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Becoming an Air Force Nurse: The Experience of Transition A New Perspective of a Known Phenomenon

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Abstract

PROBLEM—Transitions in nursing have consistently been described as complex and stressful. While the literature is replete with studies investigating role transitions in civilian healthcare settings, there is no known research that explores the role transition of experienced nurses who move from civilian to military nursing practice. Using nurses in the U.S. Air Force as an exemplar, this study serves as a starting point to understand the transition process and challenges likely encountered by nurses new to the military. The outcomes of this study could influence future efforts to recruit and retain qualified nurses.

METHODS—A hermeneutic, phenomenologic approach was used to explore and describe the lived experience of transition from civilian staff nurse to Air Force staff nurse.

FINDINGS—The results indicated that new Air Force nurses encounter challenges related to a lack of knowledge and role preparedness, which led to feelings of stress and frustration. Support from peers, mentors, and managers helped the new Air Force nurses bridge the gap in knowledge and successfully integrate into the military culture.

IMPLICATIONS—Efforts to reduce the perceived lack of knowledge through improvements to the Commissioned Officer Training program and the clinical orientation period are recommended.

Keywords

Military nurse; nursing; role transition; transition

Introduction

In the United States, registered nurses (RNs) comprise the largest portion of the healthcare workforce. As an integral member of the healthcare team, RNs provide care to complex patients, often with multiple chronic conditions, in a fast-paced environment. Advancing technologies, cost-conscious coordination of care, and the utilization of best practice principles are key factors influencing nursing practice. Yet, the profession struggles with a

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growing nursing shortage that impacts role performance and job satisfaction. One contributing factor to this shortage is turnover-connected vacancies, which have been linked to negative role transition experiences (Chandler, 2012; Spector & Echternacht, 2010).

Background

Historically, role transitions in nursing have been described as challenging and complex (Duchscher, 2009). Reinforcement of similar themes continue in current literature (Gohery & Meaney, 2013; Kumaran & Carney, 2014). Over four decades ago, nurses' described feelings of stress resulting from differences between expectations of the nursing role and the reality of nursing practice. Terms such as "reality shock" (Kramer, 1974) and "transition shock" (Duchscher, 2008) were coined to describe such feelings. The literature notes that the collective role transition process is influenced by multilevel support, feelings of role preparedness, and the work environment (Martin & Wilson, 2011; Pellico, Djukic, Kovner, & Brewer, 2009). Furthermore, the outcomes of transition are linked to the ability to recruit and retain qualified nurses (Craig, Moscato, & Moyce, 2012).

Considering the breadth of nursing practice, the unique contexts where nurses experience transition are likely to influence the outcome. Experienced civilian nurses transitioning to military nursing practice in the U.S. Air Force (USAF) is an example of one such unique context. The aim of using this example is to substantiate the impact of multiple salient factors capable of influencing the process of transition. Further, expanding what is known about role transitions to other populations of nurses is an important step toward addressing ongoing recruitment and retention issues for the profession.

Challenges to recruit and retain RNs is not limited to the civilian workforce. Of the 2.7 million employed nurses in the United States (Bureau of Labor Statistics, 2015), approximately 9,600 are currently serving on active duty in the Nurse Corps (Department of Defense, 2014). The nursing shortage impacts efforts by the Army, Navy, and Air Force Nurse Corps (AFNC) to attract sufficient numbers of nurses to fulfill recruitment goals (Donelan et al., 2014). Added to this are the challenges created by turnover, resulting in nurse vacancy rates as high as 15% in the Air Force alone (American Association of Colleges of Nursing, 2008). These factors influence the availability of military nurses to provide care for active duty and retired service members and their families. Collectively, the ability of the military to meet global demands relies, in part, on the strength and sustainability of the Nurse Corps.

While individual elements commonly associated with civilian nurse transitions have been linked with military nurse job satisfaction and presumably the intent to stay among military nurses, the transition experience itself has not yet been investigated in its own right. Donelan et al. (2014) explored the perceptions and incentives to military nursing as a career, but interestingly, the impact of role transitions was not mentioned. For new military nurses, role transition involves the unification of nursing and military knowledge and values to form a new professional identity (Chargualaf, 2016). However, elements of the military culture could present unique challenges to the transition process not encountered by civilian nurses.

