.2% from A Coruña (Table 5).

The interviews showed that vocation and professional aspirations were among the main reasons for continuing training, but also to increase employment opportunities as training leads to obtaining points for a job in the public healthcare system and can give access to specific job offers in nursing specialisations. Students also indicated that training would be an essential part of providing a better quality of care, as it would increase their safety and the safety of patients and that is a way of obtaining greater recognition. Although post-degree training was positively valued by the participants, many indicated the difficulty of financing this training to facilitate entering the labour market. Another difficulty was to find a balance between training and raising a family:

> *In the end you take courses and learn in order to give the best care to the patient. in other words. it is vocation. I think it's a very vocational career. (E 15).I think it's good that all those related to healthcare should continue to receive training because there are new advances and at this time in this technological era the advances are very quick and I think that all healthcare professionals should be aware of the latest developments. as well as not getting rusty and have new knowledge to practice. You end up going to congresses and so on. doing evidence-based searches on the Internet to find out about the best options to treat patients. I believe that even if it's just a couple of hours a week or three hours a week for individual training. there'll always be time (E 07).*

4. Discussion

This study assessed the situation and expectations of final-year nursing students from three public universities in Spain regarding their future on the labour market. Overall, findings highlighted that most nursing students were concerned about their professional future. Despite differences between the three universities regarding employment, the respondents generally considered the probability of finding well-paid employment to be very difficult. Participants from the universities of Lleida and A Coruña reported greater security in terms of finding a job compared with students from Murcia. These results reflect the differences in health management in the different regions in Spain, with nurse/patient ratios of 521/100,000 inhabitants in Lleida and 552/100,000 inhabitants in A Coruña compared with 379/100,000 inhabitants in Murcia (Gallardo, 2020), which shows that, although there is a shortage of nurses, job security in Murcia is not guaranteed. In fact, these ratios compared with the European average of 811 nurses per 100,000 inhabitants (General Nursing Coucil, 2015) shows the chronic

Table 5
Answers to continuing education after finishing the nursing degree (n = 305).

		University of A Coruña						University of Murcia				University of Lleida				Overall total				
		Yes			No			Yes			No	Yes			No	Yes		No		
		N	%	ASRs	N	%	ASRs	N	%	ASRs	N	%	ASRs	N	%	ASRs	N	%	N	%	P
Are you thinking about continuing your training?		64	97	0	2	3	0	117	95.9	-1	5	4.1	1	115	98,3	1	2	1,7	-1	296	97.0	9	3.0	0.551
If yes, what kind of studies?	Study EIR	53	81.5	4.3	12	4.1	4,3	82	96,5	3,2	36	30,5	-3,2	37	33	-6,9	75	67	6,9	172	58.3	123	41.7	0.000
	Study a master's degree	11	17.2	-4,80	53	82.8	4,8	55	45,8	0,6	65	54,2	-0,6	61	57	3.5	46	43	-3,50	127	43.6	164	56.4	0.000
	Study another degree	9	13.8	-0,30	86.2	19.2	0.3	29	24.2	3.6	91	75.8	-3,60	6	5.6	-3,4	101	94.4	3.4	44	15.1	248	84.9	0.000
	Other studies	4	6.2	-2,6	61	93,8	2.6	16	13.3	-1,3	104	86.7	1,30	29	26.9	3.5	79	73.1	-3,50	49	16.7	244	83.3	0.001

*EIR: resident nurse intern
*ASRs: the adjusted standardized residuals

shortage of nurses in Spain. In addition to the aforementioned, the nurse-to-doctor ratio in Spain (1/4) is one of the lowest in the European Union (OECD, 2017) and previous research observes a ratio of 8 patients to 1 nurse which leads to unfavourable work environments (Gómez et al., 2016). Previous studies carried out in Mexico show similar results, despite the security with which Spanish students considered finding employment being higher than in Mexico (Escobar and Covarrubias, 2019; Paz, 2014).

Most the students were women, single, living with their parents and without children, with a socio-demographic profile similar to other international (Escobar and Covarrubias, 2019; Paz, 2014) and national (Porcel et al., 2015) studies. These findings reflect the reality of the profession, which is still mostly female.

Our results also showed that the working and employment conditions that nursing students expect to find are precarious, especially in the private sector, without stability and with temporary contracts mostly for just days or weeks. This situation is in accordance with employment reports by the Spanish Ministry of Education (2021). This may be explained by the fact that nursing can be a particularly stressful profession due to the high levels of responsibility and interpersonal relationships with users (ILO, 1996). Furthermore, at the beginning of their careers, professionals are stressed and frustrated, running the risk of starting out with high levels of work stress (Bhui et al., 2016).

In this sense, the working conditions that are most valued by our participants were having a good atmosphere at work (which would allow them to continue learning, balancing between personal and professional life) and job security. These findings are in line with previous research in Mexico (Paz, 2014) and a review built on international data (Porcel et al., 2015). Nevertheless, nurses usually find low job security when they enter the job market (Escobar and Covarrubias, 2019), being one of the factors that generated most uncertainty among our participants.

Another factor they considered to influence their working conditions is the global financial crisis of 2008, which increased unemployment and worsened working conditions. This situation has already been described in several articles (Galbany et al., 2019; Ruiz and Bayle, 2016; Galbany and Nelson, 2016; Salami et al., 2014). Importantly, the current situation caused by the COVID-19 pandemic that Spanish healthcare workers have dramatically experienced has shown the urgent need to incorporate more nursing professionals into the health system Huang et al. (2020); Turale (2020)).

Although the overall mean of intolerance to uncertainty scale was low, we observed that 45.6% of the nursing students had high values of intolerance to uncertainty. These values were higher than those reported in a previous Spanish study (Lopez and Gago, 2013). The results indicated that anxiety, stress and negativity is common among nursing students, which is consistent with previous studies indicating that uncertainty about the future of the profession affects young Spanish nurses and can be considered as a risk factor for their health (Lopez and Gago, 2013, General Nursing Coucil, 2015; Vargas and Dias, 2011).

Working as a nurse outside their town or region was an option considered by more than half of the students as an alternative to guarantee their professional future. Some also considered moving abroad to be able to work as a nurse. This reality contributes to a migratory flow of nursing professionals, motivated by the opportunity to achieve better salaries, greater stability and quality of life (Galbany and Nelson, 2016; Salami et al., 2014), which causes a significant shortage of nursing professionals in Spanish health institutions (Montero, 2020; Needleman et al., 2020).

Most students surveyed and interviewed wanted to continue their training after finishing their degree, considering it an essential part of providing quality of care, which is consistent with previous studies conducted in Spain (Lopez and Gago, 2013) and Mexico (Escobar and Covarrubias, 2019; Paz, 2014). Specialisation through the RIN programme was the most popular option. Nevertheless, the large number of nurses who want to specialise in a specific field is contrasted with the low number of training places offered (Spanish Government Official State Grazzete, 2020).

The results of this study regarding the expected precarious working conditions of Nursing students could be explained because, in Spain, the nurse/patient ratio is still very low compared with Europe. Not all graduated nurses will find a position to work in the Health System and the nurses that are currently working are overloaded. As previously mentioned, the situation of the COVID-19 pandemic in Spain has highlighted the shortage of nursing professionals in our country, being some regions more affected than others. Therefore, it is necessary to increase the number of nurses per patient to improve the quality of care and, as a consequence, increase the job opportunities of graduated nurses.

This study has some limitations. Firstly, the techniques of information collection may have introduced a bias of voluntary responses since data were collected online in Lleida and A Coruña, while in Murcia data were collected in person. Secondly, data only included 3 of the 17 Spanish regions due to accessibility to student data. As our objective was not to compare data between Spanish regions, using data from three universities allowed us to increase the sample. A total of 564 fourth-year nursing students from the three universities were invited to participate, corresponding to all the students registered in 2017–18 and 2018–19. The survey was completed by 305 students, meaning that the response rate was 54.1%, which could be considered a strength of the study, since only 229 participants would have been needed to reach a representative sample with a confidence interval of 95% with a margin of error of 5.

Last, data were collected before the global COVID-19 pandemic and the health crisis which has collapsed healthcare services, exhausted health professionals and increased social vulnerability (Gallardo, 2020; Brand, 2020). Future studies could look further into regional and gender differences and should also evaluate the post-pandemic situation that has highlighted that nurses are key professionals to face any health crisis, from both primary and specialised care.

5. Conclusions

Spanish nursing students find themselves in a situation of great uncertainty when they finish their degree, visualising a future with great stress and frustration. It is therefore necessary to propose strategies to improve working conditions and to even the labour supply in the Spanish regions. The precariousness of the employment and working conditions, the lack of staff in health services and the increased privatisation of healthcare in Spain has led future nurses to consider looking for job in another field or migrating to another country, causing a significant shortage of professionals in health institutions in Spain. This situation should alert health institutions to increase investment in hiring health staff such as nurses and provide them with satisfactory working conditions to ensure the safety and quality of care for patients.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.nepr.2022.103337.

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Burnout and job satisfaction among nurses in three Spanish regions

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Abstract

Aims: To determine the levels of job satisfaction and burnout syndrome and related factors among nurses in three Spanish regions.

Background: The nursing profession involves high work stress due to emotional involvement, workload and available resources.

Methods: Descriptive multicentric cross-sectional study. Sociodemographic and migration data were collected and participants completed the Job Satisfaction Questionnaire S20/23 and Maslach Burnout Inventory. The data were analysed using descriptive statistical methods using the program SPSS.

Results: The sample included 228 nurses (187 women and 41 men), with a mean age of 37.11 ± 10.87. Reported job satisfaction was medium to high. Overall, values were low in emotional fatigue and medium in depersonalization and personal fulfilment. In terms of migration, 21.59% of the participants had already moved to other Spanish regions or another country, while 18.58% had the intention of doing so.

Conclusion: Nurses with a temporary contract showed a high burnout rate, and high levels of emotional fatigue, depersonalization and lack of personal fulfilment.

Implications for Nursing Management: Strategies are needed to improve working and contractual conditions such as enhancing teamwork, management and leadership skills in nurses; achieving internal promotion; and having higher participation in decision-making and a better balance of power between health institution managers and health professionals.

KEYWORDS

nursing, job satisfaction, burnout syndrome, surveys, questionnaires, Spain

Lorena Acea-López and María del Mar Pastor-Bravo contributed equally.

1 | INTRODUCTION

Workers' job satisfaction has a direct influence on the quality of services, patient satisfaction and organisational development (Lu et al., 2019). Job satisfaction is understood as a favourable perspective, with a balance between people's work expectations, the rewards it offers, interpersonal relationships and management type (Fernández et al., 2019). Unsatisfied health professionals tend to suffer more from mood swings and various psychosomatic complaints, as well as being less efficient, and having higher absenteeism and more frequent job changes (Gandarillas González et al., 2014).

Burnout, classified by the WHO as an occupational disease, is a consequence of chronic stress (Moreno et al., 1990; Pérula et al., 2016). This syndrome has three dimensions: emotional exhaustion, depersonalization and a feeling of low personal fulfilment (Maslach & Jackson, 1981) causing emotional, behavioural, psychosomatic and social alterations, loss of work efficiency and disturbances in the family life (Moreno et al., 1990; Pérula et al., 2016).

Health workers are especially susceptible to burnout (Chemali et al., 2019; Morse et al., 2012). In particular, nurses have a burnout prevalence of 54%, globally (Zhang et al., 2018). The nursing profession involves high work stress due to the psychological and emotional involvement, as they are in direct contact with suffering, pain and death of patients, as well as aspects related to the dichotomy between workload and available resources (Pérula et al., 2016; Ribera Domone et al., 1993). According to the Organisation for Economic Co-operation and Development (OECD), the mean nurse-patient ratio in Europe is 8.8 nurses per 1,000 inhabitants, while this ratio in Spain is 5.6 (Crespo-Montero, 2020).

International organisations like the World Health Organization (WHO), the International Council of Nurses (ICN) and the International Labour Organization (ILO) have identified inadequate working conditions that affect the nursing population (Castillo Avila et al., 2014; Chen et al., 2019) including an increase in workload, a lack of human resources, temporary contracts that diminish job security, a lack of supplies to provide services and low salaries. These factors generate work overload, fatigue, physical and mental exhaustion, and a high level of stress in this profession (Castillo Avila et al., 2014).

In addition, stress levels maintained over time can lead to symptoms of depression (Fernández Sánchez et al., 2019). International studies identified that depression is a reason for absenteeism among nurses (dos Santos Trettene et al., 2020; Méndez-Nieto et al., 2013; Vargas & Dias, 2011; Yun et al., 2010).

The type and temporality of job contracts directly contribute to the satisfaction of the health professionals (Herrera-Amaya & Manrique-Abril, 2008). In 2018, 70.38% of health professional contracts in Spain were temporary (Spanish Ministry of Science, Innovation, & Universities, 2019). This high ratio is partly due to a change in the management of the National Health System as a result of the economic crisis that began in 2008, causing a reduction in human resources, increased unemployment and job insecurity (Galbany-Estragués et al., 2019; Galbany-Estragués & Nelson, 2016).

These conditions contributed to a migratory flow of nursing professionals in search of opportunities for better salaries, greater stability and better quality of life (Galbany-Estragués & Nelson, 2016; Salami et al., 2014). Between 2010 and 2013, 4,580 nurses trained in Spain applied to the Spanish Ministry of Education to validate their nursing qualifications to work in another country within the European Economic Area (Galbany-Estragués & Nelson, 2016). This represents an average ratio of 4.52 nurses for every 1,000 active nurses per year. Nurses departing to other countries during economic crisis at the time that interest of Latin American nurses in work in Spain decreased (Pastor-Bravo & Nelson, 2019) has caused a dire shortage of nurses in health centres in Spain. In this sense, that there is a need to incorporate at least 87,890 nurses into the Spanish Public Health System, 15,514 of which are needed in primary care (Spanish Council of Nurses, 2019). The low number of nurses increases the risk of patient mortality (Needleman et al., 2020). For example, staff shortages induce an increase in job dissatisfaction and burnout among professionals, causing an increase in nursing errors, which lead to the quality of care being affected (Gandarillas González et al., 2014; Meier et al., 2001).

Research on job satisfaction and burnout syndrome among nurses can help to visualize nursing working conditions and needs. In this sense, this study aims to determine the levels of job satisfaction and burnout syndrome, and related factors among nurses in three Spanish regions.

2 | METHODOLOGY

A descriptive cross-sectional multicentre study was conducted. Data were collected between April 2019 and February 2020 in three Spanish regions (Murcia, Lleida, and Galicia).

The inclusion criteria for this study were that the nurses were registered in the nursing associations between the provinces of A Coruña, Murcia and Lleida. An email was sent in July 2019 to the registered nurses belonging to two professional associations (Official Nursing Associations of A Coruña and Lleida). Nurses who graduated from the previous year at the University of Murcia were also notified by corporate mail, as well as nurses of all the departments of two public hospitals in the region of Murcia were also notified in person, through the nursing supervisors of the hospitals, who were given the questionnaires on paper.

Data were collected on socio-demographic variables, training, work situation and migration using: (a) the Job Satisfaction Questionnaire S20/23 (Meliá & Peiró, 1989), consisting of 23 items, with which an overall average of satisfaction and the description of five factors are obtained: satisfaction with supervision (6 items), satisfaction with the physical environment (5 items), satisfaction with the benefits received (5 items), intrinsic job satisfaction (4 items) and satisfaction with participation (3 items). Each item has a Likert scale from 1 to 7, where 1 = very dissatisfied and 7 = very satisfied. A maximum of 160 points and a minimum of 22 points are obtained. (b) The Maslach Burnout Inventory

TABLE 1 Maslach Burnout Inventory subscales

	Low level	Medium level	High level
Emotional fatigue	≤19	19–26	≥27
Depersonalization	≤6	6–9	≥10
Personal achievement	≤33	34–39	≥40

(Maslach & Jackson, 1981), validated in Spanish (Gil-Monte & Peiró, 2000), consists of 22 items with a Likert scale from 0 to 6, where O = never and 6 = every day; it measures the 3 aspects of the syndrome: emotional exhaustion, depersonalization and personal fulfilment (Table 1). Scores below 34 are considered low. High scores on the subscales of emotional exhaustion (>27) and depersonalization (>10) and low scores on self-fulfilment (<33) allow a diagnosis of the syndrome.

The data were analysed using descriptive statistical methods employing the program SPSS. Percentages, measurements of central tendency (frequency and mean-*M*) and dispersion (standard deviation-*SD*) were calculated, and contingency tables were created to analyse the frequencies of different crossover variables.

This study was authorized by the Research Commission of the Faculty of Nursing and Physiotherapy of the University of Lleida and the Faculty of Nursing of the University of Murcia.

3 | RESULTS

A total of 228 nurses participated in this study (41 men, 187 women): 130 from Murcia, 54 from Catalonia and 31 from Galicia. The mean age of the participants was 37.11 years (±10.87), 104 (45.61%) were single, and 103 (54.82%) had children. The majority of participants (*n* = 193, 84.64%) lived with their families. Completion of studies was from the class of 1976 to 2018, with 127 (68.28%) participants graduating between 2000 and 2018.

Most of the participants (94.30%, *n* = 215) were currently working as nurses, 77.19% of which were currently employed at hospital departments and 9.21% at public primary health care centres. A minority of 8.33% were actively working at private centres and 5.26% in nursing homes, respectively. On the other hand, some participants (5.70%) had to resort to low-skilled jobs until the next contract as a nurse.

Between January 2017 and January 2018, 40.35% of the participants had one single contract, while 45.61% had more than 2 contracts at once. 42.98% of the participants had rotating work shifts. More than half of the nurses (62.73%) worked less than 10 years in the same company or hospital. More detailed information about the socio-demographic profile of the study population is shown in Table 2.

The average overall job satisfaction obtained was 107.91 ± 29.95 points (67.44%), corresponding to a medium-high satisfaction. Intrinsic job satisfaction (21.10 ± 5.69), satisfaction with the physical environment (23.37 ± 8.03) and satisfaction with participation (13.72 ± 4.96) obtained high averages of satisfaction with few variations (75.35%, 66.77% and 65.33%, respectively). In the case of performance satisfaction, the medium scores had a lower trend with a 68.97% (20.64 ± 7.58). Satisfaction with nursing supervision (line managers) (69.26%) also varied between dissatisfaction and average satisfaction values (29.09 ± 13.72).

