THE EXPERIENCE OF TRANSITION FROM A CIVILIAN STAFF NURSE TO AN AIR FORCE STAFF NURSE: A PHENOMENOLOGICAL STUDY

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By

Katie A. Chargualaf

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Dissertation Committee:

Alice Tse, Chairperson
Clementina Ceria-Ulep
Debra Mark
Judy Duchscher
Rosanne Harrigan

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Dedication

I would like to dedicate this dissertation to my family. First I would like the opportunity to thank my husband, Joe, for his love, support, and understanding. Your belief in my ability to tackle this degree and complete this study was unwavering. Thank you for being my biggest cheerleader and best friend! I would also like to thank my children, Michael and Alyssa. Your patience and understanding of all of the demands that pulled me away from spending time with you is so greatly appreciated. I am looking forward to spending an entire weekend with all of you instead of sitting in front of the computer. First thing on the list – a family disc golf tournament!
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Finally, I would like to thank the seven new Air Force nurses for participating in this study. I am appreciative of their time and willingness to share their experience of transition from civilian to military nursing practice. It is my hope that their voice helps to shed light on the transition experiences for this long overlooked group of nurses.
Abstract

Transitions in nursing have consistently been described as complex, problematic, and stressful. While the literature is replete with studies investigating role transitions in civilian healthcare settings, no studies have investigated the same experiences among nurses in the United States Air Force. An interpretative phenomenological approach was used to explore and describe the lived experience of transition from civilian staff nurse to Air Force staff nurse. An analysis of seven interviews, following Colaizzi’s method, identified three themes and thirteen sub-themes. The results indicated that new Air Force nurses encounter similar struggles as those reported in the civilian literature. Challenges related to a lack of knowledge and role preparedness 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. Efforts to reduce the perceived lack of knowledge through improvements to the Commissioned Officer Training (COT) program are recommended.
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Chapter 1: Introduction

Chapter one will present the argument that a frequently changing healthcare environment and unrealistic practice expectations of registered nurses are a possible impetus for nurses transitioning away from civilian nursing practice in favor of a professional nursing career in the United States military; specifically the United States Air Force (USAF). The practice environment, nursing roles, and job expectations of nurses in the USAF are vastly different from those in the civilian sector making the conclusions drawn from previous literature inappropriate and irrelevant.

Introduction

Each year approximately 100 registered nurses with clinical experience leave civilian practice to pursue a nursing career in the USAF (Zadlo, 2014). While the decision to join the military is a personal one, it may be influenced by frustrations resulting from frequent changes to the healthcare system, workforce challenges leading to job dissatisfaction, and unrealistic expectations of nurses that directly impact nursing practice and the work environment (Zangaro & Kelley, 2010). Nurses currently provide care to increasingly complex patients, often with multiple chronic conditions, in a rapidly evolving healthcare environment which employs advanced technologies, expects cost-conscious coordination of care, and the utilization of best practice principles to ensure patient safety and optimal outcomes. Longer life expectancies, an aging Baby Boomer population, millions of newly insured Americans, and increased focus on preventive care mean that the demand for healthcare services, and therefore nursing care, is expected to dramatically increase. A multitude of demands, internal and external to the profession, impact the ability of nurses to meet role expectations and provide quality care expected of professional nurses.
The nursing profession struggles with a growing nursing shortage and the retention of qualified, experienced nurses resulting from turnover. More than 2.5 million nurses are currently employed in the United States with an additional 1 million new jobs projected by 2020 (Bureau of Labor Statistics [BLS], 2012). Attributed to the nationwide recession, the vacancy rate for registered nurses employed in a civilian hospital setting decreased from 8.1% in 2006 to 4% in 2010, but this number is expected to rise drastically as nurses from the Baby Boomer generation begin retiring in the near future (American Hospital Association [AHA], 2010). Further, the national turnover rate for civilian hospital staff nurses increased from 15% in 1999 to 26.2% in 2000 (United States Government Accounting Office [GAO], 2001) with the highest rates occurring in the medical-surgical specialty (NSI Nursing Solutions, 2013). In the hospital setting, turnover is attributed to inadequate staffing, heavy workloads (nurse-patient ratio), insufficient support (GAO, 2001), and negative role transitions (Casey, Fink, Krugman, & Propst, 2004; Scott, Engelke, & Swanson, 2008; Zinsmeister & Schafer, 2009). Nursing turnover impacts job satisfaction, morale, productivity, nurse safety, patient safety, and the ability to provide quality, cost-conscious care (Chandler, 2012; Halfer & Graf, 2006; Jones & Gates, 2007).