Hundreds of nurses' transition into the military each year (Arel, 2012; The Navy Nurse Corps, 2012; B. Zadlo, personal communication, 2014, March 12). Differences in role expectations and practice environments are likely to contribute to a significant life transition for these nurses (Hutchinson, All, Loving, & Nishikawa, 2001). An awareness of elements impacting the personal and professional transition could be used to inform the provision of supports needed by the transitioning nurse. Yet, a lack of published literature on new military nurse transition prevents such insight. Using nurses in the USAF as an exemplar, this study serves as a starting point to understand the transition process and challenges likely encountered by nurses new to the military.

The Study

Currently, new graduate nurses commissioned in the USAF attend the Nurse Transition and Residency Program. The nurse transition program (NTP) is a 45-day course designed to help novice nurses gain experience in patient care while learning the role of an Air Force nurse (Hymel, 2015). Along with transitioning to the role of an Air Force nurse is the transition to an Air Force officer (Griffiths & Jasper, 2008). Following the NTP, a 1-year residency program provides opportunities to master the dual roles while strengthening clinical practice (Hymel, 2015).

However, experienced nurses (i.e., those with more than 1 year of clinical experience in the civilian workforce prior to commissioning) are not afforded the same transitional support opportunities. The transition support provided for this group consists of an assigned USAF sponsor, 4 weeks of Commissioned Officer Training (COT), followed by a unit-based orientation of varying lengths. Therefore, the purpose of this study was to describe the lived experience of transition from an experienced civilian staff nurse to an Air Force staff nurse.

Methods

Design

A qualitative, hermeneutic phenomenologic study was used to describe and interpret the perceptions and meanings of the lived experience of civilian RNs who undergo a role transition to military nursing practice in the USAF. Phenomenology serves as a framework for understanding phenomena and is an ideal methodology for studies that seek to explore the experiences that can only be described by those living it (McConnell-Henry, Chapman, & Francis, 2011).

Participants

Participants were purposefully recruited using a snowball sampling method. Following approval from the university institutional review board, recruitment began with a personal contact assigned to an Air Force medical center in the Midwestern United States and continued until data saturation was achieved. Air Force staff nurses, working on an inpatient unit, with between 1 and 5 years of civilian acute care experience but less than 2 years of Air Force clinical experience, were invited to participate. Participants working in a clinic setting, practicing in an advanced practice nurse role, previously enlisted or deployed, or who

attended the NTP were excluded from the sample. A total of seven Air Force nurses met the inclusion criteria for participation in the study (Table 1).

Data Collection

After introducing the study and assuring confidentiality, the participants completed a demographic questionnaire and signed a written informed consent for one audio-recorded semi-structured interview. Three interviews were conducted in person, one by Skype, and three by telephone. Each interview began with a broad, introductory question, which invited participants to describe their transition from civilian to military nursing practice in the USAF. Follow-up questions were used to focus and clarify the participant's transition experience. Participant interviews were conducted from May to October 2014. Interviews were transcribed verbatim by the researcher. Participants were assigned a pseudonym to assure anonymity.

Data Analysis

Data were analyzed using a tiered approach, according to the seven steps outlined in Colaizzi's (1978) method. However, the final step of Colaizzi's method requires validation of the descriptions provided by the participants. Member checks after the conclusion of an interview are inconsistent with the principles of hermeneutic phenomenology, which assert that meanings are not fixed but rather contextual (Finlay, 2009) and that any attempt to return to an experience might alter the perception and assigned meaning. Therefore, Colaizzi's method was modified to include a validation of descriptions at the conclusion of each interview.