TABLE 2 Socio-demographic profile of graduate nurses

Variable	Category	*n*	%
Marital status	Marital Status Single	104	45.61%
	Domestic partnership	17	7.46%
	Married	94	41.26%
	Divorced	8	3.51%
	Widowed	5	2.19%
Children	With children	103	45.18%
	Without children	125	54.82%
Cohabitation nucleus	Family	132	57.89%
	Shared residency	13	5.70%
	Couple	61	26.75%
	Living alone	22	9.65%
Dependents	Having dependents	87	38.16%
	Not having dependents	141	61.84%
Year of graduation	1976–1987	14	7.53%
	1988–1999	45	24.19%
	2000–2011	79	42.47%
	2012–2018	48	25.81%
Further studies	Master´s study	65	28.51%
	Postgraduate	8	3.51%
	Nursing speciality	4	1.75%
	Expert	2	0.87%
	Other bachelor's degree	1	0.43%
	Training courses	1	0.43%
	Not specified	9	3.95%
Current type of work	Nurse	215	94.30%
	Other profession	13	5.70%
Type of job	Employee	219	96.05%
	Supervisor	2	0.88%
	Middle management	6	2.63%
	Management	1	0.44%
Time spent in the company	<3 months	34	14.91%
	3–6 months	22	9.65%
	6 months–1 year	14	6.14%
	1–5 years	9	3.95%
	5–10 years	64	28.07%
	>10 years	85	37.28%
Number of contracts from January 2017 to January 2018	No contract	22	9.65%
	1 contract	92	40.35%
	2–10 contracts	88	38.60%%
	11–80 contracts	16	7.02%

TABLE 3 Burnout syndrome and time worked in the company

Contract duration	Emotional fatigue		Depersonalization		Personal fulfilment		Burnout syndrome		Total employees	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
<1 year							9	3.94	57	25
High level	14	6.14	23	10.09	24	10.09				
Medium level	7	3.07	17	7.46	16	7.46				
Low level	36	15.79	17	7.46	17	7.46				
1–5 years							8	3.50	64	28.07
High level	12	8.33	26	11.40	26	8.33				
Medium level	19	14.47	17	7.46	17	9.65				
Low level	33	9.65	21	9.21	21	9.65				
5–10 years						1.32	0	0	22	9.65
High level	3	3.51	6	2.63	6	3.51				
Medium level	8	4.82	6	2.63	6	4.82				
Low level	11	14.91	10	4.39	10	14.91				
>10 years							5	2.20	85	37.28
High level	17	7.46	19	8.33	19	14.04				
Medium level	20	8.77	24	10.53	24	10.53				
Low level	48	21.05	42	18.42	42	12.72				
Total							22	9.64	228	100

TABLE 4 Burnout syndrome, type of contract and shift/hour

Type of contract/shift and schedule	Emotional Fatigue		Depersonalization		Personal fulfilment		Burnout syndrome		Total employees	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Permanent/interim staff							1	0.43	8	3.51
High level	2	0.87	1	0.43	5	2.19				
Medium level	1	0.43	1	0.43	0	0				
Low level	5	2.19	6	2.63	3	1.31				
Temporary staff							21	9.21	220	96.46
High level	44	19.29	73	32.02	78	34.21				
Medium level	53	23.24	63	27.63	67	29.38				
Low level	123	53.95	84	34.84	75	32.89				
Flexible and/or irregular timetable							6	2.63	17	7.46
High level	6	2.63	9	3.95	4	1.75				
Medium level	5	2.19	4	1.75	2	0.87				
Low level	6	2.63	4	1.75	11	4.82				
Maximum hours intensive schedule							3	1.31	42	18.42%
High level	10	4.38	11	4.82	18	7.89				
Medium level	10	4.38	13	5.70	11	4.82				
Low level	22	9.65	18	7.89	13	5.70				
Part-time							1	0.43	17	7.46
High level	1	0.44	7	3.07	8	3.51				
Average level	4	1.75	2	0.87	4	1.75				
Low level	12	5.26	8	3.51	5	2.19				

(Continuous)

TABLE 4 (Continued)

Type of contract/shift and schedule	Emotional Fatigue		Depersonalization		Personal fulfilment		Burnout syndrome		Total employees	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Fixed part-time						0.87	0	0	2	0.87
High level	0	0	0	0	1	0.43				
Medium level	1	0.43	0	0	1	0.43				
Low level	1	0.43	2	0.87	0	0				
Fixed shift						22.80	3	1.31	52	22.80
High level	12	5.26	13	5.70	15	6.58				
Medium level	14	6.14	17	7.46	19	8.33				
Low level	26	11.40	22	9.65	18	7.89				
Rotating shift							9	3.95	98	42.98
High level	17	7.46	34	14.91	37	16.23				
Medium level	19	8.33	28	12.28	30	13.16				
Low level	62	27.19	36	15.79	31	13.60				

Regarding burnout syndrome, the results obtained in the different dimensions of the scale showed low levels of emotional fatigue (17.56 ± 11.66), medium levels in depersonalization (7.39 ± 5.32) and personal fulfilment as low (36.13 ± 6.93), with an overall average level of professional burnout. As for the burnout subscales: 46 (20.18%) presented high levels of emotional fatigue, 54 (23.68%) medium levels and 128 (56.14%) low levels. 74 (32.46%) showed high levels in depersonalization, 64 (28.07%) medium levels and 90 (39.47%) low levels. 83 (36.4%) displayed high levels in personal fulfilment, 67 (29.38%) medium levels and 78 (34.21%) low levels.

It was obtained that 9.65% ($n = 22$) of the respondents had burnout syndrome, of which 6.58% ($n = 15$) worked in a hospital, 1.31% ($n = 3$) in primary care, 0.88% ($n = 2$) in a nursing home and 0.88% ($n = 2$) in private facilities, of which 8 workers had been working between 1 and 5 years, and 5 had been working for less than 3 months; 5 workers had been working for more than 10 years, and 4 had been working between 6 months and a year (Table 3). All shifts/schedules, except for part-time and fixed part-time, had the highest burnout values (Table 4).

In terms of migration, 18.58% of the nurses had the intention of relocating, 73.80% of which stated where they wanted to migrate. The majority of nurses (61.29%) wanted to move to other Spanish regions, 16.13% had the intention of leaving the country (France, Germany, Ireland, Norway, the United States or the United Kingdom), 9.67% considered both options (abroad or moving to another region) and 12.90% had doubts about where they would go. At the time of the survey, 21.59% had already migrated to another region.

4 | DISCUSSION

This study highlights the employment situation of nurses in three Spanish regions (Murcia, Lleida and Galicia), showing a discontent population with few years of work experience. Nurses mainly work at public health institutions and have been working for <10 years, and are mostly temporary staff. Also, nurses displayed average values of burnout and satisfaction with the services and lower values of satisfaction with the nursing supervisors.

The average overall satisfaction obtained in this study was medium to high, with similar results to those obtained in other studies carried out in other Spanish regions (Cantabria) (Gandarillas González et al., 2014), as well as Argentina (Fernández et al., 2019) and Peru (Vásquez Sosa, 2007). The lowest values were obtained in the assessment of services, promotion and supervision, congruent with the results from studies carried out in hospitals in Argentina, Chile and Venezuela (Fernández et al., 2019; Garrido et al., 2020; Parada et al., 2005). Nonetheless, another Spanish study (Gandarillas González et al., 2014) reported higher scores for satisfaction with nursing supervision.

Concerning emotional fatigue, our results confirmed the values reported in a previous study carried out regarding nurses in eight hospitals of the region of Murcia in 2010 (Abad-Corpa et al., 2013), and slightly higher rates of emotional fatigue were retrieved in another study performed in Andalusia in 2015 (Cañadas-De la Fuente et al., 2015). Compared to other international studies, emotional fatigue values were slightly lower than those obtained in nurses from Venezuela (Parada et al., 2005) or Brazil (Vidotti et al., 2018) and in two systematic reviews of burnout syndrome in nurses from Asia, America and Europe (Chemali et al., 2019; Monsalve-Reyes et al., 2018).

However, our data did not coincide with the results of these studies in the fields of personal fulfilment and depersonalization (Parada et al., 2005) (Cañadas-De la Fuente et al., 2015; Monsalve-Reyes et al., 2018). This may be because our study sample includes mostly young and temporary contract nurses, with frequent job changes and with little possibilities for promotion or job recognition. These circumstances might cause increased depersonalization and little personal fulfilment. All these factors contribute to the fact that the mean rate of burnout syndrome in our study was slightly higher than in the aforementioned studies (Abad-Corpa

et al., 2013; Cañadas-De la Fuente et al., 2015; Monsalve-Reyes et al., 2018; Parada et al., 2005; Sturzu et al., 2019; Vidotti et al., 2018).

Taking into account the type of contract, we observed that nurses with a temporary contract showed high burnout rates, even in professionals who only worked at the same department for 1 year or less. These findings provide a new vision of young nursing professionals, with little seniority, and who were not as present in previous studies (Cañadas-De la Fuente et al., 2015; Sturzu et al., 2019; Vidotti et al., 2018).

Contradictory data have been found regarding seniority and burnout syndrome. While the Spanish study by Cañadas (Cañadas-De la Fuente et al., 2015) shows that seniority in the workplace favours workers with lower levels of burnout, other international studies show that seniority in the workplace led to higher values of burnout (Sturzu et al., 2019; Vidotti et al., 2018).

Our study found that nurses working in rotating shifts had a 1.5 times higher risk of burnout than those working in fixed shifts, which is consistent with other studies. Nurses in Andalusia showed lower values of personal fulfilment in rotating shifts, which are associated with a higher risk of burnout (Cañadas-De la Fuente et al., 2015). A study performed in France reported that nurses working day shifts showed higher rates of burnout than those working night shifts (Vidotti et al., 2018).

Existing literature indicates that emotional burnout and depersonalization are associated with increased rates of job abandonment (Boamah et al., 2017; Garrido et al., 2020; Jourdain & Chênevert, 2010; Van der Heijden et al., 2010), while social support received from supervisors and colleagues (Jourdain & Chênevert, 2010; Van der Heijden et al., 2010) are considered protective factors. In this study, we found high percentages of emotional exhaustion, depersonalization and dissatisfaction with supervision, which could mean a loss of well-trained professionals that would intensify the lack of health professionals in Spain (Spanish Council of Nurses, 2019).

Approximately 40% of participants had migrated or intended to migrate to another region or foreign country. This can be explained by the fact that the migratory flow of nurses abroad has been increasing, especially in the last decade. This has been a result of the situation of unemployment, precarious recruitment and the abandonment of the nursing profession (Galbany-Estragués & Nelson, 2016; Salami et al., 2014).

This study has some limitations, such as the sampling recruitment, non-representative samples and the limitations of a multicentre study such as the heterogeneity in clinical practice among centres (Youssef et al., 2008). Information collection techniques may have introduced a voluntary bias in the responses because in two of the three regions the invitation to fill in the questionnaire was by sending a link by email, while in one of the regions the participants were invited to participate directly in person, which might have pressured them to participate. In addition, it has not been possible to establish some comparisons between groups. The majority of our participants were temporary staff, which made it difficult to compare them to the small sample of permanent staff. Another limitation was the unequal proportion of responses to the test in the different regions. Our data were not comparable between men and women, reflecting the reality of the profession, which is mostly female. Furthermore, future research is needed to examine these differences and the contrast of the pre- and post-pandemic situation. The situation of the COVID-19 health crisis that we have experienced so dramatically in Spain has led to collapsed health care services, exhausted health professionals and has shown the need for more nursing professionals (Huang et al., 2020; Serrano Gallardo, 2020; Turale et al., 2020).

5 | CONCLUSIONS

Nurses hired temporarily and with little seniority show high levels of emotional fatigue, depersonalization and lack of personal fulfilment. The results suggest that nurses may be suffering from psychological problems, such as stress and anxiety. Due to precarious working conditions, economic crisis, the migratory flow of nursing professionals is increasing, causing a significant lack of nurses in health institutions, which could translate into an increase in patient morbidity and mortality. This situation should alert health authorities and managers to ensure the safety and quality of care for patients.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Our findings may be useful to propose new strategies to improve work conditions, especially in those Spanish regions where more labour supply is needed. The results of this study suggest that it is necessary: (a) to enhance teamwork, management and leadership skills to improve nursing supervision; (b) for professionals, to have greater participation in decision-making to favour a balance between managers of health institutions and health professionals, which increases the involvement of professionals; (c) to improve recruitment, reducing the eventuality to reduce the burnout syndrome and the migration of nursing professionals to other regions or countries; and (d) for newly graduated nurses, to get coaching and mentorship in the practical work.

CONFLICT OF INTEREST

Any conflict of interest is declared.

AUTHOR CONTRIBUTIONS

MG, JB and MP designed the study. LA, MP and ER collected the data. MP, LA, JB and FB analysed the data. ER and EB supervised the data. LA, MP and FB wrote the manuscript. MG, JB, EB and ER critically revised for important intellectual content.

ETHICAL APPROVAL

This study was authorized by the Research Commission of the Faculty of Nursing and Physiotherapy of the University of Lleida and the Faculty of Nursing of the University of Murcia.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Artículo 3

Stress and anxiety in nursing students during the first wave of the COVID-19 pandemic.

Archivos de prevención de riesgos laborales

2023

[En revisión]

Stress and anxiety in nursing students during the first wave of the Covid-19 pandemic

ABSTRACT

Background: The health emergency situation derived from the coronavirus disease pandemic 2019 (COVID-19) led to the incorporation of nursing students into healthcare activity.

Aim: The aim is to compare levels of anxiety and acute stress among nursing students who joined the workforce during the first wave of the COVID-19 pandemic and those who did not.

Method: A cross-sectional descriptive multicentre study of three Spanish public universities. A total of 216 nursing students participated. Data collection was done using an ad hoc online form. The Zung Anxiety Self-Assessment Scale and the Stanford Acute Stress Reaction Questionnaire were completed. Univariate and multivariate analyses were carried out.

Results: The labour market was entered by 42.6% of the students. The global anxiety score was $\bar{x}$=36.31 (SD=5.71) and the stress score was $\bar{x}$=82.39 (SD=30.84). Lower levels of anxiety were shown by those who joined ($\bar{x}$=35.67; SD=5.78) compared to those who didn't ($\bar{x}$=36.73; SD=5.67). Acute stress was higher in those who didn't work ($\bar{x}$=84.35; SD=32.38), and significantly in women.

Conclusion: Stress and anxiety levels should be taken into account by clinical practice tutors. Nursing students showed to cope with stress in situations such as the COVID-19 pandemic.

DESCRIPTORS: Anxiety; COVID-19; Nursing students; Mental health; Stress disorders.

INTRODUCTION

The health emergency situation resulting from the coronavirus disease 2019 (COVID-19) pandemic led to the suspension of teaching activities in educational centres, including universities, in March 2020 (Newell, 2020; Spanish Government, 2020). The pressure on the healthcare system at that time made it necessary to reorganise clinical activity and mobilise all available material and human resources. The shortage of staff in healthcare centres led to the involvement of health science students and specialists in health professions, who underwent training in the care of patients admitted to healthcare centres (Bosveld et al., 2021). This measure was adopted in the United Kingdon (Swift et al., 2020), Italy (Ministero della Salutte, 2020, the USA (Newell, 2020) and Spain (Ministry of Health of the Government of Spain, 2020).

In Spain and in accordance with Order SND/232/2020 of 15th March, adopting measures in terms of human resources and means for the management of the health crisis situation caused by COVID-19, students in their final years of Medicine and Nursing joined the health systems of different autonomous communities, mainly contracted under the call for 'health assistance', to carry out their healthcare activity in a support capacity and always under the supervision of a qualified health professional. Student nurses in particular were integrated into the staff of healthcare resources, such as hospitals, residences and medicalised hotels (Cuesta Santamaría et al., 2020; Gómez-Ibáñez et al., 2020). Up until then, they had completed all their theoretical training before finishing their Final Degree Project and part of their practical training (Aslan & Pekince, 2021).

Several studies have measured the levels of perceived stress (Ersin & Kartal, 2021) and anxiety (Cici &Yilmazel, 2021) in nursing students during the first months of the COVID-19 pandemic. Stress and anxiety increased during the pandemic due to academic uncertainty and also due to the health situation experience (Collado-Boira, 2020).

The aim of the present study is to analyse the anxiety levels and reactions to acute stress of student nurses during the first wave of the COVID-19 pandemic based on gender, university, employment status, recruitment and workplace characteristics.

METHOD

Design of study

This was a cross-sectional descriptive multicentre study. This study was reported following the strengthening the reporting of observational studies in epidemiology (STROBE)- statement (Supplementary file 1).

Population

The study population comprised student nurses from Universities X, Y and Z. Inclusion criteria were that the students had to be in the third or fourth year of their nursing degree with the possibility of entering the workplace during the first wave of the pandemic. Only students in their third year were also called to join the workforce.

Variables and instruments

The following variables were analysed: gender, year of nursing degree (third–fourth), university of origin (X, Y and Z), incorporation into the workplace (yes/no) and characteristics of this incorporation in terms of time elapsed since incorporation, contractual modality, incorporation service, length of working day, responsibility for the people cared for and whether or not patients with COVID-19 were cared for. The dependent variables were the scores obtained by the students on the Zung Anxiety Self-Assessment Scale (Zung, 1971) and on the Stanford Acute Stress Reaction Questionnaire (SASRQ) (Cardeña et al., 1991, 2001).

The Zung Anxiety Self-Assessment Scale – validated in a Spanish-speaking population with good psychometric properties (Hernández-Pozo et al., 2008) – consists of 20 items referring to different psychological and somatic anxiety symptoms. Responses are scored according to a four-point scale, with 1 = never or almost never and 4 = always or almost always. The score range is 20–80, with anxiety level rated as: no anxiety (< 45), moderate anxiety (45–59), severe anxiety (60–74) and clinically significant anxiety (≥ 75) (Dunstan et al., 2020). Participants were asked to respond to each item based on their experience in the past month.

The SASRQ (Cardeña et al., 1991, 2001) was developed to measure anxiety and dissociative symptoms in people who have experienced traumatic events, according to the DSM-IV criteria for acute stress disorder. The administrator fixes a period of time during which stressful events may have occurred and the person is asked to describe the

most disturbing event and the degree of disturbance it caused. Then, taking this event into account, the person scores the 30 items of the questionnaire according to the frequency with which he/she has experienced it. Finally, the person is asked to identify on how many days in the set period of time he/she has experienced the distress. A total score can be obtained from the sum of the items or an acute stress disorder can be diagnosed if the items are considered dichotomously (Bados, 2015). This questionnaire has been adapted and translated into Spanish by Cardeña and Maldonado (2001). Students were asked to recall stressful events that occurred over the previous month of their life and to score each item of the questionnaire based on the extent to which it described their experience during and/or after the previously described event.

Procedure

Data collection was carried out in April–May 2020, distributing an online form through the virtual and institutional mail of each participating university. A welcome page was used, with information about the study and informed consent. Only students who had previously read and understood the conditions and voluntarily agreed to participate in the study, through an initial form with information about the study that was sent along with the survey, were able to access and complete the questionnaire.

Ethical aspects

Permission was obtained from the three universities, with approval by the university's ethics committee [Anonymised]. After data collection, a numerical code was assigned to each participant in order to guarantee anonymity during the analysis process.

Data analysis

Basic descriptive statistical methods were used for data analysis using SPSS 23.0 for Windows. Comparison between groups (gender, year, university and employment or non-employment) was carried out using the chi-square test and Student's *t*-test or ANOVA according to the characteristics of the variables. Statistical significance was set at $p < 0.05$.

RESULTS

Characteristics of the study population

A total of 240 questionnaires were collected, 24 of which were excluded because of missing information (n = 216). As 413 students were sent the questionnaire, our response rate was 52.3%. Students from University Y represented 43.1% of the sample, with 36.6% from Z and 20.3% from X. The majority of participants were female (88.3%) and 88.5% were final-year students.

A total of 42.6% of the respondents had entered healthcare before completing their undergraduate degree. A quarter (25%) of the students at University Y had started working in the week prior to data collection, whereas 85.7% of the students at X and 65% at Z had been working for one month or more (Table 1). Employment status differed between students from different universities: 66.7% from X and 60% from Z were employed as health assistants, whereas for Y the most common employment was as a nurse (50.0%), these differences being statistically significant (p = 0.047).

Table 1: Sociodemographic characteristics of the participants by university and characteristics of labour market entry. Spain, 2020.