Professional nursing practice in the USAF is an alternative for registered nurses desiring to meet current professional and workplace demands while finding meaning in their work. Air Force nurses provide care for active duty and retired Airmen and their families in various inpatient and outpatient care environments, including military hospitals and clinics (Marquand, 2004). Although the pay is comparable to civilian nursing salaries, the Air Force offers registered nurses additional opportunities for career advancement and professional development while serving their country (Marquand, 2004; Thompson, 2014). Some of the advantages of a professional nursing career in the USAF include the opportunity to travel and experience new
cultures, paid training and education, and student loan repayment in exchange for active duty time (Santiago, n.d.; Thompson, 2014). The high job stability as an employee of the federal government, stable pay and schedule, and paid living and healthcare expenses in addition to the base salary are other reasons that nurses are drawn to a career in the USAF (Santiago, n.d.).

Similar to the reported struggles in the civilian workforce, the Air Force faces challenges in the recruitment and retention of registered nurses. Currently, the total number of Airmen on active duty service in the USAF is 312,453 with 3,229 (0.26%) serving in a registered nurse role (Air Force Personnel Center [AFPC], 2014). In 2006, the overall nurse vacancy rate in the USAF was 15% (American Association of Colleges of Nursing [AACN], 2008). Turnover among military nurses is often measured by the intent to stay in the military. Studies by Moorhead (1993) and Pagliara (2003) revealed a positive relationship between job satisfaction and retention of nurses in the military. Among military nurses, job satisfaction has been linked to the work environment, supervisory and administrative support, peer support, educational and professional development opportunities, workload which is influenced by staffing, and the availability of resources (Allgood, O’Rourke, VanDerslice, & Hardy, 2000; Patrician, Shang, & Lake, 2010; Yoder, 1995; & Zangaro & Johantgen, 2009). According to Zangaro and Kelley (2011), aspects of the military culture influence the recruitment and retention of military nurses including age restrictions which keep the workforce more uniform, the integration of civilian nurses to fill vacancies needed to sustain patient care, and controlled turnover secondary to contractual active duty service commitments and predictable changes in duty assignments.

**Introduction to the Problem**

The role transition from civilian to military nursing practice has the potential to be significantly different. And the consequences of negative role transitions maintain reaching
implications for the nurses’ career and the welfare of the Airmen receiving care. Nurses that move from civilian to military nursing practice are likely to encounter a significant role transition. The literature is replete with studies that investigate role transitions of new graduates and experienced nurses in civilian healthcare settings, yet no studies have investigated these same experiences among nurses in the USAF. The aim of this study is to describe the role transition of registered nurses moving from a civilian staff nurse position to a military staff nurse position. For the purpose of this study, references to military nurses and military nursing practice will be limited to active duty staff nurses in the USAF.

**Background**

**History of Nursing in the USAF**

The United States Air Force was created following the separation of the Army Air Forces (AAF) from the Unites States Army in September 1947 (Smolenski, Smith, & Nanney, 2005). In July 1949, under direction from the Department of the Air Force, the Air Force Medical Service was established with the Air Force Nurse Corps (AFNC) comprising a major part (Reeves, 2011). At its inception, 1199 Army nurses transferred to the Air Force and in August 1949, the first two civilian nurses were commissioned into the AFNC following a major recruitment campaign (Reeves, 2011; Steager, 2009). By the start of the Korean War, in June of 1950, there were more than 1170 nurses in the AFNC, of which, 181 were trained flight nurses; but by the peak of the war, there were 2991 nurses serving on active duty (Smolenski et al., 2005; Steager, 2009). Due to limited field hospitals on the Korean peninsula, nurses in the AFNC primarily functioned in a flight nurse role (National Center for Veterans Analysis and Statistics, 2011). By the end of the war, the AFNC totaled more than 2600 nurses but still more were needed to meet demands of the USAF and active recruitment continued (Smolenski et al., 2005). One major
recruitment strategy was to extend provisions of the Officer Personnel Act to nurses, which would grant the same or similar promotion and retirement opportunities as other officers (Smolenski et al., 2005). In April 1961, the Air Force began commissioning male nurses into the AFNC as a means of further building the nursing workforce (Smolenski et al., 2005). During the 1960s, the Air Force Medical Service, with support from the USAF and the Department of Defense (DOD), focused on developing and operating major courses and programs that sought to better train nurses in the AFNC (Smolenski et al., 2005). The timely focus on training and education of nurses proved vital in the Vietnam War, as the need for aeromedical evacuation services increased exponentially. In February 1966, the first group of nurses arrived in Vietnam and helped to establish the first Air Force hospital (Smolenski et al., 2005). Due to the continued need for support during the war, females were allowed to hold ground positions, only previously allowed by males.