Rigor was demonstrated using the four criteria of qualitative trustworthiness: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was demonstrated by recruiting participants until data saturation was achieved, member checking consistent with the philosophies of the hermeneutic method, and including informants from multiple inpatient units to triangulate the data. Although the researcher never served in the military, direct contact with the military healthcare system provided a familiarity with the culture of nursing in the USAF. In addition to the techniques used to assure credibility, dependability was demonstrated through in-depth methodological planning of the study and findings generated from the verbatim transcription of each interview. An audit trail and reflexive journaling established confirmability. Transferability was achieved through the rich description, which allows readers to discern similarities between the transition experiences reported here and their own lived experiences.

Results

The analysis of the data revealed a transition process that is often a stressful and frustrating experience owing in large part to a general lack of knowledge regarding military culture and a lack of preparation for the military nurse officer role. All the participants indicated that their transition experiences had little to do with the professional nursing role, but rather were the result of a lack of familiarity with the military way of life.

Sonya stated, “I knew the nursing aspect of it, I knew how to take care of a patient but I didn’t understand the military part because the roles, they’re different.”

To the participants, the transition experience was defined by learning the role behaviors and expectations required of military officers, integrating the new officer role with an already known nursing role, and effectively performing both according to the cultural norms of the Air Force. Three major themes and 13 subthemes were identified from the data (Table 2).

Theme 1: Learning the Military Culture

The first theme reflects the steep learning curve encountered by the participants as they began learning about and fitting into the military culture. Phrases like “sink or swim,” and “fake it till you make it,” were used to describe their lack of knowledge about the military and feelings of apprehension to assuming the officer role. The participants reported feeling overwhelmed by the volume of new information they were required to learn. Frustration created by a general lack of instruction of military policies led to fears of making a mistake. The elements of the military culture that were particularly cumbersome to learn included customs and courtesies, rank, the chain of command, wearing the military uniform, the redefinition of professional boundaries, and assimilating the military way of life.

Despite talking with Air Force recruiters and attending COT for 4 weeks, the participants felt unprepared to successfully execute the officer role. John stated,

When I went to COT I thought that I would be instructed on things of the military life, on you know, what the lifestyle was going to be and what to expect. But I really didn’t get that much – the training that I thought was going to happen there.

Participants expected to be taught what they needed to know before arriving at their first military assignment and became frustrated when this did not occur. Betty noted, “The first year was very difficult because I had no idea what any of that stuff was.” Maria agreed saying:

I kind of wished they would have stuck a little more with the military aspect because there’s so many acronyms, so many processes that, um, orders you’re supposed to do things and I think they kind of did us a disservice ... because it’s [COT] so short they mainly focus on the leadership aspect and not on the military aspect.

Correctly executing rules governing military culture proved challenging to the participants.

Another challenge was just learning the military *customs and courtesies*. As a civilian nurse you didn’t stand when your nurse manager came on the floor. When your commander comes into your unit you respect them and stand to attention. And then learning to say Sir or Ma’am or the *military rank*. And when you’re outside saluting a superior officer – that was just something a bit different. (John)

Kelly also recalled a personal challenge of “calling my colleagues, who were my friends, by their last name and rank.” Influenced by rank, the *chain of command* created frustration when the participants attempted to communicate or complete required tasks. Participants commented that it was not uncommon to have numerous “bosses,” including an immediate

supervisor, the squadron commander, the flight commander, and the medical group commander. Maria states, “I was used to being able to drop into my boss’s office and say ‘hey, there’s a problem with this ...’ whereas now there is a whole chain of command it goes all the way up.”

The rank structure and chain of command created unforeseen boundaries between members of the healthcare team. In the civilian workforce, participants acknowledged close relationships with unlicensed assistive personnel. The participants quickly learned that they needed to *redefine the professional boundaries* with the enlisted medical technicians they worked alongside. “There’s a totally different environment because I can’t be friends with the techs. I’m not allowed to be friends with them. I can’t hang out with them outside of work” (Betty).

Four of the seven participants described the challenges associated with learning and correctly *wearing the military uniform(s)*. When the participants did not receive the instruction they perceived as essential, they were left to seek out alternative sources of information, which contributed to increased feelings of stress. John stated, “not really getting any instruction on military dress and appearance ... I mostly had to learn that on my own as far as when to wear blues or putting on all of your different symbols and identifiers.” The participants were overwhelmed by the number of rules that pertained to wearing the military uniform correctly and found them difficult to keep straight at first.