		Total	X *n* (%)	Y *n* (%)	Z *n* (%)	Missing data	*p*
No. of students		216	44 (20.3%)	93 (43.1%)	79 (36.6%)	0	
Sex	**Female**	191 (88.3%)	43 (97.7%)	82 (89.1%)	66 (83.5%)	1	
	Male	24 (11.7%)	1 (2.27%)	10 (10.86%)	13 (16.4%)		
Academic year	**Third year**	27	–	27 (29.3%)	–	0	
	Fourth year	189	44 (100%)	66 (71.7%)	79 (100%)	0	
Incorporated into health care before the end of the degree	**Total**	92	23 (25%)	24 (26.1%)	45 (48.9%)	0	
	Male	14	1	6	7	1	
	Female	77	22	17	38		
Time incorporated	**1–6 days**	6 (7.4%)	1 (4.8%)	5 (25%)	–	11	0.001
	7–14 days	7 (8.6%)	–	4 (20%)	3 (7.5%)		
	15 days to 1 month	14 (17.3%)	2 (9.5%)	1 (5%)	11 (27.5%)		
	> 1 month	54 (66.7%)	18 (85.7%)	10 (50%)	26 (65%)		

Contracting role	**Nursing assistant**	16 (19.3%)	3 (14.3%)	5 (22.7%)	8 (20%)	9	0.046
	Nurse	23 (27.7%)	4 (19.0%)	11 (50.0%)	8 (20.0%)		
	Health assistance	44 (53.0%)	14 (66.7%)	6 (27.3%)	24 (60.0%)		
Attending (potential) COVID-19 patient	**Yes**	70 (84.3%)	19 (90.5%)	16 (72.7%)	35 (87.5%)	9	
	No	10 (12.0%)	1 (4.8%)	5 (22.7%)	4 (10%)		
	Other	3 (3.6%)	1 (4.8%)	1 (4.5%)	1 (2.5%)		
Type of work performed	**Reinforcement to other nurses**	47 (56.6%)	11 (52.4%)	10 (45.5%)	26 (65.0%)	9	0.029
	With patients under their full care	20 (24.1%)	2 (9.5%)	9 (40.9%)	9 (22.5%)		
	Others	16 (19.3%)	8 (38.1%)	3 (13.6%)	5 (12.5%)		
Received specific information on protection against infection	**Yes**	34 (42%)	12 (57.1%)	8 (40%)	14 (35%)	11	0.245
	No	47 (58%)	9 (42.9%)	12 (60%)	26 (65%)		
In possession of the necessary protective measures	**Yes**	44 (54.3%)	12 (52.1%)	13 (65%)	19 (47.5%)	11	0.759
	No	27 (33.3%)	7 (33.3%)	5 (25%)	15 (37.5%)		
	Not always	10 (12.3%)	2 (9.5%)	2 (10%)	6 (15%)		
Services to which incorporated	**Medical hotels**	6 (7.3%)	6 (23.8%)	1 (4.8%)	–	10	0.004
	Field hospitals	1 (1.2%)	–	–	1 (2.5%)		
	Intensive Care Units	8 (9.7%)	2 (9.5%)	1 (4.8%)	5 (12.5%)		
	Emergency department	4 (4.9%)	1 (4.8%)	-	3 (7.5%)		
	Hospitalization ward	4 (51.2%)	11 (52.4%)	8 (38.1%)	23 (57.5%)		
	Other health services (residential homes, COVID test centres, mental healthcare)	21 (25.6%)	2 (9.5%)	11 (52.4%)	8 (20.0%)		

Significant differences (p = 0.004) were found between universities, depending on the

service the students joined: for University X, medicalised hotels were the most common type of service provided (23.8%), whereas for Y it was other healthcare centres (52.4%) and for Z it was hospitalisation wards (57.5%).

A total of 84.3% of the students attended patients suffering from COVID-19, with no statistically significant differences between universities (p = 0.464). Most of the participants (56.6%) from the three universities acted as backup for another nurse. However, 40.9% of the Y students had full responsibility for patients in their care, this difference being statistically significant (p = 0.029).

For 58% of the students who entered employment, no specific information relating to protection against infection was received from their employing institution, with no significant differences between universities (p = 0.245). A total of 54.3% of the respondents considered that they had the necessary protective measures to carry out their work safely, with the value being higher for Y students (65%).

Anxiety

The values obtained on the Zung Anxiety Self-Assessment Scale (n = 168) show that 84 (50%) students were anxious and 84 (50%) were not. The mean corresponds to a low level of anxiety ($\bar{x}$ = 36.3; SD = 5.7), with no significant gender differences observed (p = 0.057). The highest values were found among the students of University Z ($\bar{x}$ = 37.4; SD = 6.3), these differences not being statistically significant (p = 0.139) with the other universities.

Students who joined the workforce ($\bar{x}$ = 35.7; SD = 5.8) had lower levels of anxiety compared to those who did not join ($\bar{x}$ = 36.7; SD = 5.7), but these differences were not significant (p = 0.237). Among the incorporated students, the females obtained higher values ($\bar{x}$ = 36.3; SD = 5.7) of anxiety compared to males ($\bar{x}$ = 33.9; SD = 4.6) and this situation was repeated in the unincorporated students ($\bar{x}$ = 37; SD = 5.8 vs. $\bar{x}$ = 33.9; SD = 5.7), without these differences being significant among the students of the different universities (p = 0.274; p = 0.138) (Table 2).

Table 2: Anxiety and stress levels among participants (*n* = 216). Spain, 2020.

		Anxiety (Zung scale) $\bar{x}$ (SD)	*p*	Stress (Stanford scale) $\bar{x}$ (SD)	*p*
Gender	**Total**	**36.3 (5.7)**		**82.4 (30.8)**	
	Female	**36.6 (5.8)**	0.057	**84.5 (30.8)**	0.023
	Male	33.9 (3.9)		**67.4 (27.4)**	
University	**X**	35.9 (5.5)	0.139	**78.8 (30)**	0.773
	Y	35.5 (5.1)		**83.51 (30.6)**	
	Z	**37.4 (6.3)**		**82.98 (32)**	
Academic year	**4th and 5th year**	**36.3 (5.9)**	0.919	**82.58 (30.6)**	0.827
	3rd year	36.2 (3.7)		**80.9 (33.8)**	
Work incorporation	**Yes**	35.7(5.8)	0.237	**80 (28.9)**	0.382
	No	**36.7 (5.7)**		**84.3 (32.4)**	
Participants in employment	**X**	35.5 (5.7)	0.192	**73.2 (27.3)**	0.484
	Y	33.8 (4.3)		**79.5 (27.2)**	
	Z	**36.8 (6.3)**		**83.6 (28.9)**	
	Female	**36.1 (5.9)**	0.274	**81.1 (28.4)**	0.443
	Male	33.9 (4.6)		**73.8 (32.3)**	
Participants not in employment	**Female**	**367 (5.8)**	0.138	**87 (32.5)**	0.017
	Male	33.9 (3.2)		**58.5 (16.7)**	

A high level of anxiety (moderate, severe or clinically significant) was reported by 36.4% of respondents who believed they had the essential protective measures in place compared to 51.5% of those who did not, and this difference was statistically significant ($p = 0.005$) (Table 3).

Table 3: Levels of anxiety and stress in relation to protective measures (*n* = 92). Spain, 2020.

		Anxiety				Stress			
		No	**Yes**	**Total**	***p***	**No**	**Yes**	**Total**	***p***
Do you think you have the necessary protective measures to practice safely?	**Yes**	29 (72.5%)	12 (36.4%)	41 (56.2%)	0.005	**28 (60.9%)**	10 (40.0%)	38 (53.3%)	0.116
	No	8 (20.0%)	**17 (51.5%)**	25 (34.2%)		15 (32.6%)	10 (40.0%)	25 (35.2%)	
	Not always	3 (7.5%)	4 (12.1%	7 (9.6%)		3 (6.5%)	5 (20.0%)	8 (11.3%)	
	Missing data			19				21	

Stress

The range of stress scores among the students was 110 (maximum 140, minimum 30). According to the cut-off point of 90, 5 (29.5%) students had no stress and 25 (16%) had stress. The mean acute stress score in the surveyed students (*n* = 157) was 82.4 (SD = 30.8), being higher in female students ($\bar{x}$ = 84.5; SD = 30.8) than in male students ($\bar{x}$ = 67.4; SD = 27.4), and these differences were statistically significant (p=0.023). The highest mean values were found in students from University Y ($\bar{x}$ = 83.5; SD = 32), with no significant differences between universities (*p* = 0.747).

It was observed that students who entered the labour market had lower levels of stress ($\bar{x}$ = 80; SD = 28.9) compared to those who did not ($\bar{x}$ = 84.3; SD = 32.4), although these differences were not significant (*p* = 0.382). Female students had higher stress scores than males in both the incorporated and unincorporated groups, these values being statistically significant in the unincorporated group (*p* = 0.017) (Table 2). Among the newly incorporated students, 40% of those who did not have protective measures in place experienced stress, although the difference was not statistically significant (*p* = 0.116) (Table 3). Caring for patients with COVID-19 was not significantly related to stress or anxiety.

DISCUSSION

The results of the study indicate that nursing students, whether they had entered clinical practice or not, experienced elevated levels of anxiety and stress during the first wave of the pandemic, especially unincorporated female students.

Several international studies have shown how the mental health of health science students worsened during the pandemic, with varying degrees of depressive symptoms, anxiety and stress (Alsolais et al., 2021; Aslan & Pekince, 2021; Ersin & Kartal, 2021; Kalkan et al., 2021). The lack of protective equipment reported in the study by Ersin and Kartal (2021) was a factor that increased the stress level of students because it was associated with an increased risk of infection.

In line with our results, another study found that the stress level of female students was higher than that of male students (Kalkan et al., 2021). Similarly, anxiety levels among female students were not only higher during the pandemic, but previous studies have already shown that anxiety levels among female students are higher than among male students under normal conditions (Savitsky et al., 2020). Moreover, among students who carried out their internships during the pandemic, women were found to have higher levels of stress and psychological difficulties in coping with their work (Eweida et al., 2020).

Studies carried out in the Spanish context indicate that, during the pandemic, nursing students were at greater risk of suffering mental health problems -specifically, twice as many- as their peers on the same course in previous years (Reverte-Villarroya et al., 2021). In Spain, students lived under great uncertainty due to the initial lack of clarity about the end of the course and how to assess the pending subjects (Ramos-Morcillo et al., 2020), as well as concern about the knowledge not acquired due to the interruption of their clinical practice, in line with what happened in other European countries (Bosveld et al., 2021). This is evidenced by the fact that unincorporated students reported higher levels of anxiety and stress.

The results suggest the possibility that, despite the potentially stressful experiences in healthcare institutions, those who started their careers perceived positive aspects of this incorporation that helped to reduce their levels of anxiety. In line with Roca (2021), despite the negative emotions and their consequences, they were able to develop coping strategies and saw the experience as a learning opportunity, reinforcing the feeling of being useful at a crucial time for public health.

However, for student nurses, although the experience of the pandemic may have contributed to reinforce their desire to become nurses (Ramos-Morcillo et al., 2020), other research found that high levels of anxiety led to greater reluctance to practice their profession in the future (Cici & Yilmazel, 2021).

On the other hand, the results suggest that the high levels of anxiety and stress could explain why some students decided not to join the profession. It is possible that, based on their high self-perceived levels of anxiety and stress, students decided not to participate in the work activity, making their self-care prevail at that moment, as final-year students were forced to choose between the option of being confined at home or starting their professional career under adverse conditions (Usher et al., 2020).

Although not significant, the students at University Z scored the highest on stress and anxiety. This could be explained by a possible delay in communication from the university on how to compensate for pending assessments and the offer of contracts by the regional health system.

It is worth reflecting on the suitability of interventions described in other countries to alleviate the psychological effects. For example, psychological support programmes for students (Cici & Yilmazel, 2021; Eweida et al., 2020) and nurses (Canet-Vélez et al., 2021), in order to help them cope with the fear, anxiety and stress caused by the pandemic and the resulting work situation, should focus on building resilience (Savitsky et al., 2020; Umeda et al., 2020) and the importance of taking care of oneself in order to care for the patients (Alvarez-Nieto et al., 2015).

Limitations

This study, due to its temporal nature, has not allowed us to determine how long the high levels of anxiety and stress lasted or whether there are currently any specific mental health problems in these students that have developed since the pandemic. It would therefore be interesting to analyse the medium- and long-term mental health consequences, such as post-traumatic stress disorder. Universities should protect the health and well-being of their students (Hayter, 2020) and address the possible emotional consequences by opening lines of research in this regard and implementing intervention programmes.

Among the strengths of the study are the geographical representativeness of three universities in different autonomous communities where students were incorporated into

clinical practice, providing a greater diversity of participant profiles, given that other studies in Spain have only been carried out in one territory territory (Casafont et al., 2021; Gómez-Ibáñez et al., 2020; Ramos-Morcillo et al., 2020; Roca et al., 2021). The data collection, between March and May 2020, allowed us to gather impressions very close to the moment of cessation of face-to-face teaching for the whole group of students and the moment of incorporation for the incorporated students.

CONCLUSION

The pandemic situation exposed nursing students to an additional level of anxiety and stress. Students in employment had lower levels of anxiety and stress. Among students entering the workplace, caring for infected patients without full supervision or adequate training in the use of protective equipment may have increased stress. However, this was possibly mitigated by the type of work performed as reinforcement and support to other nurses and the perception of feeling useful.

Our study found that stress and anxiety levels of nursing students were high during the pandemic, which should be taken into account by clinical practice nursing tutors. However, our results also showed the ability of nursing students who joined the workforce to cope with stress in exceptional situation such as the COVID-19 pandemic.

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Artículo 4

From students to nurses under pressure: Incorporation of nursing students into care activity during the first wave of COVID-19 in Spain.

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From students to nurses under pressure: Nursing students' entry into employment during the first COVID-19 wave

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Abstract

Aims and objective: To describe the experiences of nursing students and their mental health as they entered employment during the first wave of the COVID-19 pandemic (May–June 2020).

Background: As other healthcare professionals, nursing students who worked during the first COVID-19 wave suffered from dysfunctional mental health symptoms.

Design: Sequential, mixed-method, multicentre study.

Methods: The study population comprised 92 students in the third and fourth year of the Nursing degree at three Spanish universities, who entered employment during the pandemic. Data were collected between May and June 2020. In the quantitative phase, data were collected using an online questionnaire containing both validated anxiety and stress scales. In the qualitative phase, semi-structured interviews were conducted with 18 participants. A descriptive analysis of the quantitative data and a reflexive thematic analysis of the qualitative data were carried out, and analyses were combined. COREQ checklist was used for reporting.

Results: The combined quantitative and qualitative results were organised into five thematic areas: (1) Interruption of clinical placements, (2) Entering employment on a healthcare assistant contract, (3) Preventing contagion, (4) Adapting to the situation and managing emotions, and (5) Lessons learned.

Conclusion: The students had a positive overall experience of entering employment, as they were able to develop their nursing skills. However, they had an emotional impact in form of stress caused by excessive responsibility, academic uncertainty, lack of personal protective equipment and training in its use, and the possibility of spreading disease to their family members.

Relevance to Clinical Practice: In the current context, changes must be made in study programmes to instruct nursing students to be able to cope with extreme clinical

situations, such as pandemics. The programmes should include a more extensive coverage of epidemics and pandemics and management of emotional aspects such as resilience.

KEYWORDS
anxiety, COVID-19, mixed methods design, nursing students, stress

1 | INTRODUCTION

In March 2020, the WHO declared the outbreak of the novel coronavirus SARS-CoV-2 as a pandemic. Amid the ensuing public health emergency, teaching activity at educational establishments was suspended, including universities (Newell, 2020). The pressures placed on the health system by the COVID-19 outbreak made it necessary to reorganise healthcare activity to make more units available for treating infected people and to reduce or even suspend activities deemed to be non-essential. The shortage of material and human resources to meet demand prompted initiatives to recruit healthcare students and trainee specialists to assist in providing health care. Similar measures were adopted in several countries, including the United Kingdom (Swift et al., 2020). These measures provoked controversy in the academic world and in the healthcare sector (Swift et al., 2020), due in part to concerns over the conditions in which students would enter employment.

During the first wave of COVID-19, Spain recorded the highest number of infected professionals in the world, as there was a severe lack of personal protective equipment. At the end of March 2020, almost 14% of the reported cases involved healthcare workers (Royo, 2020). In June 2020, Spain was the third country in Europe in terms of the number of COVID-19 cases, which led to the collapse of healthcare resources. This made it necessary to redistribute hospital resources and relocate healthcare professionals. For instance, ICUs were expanded to double or triple their capacity (Miralles et al., 2021).

In this context, the national Spanish government approved *Order SND/232/2020 of 15 March containing measures to provide human and material resources to manage the public health crisis caused by COVID-19*. This norm stipulated that students in the final year of the Medicine and Nursing degrees could be recruited to the healthcare services in the different regions in the country on an immediate basis. Under the Order, the medical and nursing students were recruited as Healthcare Assistants, who would provide assistance in healthcare settings and were to be supervised at all times by a qualified healthcare professional. In subsequent weeks, nursing students, mostly in the fourth year of the Nursing degree or those who had finished their theoretical training and had only the bachelor thesis and their practical training left to complete (Aslan & Pekince, 2020), began to work in healthcare settings such as hospitals, nursing homes and medicalised hotels (Gómez-Ibáñez et al., 2020).

What does this paper contribute to the wider global community?

- Excessive responsibility, academic uncertainty, lack of personal protective equipment and training in its use, and the possibility of spreading disease were aspects that made nursing students who worked during the first COVID-19 wave suffer from dysfunctional mental health symptoms, leading to stress and anxiety.
- It is important to reinforce healthcare studies' curriculum to include more aspects on epidemics and pandemics and on emotional coping strategies to better deal with potential future similar situations.

2 | BACKGROUND

Nurses and nursing students faced professional and psychological challenges in providing care during the COVID-19 pandemic. Recent studies indicate that the risk of negative health impacts for nurses caring for patients during a pandemic was higher than for other healthcare professionals (Sun et al., 2020). When confronted with COVID-19, negative reactions, such as fear, anxiety and psychological distress, were frequently observed among health professionals (Majrashi et al., 2021). Studies have already been conducted on the emotional distress experienced by nurses during a health emergency (Xiao et al., 2020) and after the crisis has passed (Sun et al., 2020). In Spain, senior nursing students who experienced the COVID-19 pandemic reported an increased risk of mental health problems after the pandemic (Reverté-Villarroya et al., 2021).

However, both positive feelings (desire to help, opportunity to learn, affirmation of professional identity, sense of self-growth) and negative feelings (fear of becoming infected and concern about their inadequate psychological preparation for practice in clinical settings) have been reported, particularly during unexpected situations such as the COVID-19 pandemic (Luo et al., 2023; Sun et al., 2020; Velarde-García et al., 2021).

Spanish studies on students' experiences as healthcare assistants highlight the emotional intensity of the experience, which aroused contrasting emotions such as pride, fear, sadness, anger and powerlessness, with fear and uncertainty emerging as the most prevalent emotions (Collado-Boira et al., 2020). Students were also concerned

provided, rather than on the mental health part of the experience. This also helps to reinforce the confirmability of the qualitative results, which include verbatim descriptions that support the content of each category. In terms of transferability, although a detailed description of the context has not been provided in order to preserve the anonymity of the universities and participants, given the similarities of the results compared to the literature on the topic in different settings, the reader can decide whether or not the results are transferable to other specific contexts based on the wealth of information provided.

Pair coding was employed and the researchers who created the codes met to discuss differences and resolve any discrepancies that arose. In this way, the coherence of the data and categories was discussed with the whole research team involved in the analysis.

Data triangulation was used to improve the validity and reliability of the research, gathering information from nursing students at different universities in different geographical regions to obtain multiple perceptions of the same reality. Methodological triangulation was also used to contrast and supplement the results obtained using quantitative and qualitative instruments.

4 | RESULTS

In the quantitative phase, 92 students from the three universities (X, Y, Z) who had started working as healthcare assistants responded to the questionnaire (42.6% of the respondents). All students who had completed their theoretical training and had only their bachelor theses and practical training to complete were invited to participate. As a result, third-year students of the Nursing degree ($n=7$), fourth-year students of the Nursing degree ($n=81$), and fifth-year students of the Nursing and Physiotherapy degree ($n=4$) participated in this phase. In the qualitative phase, 18 of these participants were interviewed (13 women and 5 men). The participants had a median age of 21 (age range: 23–21). Table 2 shows the composition of the total sample ($n=92$) and of the participants for the qualitative interviews ($n=18$).

The overall results were organised into five categories: (1) Interruption of clinical placements, (2) Entering employment on a healthcare assistant contract, (3) Preventing contagion, (4) Adapting to the situation and managing emotions, and (5) Lessons learned.

4.1 | Interruption and suspension of clinical placements

72.8% ($n=67$) agreed with the suspension of the clinical placements. The positive impacts of the interruption of the clinical placements identified by the students were as follows: protecting students/preventing contagion/preventing them from becoming vectors of contagion (51.1%, $n=47$); having more time to dedicate to their bachelor theses, work/study and/or preparation for the Resident Nursing Intern (EIR) examinations (22.8%, $n=21$); and avoiding putting family members or cohabitants at risk (9.8%, $n=9$).