For the next three decades, the AFNC and the Air Force Medical Service worked to increase the number of nurses on active duty, solidify commission requirements of all nurses, develop and execute programs and community-based partnerships aimed at supporting nurses to achieve specialized degrees (example: nurse practitioners), define military nursing roles, provide professional development opportunities, enhance strategic planning efforts, and participate in nursing scholarship in conjunction with professional nursing organizations (such as the American Nurses Association) (Smolenski et al., 2005). During this time, nurses also provided support during humanitarian missions, rendered aid following natural disasters at home and abroad, and supplied medical support during wartime. In 1990, the AFNC deployed registered nurses to Kuwait (the largest group since the Vietnam War) in support of Operation Desert
Shield (Smolenski et al., 2005). Other wartime missions in Bosnia in 1993 and Kosovo in 1999 also required assistance from the AFNC (Smolenski et al., 2005).

Nurses in the AFNC were again called into action following the terrorist attacks on the United States in September, 2001. Initially, active duty nurses were tasked with providing back-up medical support to civilian medical personal. However, due to the large numbers of causalities that resulted, assistance from military nurses was unnecessary (Smolenski et al., 2005). In October 2001, more than 300 Air Force nurses deployed to Afghanistan in support of Operation Enduring Freedom (Smolenski et al., 2005). Their mission was to provide medical support and evacuation services to soldiers fighting on the ground and in the air. In April 2003, an additional 400 Air Force nurses deployed to Iraq in support of Operation Iraqi Freedom (Smolenski, et al., 2005). The services of nurses from the AFNC, resulting from these wars, continue to this day.

Military Nurses and Nursing Practice

Increased work demands related to position and rank, differing work environments, and altered role expectations, all influenced by the mission of the USAF, mean that the transition from civilian to military nursing practice has the potential to be significantly different. While there are numerous advantages of joining the USAF and beginning a career as a professional military nurse; there are challenges related to active duty service in the U.S. military. Frequent moves, prolonged separation from friends and family, and deployments are examples of challenges often encountered by military nurses (Brewer & Ryan-Wenger, 2009). The following section discusses the military healthcare system, the role of military nurses, and the issues surrounding nursing practice in a deployed environment.
Education and Training. All nurses must graduate from an accredited baccalaureate program, hold an active license to practice in the United States, meet minimum physical fitness standards, and be younger than 42 years of age to be eligible to commission into the USAF (United States Air Force [USAF], 2013; Marquand, 2004). As newly commissioned officers, nurses attend the four-week Commissioned Officer Training (COT) course which is designed to facilitate the transition from civilian to military life and includes physical conditioning and classroom study on such topics as Air Force customs and courtesies, combat and disaster preparedness, and military law. After successful completion of the COT course, nurses report directly to their first duty assignment and begin orientation with an assigned preceptor.

Military Nursing in the USAF. Differences exist between civilian and military nursing careers from the beginning. Most civilian nurses are employed in acute care hospitals (Kovner et al., 2007) without commitment contracts which prevent the nurse from pursuing other job opportunities. The lack of contractual obligation to remain employed at any one particular facility coupled with inadequate staffing, heavy workloads (expressed as high nurse-to-patient ratios), and insufficient support frequently reported by nurses is often implicated with a high rate of turnover within the profession (GAO, 2001). Air Force nurses, on the other hand, incur a minimum three (3) year service commitment from the day of commissioning (USAF, 2013) and receive duty assignments, based upon Air Force needs, that may not be changed or broken (Thompson, 2014).