In the absence of familiar sources of support, the participants looked to their peers for help in *assimilating the military way of life*. All of the participants identified their current military assignment as their first and as being geographically separated from known sources of support. Because of this, the nurses appreciated the importance of looking out for one another and desired to make connections with others on the unit. Initially, the single greatest source of information and support for the participants was their assigned sponsor. Sponsors who were knowledgeable about the base, the local area, and the Air Force, and who were willing to share what they knew were valued by the participants.

Linda stated, “The piece that I found helpful was my sponsor. ...I was given a particularly awesome and enthusiastic sponsor. She was just that constant person that was always there helping me with the nurse aspect, with the moving aspect. Just always there.”

Yet, the quality and helpfulness of sponsors varied widely. Feelings of isolation and fear resulted for three participants who reported receiving insufficient support from their assigned sponsor. Words like “stressful” and “blind” illustrate the challenge of fitting into the military culture with inadequate support from a sponsor.

Theme 2: Bridging the Gap

This theme reflects the gap in knowledge between where the civilian nursing role left off and where the knowledge and expectations of the Air Force nursing role began. Orientation, preceptor support, peer and managerial support, and the work environment all contributed to the formation of the military nurse identity.

Orientation—The orientation period provided an opportunity for participants to further define and clarify their new professional role. The participants had both the competence and confidence in their ability to perform the nursing role, which meant that they could focus their attention on learning the officer role. Despite the fact that all seven participants had some type of unit-based orientation, the length and quality varied greatly and often failed to appreciate the previous knowledge or experience garnered from civilian practice or the learning needs of the new nurse. Sonya stated it was “kind of demeaning a little bit because I have done this stuff for a long time and I felt like they gave me no credit at all for the experiences that I have had.”

Preceptor support—Preceptors played an integral role in the orientation of the participants to their first military nursing role. New to the base and the Air Force, but not to nursing, the participants desired an experienced nurse and knowledgeable officer who could bridge the gap between the two. All of the participants acknowledged the assignment of multiple preceptors during their orientation to the unit. The participants were frustrated by a lack of continuity and interrupted learning this created. Maria stated, “The difficult part might have been just the lack of continuity. And having to kind of start over with each preceptor” and it was challenging because “they didn’t know where I was when they would switch.” Participants valued preceptors who were role models, followed established rules, were present, maintained open channels of communication, were knowledgeable, provided timely feedback, took the preceptor role seriously, shared knowledge, shared military experience, were good leaders, and answered questions.

Peer and managerial support—The participants identified support from peers and immediate supervisors as helpful to their transition into the military. Managers were in an ideal position to provide support. Participants appreciated managers who were accessible, knowledgeable, and readily communicated with the staff. Peers assigned to the same unit were an additional source of valuable support. Having both nursing and military experience, peers were able to provide invaluable guidance to the participants. Role socialization was supported by the positive interactions with peers.

John stated,

I believe the support I received from my managers and my flight commander and fellow Nurse Corps officers – I think getting their support really helped me. And learning from them – observing their actions and kind of following their lead really helped out.

Work environment—Accustomed to working in fast-paced units caring for complex patients, four of the seven participants were surprised by the smaller size of the inpatient units, smaller patient care assignments, and lower patient acuity. Andrea commented, “We just don’t have the patient demand that the civilian world does because we only cater to a specific population of people.” For the participants included in this study, inpatient units averaged 13 beds with a typical staffing pattern of three to four RNs and one or two medical technicians per shift. Some nurses felt that staffing patterns and lower patient acuities

resulted in less patient contact and decreased opportunities to use nursing skills. Maria stated, “It’s been frustrating because I feel like I’m losing my skills.”

In general, clinical units that were smaller and where staff functioned as a cohesive group seemed to support the participants during transition. Such environments allowed participants to learn and master their new role. Conversely, work environments that were consistently understaffed caused additional sources of stress to the participants and contributed to negative feelings related to the transition and being a military nurse.