Among the negative impacts of the suspension of the clinical placements, 76.1% ($n=70$) highlighted the loss of opportunities to acquire relevant knowledge, skills and experience of providing care, followed by uncertainty (16.3%, $n=15$), and the academic work that they were required to complete to pass the clinical placement (16.3%, $n=15$).

52.2% ($n=48$) of the participating students believed that the university had handled the situation appropriately, while 47.8% ($n=44$) considered the university's management to have been inadequate. They stated that they would have preferred more information about what was happening and that communication should have been more fluid and direct to avoid uncertainty (21.7%, $n=20$).

The qualitative data showed that students considered the suspension of the planned clinical placements to have been too sudden, giving rise to uncertainty regarding the possibility of graduating that year after failing to complete the number of clinical credits required under current legislation. This uncertainty was heightened or diminished depending on the flow of communication between the students and the university. Meanwhile, being unable to complete their clinical placements in the planned units was viewed as an obstacle to the students' training, especially for those who were scheduled to complete their placements at specialist departments such as Critical Care Units, Operating Theatres or Emergency Departments. In addition to the suspension of clinical placements, the conditions in which the students would complete their bachelor theses were another source of concern.

> It's like we've completely slowed down; it makes you feel uncertain about the future too, not knowing what will happen; or when we didn't know at the beginning if we'd graduate in June or what would happen with our bachelor theses. In the end, it makes you

TABLE 2 Composition of the sample of participants.

	Participants in the quantitative phase			Participants in the qualitative phase		
	Total	Women	Men	Total	Women	Men
University X	23	22	1	7	7	0
University Y	24	17	6	6	4	2
University Z	45	38	7	5	4	1

> feel really tense and uncertain, a bit overwhelmed sometimes…
>
> (E2, Y)

4.2 | Nursing students' entry into employment

The decision to begin working in health care earlier than planned in the midst of a pandemic may be explained by students' sense of moral responsibility. After completing the majority of their academic training, they believed that they could make an active contribution ('help') to this critical public health emergency.

> As soon as the pandemic and the public health crisis began, because I saw that I could, I wanted to help because I felt that I could make a contribution and that many people wanted to help and couldn't. Having studied, well, being in the middle of studying for this degree, I felt that I needed to help and that I couldn't stay at home all day writing my bachelor thesis and watching stuff on TV constantly about the health crisis that was happening
>
> (E3, X)

Table 3 shows the conditions in which the participants entered employment.

4.2.1 | Recruitment

Of the 92 students who entered employment in the clinical setting, 51.1% ($n=47$) were notified 1 day before starting work, while 29.3% ($n=27$) received at least 1 week's notice. 83% had started work more than 15 days before the study began. The duration of the temporary contracts they had been offered ranged from contracts by days to contracts lasting until the end of the state of emergency.

> Yes [I started work before signing the contract]; actually, I signed the contract quite late, after about two weeks or something like that.
>
> (E3, Y)

> I felt a bit hesitant about working without signing the contract […] I spent about two days in limbo, but I also found it reassuring to see what I was going to come up against before signing or officially committing to the job
>
> (E5, X)

53% ($n=44$) were offered contracts as healthcare assistants or nursing assistants, while others signed (47%, $n=39$) as nurses or assistants. 66.7% of the participants at X and 60% at Y were recruited as healthcare assistants, while the most common role at Y was that of nurses (50.0%). These differences are statistically significant ($p=.046$).

4.3 | Working conditions

The departments where students worked ranged from inpatient wards to medicalised hotels, field hospitals, Critical Care Units, Emergency Departments, COVID-19 screening facilities and mental health units.

The quantitative data show significant differences ($p=.004$) between universities in terms of the departments where students worked: Medicalised hotels were the most common facilities recruiting students from X (23.8%), nursing homes from Y (52.4%) and inpatient wards from Z (57.5%).

> So, I went to the medicalised hotel in (location) and I went to speak to the supervisor. She explained everything and told me: "OK, you can start tomorrow"
>
> (E3, X)

The majority of the participants (56.6%) from the three universities provided support to another nurse. This difference was statistically significant ($p=.029$). However, 40.9% of the students at Y were fully responsible for the patients in their care. In the interviews, the students described a variety of situations in which their involvement depended on the facility's workload, ranging from providing support to other nursing professionals to taking on nursing work without direct supervision.

> It was just supporting the nursing staff, staying in the corridors to offer help if the nurses had to do a test on the patients, maybe you'd hold the bag so that they could insert the tubes or change a diaper, you'd pass them things from the corridor to the room so that they didn't have to leave the room all the time and remove their PPE (personal protective equipment)
>
> (E10, X)

> The first week at the hospital, I did work as an assistant, but… in the end, I spent three days doing the work of a nurse. I remember that worried me quite a lot because I knew that my contract didn't include those tasks
>
> (E5, Z)

In situations of excess workload, students were asked to carry out tasks unsupervised, taking full responsibility for the care of patients, some of whom had COVID-19. When the workload was lower, nursing professionals attempted to protect the students as far as possible by avoiding direct exposure to patients with COVID-19.

> I got dressed, I went in and they said: 'Look. These two patients will be yours, they're pretty easy'. You're listed as a nurse so they keep an eye on you but your patients are your patients
>
> (E13, X)

TABLE 3 Characteristics of participants' entry into employment by university[b].

		Total	Univ. X, *n* (%)	Univ. Y, *n* (%)	Univ. Z, *n* (%)	Lost to follow-up	*p*[c]
Entered employment in health care before completing their degree	Total	92	23 (25%)	24 (26.1%)	45 (48.9%)	0	–
	Men	14	1	6	7	1	
	Women	77	22	17	38		
	No response	1	–	1	–		
Time spent in employment	1–6 days	6 (7.4%)	1 (4.8%)	5 (25%)	–	11	.001
	7–14 days	7 (8.6%)	–	4 (20%)	3(7.5%)		
	15 days to 1 month	14 (17.3%)	2 (9.5%)	1 (5%)	11 (27.5%)		
	More than a month	54 (66.7%)	18 (85.7%)	10 (50%)	26 (65%)		
Role indicated on contract	Nursing assistant	16 (19.3%)	3 (14.3%)	5 (22.7%)	8 (20%)	9	.046
	Nurse	23 (27.7%)	4 (19.0%)	11 (50.0%)	8 (20.0%)		
	Healthcare assistant	44 (53%)	14 (66.7%)	6 (27.3%)	24 (60%)		
	No response	9	2	2	5		
Department	Medicalised hotels	6 (7.32%)	6 (23.8%)	1 (4.8%)	–	10	.004
	Field hospitals	1 (1.22%)	–	–	1 (2.5%)		
	ICU	8 (9.76%)	2 (9.5%)	1 (4.8%)	5 (12.5%)		
	Emergency Dept.	4 (4.88%)	1 (4.8%)	–	3 (7.5%)		
	Inpatient ward[c]	4 (51.21%)	11 (52.4%)	8 (38.1%)	23 (57.5%)		
	Other healthcare facilities[a]	21 (25.61%)	2 (9.5%)	11 (52.4%)	8 (20%)		
	No response	10	2	3	5		
Provided care for confirmed or suspected COVID-19 patients	Yes	70 (84.3%)	19 (90.5%)	16 (72.7%)	35 (87.5%)	9	.464
	No	10 (12.0%)	1 (4.8%)	5 (22.7%)	4 (10%)		
	Other	3 (3.6%)	1 (4.8%)	1 (4.5%)	1 (2.5%)		
	No response	9	2	2	5		
Type of work	Support for other nurses	47 (56.6%)	11 (52.4%)	10 (45.5%)	26 (65.0%)	9	.029
	Full responsibility for patients	20 (24.1%)	2 (9.5%)	9 (40.9%)	9 (22.5%)		
	Other	16 (19.3%)	8 (38.1%)	3 (13.6%)	5 (12.5%)		
	No response	9	2	2	5		
Received specific information on protection from contagion	Yes	34 (42%)	12 (57.1%)	8 (40%)	14 (35%)	11	.245
	No	47 (58%)	9 (42.9%)	12 (60%)	26 (65%)		
	No response	11	2	4	5		
Had access to necessary protective measures	Yes	44 (54.3%)	12 (52.1%)	13 (65%)	19 (47.5%)	11	.759
	No	23 (33.3%)	7 (33.3%)	5 (25%)	15 (37.5%)		
	Other (yes, but not always/ sporadically)	10 (12.3%)	2 (9.5%)	2 (10%)	6 (15%)		
	No response	11	2	4	5		

(Continues)

TABLE 3 (Continued)

		Total	Univ. X, *n* (%)	Univ. Y, *n* (%)	Univ. Z, *n* (%)	Lost to follow-up	*p*[c]
Number of patients cared for per shift	<5 patients	6 (7.8%)				15 (16.3%)	.334
	6–10 patients	21 (27.3%)					
	11–20 patients	25 (32.5%)					
	21–30 patients	5 (6.5%)					
	31–40 patients	2 (2.6%)					
	41–50 patients	4 (5.2%)					
	51–60 patients	1 (1.3%)					
	61–70 patients	2 (2.6%)					
	>81 patients	4 (5.2%)					
	Support role, no specific patients in their care	2 (2.6%)					
	Whole ward	5 (6.5%)					

[a]Nursing homes + COVID-19 screening facilities+mental health units.

[b]Used descriptive statistics: frequency and percentage for the categorical variables; mean and standard deviation for the quantitative variables. The chi-squared statistical test was applied to assess the differences between universities of the categorical variables. For those variables where the expected cell size was <5, Fisher's exact test was used.

[c]A significance level of 5% was considered throughout the analysis.

> I was meant to be providing general support to anyone who needed it, but that was impossible in practice because there weren't enough professionals to keep an eye on you. So, I asked about anything I didn't know, but I was quite independent.
>
> (E3, Z)

In other cases, direct care for patients with COVID-19 fell entirely to qualified nurses and students were only asked to complete auxiliary tasks, reducing the risks to which they were exposed.

84.3% of the students ($N = 70$) cared for patients with confirmed or suspected COVID-19, with no statistically significant differences between universities ($p = .464$). 56.6% ($n = 47$) provided support to other nurses and 24.1% ($n = 20$) had patients for whom they were solely responsible, while four students had full responsibility for patients only when there was a shortage of personnel or during the night shift, with the situation changing over time.

The students' workload varied: 27.3% ($n = 21$) cared for 6–10 patients per shift, while 32.5% ($n = 25$) cared for 11–20 patients per shift. The shifts ranged from 4 to 13 hours, although the majority (56.1%, $n = 46$) were equal to or <7 h.

4.4 | Support received

With regard to the support they received, 67% ($n = 55$) of the students stated that they did not receive support from any institution. Those who had received support highlighted the role of their university in particular.

81.5% ($n = 75$) had felt welcomed by their colleagues in the professional setting. They emphasised positive aspects such as a warm welcome to the team (37%, $n = 34$), receiving help and advice (21.7%, $n = 20$), and coordination between colleagues (10.9%, $n = 10$). 8.7% ($n = 8$) stated negative aspects such as the belief that students would increase the professionals' workload/were not useful (7.6%, $n = 7$).

> As the days went by, I got used to working at the hospital, because of my colleagues especially, who gave me a really warm welcome and supported me, so, in the end, it was good
>
> (E2, Y)

4.5 | Consequences

Among the 19 negative aspects identified in relation to students entering employment before completing their degrees and during a public health crisis, the participants highlighted the lack of legal backing/lack of membership of an official nurses' association (17.4%, $n = 16$); temporary contracts with poorly defined roles (17.4%, $n = 16$); fear (17.4%, $n = 16$); uncertainty, anxiety, stress and lack of psychological preparation (18.5%, $n = 17$); lack of confidence and knowledge due to the failure to complete training (14.1%, $n = 13$); and risk of catching the disease or of infecting others (9.8%, $n = 9$).

The qualitative data show that entering employment as a student on a healthcare assistant contract rather than as a nurse, receiving

inadequate information about their role and department or the type of patients they would be caring for, and having to start work before reading or signing the contract gave rise to mistrust and distress among the students. The participants described the way in which their recruitment was organised as chaotic, sudden and lacking safeguards on some occasions. They also missed the protection that they would have received from the Official Nurses' Associations had they entered employment in the health system as nurses rather than students. The students on healthcare assistant contracts explained that they were taking more responsibility than that stipulated in their contracts.

> You have more responsibility than you're meant to because you don't have an Official Nurses' Association to protect you or to provide legal support if you have a problem, and your salary doesn't correspond to your level of responsibility
>
> (E13, X)

4.6 | Preventing contagion

42% ($n=34$) of the students did not receive any kind of specific training on protecting themselves from contagion. The types of training mentioned were explanations from hospital colleagues, university training, online searches on the students' own initiative and online courses. 45.7% ($n=42$) said that they had required specific information and training on the theory and practice of personal protective equipment (PPE; putting on and removing PPE).

The students who had received information on handling PPE had done so at different times in their entry into employment. However, they viewed the information they were given as inadequate or insufficient in terms of the content or timing. In some cases, informal training was provided by nursing colleagues at the department. In others, students missed out on training as they started work after the training had been offered.

> In my view, the training I received on protecting myself from a disease that could kill me was a complete joke. I really don't think it's fair for us to receive such brief training given the situation we're going into. I'm talking about the hospital providing you with formal training then washing its hands of the matter, because your colleagues train you quite well
>
> (E13, X)

> We got to the hospital and they told us: 'you can start', without explaining the situation the hospital was in at the time and the protocols in place on how to protect ourselves
>
> (E2, Y)

54.3% ($n=44$) thought that the protection measures in place were sufficient to allow them to work safely, although 26.1% ($n=24$) needed more materials/more PPE/more gloves to avoid having to reuse them, 6.5% ($n=6$) complained of insufficient equipment, and 3.3% ($n=3$) observed ineffective PPE or PPE in poor condition.

> I mean, mine do. I don't come into contact with any COVID patients, I'm given an FFP3 mask when I get to work. If I arrive tomorrow morning and they tell me there aren't any FFP3 masks or you have to wear a surgical mask, I'll say 'sorry, I'm going home'. I'm very clear on all of that. But I'm alright, the problem is that my colleagues, I don't know if you've seen on the news but the PPE is running out and they have to reuse it. There comes a point when they're wearing bin bags in the ICU
>
> (E1, Y)

> The PPE was the same as for all the patients, even when we didn't have much left. They told us we'd have to remove the PPE and put it on a hanger or hold it in case we needed it to go into the patient's room again to… there wasn't any more; so, we'd spray disinfectant on it, but there wasn't any more, we had no choice but to reuse it.
>
> (E16, Z)

In situations in which the students had to provide care for patients with COVID, the use of PPE was perceived as stressful, especially when it came to removing it as incorrect handling carried a high risk of contagion. Sometimes, there was a lack of protective equipment. The participants also emphasised the after-effects of the use of PPE.

> Then you had to be careful when taking it off [the PPE] because it was all dirty, so everyone would take it off in their own way, and me, in my training I was told I had to take it off like this, but then on the ward, they took it off a different way, and the first time I took the PPE off, I don't know how I didn't get COVID then and there. Because everyone was telling me something different. I took it off as best I could, as best I knew how. […] The first time was really, really bad. I think I showered three times when I got home that day, just in case.
>
> (E10, X)

4.6.1 | Strategies to avoid contagion

45.7% ($n=42$) of the students stated that they had experienced fear of contagion on some occasions, while 29.3% ($n=27$) experienced it frequently. Meanwhile, fear of infecting their relatives or cohabitants was 'always' present for 33.7% ($n=31$) of the students, and frequently present for 21.7% ($n=20$). The interviews showed that

the students were aware of the virus's potential to cause disease and death, as they had seen the consequences of infection for patients first-hand. Despite this, they did not tend to fear getting infected themselves as they viewed it as a risk inherent to the nursing profession; their main fear was acting as a vector of contagion for their family members. Overall, the students' fear of catching the disease themselves or infecting their families diminished over time as their confidence that they were applying protective measures correctly grew.

The interviews revealed the strategies used by the students to avoid contagion. These strategies were implemented from the very beginning. One example was 'using all six senses' when coming into contact with patients to avoid carelessness. Whenever the situation allowed, direct contact with patients was limited as much as possible by using other forms of communication that did not require face-to-face interaction and grouping together tasks involving direct contact with the patient to limit exposure. In departments where this was not possible (e.g. the ICU), they followed the established guidelines, maintaining a distance from patients, distributing tasks by contact time with patients and alternating these tasks with breaks. They also constantly disinfected the equipment and avoided contact with surfaces. In some ICUs, the students had less contact with patients and spent most of their time preparing medication.

Beyond the workplace, some participants stayed in a hotel for healthcare personnel or a flatshare with other nurses in order to keep a distance between them and their family members or cohabitants. They remained in these locations until the end of the lockdown out of fear of infecting vulnerable people in their households. Keeping clothing or shoes solely for the workplace, using gloves and protective equipment intended for the hospital setting outside it, and showering upon returning home were also common practices.

> When I was working, I moved out of my home to avoid infecting my parents, just in case.
>
> (E11, X)

> I 'isolated' in the downstairs flat in my house in an attempt to cope with my fear of infecting my family, because that was almost the worst part of it all. More than the possibility of catching it myself, the idea of passing it on to them
>
> (E5, X)

4.7 | Emotional management

The emotional impacts most commonly cited by the students were stress, with 25% ($n=23$), and anxiety, with (15.2%, $n=14$; Table 4). The overall anxiety levels were (M = 35.67; SD = 5.78), and the stress level was (M = 80.01; SD = 28.92).

TABLE 4 Symptoms of emotional distress identified among participants.

Variable	*N*	%
Stress	23	25
Anxiety	14	15.2
Overwhelm	8	8.7
Insomnia/difficulty sleeping	8	8.7
Excessive empathy with patients and/or family members	8	8.7
Sadness	7	7.6
Fear	5	5.4
Fatigue	5	5.4
Uncertainty	4	4.3
Concern for own family	4	4.3
Despondency	4	4.3
Irritation/frustration	3	3.3
Concern over situation and future	2	2.2
Powerlessness	2	2.2
Anger	2	2.2
Overload	2	2.2
Loneliness	1	1.1

4.7.1 | Anxiety

33.7% ($n=31$) felt more nervous and anxious than usual sometimes, while 28.3% ($n=26$) felt this way quite frequently. 34.8% ($n=32$) experienced palpitations, 13.0% ($n=12$) dizziness, 31.5% ($n=29$) stomach aches or indigestion, 20.7% ($n=19$) high urinary frequency, 23.9% ($n=22$) dry and warm hands, 25.0% ($n=23$) face flushing, and 30.4% ($n=28$) nightmares. In the interviews, the students mentioned having problems falling asleep.

> Emotionally, it does affect you to some degree. I've had trouble sleeping sometimes, I've had nightmares, I don't know, not many, but since I joined the ICU especially, I've seen things that I don't like seeing, but I mean, that's also because I'm new there.
>
> (E3, X)

4.7.2 | Stress and emotional exhaustion

With regard to stress, 54.4% ($n=50$) of the participants felt worried frequently or very frequently. Other frequent or very frequent symptoms were sleeping (29.4%, $n=27$) and concentration difficulties (26.1%, $n=24$). 27.2% ($n=25$) experienced these symptoms for 5 days or more. The interviews revealed that, especially in the first few weeks after starting work, the students reported suffering stress and feelings of powerlessness as a result of their excessive workload. This was exacerbated by personnel shortages, the

complexity of the patients' conditions, the need to group interventions and adopt new habits, and numerous instances of therapeutic failure.