Military nurses maintain little or no control over where and when permanent change of duty locations will occur. Often, nurses change work assignments every few years which requires packing and moving to new duty locations, within or outside of the United States, which has the potential for a loss of support resulting from geographical separation from family and
friends. This is a well-documented source of stress for military service members, including nurses (Brewer & Ryan-Wenger, 2009).

Newly commissioned nurses, with more than one year of clinical experience, are classified as *fully qualified* and may be stationed at one of 64 bases stateside or 20 bases overseas (USAF, 2013). Fully qualified nurses are assigned to clinical units based upon past professional experience and successful completion of courses or certifications needed to maintain competence for the role. A majority will practice as clinical nurses in the medical-surgical unit however some nurses may qualify as nurse specialists who provide care for more complex patients; such as those found in the intensive care unit (ICU), operating room (OR), emergency room (ER), or obstetrics and gynecology (OB/GYN) units (USAF, 2013). According to the AFNC (USAF, 2013, p. 4), the responsibilities of all registered nurses includes:

1. Diagnosing and treating human responses to actual or potential health conditions.
2. Providing healthcare services in collaboration with other health service personnel, including carrying out diagnostic and therapeutic regimens prescribed by duly licensed practitioners authorized to order such regimens.
3. Teaching healthcare practices.
4. Making a nursing diagnosis that identifies the needs of an individual, family, or group.
5. Administering a nursing treatment regimen through selection.
7. Administering, supervising, delegating, and evaluating nursing and medical technician actions.
Air Force nurses must also learn and integrate into the military organizational hierarchy that is vastly different than healthcare organizational structures in the civilian sector. Under the direction of the wing commander, the medical group commander, with assistance from smaller subsections, or squadrons, and their respected commanders, manages the medical group at each Air Force instillation. During patient care and interactions with the healthcare team, nurses must know, recognize, and acknowledge job titles in addition to rank. All active duty and reservists serving in the U.S. Air Force, including nurses, wear the Airman Battle Uniform (ABU). The ABU includes the service member’s last name, rank, and medical insignia including occupational badges (USAF, 2013). Consistency in attire across the Air Force allows for ready identification of rank so that appropriate customs and courtesies may be rendered as required. Lastly, in addition to becoming familiar with the military base and organizational hierarchy, in and out of the medical group, Air Force nurses must learn the operating instructions (OIs) for their assigned medical facility (hospital or clinic).

**Military Medicine.** Military medicine in the United States is a tiered system that includes medical trauma centers, hospitals, and clinics. The numbers of available services and patient acuity decrease with each tier (Derr, Roepke, & Lyons, 2008). Routine outpatient care and primary prevention measures of active duty, dependents, and retirees are handled in a clinic setting located at each military instillation worldwide while hospitals and medical trauma centers provide acute care treatment. In recent years, the numbers of military hospitals have decreased in response to rising costs of war and an analysis of the U.S. military “footprint” by the Base Closure and Realignment Commission (Derr et al., 2008, p. 200). The reduction of acute care facilities in the U.S. Air Force means that more nurses practice in a clinic setting which presents issues in sustaining clinical skills and combat readiness (Derr et al., 2008).
**Deployment.** Inherent to the job as an Air Force nurse is the chance of deployment in support of war or humanitarian efforts with which the United States is involved. Deployments vary in length and location depending upon Air Force need and the assigned mission. The prolonged wars in Iraq and Afghanistan frequently require military nurses to deploy to a combat environment.

The work environment in a combat setting is austere at best. In Iraq and Afghanistan, for example, the temperature is sweltering and the physical terrain dirty and dusty, all of which impact the environment where care is provided (Scannell-Desch & Doherty, 2010). Field hospitals vary from makeshift tents to repurposed existing structures. Living quarters for medical personnel have included tents, “containerized housing units,” and fixed living quarters (Scannell-Desch & Doherty, 2010, p. 7). Additional environmental challenges include noise levels often resulting from overhead aircraft, low or decreased lighting used as a security measure, and scarce resources (Agazio, 2010; Brewer & Ryan-Wenger, 2008). The close proximity of fighting results in a heightened threat level requiring nurses and other medical personnel to remain vigilant and maintain basic soldier knowledge and skills (Agazio, 2010). In combat, military nurses work as a member of the healthcare team to perform life-saving treatment and prepare soldiers for evacuation from forward deployed medical facilities to a medical center in Germany (Brewer & Ryan-Wenger, 2009; Johansson, Odén, Dahlgren, & Sjöström, 2007).