Theme 3: Being a Military Nurse

The third theme represented the movement from a state of unknowing to an appreciation of the role responsibilities and expectations, which signified the participant’s military nurse identity. The question of what it means to be a military nurse was answered by the acknowledgement of differences between civilian and military nursing practice by the participants. The unique differences are reflected in the following subthemes: juggling dual roles, role expectations, and scope of practice.

Juggling dual roles—Upon commissioning, military nurses assume dual roles: that of an officer and an RN. “So for the military you have to worry about being an officer and a nurse. On the civilian side you just have to worry about being a nurse” (Sonya).

Although the participants acknowledged the military environment as different and expected differences in their new work role as a result, they were no less surprised by the degree of importance the Air Force placed on this concept in their military career and nursing practice. “It’s just different for the fact that we are military too and that’s our first designation. That’s been drilled into us that we’re officers first and nurses second” (John). The participants struggled to make sense of the idea that the officer role superseded, or was somehow more important than, their role as a nurse. Two participants voiced confusion over how the mission, for an RN, could be anything other than caring for a patient.

Role expectations—The nurses expected that military leaders would clearly communicate what was expected of them so that they could be successful in their new roles. However, most of the participants describe receiving little or no clarification of the role expectations within their assigned unit and hospital orientation. This contributed to the feelings of stress and frustration. The lack of role clarity left the participants surprised by the assignment of extra tasks beyond their staff nurse responsibilities. Betty said,

Whenever I did travel nursing, they told me right away – this is what we need from you. This is what you need to do. When I started in the Air Force it was different. There really wasn’t a set, like, this is what we expect from you this shift. I felt like there was no guideline.

Some examples of extra assigned tasks, described by participants, included infection control nurse, crash cart coordinator, staff educator, and physical training leader (PTL). Surprisingly, all but one of the participants was expected to begin performing his or her extra duties once orientation to the base, medical group, and unit was completed.

Scope of practice—Perhaps most startling for the participants were the unanticipated differences in the scopes of practice for members of the military healthcare team. Enlisted medical technicians in the Air Force often perform skills typically reserved for licensed nurses in the civilian workplace, including IV and Foley catheter insertions. John admitted that an Air Force medical technician's scope of practice allows for greater flexibility in completing required tasks and results in improved patient care. On the other hand, Maria noted the expanded practice roles meant less opportunities for nurses to provide care and left Kelly often wondering, "when was the last time I did this [a particular skill]?" In addition, more complex skills such as central line removal, traditionally performed by RNs in civilian hospitals, are often the responsibility of Air Force physicians. Sonya commented that the result of the change in practice between civilian and military made it "seem like you're losing some of your skills."

The Essence of the Experience of Transition From Civilian to Military Nursing Practice

Role transitions in nursing are described as challenging and stressful. To the participants, RNs with previous civilian clinical experience, the transition to military nursing practice in the USAF was no different. The themes generated from the data in this study helped describe the essence, or meaning, of the transition experience (Figure 1).

The data suggest that learning the military nurse role was far easier than learning the officer role. New Air Force nurses with previous civilian experience came onto active duty service comfortable and competent in their role as a nurse but found the transition to the officer role frustrating and stressful. While the participants felt that it took a few months to learn the new role, becoming confident in their ability to consistently perform the officer role independently took significantly longer.

Betty commented,

I didn't feel like an Air Force officer for probably the first year. I'm just here. I'm doing my job but I'm wearing a uniform but I didn't really feel like an Air Force officer for about the first year.

The participants identified two major factors which hindered the transition including: a lack of military knowledge and a lack of role preparedness. Despite attending COT, a 4-week course designed to teach new Airmen about the Air Force and the officer role, participants felt unprepared to fulfill the responsibilities and expectations required of Air Force officers. Juggling the competing roles of nurse and officer further led to role confusion and stress as participants learned to realign professional priorities. All of the participants indicated their transition experience largely focused on learning about and integrating into the military culture. Participants spent a great deal of time and energy amassing the knowledge needed to successfully perform the new role(s).