> I found the whole situation of being distanced from the patients and not being able to offer the support we usually give them stressful.
>
> (E2, Y)

> At the start, it was more or less OK but you also have that stress, a bit more emotional stress because of what's happening, because of the situation, because you're there at the hospital... So there came a point when, if I had to work seven or eight days in a row, five or six, however many, in the end there came a point when I was a bit physically and mentally tired.
>
> (E7, Y)

4.7.3 | Emotional distress

The students experienced distress and sadness at the solitude and isolation that they perceived patients to experience in hospital, as well as after witnessing patient deaths.

> Seeing that really affects you, when you see your first [cardiorespiratory] arrest, because I'd never seen an arrest with CPR and the first one was a very, very young girl who didn't make it in the end; so for me, that case in particular, as always, it really got in my head, it really got under my skin, so I was still processing that a bit emotionally.
>
> (E15, X)

> Of course, it's tough seeing people go to say goodbye to someone, their wife going to say goodbye and then her being admitted too. When the children come, you have to prepare them, dress them in PPE, all that to go and say goodbye, you say 'Damn. It's really cold-hearted having to use all the protective equipment, the masks, the coveralls, the goggles...' But it's the situation we have to deal with.
>
> (E 18, Y)

> Having to wear something over the top, having to face up to difficult situations, having to be so careful, not being able to approach people because no matter how much protection you have you're still afraid of getting infected, so you don't want to get too close but you also don't want to be too distant because, hell, they're alone. You know? And you want to show them a bit of affection but you also have to look out for yourself. [...] I don't know, there were a lot of mixed feelings.
>
> (E 11, X)

The participants also mentioned their anger at witnessing irresponsible behaviour from the general public, who appeared not to be aware of the consequences of their actions as they contravened public health recommendations and put themselves at risk. They believed that these behaviours could give rise to further situations such as those that they had experienced at the hospitals, which stayed with them even after the end of the working day. Participants whose loved ones had had COVID experienced an even greater sense of fear.

The new habits adopted by the participants to prevent contagion, such as washing when arriving home or avoiding physical proximity with their cohabitants, required a process of adaptation and provoked emotional distress.

> It was like, if you were on the sofa, you'd sit in a corner to keep a distance just in case. Even though I was 70% certain that I'd already had it and him [my father] too and that I'd disinfected everything well, I didn't want to get too close to him just in case.
>
> (E11, X)

> When you got out of work, you felt like... 'have I done it all properly? Am I clean enough to leave and go home?' You had those doubts and that uncertainty of not knowing what you had on you. When I got home, I'd take off all my clothes in the entrance, put them in the wash and head straight to the shower. In the first few days, I had those fears [...] as the days passed, I knew I was doing it right. So I'd get home and I wouldn't have that same fear as I walked inside.
>
> (E6, Z)

> At the start especially, it was really tough because I was living at home with my parents and my brother and I had to come here and I was alone, the uncertainty of not knowing when I would see them again, being here alone, having to organise everything myself, it was difficult, but oh well...
>
> (E2, Y)

4.7.4 | Satisfaction

The participants also reported positive emotions aroused by perceived gratitude from patients. The fact that the people they were caring for were so dependent on their care enhanced their sense of capability and responsibility.

> The positive aspect was that I feel really proud now thinking that I was able to contribute in some way, no matter how small, to improving this situation
>
> (E5, X)

> I mean, I'd go home feeling grateful for having the opportunity to work in this situation that we've been thrown into and for being able to help. I felt good about myself
>
> (E3, X)

> Then, as well as getting involved, after watching on TV the whole time we were there, all the healthcare professionals' work, and from the first day, I started work at 8:00 but I got out at 20:00 and I saw the first round of applause. Oh my God, I just started crying. I thought 'this can't be happening': the people in the flats opposite were coming out onto the balconies and yeah, it was really emotional, so I was already affected by the situation in my head, because you were seeing it from the outside and then suddenly you're seeing it from the inside
>
> (E13, X)

4.8 | The transition to professional life: Lessons learned

Among the positive aspects of entering employment before completing their degrees and during a public health crisis, the students highlighted: acquiring greater experience and knowledge (28.2%, $n=61$), pride at having been able to help (7.9%, $n=17$), and team spirit (4.2%, $n=9$), followed by greater responsibility and autonomy (3.7%, $n=8$), improved self-confidence (3.2%, $n=7$), and greater emotional resilience (2.8%, $n=6$).

In professional terms, the students felt very proud of their contribution to improving public health and their patients' conditions. Once they had finished working as healthcare assistants, they perceived an improvement in their nursing skills as they had delivered care under constant pressure and their ability to care for critical patients had increased. In addition, their capacity to manage the emotions deriving from their work had improved and they had been able to reflect on the ethical dilemmas they faced during that time. Although they did not forget the stressful circumstances in which they learned these lessons, some students found the knowledge that they acquired during their experience as healthcare assistants positive, as their work represented a continuation of their supervised clinical placements, while offering a greater degree of responsibility for patients. This allowed them to gain confidence in their role as nurses, consolidating knowledge of complex care and improving their ability to build relationships with patients or their team.

> Now, when my classmates start work they're really nervous, as I would be too in that situation, and now I think 'if I can do it, so can they'. Even so, now, when I start work as a nurse, I think it's going to be even worse because I knew that I had responsibilities but there was always a legal loophole – you hire me as an assistant and have me working as a nurse – to back me up if necessary, but not anymore. Now you're 100% responsible by law
>
> (E8, X)

> It was work experience that we got early on and that you don't get from the clinical placements, even if you do an extra year; what I got out of that month, I'd never have got it any other way. I mean, I've done real work without a nurse supervising me. I've seen what it's really like to work as a nurse.
>
> (E1, Y)

> I think starting work amid the madness of a public health crisis has been very positive for me professionally, because ultimately you can see how you perform. [...] It's also been positive because I've learned a lot and I've been able to really get involved.
>
> (E3, Z)

5 | DISCUSSION

This study has shown that during the first wave of the COVID-19 pandemic from March to May 2020, the participating nursing students began to work in healthcare settings, mostly on healthcare assistant contracts, out of a desire to help in this emergency situation. Although they had a positive experience in terms of professional training, there was also a significant emotional impact in the form of anxiety, stress and worry caused by uncertainty over completion of the academic year, lack of information about their contracts and responsibilities, and the possibility of infecting their family members.

The participants perceived an improvement in their nursing skills after entering employment, as well as an increase in their confidence and knowledge of complex care. Their experience also enabled them to handle different moral and ethical dilemmas (Bosveld et al., 2021) and to carry out tasks related to critical or dying patients, which they had never experienced previously, which is a critical aspect of nursing practice. As reported in our results, recent studies have explored the experiences of nursing students recruited as healthcare assistants in Spain, highlighting the value of this period in allowing them to gain clinical experience and build self-confidence in conditions where they had less professional responsibility (Casafont et al., 2021; Velarde-García et al., 2021), as well as the emotional intensity of the experience, which aroused ambivalent emotions such

as pride, sadness, anger, and powerlessness, with fear and uncertainty being the most prevalent feelings (Collado-Boira et al., 2020). Studies in different settings emphasise that allowing students to work in healthcare settings during a pandemic can have a beneficial effect on the formation of their professional identity (Bank & Wijnen-Meijer, 2020), as well as reinforcing their sense of professional belonging and increasing their feelings of pride and privilege at having been able to help (Gómez-Ibáñez et al., 2020).

Nurses' professional identity is linked to the motivation and vocation to help others. Therefore, during the pandemic, students wished to make a significant contribution to patient care and support frontline healthcare personnel (Bank & Wijnen-Meijer, 2020). To do so, they had to choose between their professional and ethical commitment and their risk of infection (Eweida et al., 2020), weighing up the risks and benefits of working on COVID wards. Despite their good will, they may have felt some degree of pressure to support efforts to provide health care during the COVID-19 pandemic (Swift et al., 2020). Like in our results, some studies in European settings suggest that the COVID-19 pandemic has shown that students can take more responsibility (albeit under supervision) in caring for patients at the start of their clinical placements (Bosveld et al., 2021). In addition, excessive workload on the part of the person allocated to supervise them may put the student, their colleagues and patients at risk (Bank & Wijnen-Meijer, 2020).

Several studies have shown that, among Health Sciences students, the fear of infecting people close to them was greater than their fear of catching the disease themselves (Cervera-Gasch et al., 2020; Cici & Yilmazel, 2020; Eweida et al., 2020; Gómez-Ibáñez et al., 2020), which is corroborated by this study. As in other contexts, not having the necessary equipment considerably increased stress levels among the students (Ersin & Kartal, 2020), as did their lack of perceived competence in handling protective clothing (Bank & Wijnen-Meijer, 2020). The fact that half of the nursing students perceived the protective measures available to them as sufficient in protecting themselves from contagion may owe to their role primarily being as healthcare assistants, which placed them on the second line of care for infected people (or made it more likely that they would not be on the frontline).

Like the participants in this study, other Spanish nursing students expressed fear and anxiety in the first few days after starting work, uncertainty regarding their roles and responsibilities, insecurity, and lack of confidence in their professional abilities (Gómez-Ibáñez et al., 2020). The participants expressed uncertainty due to the lack of information about their contracts and responsibilities, the lack of supervision, and the lack of specific training on safety aspects. These experiences and uncertainty had an impact on their health, giving rise to physical (sleep disturbances) and emotional (stress, anxiety, fear) issues similar to those reported in other national (Obando Zegarra et al., 2020) and international studies (Cici & Yilmazel, 2020; Eweida et al., 2020; Savitsky et al., 2020). The results also showed that the students' uncertainty and fear diminished over time (Gómez-Ibáñez et al., 2020; Ramos-Morcillo et al., 2020).

In other countries, such as China, nursing students showed 34.97% prevalence of anxiety (nearly 8% of students reported moderate or severe anxiety), 40.22% prevalence of depression (more than 12% reported moderate or major depression) and 4.97% prevalence of post-traumatic stress during the pandemic (Li et al., 2021). Another study in the country also found that health students reported higher levels of anxiety compared to students in other university degrees (Yang et al., 2021). However, a study conducted in Saudi Arabia (Alsolais et al., 2021) found that nursing students reported some degree of depression, anxiety and stress. In turn, a qualitative analysis of tweets from nursing students in the United Kingdom, the United States and South Korea (De Gagne et al., 2021) indicated that emotions such as stress, fear, anxiety and uncertainty about their academic future were more directly communicated as time progressed, confirming that the pandemic was associated with student distress.

In order to alleviate the psychological effects described, several studies have highlighted the need to prepare students via psychological training programmes and to develop support systems for future work in pandemic circumstances (Cici & Yilmazel, 2020; Eweida et al., 2020), with a particular focus on training in resilience (Lorente et al., 2020; Savitsky et al., 2020; Umeda et al., 2020) and the importance of self-care in enabling care for others (Pérez-Moreno et al., 2020). With regard to the strategies used by students to cope with the situation, psychological distress was mitigated by the adoption of self-care practices and physical exercise (Gallego-Gómez et al., 2020).

5.1 | Implications

In the current context, it has become particularly important to cover epidemics and pandemics in greater depth in study programmes, as well as to provide more extensive training equipping students with knowledge and skills relating to caring for patients with COVID-19 (Bosveld et al., 2021). Adequate preparatory learning and training in knowledge and skills relating to caring for patients with COVID-19, provision of all necessary PPE, adequate insurance and appropriate economic compensation for students' efforts are prerequisites for students in the healthcare professions to begin working in healthcare settings (Bosveld et al., 2021). Training on emotional aspects such as resilience is also important in enabling students to cope better with similar situations in the future (Lorente et al., 2020; Umeda et al., 2020).

5.2 | Limitations

This study has a series of limitations. The sampling technique used for the quantitative part could have affected the representativeness of the participants, since, by not using a random sample, students who voluntarily decided to participate may have been partly motivated to do so due to higher or lower levels of affect than the other

students. However, the three universities were selected on the basis that they were located in autonomous regions where students had begun working in healthcare settings, in order to obtain a broader sample with some degree of geographical representativeness, unlike other studies conducted in the Spanish context, which focused on a single region (Casafont et al., 2021; Gómez-Ibáñez et al., 2020; Ramos-Morcillo et al., 2020).

The fact that the interviewers were lecturers may have introduced some degree of social desirability bias among the interviewees, especially during the qualitative phase. To mitigate this effect, the interviews were carried out by lecturers who did not have a direct academic relationship with the students at that point in time.

As the data collection process took place between March and May 2020, the students' accounts were gathered very near the start of their employment. It would be interesting to analyse the consequences for mental health in the medium and long term, as well as the impact on the professional careers of the students who had their first experience of work during the pandemic.

6 | CONCLUSIONS

During the first wave of the COVID-19 pandemic, nursing students played a part in providing health care and showed great professionalism. Allowing students in the final years of their degrees to enter employment in healthcare settings, as healthcare assistants in particular, was beneficial for their training in responding to public health crises, for fellow nurses who received support amid a shortage of qualified personnel, for the rest of the healthcare team, and for patients themselves, who had a larger number of nursing professionals to care for them in a context of significant shortages. Although the students' attitude is praiseworthy and indicative of their professionalism, universities have a moral and legal duty to protect their students' health and wellbeing, as well as to deal with the emotional consequences of this work for nursing students.

7 | RELEVANCE TO CLINICAL PRACTICE

Considering the current worldwide situation, a more extensive coverage of epidemics and pandemics must be included in healthcare degree study programmes. In addition, emotional aspects such as resilience should also be reinforced to ensure that nursing and healthcare degree students, and then as professionals, are able to cope better potential epidemic and pandemic clinical situations in the future.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and participated substantially in at least one of the following steps: Conception and design of the study; data collection, analysis and interpretation; drafting the article and revising it critically.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author (IPU), upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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APPENDIX 1

The Zung Self-Rating Anxiety Scale (1971)

	None OR A little of the time	Some of the time	Good part of the time	Most OR All of the time
1. I feel more nervous and anxious than usual				
2. I feel afraid for no reason at all				
3. I get upset easily or feel panicky				
4. I feel like I'm falling apart and going to pieces				
5. I feel that everything is all right and nothing bad will happen				
6. My arms and legs shake and tremble				
7. I am bothered by headaches, neck and back pains				
8. I feel weak and get tired easily				
9. I feel calm and can sit still easily				
10. I can feel my heart beating fast				
11. I am bothered by dizzy spells				
12. I have fainting spells or feel like it				
13. I can breathe in and out easily				
14. I get feelings of numbness and tingling in my fingers, toes				
15. I am bothered by stomach aches or indigestion				
16. I have to empty my bladder often				
17. My hands are usually dry and warm				
18. My face gets hot and blushes				
19. I fall asleep easily and get a good night's rest				
20. I have nightmares				

APPENDIX 2

The Stanford Acute Stress Reaction Questionnaire (SASRQ) (2000)

- Description of the event
- How disturbing was this event to you?
  - ○ 0. Not at all disturbing
  - ○ 1. Somewhat disturbing
  - ○ 2. Moderately disturbing
  - ○ 3. Very disturbing
  - ○ 4. Extremely disturbing

1- Not experienced **2- Very rarely experienced** **3- Rarely experienced** **4- Sometimes experienced** **5- Often experienced** **6- Not experienced**	**1**	**2**	**3**	**4**	**5**	**6**
1. I had difficulty falling or staying asleep						
2. I felt restless						
3. I felt a sense of timelessness						
4. I was slow to respond						
5. I tried to avoid feelings about the stressful event						
6. I had repeated distressing dreams of the stressful event						
7. I felt extremely upset if exposed to events that reminded me of an aspect of the stressful event						
8. I would jump in surprise at the least thing						
9. The stressful event made it difficult for me to perform work or other things I needed to do						
10. I did not have the usual sense of who I am						
11. I tried to avoid activities that reminded me of the stressful event						
12. I felt hypervigilant or 'on edge'						
13. I experienced myself as though I were a stranger						
14. I tried to avoid conversations about the stressful event						
15. I had a bodily reaction when exposed to reminders of the stressful event						
16. I had problems remembering important details about the stressful event						
17. I tried to avoid thoughts about the stressful event						
18. Things I saw look different to me from how I know they really looked						
19. I had repeated and unwanted memories of the stressful event						
20. I felt distant from my own emotions						
21. I felt irritable or had outbursts of anger						
22. I avoided contact with people who reminded me of the stressful event						
23. I would suddenly act or feel as if the stressful event was happening again						
24. My mind went blank						
25. I had amnesia for large periods of the stressful event						
26. The stressful event caused problems in my relationships with other people						
27. I had difficulty concentrating						
28. I felt estranged or detached from other people						
29. I had a vivid sense that the stressful event was happening all over again						
30. I tried to stay away from places that reminded me of the stressful event						

- On how many days did you experience any of the above symptoms of distress?
  - No days
  - One day
  - Two days
  - Three days
  - Four days
  - Five or more days

APPENDIX 3

Interview script

1. What year of your degree are you in currently?
2. With regard to the situation caused by the COVID-19 pandemic, please tell us about the entire process from the suspension of the clinical placements in a linear manner: when they called you to start working, when you signed the contract, the department you joined, and what the experience was like.

Themes to explore (check that they emerge in the explanation and, if not, ask about them specifically):

- Type of contract
- Whether or not the department they worked in was related to COVID-19
- Whether or not they had full responsibility for patients or provided support to other nurses
- The tasks they carried out at work
- The training and knowledge they required to cope with the situation, such as use of PPE.
- The relationship with their colleagues/their welcome to the department
- Fear of contagion and infecting others

3. How has it affected you personally and emotionally?
4. What do you think are the negative aspects of entering employment before completing your degree and during a public health crisis?
5. What are the positive aspects?
6. What lessons have you learned for the future?
7. How do you think the situation could have been better managed?
8. Is there anything else you would like to add about the handling of the crisis?

7. DISCUSIÓN

Resumen de resultados

Las expectativas laborales que presentaban los/as estudiantes de último curso del Grado de Enfermería de tres Universidades Españolas (A Coruña, Lleida y Murcia) fueron: la preocupación por su futuro laboral precario con escasez de empleo y contratos temporales. Esta situación afecta a la salud de los futuros egresados/as enfermeros/as, provocando ansiedad y estés durante la etapa de estudiante. Un poco menos de la mitad de los/as estudiantes presentaban valores altos de intolerancia a la incertidumbre, lo que pone de manifiesto la dificultad para gestionar situaciones inciertas, como es su futuro laboral. Sobre, los niveles de satisfacción laboral de los/as enfermeros/as españoles/as de tres regiones (Murcia, Lleida y Galicia), la tendencia era que estaban satisfechos/as en términos generales, pero en cuanto a la supervisión (jefes/as de servicio) y su desempeño de la actividad laboral (desarrollo y promoción), los valores obtenidos tenían una tendencia más baja, aproximándose a la insatisfacción. En cuanto a al Síndrome de Burnout, se encontraron valores bajos de fatiga emocional pero niveles medios- altos de despersonalización y realización personal. Aquellos/as enfermeros/a que tenían contrato temporal y los/as que trabajan en turnos rotatorios tenían cifras más altas de Burnout.

Los niveles de ansiedad y estrés agudo entre los/as estudiantes de Enfermería que se incorporaron al trabajo durante la primera oleada de la pandemia COVID-19 (Abril-Junio de 2020), mostraron valores más bajos en comparación con los que no lo hicieron. Los/as estudiantes de Enfermería demostraron afrontar el estrés en situaciones como la pandemia de COVID-19 y tuvieron una experiencia global enriquecedora al incorporarse al mundo laboral.