Nurses in combat maintain personal, professional, and physical characteristics unique to the environment and job expectations. A study of critical care air transport team (CCATT) nurses revealed the characteristics of practice readiness needed by deployed Air Force nurses (Brewer & Ryan-Wenger, 2009). Many of the practice readiness dimensions, outlined by the CCATT nurses, are applicable to all nurses serving in a deployed capacity. Military nurses serving in
deployed locations must have and maintain clinical competence, which is defined as the ability to care for and perform skills necessary to sustain life in a combat injured patient (Brewer & Ryan-Wenger, 2009). Operational competence, defined as the ability to use and manage available equipment in an austere environment with few other resources, which requires flexibility and resourcefulness in nursing practice (Brewer & Ryan-Wenger, 2009). Due to increased threat levels, common in combat locations, nurses need “soldier and survival skills” that include the ability to protect self and others in dangerous situations (Brewer & Ryan-Wenger, 2009, p. 510). Finally, nurses in combat need psychosocial readiness, which is the mental and emotional fortitude to handle prolonged separations from family and friends and multiple, often simultaneous, stressors while remaining self-confident (Brewer & Ryan-Wenger, 2009).

Combat-related injuries are vastly different than injuries encountered in civilian trauma centers which further emphasize the importance of continuing education, support, and training for military nurses. Improvements to personal protective battle armor and battlefield care training, in addition to rapid evacuations of critically injured patients have resulted in lower fatality rates than recorded during previous wars (Brewer & Ryan-Wenger, 2009; Holcomb, Stansbury, Champion, Wade, & Bellamy, 2006). Less causalities mean that more, critically injured, soldiers present to military field hospitals requiring rapid life-saving care (Holcomb et al., 2006). In fact, the Air Force Theater Hospital (AFTH), directly located in an active combat environment in Iraq, is one of the busiest trauma hospitals in the world and maintains a 98% survivability rate for patient’s presenting with a pulse (Clare, 2008). However, presenting injuries sustained in combat requires medical personnel to have specialized knowledge and skills to provide effective care.
Sustainment of knowledge and practical skills related to traumatic injuries and critically ill patients are an issue for military nurses (Derr et al., 2008). It has been concluded that civilian nursing education does not sufficiently prepare military nurses to care for soldiers with combat-related injuries (Johansson et al., 2007). And, once trained, military nurses must periodically refresh knowledge and skills needed to maintain practice readiness in a military environment (De Lorenzo, 2005). Yet, reports revealed that medical personnel deployed in support of Operation Desert Storm lacked exposure to wounds commonly seen in combat and the experience needed to successfully treat such injuries which directly impacted patient outcomes (Derr et al., 2008). Subsequently, provisions of the National Defense Authorization Act of 1996 required the development of trauma training programs in corporation with civilian trauma centers (Derr et al., 2008).