Notwithstanding these challenges, participants acknowledged that support from assigned sponsors, peers, and managers helped them to bridge the gap between the role expectations and responsibilities of civilian and Air Force nurses. Mentors who were patient, willing to share knowledge and experience, and appropriately modeled both roles were beneficial to the participants. Moreover, they quickly became trusted sources of support. In the future, as

more experienced nurses commission into the USAF, it is important to assure that they receive the information needed to feel adequately prepared to assume the officer role at the first duty location. They should also have access to knowledgeable, well-trained sources of support during that transition.

Discussion

A lack of published research on military nurse transition prevents a direct comparison between this study and existing literature; therefore, the findings are discussed within the context of known characteristics of role transitions. Initially the participants were drawn to Air Force nursing practice as a means of serving their country, paying off student loans, and traveling the world but quickly realized that their expectations of the role did not match the reality that they encountered at their first duty assignment. Perhaps most alarming was the realization that nurses were also expected to be Airmen and that there was an unforeseen prioritization of these roles within the Air Force hierarchy. Simultaneous membership in two, often competing, professions means that military nurses must maintain competencies for both (Griffiths & Jasper, 2008). The participants struggled to make sense of the mutually exclusive nature of the dual roles that seemed to place greater importance on the Airmen role as compared to the nursing role. While they acknowledged why the military officer role existed they had trouble understanding how the mission could be anything other than patient care. Despite all of this, the participants voiced pride in serving as military nurses.

A review of literature revealed recurrent challenges to the transition process, including a lack of preparedness (Duchscher, 2008), lack of knowledge (Duclos-Miller, 2011), fitting in to a new culture (Asselin, Osterman, & Cullen, 2006), and unrealistic expectations (Craig et al., 2012). This study uncovered similar challenges. Beyond basic nursing skills and professional practice, military nurses are expected to maintain unique competencies related to patient care of military populations, deployment, and leadership (Ross, 2010). The participants felt overwhelmed by the expectations of the new role and more specifically with the burden of learning a great deal of new information in a short period of time. Further, a desire to fit in and integrate into the military culture were sources of frustration due to a perceived lack of knowledge and feelings of unpreparedness. The culmination of these challenges resulted in stress for the participants. Additionally, stress resulting from a disparity between the expectations of the military nursing role and practice, held by participants prior to commissioning, and the reality encountered at their first duty assignment correlates with previous research (Duchscher, 2008; Kramer, 1974). The participants believed that the Air Force would provide them with the information necessary to seamlessly bridge the gap between civilian and military work environments and role expectations but were surprised and even aggravated when this did not occur.

The participants identified factors that were perceived to both facilitate and hinder the transition process. This study supported previous findings that supportive work environments, which foster collaboration and learning, were helpful to nurses in transition (Zinsmeister & Schafer, 2009). Unlike a typical civilian work setting where new nurses are often unwelcomed (Pellico et al., 2009), all military nurses have experience being new and because of this the inpatient unit and its staff were generally more accepting of new

members of the healthcare team. Adequate support and positive experiences with preceptors and mentors help to ease the feelings of stress and are vital to a successful role transition (Zinsmeister & Schafer, 2009). For the participants, the single greatest factor that facilitated the transition process was the support received from peers, mentors, and nurse managers. Among experienced nurses, studies have shown that mentors are in an ideal position to bridge the gap between what is known and what needs to be learned while serving as resource advisors for the unit and facility (Hartung, 2005). But more than that, mentors can provide interpersonal support to nurses struggling to manage multiple simultaneous demands and cope with unfamiliar surroundings (Cranford, 2013).

All of the participants reported taking part in a unit-based orientation, whether formal or informal, at their first military assignment. Consistent with existing literature, this study demonstrated wide variations in the format, content, and duration of the orientation period. The length of orientation ranged from 6 weeks to more than 3 months. Comfortable in their ability to perform the nursing role, the participants depended on the orientation period to learn more about the officer role by asking questions and understanding the differences between civilian and military scopes of practice. Studies show that the most effective orientation programs are well defined, include a comprehensive initiation to the work environment, and clearly delineate role expectations (Scott, Engelke, & Swanson, 2008). Though not often well defined, the participants generally felt that their orientation sufficiently met their learning and transitional needs.