Expectativas laborales de los/as estudiantes de enfermería

En general, los resultados destacaron que la mayoría de los/as estudiantes de Enfermería estaban preocupados/as por su futuro profesional. A pesar de las diferencias entre las tres Universidades respecto al empleo, los encuestados consideraban difícil encontrar un empleo bien remunerado. Los/as participantes de las Universidades de Lleida y A Coruña informaron de una mayor seguridad en cuanto a encontrar un empleo en comparación con los/as estudiantes de Murcia. Estos resultados reflejan las

diferencias en la gestión sanitaria de las distintas Regiones de España, con ratios de enfermeros/as/pacientes de 521/100.000 habitantes en Lleida y 552/100.000 habitantes en A Coruña frente a 379/100.000 habitantes en Murcia (Gallardo, 2020), lo que demuestra que, aunque hay escasez de enfermeros/as, la seguridad laboral en Murcia no está garantizada. De hecho estos ratios comparados con la media europea de 811 enfermeros/as por cada 100000 habitantes (Consejo General de Enfermería, 2019) muestra la escasez de enfermeros/as en España. Además de lo anterior, la relación enfermero/a-médico/a en España (1/4) es una de las más bajas de la Unión Europea (OCDE, 2017) lo que da lugar a entornos de trabajo desfavorables (Gómez et al., 2016). Estudios anteriores realizados en México muestran resultados similares, a pesar de que la seguridad con la que los/as estudiantes españoles/as consideraban encontrar empleo sea mayor que en México (Escobar y Covarrubias, 2019; Paz, 2014). La mayoría de los/as estudiantes eran mujeres, solteras, que vivían con sus padres y sin hijos, con un perfil sociodemográfico similar al de otro/as estudiantes internacionales (Escobar y Covarrubias, 2019; Paz, 2014) y nacionales (Porcel et al., 2015). Estos resultados reflejan la realidad de la profesión, que sigue siendo mayoritariamente femenina.

Nuestros resultados también mostraron que las condiciones laborales y de empleo que esperan encontrar los/as estudiantes de Enfermería eran precarias, especialmente en el sector privado, sin estabilidad y con contratos temporales en su mayoría por sólo días o semanas. Esta situación está en consonancia con los informes del Ministerio de Educación español (2021). Esto puede explicarse por el hecho de que la Enfermería es una profesión especialmente estresante, debido a los altos niveles de responsabilidad y a las relaciones interpersonales con los usuarios (OIT, 2012). Además, al principio de su carrera, los/as profesionales están estresados y frustrados, corriendo el riesgo de comenzar su actividad profesional con altos niveles de estrés laboral (Bhui et al., 2016).

En este sentido, las condiciones laborales más valoradas por nuestros/as participantes eran tener un buen ambiente en el trabajo (que les permitiera seguir aprendiendo, conciliando la vida personal con la profesional) y la seguridad laboral. Estos resultados están en consonancia con anteriores investigaciones en México (Paz, 2014) y una revisión sistemática con datos internacionales (Porcel et al., 2015). No obstante, los/as enfermeras suelen encontrar una baja seguridad laboral cuando ingresan al mercado laboral (Escobar y Covarrubias, 2019), siendo uno de los factores que más incertidumbre generó entre nuestros/as participantes. Otro factor que se consideró que influye en sus condiciones laborales es la crisis financiera mundial de 2008, que

aumentó el desempleo y empeoró las condiciones laborales. Esta situación ya ha sido descrita en varios artículos (Galbany et al., 2019; Ruiz & Bayle, 2016; Galbany y Nelson, 2016; Salami et al., 2014).

Aunque la media global de la Escala de Intolerancia a la Incertidumbre fue baja, observamos que el 45,6% de los/as estudiantes de Enfermería tenían valores altos de intolerancia a la incertidumbre. Estos valores eran más altos que los reportados en un estudio español anterior (López & Gago, 2013). Los resultados indicaron que la ansiedad, el estrés y la negatividad son comunes entre los/as estudiantes de Enfermería, lo que coincide con estudios anteriores que indican que la incertidumbre sobre el futuro de la profesión afecta a los/as jóvenes enfermeros/as españoles/as y puede considerarse como un factor de riesgo para su salud (Consejo General de Enfermería, 2019, López & Gago, 2013, Vargas & Dias, 2011).

Trabajar como enfermero/a fuera de su ciudad o región fue una opción considerada por más de la mitad de los/as estudiantes, siendo una alternativa para garantizar su futuro profesional. Algunos también consideraron la posibilidad de trasladarse al extranjero para poder trabajar como enfermero/a. Esta realidad contribuye a un flujo migratorio de profesionales de Enfermería, motivado por la oportunidad de conseguir mejores salarios, mayor estabilidad y calidad de vida (Galbany & Nelson, 2016; Salami et al., 2014), lo que provoca un importante déficit de profesionales de Enfermería en las instituciones sanitarias españolas (Montero, 2020; Needleman et al., 2020). La mayoría de los/as estudiantes encuestados y entrevistados deseaban continuar su formación una vez terminada la carrera, por considerarla una parte esencial para de la calidad asistencial, lo que coincide con estudios anteriores realizados en España (López & Gago, 2013) y México (Escobar y Covarrubias, 2019; Paz, 2014). La especialización a través de la vía EIR (Enfermero/a Interno/a Residente) fue la opción más señalada. Sin embargo, el gran número de enfermeros/as que quieren especializarse en un campo específico contrasta con el bajo número de plazas de formación ofertadas (Boletín Oficial del Estado, 2022).

Los resultados de este estudio en cuanto a la precariedad laboral y las condiciones laborales podrían explicarse, porque en España, la ratio enfermero/a/paciente es todavía muy baja en comparación con Europa. No todas los/as enfermeros/as graduados/as encontrarán un puesto de trabajo en el Sistema Sanitario y los/as enfermeros/as que actualmente trabajan están sobrecargados/as.

Aplicando la teoría de Benner, los/as estudiantes de último curso del Grado de Enfermería se encuentran en el nivel principiante avanzado y para poder seguir avanzando y adquirir las competencias necesarias para desarrollarse como profesionales, necesitan la motivación que genera el empleo seguro y continuo, lo cual permite seguir adquiriendo las destrezas necesarias. Si no disponen de esa motivación no pueden continuar desarrollándose como profesionales y corremos el riesgo de profesionales poco motivados que se planteen migrar como única salida laboral.

Como ya se ha visto, la situación de la pandemia de COVID-19 en España, ha puesto de manifiesto la escasez de profesionales de Enfermería, siendo algunas regiones más afectadas que otras. Por ello, es necesario aumentar el número de enfermeros/as por paciente para mejorar la calidad de los cuidados y, como consecuencia, aumentar las oportunidades de trabajo de los/as enfermeros/as graduados/as.

Satisfacción laboral y síndrome de Burnout de los egresados /as enfermeros/as

Los/as enfermeros/as que participaron en el estudio trabajaban principalmente en instituciones sanitarias públicas y llevaban trabajando <10 años, siendo en su mayoría personal temporal. La media de satisfacción global obtenida en este estudio fue de media a alta, con resultados similares a las obtenidas en otras regiones españolas (Cantabria) (Gandarillas González et al., 2014), así como en Argentina (Fernández-Sánchez et al., 2019) y Perú (Vásquez Sosa, 2007). Los valores más bajos se obtuvieron en la evaluación de los servicios, la promoción y la supervisión, coincidiendo con los resultados de estudios realizados en hospitales de Argentina, Chile y Venezuela (Fernández-Sánchez et al., 2019; Garrido et al., 2020; Parada et al., 2005).No obstante, otro estudio español (Gandarillas-González et al., 2014) informó de puntuaciones más altas en la satisfacción con la supervisión de Enfermería.

En cuanto al cansancio emocional, nuestros resultados confirmaron los valores aportados en un estudio previo realizado con enfermeros/as de ocho hospitales de la Región de Murcia en 2010 (Romero-Pelegrín &González María, 2013), y se obtuvieron tasas ligeramente superiores de cansancio emocional que en otro estudio realizado en Andalucía en 2015 (Cañadas-De la Fuente et al., 2015). En comparación con otros estudios internacionales, el cansancio emocional fue ligeramente inferior a los obtenidos en enfermeros/as de Venezuela (Parada et al., 2005) o Brasil (Vidotti et al., 2018) y en dos revisiones sistemáticas sobre el síndrome de burnout en enfermeros/as de Asia, América y Europa (Chemali et al., 2019; Monsalve-Reyes et al., 2018). Sin embargo,

nuestros datos no coinciden con los resultados de estos estudios en el ámbito de la realización personal y la despersonalización (Parada et al., 2005) (Cañadas-De la Fuente et al., 2015; Monsalve-Reyes et al., 2018). Esto puede deberse a que la muestra de nuestro estudio incluye mayoritariamente enfermeras jóvenes y con contrato temporal, con frecuentes cambios de trabajo y con pocas posibilidades de promoción o reconocimiento laboral. Estas circunstancias podrían provocar una mayor despersonalización y poca realización personal. Todos estos factores contribuyen a que los valores medios del síndrome de burnout en nuestro estudio fuera ligeramente superior a la de los estudios mencionados anteriormente (Abad-Corpa et al., 2013; Cañadas-De la Fuente et al., 2015; Monsalve-Reyes et al., 2018; Parada et al., 2005; Sturzu et al., 2019; Vidotti et al., 2018). Teniendo en cuenta el tipo de contrato, observamos que los/as enfermeros/as con un contrato temporal mostraban altas tasas de burnout, incluso en profesionales que solo trabajaban en el mismo servicio durante 1 año o menos. Estos hallazgos proporcionan una nueva visión de los/as jóvenes profesionales de Enfermería con poca antigüedad, y que no estaban tan presentes en estudios anteriores (Cañadas-De la Fuente et al., 2015; Sturzu et al., 2019; Vidotti et al., 2018). Se han encontrado datos contradictorios respecto a la antigüedad y el síndrome de burnout. Mientras que el estudio español de Cañadas (2015) muestra que la antigüedad en el trabajo favorece a trabajadores/as con menores niveles de burnout, otros estudios internacionales demuestran que la antigüedad en el puesto de trabajo provocó valores más altos de burnout (Sturzu et al., 2019; Vidotti et al., 2018).

Nuestro estudio encontró que los/as enfermeras que trabajan en turnos rotativos tenían un riesgo 1,5 veces mayor de sufrir burnout que los que trabajaban en turnos fijos. Los/as enfermeros/as de Andalucía mostraron valores menores de realización personal en los turnos rotativos, lo que se asocia a un con un mayor riesgo de burnout (Cañadas-De la Fuente et al., 2015) y un estudio realizado en Francia informó que los/as enfermeros/as que trabajan en turnos de día mostraban mayores tasas de burnout que los que trabajaban en turnos de noche (Vidotti et al., 2018).

La literatura existente indica que el agotamiento emocional y la despersonalización se asocian con mayores tasas de abandono del trabajo (Boamah et al., 2017; Garrido et al., 2020; Jourdain & Chênevert, 2010; Van der Heijden et al., 2010), mientras que el apoyo social recibido de supervisores/as y colegas (Jourdain & Chênevert, 2010; Van der Heijden et al., 2010) se consideran factores de protección. En este estudio encontramos altos porcentajes de agotamiento emocional, despersonalización e

insatisfacción con la supervisión, lo que podría significar una pérdida de profesionales bien formados, lo que intensificarían la falta de profesionales en España (Consejo Español de Enfermería, 2019).

Aproximadamente el 40% de los participantes había emigrado o tenía intención de emigrar a otra región o país extranjero. Esto puede explicarse por el hecho de que el flujo migratorio de enfermeros/as al extranjero ha ido aumentando, especialmente en la última década. Esto ha sido el resultado de la situación de desempleo, la precariedad en la contratación y el abandono de la profesión enfermera (Galbany-Estragués & Nelson, 2016; Salami et al., 2014). Estos resultados se complementan con los resultados previos, en los que los/as estudiantes de último curso se plantean emigrar como salida profesional.

Los/as egresados/as enfermeros/as representan el nivel competente, según la teoría de Benner, lo que significa que debido a las experiencias vividas y los conocimientos adquiridos pueden desempeñar su trabajo. La seguridad laboral, la satisfacción durante el desarrollo de su profesión y la motivación por parte de las instituciones sanitaria constituyen el camino hacía el siguiente nivel según Benner (1984), pudiendo alcanzar el nivel experto. Dicha evolución aumentaría la calidad de los cuidados y por tanto la calidad sanitaria. Cuando esta situación no se da, tenemos profesionales insatisfechos, con poca continuidad en su puesto de trabajo y escasa perspectiva de alcanzar una mejor situación laboral, corremos el riesgo de burnout y un deterioro de la salud mental que repercute negativamente en la calidad asistencial.

Incorporación de estudiantes de Enfermería a la práctica clínica durante la pandemia

La situación de la COVID-19 que hemos vivido de forma tan dramática en España puso de manifiesto el colapso de los servicios sanitarios, precisando incorporar a estudiantes de Enfermería.

Los resultados de esta tesis indicaban que lo/as estudiantes de Enfermería, tanto si habían entrado en la práctica clínica como si no, experimentaron niveles elevados de ansiedad y estrés durante la primera oleada de la pandemia, especialmente las estudiantes no incorporadas. Varios estudios internacionales han mostrado cómo la salud mental de los/as estudiantes de ciencias de la salud empeoró durante la pandemia, con diversos grados de síntomas depresivos, ansiedad y estrés (Alsolais et al., 2021; Aslan & Pekince, 2021; Ersin & Kartal, 2021; Kalkan et al., 2021). La falta de material de protección señalada en el estudio de Ersin y Kartal (2021) era un factor que

aumentaba el nivel de estrés de los/as estudiantes porque se relacionaba con un mayor riesgo de contagio.

En consonancia con nuestros resultados, otro estudio descubrió que el nivel de estrés de las estudiantes era mayor que el de los estudiantes varones (Kalkan et al., 2021). Del mismo modo, los niveles de ansiedad entre los/as estudiantes no sólo fueron más altos durante la pandemia, sino que estudios anteriores ya han demostrado que los niveles de ansiedad entre las estudiantes son más altos que entre los estudiantes masculinos en condiciones normales (Savitsky et al., 2020). Además, entre los estudiantes que realizaron sus prácticas durante la pandemia, se descubrió que las mujeres tenían mayores niveles de estrés y dificultades psicológicas para afrontar su trabajo (Eweida et al., 2020).

Los estudios realizados en el contexto español indican que los/as estudiantes de Enfermería que vivieron la situación de pandemia tuvieron un mayor riesgo de sufrir problemas de salud mental: concretamente, el doble que sus compañeros/as del mismo curso en años anteriores (Reverte-Villarroya et al., 2021). En España, los/as estudiantes vivieron una gran incertidumbre por la falta de claridad inicial sobre el final del curso y la forma de evaluar las asignaturas pendientes (Ramos-Morcillo et al., 2020), así como la preocupación por los conocimientos no adquiridos debido a la interrupción de sus prácticas clínicas, en línea con lo ocurrido en otros países europeos (Bosveld et al., 2021). Esto se evidencia en el hecho de que los/as estudiantes no incorporados reportaron mayores niveles de ansiedad y estrés.

Por otro lado, los resultados sugieren que los altos niveles de ansiedad y estrés podrían explicar por qué algunos/as estudiantes decidieron no incorporarse a la profesión. Es posible que, en base a sus altos niveles autopercibidos de ansiedad y estrés, los/as estudiantes decidieran no participar en la actividad laboral, haciendo prevalecer su autocuidado en ese momento, ya que los/as estudiantes de último curso tenían que elegir entre la opción de recluirse en casa o iniciar su carrera profesional en condiciones adversas (Usher et al., 2020).

Aunque no es significativo, los/as estudiantes de la Universidad del País Vasco obtuvieron las puntuaciones más altas en estrés y ansiedad. Esto podría explicarse por un posible retraso en la comunicación de la Universidad sobre cómo compensar las evaluaciones pendientes y la oferta de contratos por parte del Sistema Sanitario Vasco.

Los resultados sugieren la posibilidad de que, a pesar de las experiencias potencialmente estresantes en las instituciones sanitarias, los que iniciaron la asistencia

sanitaria percibieron aspectos positivos de esta incorporación que contribuyeron a reducir sus niveles de ansiedad. En línea con Roca (2021), a pesar de las emociones negativas y sus consecuencias, fueron capaces de desarrollar estrategias de afrontamiento y consideraron la experiencia como una oportunidad de aprendizaje, reforzando el sentimiento de ser útiles en un momento crucial para la salud pública.

Sin embargo, en el caso de los/as estudiantes de Enfermería, aunque la experiencia de la pandemia puede haber contribuido a reforzar su deseo de convertirse en enfermeros/as (Ramos-Morcillo et al., 2020), otras investigaciones encontraron que los altos niveles de ansiedad provocaban una mayor reticencia a ejercer su profesión en el futuro (Cici & Yilmazel, 2021).

En cuanto a los/as estudiantes de Enfermería que se incorporaron a la asistencia sanitaria, esta Tesis ha puesto de manifiesto que aunque vivieron esta experiencia como algo positivo desde el punto de vista de aprendizaje profesional, también llevo a aparejada un importante impacto emocional en forma de ansiedad, estrés y preocupación por la incertidumbre ante la finalización del curso, falta de información sobre los contratos y sus responsabilidades y posibilidad de contagiar a sus familiares.

Los/as participantes percibieron tras su incorporación un aumento de su competencia como enfermeros/as, además de haber adquirido mayor confianza y conocimientos en cuidados complejos. Además, la incorporación les permitió enfrentarse a diversos dilemas morales y éticos (Bosveld, 2021) y llevar a la práctica tareas en relación con pacientes críticos o en proceso de muerte, que probablemente nunca antes habían realizado. Estudios recientes han explorado la experiencia de los/as estudiantes enfermeros/as que se incorporaron en tareas de auxilio sanitario, apuntando, por un lado, al valor de este período para ganar experiencia clínica y autoconfianza en condiciones de menor responsabilidad profesional (Casafont et al., 2021); y, por otro, a la intensidad emocional de la vivencia, coexistiendo emociones ambivalentes tales como el orgullo, la tristeza, la rabia o la impotencia, pero siendo el miedo y la incertidumbre los sentimientos más prevalentes (Collado-Boira et al., 2020). Permitir a los/as estudiantes incorporarse a la atención sanitaria en una situación pandémica puede tener un efecto beneficioso en la formación de su identidad profesional (Bank & Wijnen-Meijer, 2020), al igual que fortalece su sentido de pertenencia profesional y aumenta su sentimiento de orgullo y de privilegio por haber ayudado (Gómez-Ibañez et al., 2020).

La identidad de la enfermera va ligada a la motivación y a la vocación por ayudar. Por eso, durante la pandemia, los/as estudiantes quisieron contribuir de forma significativa a la atención a pacientes y apoyar al personal sanitario de primera línea (Bank & Wijnen-Meijer, 2020). Para ello, tuvieron que elegir entre su compromiso profesional y ético o el riesgo de infectarse y valorar el riesgo frente al beneficio de trabajar en plantas COVID (Eweida, 2020). A pesar de su buena disposición, posiblemente también sintieran cierta presión para apoyar los esfuerzos sanitarios frente a la COVID-19 (Swift et al, 2020). Aunque algunos estudios sugieren que la pandemia de COVID 19 ha puesto de manifiesto que los/as estudiantes pueden tener una mayor responsabilidad (aunque supervisada) en la atención a los pacientes al principio de sus prácticas (Bosveld et al., 2021) es cierto que la sobrecarga de tareas de la persona que le debe supervisar puede poner en riesgo al estudiante, a sus compañeros y a las personas atendidas (Bank & Wijnen-Meijer, 2020).

Diversos estudios apuntan a que, entre el alumnado de ciencias de la salud, el miedo al contagio de terceras personas de su entorno prevaleció frente al miedo al propio contagio (Gómez-Ibañez et al., 2020; Eweida, 2020; Cici & Yilmazel, 2020), algo que también se pone de manifiesto en nuestro estudio. Al igual que en otros contextos, no contar con material adecuado aumentó considerablemente el nivel de stress de los/as estudiantes (Ersin & Kartal, 2020), al igual que su falta de competencia percibida para manejar la ropa de protección (Bank & Wijnen-Meijer, 2020). El hecho de que la mitad del estudiantado enfermero percibiera las medidas de protección que estaban a su alcance como suficientes para protegerse del contagio, pudo ser debido a que desarrollaron su actividad fundamentalmente en la figura de auxilio sanitario y, por tanto, presumiblemente se situaron en una segunda línea de atención a las personas infectadas (o con probabilidad de estarlo).