The single greatest factor that hindered the transition was a lack of knowledge and feelings of role preparedness. Nursing literature on transitions in civilian practice often link role unpreparedness to inadequate academic preparation (Berkow, Virkstis, Stewart, & Conway, 2008; Romyn et al., 2009). The participants believed that the COT course focused more on leadership than on core foundational knowledge deemed important by those new to the Air Force. This lack of military and officer role knowledge created additional sources of stress. They depended on role modeling and ready access to information from peers and mentors to learn the role.

Preceptors influence the perception and outcome of transition (McKenna & Newton, 2008). Ready access to well-trained, experienced, and consistent preceptors during transition is vital (Andersson & Edburg, 2010). Research by the National Council of State Boards of Nursing (2004) supports matching a single preceptor to each new nurse for the duration of the orientation period. This sentiment was also supported by a majority of participants in this study following negative experiences resulting from numerous assigned preceptors. The participants reported having between two and more than seven preceptors during their unit orientation. Most felt that there was little thought and consideration given to preceptor assignments. In some cases, preceptors were merely selected based on who was scheduled to work the same shift as the new Air Force nurse rather than formally choosing a well-matched preceptor who would work the same schedule. The participants expressed frustration when their orientation had to “start over” or “go back to the beginning,” with each change in preceptor resulting in a lack of continuity and interrupted learning. For nurses with clinical experience, consistent support and feedback from preceptors are important to role actualization (Anderson, 2009). Further, they are in a position to provide

interpersonal support to nurses struggling to cope with transition (Cranford, 2013). Attempts to streamline the unit orientation and consciously assign a single, well-qualified preceptor are suggested by the participants.

Finally, studies have isolated essential skills that have been reported to impact the transition, including physical assessment, time management, delegation, prioritization, communication, and critical thinking (Berkow et al., 2008; Chandler, 2012). The participants in this study felt that all elements, whether learned in school or through clinical practice, were useful to the transition and to the successful role performance as a military nurse. Experienced nurses in transition bring transferrable skills but must often reframe their base of knowledge and skill set to match the new environment and role expectations (Cranford, 2013; Robinson, Kellett, King, & Keating, 2012). According to Benner (1984), it is not uncommon for nurses with prior experience, undergoing a change in work roles, to temporarily return to an advanced beginner stage. This study supported this assertion as the participants described many of the same fears, feelings, and challenges encountered by new graduate nurses beginning professional practice. Therefore, the impact of the work environment and role expectations, not solely a lack of experience, cannot be overlooked as impacting the overall transition experience and the potential cause for a temporary return to a lower level of perceived and measured proficiency.

Recommendations

The exemplar of role transition for new Air Force nurses illustrates the nuances demanding consideration when planning transition support in any unique context. Regardless of the type of transition or the professional developmental level of the nurse, the participants' perspectives serve to inform the context-specific supports needed to achieve successful transitions. Recommendations gleaned from interviews with new Air Force nurses in this study substantiate general suggestions for improving transitions in nursing. The participant's specific recommendations are presented below.

Provide consistent and supportive preceptors—The participants brought their nursing skills to their new positions. While “new” to the Air Force setting, they were not considered “novice” nurses because of their patient care expertise. Many (civilian) nursing preceptor programs are designed for beginners with limited experience. The data demonstrated that “expert” preceptors were not needed for this group, but proficient preceptors were needed to provide more information related to the military culture so these new nurses could function in their job.

Consider the learner—The participants were already bringing their nursing skills to the new environment, but they did not have any military skills. The nursing orientation for the Air Force and other military branches must consider ways to assimilate confident practicing nurses into a military culture. Individualized unit-based orientation, based on prior clinical experience, is encouraged.

Make staffing assignments according to expertise—Experienced nurses have an intuitive grasp of clinical situations. Capitalizing on these skills is necessary to enhance the

efficiency and effectiveness of military nurses. Although the Air Force demands flexibility and high-proficiency practice, the preliminary assignment of a new experienced nurse should reflect the individual's prior expertise. Maintaining the individual's practice expertise fosters a greater sense of self-worth and pride. Cross-training to different nursing fields, after the new nurse becomes grounded into the military culture, is suggested.

Bridge the gap—Implementation of self-directed learning materials, with discussions emphasizing the differences between civilian and military nursing practice, is suggested. The findings of the study indicate the participants were surprised at the focus of their orientations to be predominately on military culture. Self-directed learning materials may serve as an efficient and time-saving mechanism to provide the information. The strength of this approach would be using “live” discussions led by military nursing leaders as role models to enable the newly hired nurses to engage in their officer roles by talking about situations and actively problem-solving within a supportive group environment.

On an international level, the impact of transition cannot be underestimated. As key partners in wartime and humanitarian missions, the ability of Air Force nurses to function on a global stage is grounded in the knowledge, experience, and role preparedness established during role transition. Transitions perceived to be challenging or overly stressful may impact the ability of the AFNC to meet its vision of “a total nursing force delivering evidence-based, patient-centered care to meet global operations” (Siniscalchi, 2009, para. 1). Therefore, this study recommends that Air Force nurses, with some civilian clinical experience before commissioning, receive the same or similar degree of support and educational opportunities as new graduates. Doing so will ensure that Air Force nurses are knowledgeable, well-rounded, and capable of meeting mission requirements.

These recommendations align with those published in the literature of civilian role transitions in nursing. Greater attention to closing the gap in knowledge and decreasing feelings of role unpreparedness will aid in the retention of Air Force nurses while improving recruitment efforts.

Limitations

Potential limitations to this study are the inclusion of nurses from only one Nurse Corps of the three military services, although their experiences are likely similar. Second, the findings describe the transition process for seven nurses at a single point in time and may not accurately reflect the experiences held by all new Air Force nurses. Recruitment of the participants depended on a personal contact, which could have influenced the responses and behaviors of the participants. Finally, due to geographical separation, three of the interviews were conducted by telephone, which introduces the possibility of missed nonverbal cues.

Conclusion

Role transitions in professional nursing are consistently described as challenging and stressful. The uniqueness of the context prompts different personal and professional struggles. The exemplar of USAF nurse transition illustrated challenges including a lack of

knowledge and role preparedness, which were related to learning and correctly executing the officer role. Support from peers, mentors, and managers helped the new Air Force nurses bridge the gap in knowledge and successfully fit into the military culture. Other exemplars are needed to assist the nursing profession to acknowledge and support all nurses in transition. Accounting for contextual differences, such as the military setting, will expand what is known about the transition process and help to shape best practice for sustaining the nursing workforce.

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Figure 1.
The Essence of the Experience

Table 1**Participant Demographics**

Demographic characteristic	<i>n</i>	%
Age (years)		
24–26	4	57
27–29	1	14
30–33	2	29
Gender		
Male	1	14
Female	6	86
Race		
Caucasian	6	86
African American	1	14
Years of civilian clinical practice		
1–2	5	71
3–4	2	29
Civilian clinical experience (unit) ^a		
Medical surgical	4	57
Other inpatient unit	7	100
Long-term care	1	14
Years of Air Force experience		
<1	1	14
1	4	57
2	2	29
Currently at first Air Force duty assignment	7	100

^a Note: Some participants worked in multiple civilian care units before commissioning.

Table 2

Themes

Major themes	Subthemes	
Theme 1: Learning the Military Culture	1	Customs and courtesies
	2	Rank and respect
	3	The chain of command
	4	The military uniform
	5	Redefining professional boundaries
	6	The military lifestyle
Theme 2: Bridging the Gap	1	Orientation
	2	Preceptor support
	3	Peer and managerial support
	4	The work environment
Theme 3: Being a Military Nurse	1	Juggling dual roles
	2	Role expectations
	3	Scope of practice