Al igual que los/as participantes de nuestro estudio, otros/as estudiantes de Enfermería españoles/as manifestaron sentimientos de miedo, nerviosismo en los primeros días, incertidumbre sobre sus funciones y responsabilidades, inseguridad y falta de confianza en su competencia profesional (Gómez-Ibañez et al., 2020). Los/as participantes expresaron incertidumbre debido a la falta de información sobre los contratos y sus responsabilidades, la falta de supervisión y de formación específica en aspectos de seguridad. Las vivencias y la incertidumbre tuvieron consecuencias en su salud como problemas físicos (alteración del sueño) y emocionales (estrés, ansiedad y miedo), al igual que ha sido reportado en otros estudios nacionales (Obando-Zegarra et

al., 2021) e internacionales (Savitsky et al., 2020; Cici & Yilmazel, 2020; Eweida, 2020). Los resultados también han mostrado que el tiempo jugó a favor de una evolución favorable en la reducción de la incertidumbre y el miedo (Ramos-Morcillo et al. 2020; Gómez-Ibañez et al., 2020).

Aunque los/as estudiantes de Enfermería se encontraban en el nivel I (principiante), de la Teoría de Patricia Benner, debido a la pandemia COVID-19, comenzaron a trabajar de manera prematura. Esta situación supuso una gran oportunidad para aprender e iniciarse como profesionales, pero también se vieron sometidos/as a una situación nueva de gran carga emocional. Para poder enfrentarse a estas situaciones es preciso replantear un modelo académico y práctico que pueda preparar a los/as estudiantes para enfrentarse a estas situaciones.

Para paliar los efectos psicológicos descritos, han sido varios los estudios que han destacado la necesidad de preparar a los/as estudiantes mediante programas de entrenamiento psicológico y desarrollar sistemas de apoyo para su futuro trabajo en pandemia (Cici & Yilmazel, 2020; Eweida, 2020), incidiendo en el entrenamiento de la resiliencia (Savitsky et al., 2020; Vitale et al., 2020; Umeda et al., 2020) y la importancia de cuidarse para poder cuidar (Pérez-Moreno et al.,2020). Respecto a las estrategias para sobrellevar la situación entre el estudiantado, un importante mitigador del distrés psicológico fue la adopción de prácticas de auto cuidado y el ejercicio físico (Gallego-Gómez et al., 2020).

8. IMPLICACIONES EN LA PRÁCTICA

Es necesario plantear estrategias para mejorar las condiciones laborales e igualar la oferta de trabajo en las Regiones Españolas. La precariedad del empleo y de las condiciones laborales, la falta de personal en los servicios sanitarios y la creciente privatización de la sanidad en España ha llevado a los futuros/as enfermeros/as a plantearse buscar trabajo en otro campo o emigrar a otro país, lo que provoca una importante escasez de profesionales en las instituciones sanitarias en España. Esta situación debería alertar a las instituciones sanitarias para que aumenten la inversión en la contratación de personal sanitario, como los/as enfermeros/as, y proporcionarles condiciones laborales satisfactorias como: mejorar el trabajo en equipo, la gestión y el liderazgo, la promoción interna y una mayor participación en la toma de decisiones y un mayor equilibrio de poder entre los/as gestores/as de las instituciones sanitarias y los/as profesionales sanitarios/as. Todo ello contribuye a garantizar la seguridad y la calidad de la asistencial de los/as pacientes, siendo uno de los pilares fundamentales de la Sanidad.

En el contexto de la pandemia del COVID-19 resulta especialmente importante profundizar en los programas de estudios sobre salud pública, así como proporcionar una formación más amplia que dote a los/as estudiantes de los conocimientos y habilidades necesarios para atender a pacientes con COVID-19 (Bosveld et al., 2021). Un aprendizaje y una formación preparatoria adecuada en conocimientos y habilidades relacionados con la atención a pacientes con COVID-19, la provisión de todos los EPI necesarios, un seguro adecuado y una compensación económica apropiada por los esfuerzos de los/as estudiantes son requisitos previos para que lo/as estudiantes de profesiones sanitarias empiecen a trabajar en entornos sanitarios (Bosveld, 2021). La formación en aspectos emocionales como la resiliencia para garantizar que los/as estudiantes de Enfermería y de carreras sanitarias, y luego como profesionales, sean capaces de afrontar mejor posibles situaciones clínicas epidémicas y pandémicas en el futuro.

9. LIMITACIONES

Durante el desarrollo de esta tesis nos encontramos con algunas limitaciones. Las técnicas de recogida de información de los/as estudiantes y egresados/as enfermeros/as de A Coruña, Murcia y Lleida pudieron haber introducido un sesgo de voluntariedad ya que los datos se recogieron online en Lleida y A Coruña, mientras que en Murcia los datos se recogieron en persona. Los datos solo incluían 5 de las 17 regiones españolas debido a la accesibilidad a los datos de los/as estudiantes. Como nuestro objetivo no era comparar datos entre regiones españolas, el uso de datos de cinco Universidades nos permitió aumentar la muestra. Al ser un estudio mulcéntrico presenta la limitación de la heterogeneidad en la práctica clínica entre centros estudiados (Youssef et al., 2008).
En el caso de egresados/as enfermeros/as, no ha sido posible establecer algunas comparaciones entre grupos. La mayoría de los participantes eran temporales, lo que dificultaba compararlos con la pequeña muestra de personal fijo. Otra limitación fue la desigual proporción de respuestas en las distintas regiones. Nuestros datos no eran comparables entre hombres y mujeres, lo que refleja la realidad de la profesión, mayoritariamente femenina.

Debido a su carácter temporal de los estudios, no se ha podido determinar si los altos niveles de ansiedad y estrés en los/as estudiantes enfermeros/as que vivieron la pandemia del COVID-19 se mantuvieron en el tiempo y si existen en la actualidad problemas específicos de salud mental en estos/as estudiantes.

En las fases cualitativas en las que se realizaron entrevistas en profundidad, el hecho de que los/as entrevistadores/as fueran profesores/as pudo haber introducido cierto grado de sesgo de deseabilidad social entre los/as entrevistados/as. Para mitigar este efecto, las entrevistas fueron realizadas por profesores/as que no tenían una relación académica directa con los/as estudiantes en ese momento.

Dado que el proceso de recogida de datos tuvo lugar entre Abril y Junio de 2020, los relatos de los/as estudiantes se recogieron muy cerca del inicio de su actividad laboral. Sería interesante analizar las consecuencias para la salud mental a medio y largo plazo, así como el impacto en la carrera profesional de los/as alumnos/as que tuvieron su primera experiencia laboral durante la pandemia.

10. FORTALEZAS

Carecemos de estudios en España que pongan de manifiesto la incertidumbre y la frustración que manifiestan los/as estudiantes del Grado de Enfermería, de varias Universidades Españolas cuando se les pregunta sobre su futuro laboral.

En el artículo 2 se obtuvo una tasa de respuesta fue del 54,1%, de egresados/as enfermeros/as, lo que podría considerarse un punto fuerte de la tesis, ya que solo se habrían necesitado 229 participantes para alcanzar una muestra representativa con un intervalo de confianza del 95% y con un margen de error del 5. Lo que nos da una buena representación de la situación laboral de la Enfermería española.

La representatividad geográfica que muestra esta tesis, en la que participan cinco Universidades (Universidad de A Coruña, Murcia, Lleida, País Vasco y Madrid) aporta una mayor diversidad de los perfiles de los/as participantes, dado que otros estudios en España sólo se han realizado en un territorio (Gómez -Ibañez et al., 2020; Ramos-Morcillo et al., 2020; Roca et al., 2021). La recogida de datos, entre Abril y Junio de 2020, nos permitió recoger impresiones muy cercanas al momento del cese de la docencia presencial para el conjunto de los/as estudiantes y al momento de la incorporación para los/as estudiantes incorporados/as.

11. CONCLUSIONES

Las conclusiones que se derivaron de esta Tesis son:

- Los/as estudiantes de Enfermería españoles/as se encuentran en una situación de gran incertidumbre cuando terminan la carrera, visualizando un futuro con gran estrés y frustración debido a la precariedad laboral y la falta de empleo.
- Los/as enfermeros/as contratadas temporalmente y con poca antigüedad muestran altos niveles de fatiga emocional, despersonalización y falta de realización personal.
- La situación de pandemia COVID-19 expuso a los/as estudiantes de Enfermería a un nivel adicional de ansiedad y estrés, independientemente de que se hayan incorporado o no a la actividad asistencial.
- La incorporación de las/os estudiantes de últimos cursos del grado de Enfermería, principalmente bajo la figura de auxilio sanitario, benefició a su formación en situaciones de crisis sanitarias, a los/as compañeras enfermeras que tuvieron apoyo en una situación de falta de personal cualificado, al resto del equipo sanitario, y a los propios pacientes que dispusieron de mayor ratio de profesionales enfermeros/as en una situación precaria.

12. BIBLIOGRAFÍA

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13. ANEXOS

Anexo 1: Comité de Ética Universidad de Murcia (Artículo 1 y Artículo2)

INFORME DE LA COMISIÓN DE ÉTICA DE INVESTIGACIÓN DE LA UNIVERSIDAD DE MURCIA

Jaime Peris Riera, Catedrático de Universidad y Secretario de la Comisión de Ética de Investigación de la Universidad de Murcia,

CERTIFICA:

Que Dª. María del Mar Pastor Bravo ha presentado el proyecto de investigación titulado *"Estudio sobre la Vocación, Expectativas laborales y Situación Laboral de los estudiantes y enfermeros egresados en la Región de Murcia"*, a la Comisión de Ética de Investigación.

Que dicha Comisión analizó toda la documentación presentada, y de conformidad con lo acordado el día trece de abril de dos mil dieciocho[1], por unanimidad, se emite INFORME FAVORABLE, desde el punto de vista ético de la investigación.

Y para que conste y tenga los efectos que correspondan, firmo esta certificación con el visto bueno del Presidente de la Comisión.

Vº Bº
EL PRESIDENTE DE LA COMISIÓN
DE ÉTICA DE INVESTIGACIÓN DE LA
UNIVERSIDAD DE MURCIA

Fdo.: Francisco Esquembre Martínez

ID: 1886/2018

[1] A los efectos de lo establecido en el art. 19.5 de la Ley 40/2015 de 1 de octubre de Régimen Jurídico del Sector Público (B.O.E. 02-10), se advierte que el acta de la sesión citada está pendiente de aprobación

Anexo 2: Datos Sociodemográficos (Artículo 1)

- Sexo: Masculino / Femenino
- Edad (Escriba su edad en años):
- Estado civil: Solter@ / Casad@ / Pareja
- ¿Tiene hijos? Sí / No
- ¿Con quién vives? Sol@ / Con familia / Con pareja / Con compañer@s de piso.
- ¿Trabaja actualmente? Sí / No
- En caso afirmativo, ¿cuántas horas trabaja a la semana?
- ¿Hay alguien que dependa económicamente de ti? Sí / No
- ¿Habla con fluidez algún idioma extranjero? Sí /No ¿Cuál?
- ¿Has realizado un intercambio internacional Erasmus u otra rotación (hospitalaria/académica) en el extranjero? Sí / No. ¿Dónde?
- Cuando termines la carrera, ¿has pensado en seguir formándote? Sí/No. En caso afirmativo, seleccione una opción: EIR (Enfermero/a Interno/a Residente), indicar especialidad / Máster, indicar cuál y en qué universidad / Estudiar otra carrera, indicar cuál/ Realizar otros estudios, indicar cuáles
- ¿Cuáles son los motivos que le llevan a seguir estudiando?
- ¿Cómo va a realizar sus estudios? ¿A tiempo completo o parcial?

Anexo 3: Cuestionario de Expectativas laborales (Paz et al., 2014) (Artículo 1)

1. **Indica con una cruz la respuesta.**

	Si	No
¿Piensas buscar un empleo?		
¿Te preocupa tu futuro laboral?		
¿Consideras urgente buscar trabajo?		

2. **Indica con una cruz la respuesta**

¿Qué grado de dificultad crees que tendrías para encontrar un trabajo bien pagado?

Muy difícil	Moderadamente difícil	Difícil	Poco difícil	Ninguna dificultad

3. **¿En qué medida consideras probable que llegues a desarrollar una actividad profesional relacionada con tu profesión?**

Poco probable	probable	Casi seguro	Estoy seguro

4. ¿Cuál crees que será tu situación laboral a los 5 años de terminar el grado en enfermería? Indica con una cruz tantas como apliquen.

Ejercer mi profesión fuera de mi Localidad/ Región	
Ejercer mi profesión en el extranjero	
Espero acceder a un empleo permanente	
Espero acceder a un empleo temporal	
Espero acceder a un empleo a tiempo parcial	
Espero acceder a un empleo a tiempo completo	
Trabajar en un empresa privada (ONG, Clínica)	
Trabajar en el Ministerio de Salud	
Trabajar en el Servicio Nacional de Salud	
Trabajar en el área rural	
Trabajar en el área urbana	
Trabajar en el área asistencial	

Trabajar en el área administrativa	
Trabajar en el área de investigación	
Trabajar en el área de docencia	
Preferiría trabajar en zona urbana	
El grado de preparación es el factor más influyente	
Tener dos trabajos al mismo tiempo	
Espero a lo largo de mi vida laboral ser un subempleado relacionado a mi carrera.	
Trabajar en un área distinta de la enfermería	
El salario mensual dentro de 5 años mayor de 1500 Euros	
El salario mensual dentro de 10 años mayor de 1500 Euros.	
Abriré mi consultorio a los 5 años de graduarme	
Abriré mi consultorio a los 10 años de graduarme	
Abriré mi clínica a los 10 años de graduarme	

5. **Indica del 1 al 10 en que grado valoras los siguientes ítems según la importancia que le das para la elección de un empleo.**

Puntuación de 1 "no lo valoro" a 10 "muy valorado"(indica con una cruz en el número que corresponda)										
	1	2	3	4	5	6	7	8	9	10
La posibilidad de desarrollo										
Trabajo interesante, aprendizaje y formación										
Equilibrio entre la vida personal y profesional										
Buen ambiente de trabajo										
Promoción										
Buen sueldo										
Seguridad										
Horario cómodo										
Proyección										
Prestigio										
Cercanía al domicilio										

6. **<u>Indica del 1 al 10 en que grado valoras los siguientes ítems según tu aportación como profesional al trabajo:</u>**

Puntuación de 1 “no lo valoro” a 10 “muy valorado”(indica con una cruz en el número que corresponda)										
	1	2	3	4	5	6	7	8	9	1
Ser capaz de orientar a los demás										
prestar un servicio										
Innovar o experimentar										
Tener independencia / autonomía										
Alcanzar el éxito										
Sentir que aporto / ser útil										
Superarse constantemente										
Tener retos										
Conocer nuevas situaciones y experiencias										
Aceptación e integración con el grupo de trabajo										
Tener buenas relaciones con el grupo de trabajo										
Aprendizaje										
Reconocimiento en el trabajo										
Prestigio										

7. **<u>En cuanto a como consideras un buen trabajo, indica en las siguientes afirmaciones si estás o no estás de acuerdo (Si/No):</u>**

	SI	NO
Trabajar en un puesto donde tenga que dirigir a los demás en lugar de ser dirigido		
Que permita ejercer la profesión aunque el sueldo sea más bajo		
Estar en una empresa innovadora, creativa y en continuo cambio aunque tenga poca seguridad laboral a futuro		
Un trabajo que permita viajar		
Que pueda realizarlo conjuntamente con otros		
Que le permita seguir estudiando		
Que pueda continuar y desarrollar la vida profesional		
Donde tenga responsabilidades y dé cuenta de lo que se hace		
Que deje tiempo libre aunque el sueldo no sea muy bueno		

Anexo 4: Escala de Intolerancia hacia la Incertidumbre (IUS) (Freeston et al, 1994), que fue previamente validada en población española (González et al., 2006) (Artículo 1).

Conteste a cada frase teniendo en cuenta la siguiente escala. Nada característico de mí: 1; Poco característico de mí: 2; Moderadamente característico de mí: 3; Muy característico de mí: 4; Extremadamente característico de mí: 5.

	1	2	3	4	5
1. La incertidumbre me impide tener una opinión firme.					
2. Estar inseguro/a sobre algo me desorganiza.					
3. La incertidumbre hace intolerable la vida.					
4. Es injusto no tener garantías de que las cosas vayan a salir bien en la vida.					
5. No puedo estar tranquilo/a mientras no sepa lo que va a suceder al día siguiente.					
6. La incertidumbre me produce inquietud, ansiedad o estrés.					
7. Los imprevistos me molestan mucho.					
8. Es frustrante para mí no tener toda la información que necesito.					
9. La incertidumbre me impide disfrutar plenamente de la vida.					
10. Se debería prever todo para evitar las sorpresas.					
11. Un pequeño imprevisto puede arruinarlo todo, incluso con la mejor de las planificaciones.					
12. Cuando llega el momento de actuar, la incertidumbre me paraliza.					
13. Estar inseguro implica no poder figurar entre los mejores.					
14. Cuando estoy indeciso/a no puedo seguir adelante.					
15. Cuando estoy indeciso/a no puedo funcionar muy bien.					
16. A diferencia de mí, los demás siempre parecen saber hacia dónde dirigen sus vidas.					
17. La incertidumbre me hace vulnerable, infeliz o triste.					
18. Quiero saber siempre qué me depara el futuro.					
19. No soporto que me cojan por sorpresa.					

20. La más mínima duda me puede impedir actuar.					
21. Tendría que ser capaz de organizar todo de antemano.					
22. La incertidumbre me produce falta de confianza en mí mismo/a.					
23. No entiendo cómo otras personas parecen tan seguras y decididas acerca de su futuro.					
24. La incertidumbre me impide dormir bien.					
25. Debo alejarme de toda situación incierta.					
26. Las ambigüedades de la vida me causan estrés.					
27. No soporto estar indeciso/a acerca de mi futuro.					

Anexo 5: Entrevista expectativas laborales (Artículo 1).

PREGUNTAS SOBRE EXPECTATIVAS LABORALES

1. ¿Cuáles eran tus expectativas laborales cuando empezaste la carrera?
2. ¿Tiene las mismas expectativas o han cambiado?
3. ¿Qué expectativas crees que son las más difíciles de alcanzar?
4. Cómo ha cambiado tu motivación desde que empezaste la carrera?
5. Si pudieras volver atrás en el tiempo, ¿tomarías la misma decisión de estudiar enfermería? ¿Por qué?
6. ¿Hay opciones laborales que consideres ahora y antes no?
7. Después de tus prácticas clínicas, ¿qué opinas de las condiciones laborales actuales en Enfermería?
8. ¿Cómo crees que ha afectado la crisis económica a las condiciones de trabajo en Enfermería?

PREGUNTAS SOBRE LAS CONSECUENCIAS DE LA INCERTIDUMBRE

1. ¿Cómo crees que será tu vida laboral tras finalizar el curso?
2. ¿Cómo te afecta el panorama laboral actual?
3. ¿Crees que la enfermería se enfrenta a más retos laborales que otras titulaciones? ¿Cómo te hace sentir?
4. ¿Cómo afecta a tu salud la incertidumbre sobre tu futuro profesional?
5. ¿Qué cosas te preocupan sobre tu futuro laboral?
6. ¿Cómo afecta la incertidumbre laboral a la hora de hacer planes de futuro? 7. ¿Cómo le afecta a la hora de disfrutar de las cosas cotidianas?

PREGUNTAS SOBRE LA FORMACIÓN CONTINUA

1. ¿Qué quieres estudiar cuando acabes la carrera? ¿Por qué?
2. ¿Qué te motiva a seguir formándote después de terminar la carrera?
3. ¿Qué sentimientos tienes cuando piensas que tienes que seguir formándote después de la carrera?
4. Si tuvieras la oportunidad de tener un trabajo estable, con un buen sueldo y un horario cómodo como enfermero/a generalista, ¿continuarías formándote?
5. Crees que te sentirías mejor como profesional y más valorado si estudiaras más?
6. Qué opinas sobre el estatus social y la valoración profesional, ¿crees que influye el número de títulos?
7. ¿Qué inconvenientes encuentras o podrías encontrar a la formación continua?

PREGUNTAS SOBRE EXPECTATIVAS DE MIGRACIÓN

1. ¿Se ha planteado la posibilidad de trasladarse para ejercer su profesión? ¿Cuándo y por qué?

Anexo 6: Datos sociodemográficos (Artículo 2).

- Sexo:
- Edad.
- ¿En qué universidad realizó sus estudios de Grado/Diplomatura en Enfermería?
- ¿En qué curso académico finalizó sus estudios de Grado/Diplomatura en Enfermería?
- ¿Tiene estudios de postgrado? (máster, doctorado…) Si/No. En caso afirmativo especifique cual
- Estado civil: Solter@/Casad@/Pareja de hecho/Divorciad@/viud@
- ¿Tiene hijos? Si/No
- ¿Con quién convive? Solo/a/ Con mi familia/ con mi pareja/ compañeros/as de piso
- ¿Alguna persona depende económicamente de usted? Si/No
- ¿Domina algún idioma extranjero? Si/No. ¿Cuál?
- ¿Ha presentado trabajo de investigación en algún congreso? Si/No
- He realizado Erasmus u otra rotación (hospitalaria/académica) en el extranjero: Si/No
- ¿Cuál es su ocupación? (Escríbala y detalle, por favor, su rama profesional o especialidad. Escriba sólo aquella ocupación que desempeña en su actual puesto de trabajo). En caso de que sean varias, la que le ocupe más tiempo.
- ¿Está trabajando en otra profesión diferente a enfermería? Si/ NoIndica cuál
- ¿Cuántos trabajos como enfermero/a ha tenido desde enero de 2017 a enero de 2018?
- ¿Trabaja actualmente como enfermero/a? Si / No. En caso contrario indique con una cruz cuál fue su último contrato como enfermero.
  - ( ) Trabajo sin nómina o contrato legalizado.
  - ( ) Eventual por terminación de tarea o realizando una sustitución.
  - ( ) Contrato de una quincena o menos.
  - ( ) Contrato de un mes o menos.
  - ( ) Contrato de tres meses o menos.
  - ( ) Contrato de seis meses o menos.
  - ( ) Contrato hasta un año.
  - ( ) Contrato hasta dos años.

( ) Contrato hasta tres años.

( ) Contrato hasta cinco años.

( ) Fijo.

- ¿En qué tipo de centro trabaja?

  ( ) Hospital

  ( ) Centro de Atención Primaria

  ( ) Residencia de ancianos

  ( ) SUAP

  ( ) Otros. Especifique _____

- ¿Qué tipo de horario tiene usted en su trabajo? (Indique con una cruz donde proceda)

  ( ) Jornada partida fija. ( ) Jornada parcial

  ( ) Jornada intensiva fija. ( ) Turnos fijos.

  ( ) Horario flexible y/o irregular. ( ) Turnos rotativos

- ¿Qué número de horas le dedica semanalmente a su trabajo?
- Indíquenos en cuál de las siguientes categorías jerárquicas se sitúa usted, aproximadamente en su actual puesto de trabajo dentro de su empresa:

  ( ) Empleado/a o trabajador/a

  ( ) Superviso/ar

  ( ) Mando intermedio

  ( ) Directivo/a

  ( ) Alta dirección o dirección general

- ¿Cuál es su antigüedad en la empresa? Años _____ y Meses _____.

Anexo 7: Cuestionario de satisfacción laboral S20/23 J.L. Meilá y J.M. Peiró (Meliá y Peiró, 1989) (Artículo2).

En todos los demás casos posibles escoja siempre para cada pregunta una de las siete alternativas de respuesta y márquela con una cruz.

1	Las satisfacciones que le produce su trabajo por sí mismo	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
2	Las oportunidades que le ofrece su trabajo de realizar las cosas en que usted destaca.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
3	Las oportunidades que le ofrece su trabajo de hacer las cosas que le gustan	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
4	El salario que usted recibe.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
5	Los objetivos, metas y tasas de producción que debe alcanzar	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
6	La limpieza, higiene y salubridad de su lugar de trabajo.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
7	El entorno físico y el espacio de que dispone en su lugar de trabajo	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
8	La iluminación de su lugar de trabajo.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
9	La ventilación de su lugar de trabajo.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy

10	La temperatura de su local de trabajo	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
11	Las oportunidades de formación que le ofrece la empresa	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
12	Las oportunidades de promoción que tiene.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
13	Las relaciones personales con sus superiores.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
14	La supervisión que ejercen sobre usted.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
15	La proximidad y frecuencia con que es supervisado.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
16	La forma en que sus supervisores juzgan su tarea.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
17	La "igualdad" y "justicia" de trato que recibe de su empresa	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
18	El apoyo que recibe de sus superiores.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
19	La capacidad para decidir autónomamente aspectos relativos a su trabajo.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy

20	Su participación en las decisiones de su departamento o sección	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
21	Su participación en las decisiones de su grupo de trabajo relativas a la empresa	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
22	El grado en que su empresa cumple el convenio, las disposiciones y leyes laborales.	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy
23	La forma en que se da la negociación en su empresa sobre aspectos laborales	Insatisfecho ☐ ☐ ☐ Muy Bastante Algo	Indiferente ☐	Satisfecho ☐ ☐ ☐ Algo Bastante Muy

Anexo 8: Cuestionario de Maslach Burnout Inventory (Maslach & Jackson, 1981) (Artículo2).

0= Nunca. **1**= Pocas veces al año. **2**= Una vez al mes o menos. **3**= Unas pocas veces al mes. **4**= Una vez a la semana. **5**= Pocas veces a la semana. **6**= Todos los días.

1	Me siento emocionalmente agotado por mi trabajo.	
2	Cuando termino mi jornada de trabajo me siento vacío.	
3	Cuando me levanto por la mañana y me enfrento a otra jornada de trabajo me siento fatigado.	
4	Siento que puedo entender fácilmente a los pacientes.	
5	Siento que estoy tratando a algunos pacientes como si fueran objetos impersonales.	
6	Siento que trabajar todo el día con la gente me cansa	
7	Siento que trato con mucha eficacia los problemas de mis pacientes.	
8	Siento que mi trabajo me está desgastando.	
9	Siento que estoy influyendo positivamente en la vida de otras personas a través de mi trabajo.	
10	Siento que me he hecho más duro con la gente	
11	Me preocupa que este trabajo me esté endureciendo emocionalmente	
12	Me siento con mucha energía en mi trabajo.	
13	Me siento frustrado en mi trabajo.	
14	Siento que estoy demasiado tiempo en mi trabajo.	
15	Siento que realmente no me importa lo que les ocurra a mis pacientes.	
16	Siento que trabajar en contacto directo con la gente me cansa.	
17	Siento que puedo crear con facilidad un clima agradable con mis pacientes	
18	Me siento estimado después de haber trabajado íntimamente con mis pacientes.	
19	Creo que consigo muchas cosas valiosas en este trabajo.	
20	Me siento como si estuviera al límite de mis posibilidades.	
21	Siento que en mi trabajo los problemas emocionales son tratados de forma adecuada.	
22	Me parece que los pacientes me culpan de alguno de sus problemas.	

Anexo 9: STROBE Statement—checklist of items that should be included in reports of observational studies (Artículo3).

	Item No	Recommendation	Page No
Title and abstract	1	*(a)* ndicate the study's design with a commonly used term in the title or the abstract	P.1
		(b) rovide in the abstract an informative and balanced summary of what was done and what was found	P.1
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	P.2
Objectives	3	State specific objectives, including any prespecified hypotheses	P.2
Methods			
Study design	4	Present key elements of study design early in the paper A multicentre descriptive cross-sectional study (March-April 2020) was conducted in three Spanish public universities. The aim was to compare anxiety levels and reactions to acute stress among nursing students who started working during the first wave of the COVID-19 pandemic and those who did not.	P.3
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	P.4
Participants	6	(*a*) *Cohort study*—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up *Case-control study*—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls *Cross-sectional study*—Give the eligibility criteria, and the sources and methods of selection of participants (*b*) *Cohort study*—For matched studies, give matching criteria and number of exposed and	P.3

		unexposed *Case-control study*—For matched studies, give matching criteria and the number of controls per case	
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	P.3
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	P.3-4
Bias	9	Describe any efforts to address potential sources of bias	
Study size	10	Explain how the study size was arrived at	P.4
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	P.4
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	P.4
		(*b*) Describe any methods used to examine subgroups and interactions	NA
		(*c*) Explain how missing data were addressed	NA
		(*d*) *Cohort study*—If applicable, explain how loss to follow-up was addressed *Case-control study*—If applicable, explain how matching of cases and controls was addressed *Cross-sectional study*—If applicable, describe analytical methods taking account of sampling strategy	
		(*e*) Describe any sensitivity analyses	NA
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	P.4
		(b) Give reasons for non-participation at each stage The reasons for exclusion were the non-completion of the questionnaires applied.	NA
		(c) Consider use of a flow diagram	NA
Descriptive	14	(a) Give characteristics of study participants (eg	P.5

data	*	demographic, clinical, social) and information on exposures and potential confounders	
		(b) Indicate number of participants with missing data for each variable of interest	NA
		(c) *Cohort study*—Summarise follow-up time (eg, average and total amount)	
Outcome data	15 *	*Cohort study*—Report numbers of outcome events or summary measures over time	
		Case-control study—Report numbers in each exposure category, or summary measures of exposure	
		Cross-sectional study—Report numbers of outcome events or summary measures	P.5
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	p.5-6
		(*b*) Report category boundaries when continuous variables were categorized	P.6
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	NA
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	NA
Discussion			
Key results	18	Summarise key results with reference to study objectives	P.7
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	P.9
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	P.8
Generalisability	21	Discuss the generalisability (external validity) of the study results	P.9
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	Title page

Anexo 3: Comité de Ética Universidad de Madrid (Artículo 3 y Artículo 4).

Universidad Autónoma de Madrid

COMITÉ DE ÉTICA DE LA INVESTIGACIÓN

El Comité de Ética de la Investigación de la Universidad Autónoma de Madrid ha recibido la documentación relativa al Estudio:" **Incorporación laboral de los y las estudiantes del Grado de Enfermería debido a la Crisis COVID-19. Estudio multicéntrico en tres universidades españolas.",** que tiene como Investigadora Responsable a la Dra. **Juana Robledo.**

A la vista de la documentación presentada este Comité considera que cumple los requisitos éticos requeridos para su ejecución.

Madrid, 20 de mayo de 2020

JOSE MANUEL GONZALEZ SANCHO - 09309294K

Nombre de reconocimiento (DN): 2.5.4.13=Qualified Certificate: AAPP-FP-M-SW-KPSC, title=VICERRECTOR, ou=certificado electrónico de empleado público, ou=VICERRECTORADO DE INVESTIGACIÓN, o=UNIVERSIDAD AUTONOMA DE MADRID, serialNumber=09309294K, sn=GONZALEZ SANCHO, givenName=JOSE MANUEL, cn=JOSE MANUEL GONZALEZ SANCHO - 09309294K, c=ES
Fecha: 2020.05.22 00:52:01 +02'00'

José Manuel González Sancho

Presidente CEI-UAM

Anexo 11: Cuestionario datos sociodemográficos (Artículo3 y Artículo 4).

- Indica sexo: mujer/hombre
- Indica curso académico que estás cursando: 3º Enfermería/4ºEnfermeria.
- Sobre la interrupción de las prácticas: ¿Crees que las prácticas de Grado debería de ser suspendidas? Si/No. Indica porqué.
- ¿Crees que desde la Universidad se ha gestionado correctamente la situación del alumnado de enfermería? Si/No. Describe los aspectos positivos y/o negativos
- ¿Te has incorporado a la sanidad antes de finalizar el Grado? Si/No.
- En el caso de que no te incorporaras a la sanidad rellena el cuestionario escala de ansiedad. En el caso de que sí continúa el cuestionario y al finalizar completa la escala de ansiedad.
- ¿Cuantos días hace que te has incorporado? Marca con un óvalo
- < 1 semana />1 semana/< 15 días/15 días
- ¿Con cuántos días te antelación te avisaron? Marca solo un óvalo.
    - Contrato por horas
    - Contrato por días
    - Contrato por semanas
    - Contrato de mes
    - Contrato de más meses
- ¿Qué tipo de contrato te han ofrecido? Marca solo un óvalo.
    - Contrato por horas
    - Contrato por días
    - Contrato por semanas
    - Contrato de mes
    - Contrato de más meses

- ¿En tu servicio atiendes a pacientes que tengan o puedan tener COVID 19? Si/No
- ¿De cuantas horas es cada turno?
- ¿Tienes pacientes a cargo completo o actúas de refuerzo de otras enfermera/o?
- ¿Cuantos pacientes atiendes por turno?
- ¿Has recibido algún tipo de formación específica relacionada con la protección frente a al contagio? Si/No
- ¿Crees que dispones de las medidas de protección necesarias para ejercer con seguridad? Si/No
- En caso de que respondieras negativamente en la anterior pregunta indica ¿Qué es lo que hubieras necesitado?
- ¿Has tenido miedo a contagiarte durante el trabajo? Si/No. En caso de responder afirmativamente en la pregunta anterior especificar: A veces/Frecuentemente/Siempre
- ¿Has tenido miedo a contagiar a tus familiares o personas con las que convives? Si/No. En caso afirmativamente a la pregunta anterior, especifica:
- ¿Crees que dispones del conocimiento necesario para afrontar esta situación profesional? Si/No. Si respondiste negativamente a la pregunta anterior, especifica que hubieses necesitado:
- ¿Has recibido apoyo por parte de la Facultad o del Colegio de Enfermería? ¿Qué hubieras necesitado?
- ¿Te has sentido bien acogido por tus compañeros/as en el ámbito profesional? Si/ No. En caso de que respondieras negativamente la pregunta anterior especifica el motivo.
- ¿Cuáles sientes que son los aspectos negativos de haberte incorporado al mundo laboral antes de finalizar el grado y en un momento de crisis sanitaria?
- ¿Cuáles sientes que son los aspectos positivos de haberte incorporado al mundo laboral antes de finalizar el grado y en un momento de crisis sanitaria?
- ¿Hay algo que te gustaría añadir?

Anexo 12: Cuestionario de asiedad (Zung Self-Rating Anxiety Scale) (1971) (Zung, 1971) (Artículo 3 y Artículo 4).

Marque con una X según como se haya sentido durante la última semana.

	Nunca o casi nunca	A veces	Con bastante frecuencia	Siempre
1.Me siento más nervioso/a y ansioso/a que de costumbre				
2.Me siento con temor sin razón				
3.Despierto con facilidad y siento pánico				
4. Me siento como si fuera a reventar y partirme en pedazos				
S. Siento que todo está bien y que nada malo puede sucederme				
6. Me tiemblan los brazos y las piernas				
7. Me mortifican los dolores de cabeza, cuello o cintura.				
8. Me siento débil y me canso fácilmente				
9. Me siento tranquilo/a y puedo permanecer en calma fácilmente				
10. Puedo sentir que me late muy rápido el corazón				
11. Sufro de mareos				
12. Sufro de desmayos o siento que me voy a desmayar				
13. Puedo inspirar y expirar fácilmente				
14. Se me adormecen o hinchan los dedos de las manos				
15. Sufro de molestias estomacales o indigestión				
16. Orino con mucha frecuencia				
17. Generalmente mis manos están secas y calientes				
18. Siento sofocos				
19. Me quedo dormido/a con facilidad y descanso bien durante la noche				
20. Tengo pesadillas				

Anexo 13: Cuestionario estrés Stanford (The Stanford Acute Stress Reaction Questionnaire) (SASRQ) (Cardeña et al., 1991) (Artículo 3 y Artículo4)

Instrucciones: Recuerde los eventos estresantes que ocurrieron en su vida en el último mes:

Brevemente describa en este espacio los aspectos del suceso que le resultaron más perturbadores

¿En qué medida le resultó perturbador el suceso?

0. En absoluto, 1. Un poco perturbador, 2. Bastante perturbador, 3. Muy perturbador, 4. Extremadamente perturbador

A continuación, hay una lista de reacciones que algunas personas experimentan después de un suceso perturbador. Por favor, lea cada frase y decida en qué medida describe su experiencia durante y/o después del suceso que describió arriba. Use la escala de 0-5 descrita a continuación y marque el número que mejor describa su experiencia.

0: nunca, 1: muy rara vez, 2: rara vez, 3: de vez en cuando, 4. Con frecuencia, 5. Con mucha frecuencia

	0	1	2	3	4	5
1. Me resultaba difícil dormir o quedarme dormido/a						
2. Me sentía inquieto/a						
3. Perdía la noción del tiempo						
4. Reaccionaba con lentitud						
5. Intentaba evitar tener emociones relacionadas con el suceso						
6. Tenía pesadillas frecuentes sobre el suceso						
7. Me sentía extremadamente angustiado/a cuando experimentaba acontecimientos que me recordaban al suceso						
8. Cualquier cosa me sobresaltaba						
9. Me era difícil trabajar o hacer otras cosas que tenía que hacer						
10. No tenía la sensación de ser quien habitualmente soy.						
11. Intentaba evitar actividades que me recordaran al suceso						
12. Estaba continuamente al acecho o nervioso/a						
13. Me sentía como si fuera un/a desconocido/a						
14. Trataba de evitar conversaciones relacionadas con el suceso.						
15. Mi cuerpo reaccionaba cuando percibía algo que me recordaba al suceso.						
16. Me era difícil recordar detalles importantes del suceso						
17. Trataba de evitar pensar en el suceso.						
18. Las cosas que veía parecían distintas a como realmente son.						
19. En varias ocasiones tuve recuerdos no deseados del suceso.						

20. Me sentía distante de mis propias emociones						
21. Estaba irritable o tenía arranques de ira.						
22. Evitaba tener contacto con personas que asociaba con el suceso.						
23. Repentinamente actuaba o me sentía como si el suceso ocurriera de nuevo.						
24. Mi mente se quedaba en blanco.						
25. No podía recordar periodos prolongados del suceso.						
26. El suceso me causó problemas en mis relaciones con los demás.						
27. Me era difícil concentrarme.						
28. Me sentía distanciado/a o desconectado/a de otras personas						
29. Tenía una sensación intensa de que el suceso iba a ocurrir de nuevo.						
30. Trataba de evitar lugares que me recordaran al suceso.						

¿Cuántos días tuvo los síntomas mencionados arriba?

Uno

Dos

Tres

Cuatro

Cinco o más

Anexo 14: Guion de la entrevista (Artículo4).

1. ¿En qué curso de la carrera se encuentra actualmente?
2. En relación con la situación provocada por la pandemia de COVID-19, cuéntanos todo el proceso desde la suspensión de las prácticas clínicas de forma lineal: cuándo te llamaron para empezar a trabajar, cuándo firmaste el contrato, el departamento al que te incorporaste y cómo fue la experiencia.
3. Temas a explorar (comprueba que surgen en la explicación y, si no es así, pregunta por ellos específicamente):
4. Tipo de contrato
5. Si el departamento en el que trabajaban estaba relacionado o no con COVID-19
6. 6.Si tenían o no plena responsabilidad sobre los pacientes o prestaban apoyo a otros/as enfermeros/as
7. Las tareas que realizaban en el trabajo
8. La formación y los conocimientos que necesitaban para hacer frente a la situación, como el uso de EPI, etc.
9. La relación con sus colegas en su acogida en el departamento
10. El miedo al contagio y a infectar a otras personas
11. ¿Cómo le ha afectado personal y emocionalmente?
12. ¿Cuáles cree que son los aspectos negativos de entrar a trabajar antes de terminar la carrera y durante una crisis de salud pública?
13. ¿Cuáles son los aspectos positivos?
14. ¿Qué lecciones has aprendido para el futuro?
15. ¿Cómo crees que se podría haber gestionado mejor la situación?
16. ¿Hay algo más que quieras añadir sobre la gestión de la crisis?