Developed and sustained by the Department of Defense (DOD), the Center for Sustainment of Trauma and Readiness Skills (C-STARS), a trauma-training site for U.S. Air Force medical personnel, was opened in 2000 at the R. Adams Cowley Shock Trauma Center (STC) of the University of Maryland, Baltimore. This program provides physicians, nurses, and other medical personal with the training and skills needed to deploy and successfully care for trauma patients likely to be encountered in the combat environment (McCunn, York, Hirshon, Jenkins, & Scalea, 2011). Course curricula is specific to the practitioner and includes didactic as well as participation in cadaver labs, and simulation exercises based upon Air Force identified knowledge and skill sets necessary to function effectively in a combat environment (McCunn et al., 2011). The combat environment is defined as “any environment in which healthcare providers and patients are exposed to armed fighting with enemy forces” (Brewer & Ryan-Wenger, 2009, p. 508).
The mechanism of injury seen in combat hospitals has evolved in part from changes in enemy tactics and increased sophistication of weaponry including the use of improvised explosive devices (IEDs) (Kelly et al., 2008). From September 2006 to August 2007 the Air Force Theater Hospital (AFTH) located in Balad, Iraq, admitted more than three thousand patients, of which, more than 50% had sustained a blast injury resulting from IEDs, mortars, or rocket propelled grenades (RPGs) (McCunn et al., 2011). Similarly, in a 9-month study at a British Military Field Hospital in Iraq, 50.6% of combat injuries resulted from IEDs making it the most common cause of injury recorded during the study (Ramasamy, Harrisson, Lasrado, & Stewart, 2009). Though common in the combat environment, penetrating injuries are rarely encountered in the civilian setting. In fact, more than 90% of civilian trauma injuries are due to blunt force resulting from motor vehicle accidents (MVAs) or falls (Schreiber et al., 2008). “The ferocity of modern weaponry and the change in enemy operation tempo and tactics are not comparable with the civilian sector” (Kelly et al., 2008; p. S24).

The sounds, smells, and memories of combat nursing are not soon forgotten. One of the greatest sources of stress for deployed nurses is the frequency with which combat casualties are encountered. The use of explosive devices by enemy insurgents in Iraq and Afghanistan increased from 56% in 2003-2004 to 76% in 2006 (Kelly et al., 2008). The severity of injuries resulting from IEDs and other explosive devices and an almost daily exposure to combat fatalities has a lasting physical and psychological impact on nurses. Nurses previously deployed to Iraq and Afghanistan recalled, with vivid detail, the frequency and severity of injuries sustained by soldiers, civilians, and children (Scannell-Desch & Doherty, 2010). One method, described by nurses, to deal with combat-related stressors, such as the reality of war and soldier fatalities, is psychological distancing (Griffiths & Jasper, 2008). The stressful work environment
and the frequency of dealing with death has been associated with compassion fatigue, clinical errors, and low morale which may contribute to feelings of burnout and job dissatisfaction (Kashani, Eliasson, Chrosniak, & Vernalis, 2010).

Lastly, nurses deployed to combat environments must often juggle dual roles of an Airmen, officer, and nurse which can lead to role conflicts (Agazio, 2010; Griffiths & Jasper, 2008). Inherent to the profession of nursing is a dedication to providing quality care and advocating for all individuals, families, and communities. But in combat, situations arise where nurses must provide care to enemy forces or take active measures to restore safety (Griffiths & Jasper, 2008). The issue at hand is the code of practice for military service members does not always align with the code of professional nursing practice. Balancing the amount of caring with military roles and obligations, in addition to ensuring the safety of everyone in the facility, leaves nurses conflicted (Griffiths & Jasper, 2008). In fact, according to the regulations outlined by the North Atlantic Treaty Organization (NATO), medical personnel, including nurses, may use weapons for protection (Griffiths & Jasper, 2008). The additional elements of the Airmen role above the already complex nursing role only contribute to sources of stress for nurses deployed to a combat environment.

Circumstances unique to the military environment have the potential to impact the transition from civilian to military nursing practice. Experienced, professional nurses must adapt not only to their new role in a military environment but also to their role as a service member and officer, differing practice settings and expectations, and the possibility of deployment. In order to optimally function and contribute fully, military nurses require additional support and added professional training (Griffiths & Jasper, 2008).
Statement of the Problem

The nursing literature has consistently described transitions as complex, problematic, and stressful (Clare & van Loon, 2003; Newton & McKenna, 2007). Currently there is no known research that explores the role transition of experienced nurses who move from civilian to military nursing practice. The results and conclusions derived from research investigating role transitions among civilian nurses simply cannot be generalized to military nurses due to the vast differences in the nursing role, expectations, and clinical practice environments as outlined above.

Purpose of the Study

The purpose of this study is to explore and describe the lived experience of transition from civilian staff nurse to an Air Force staff nurse. It is important to investigate and understand the role transition that new military nurses in the USAF undergo in order to better support future Air Force nurses during transition.

Research Question

The over-arching question guiding this study is: What is the lived experience of civilian registered nurses, with more than one year of clinical experience, who undergo a role transition to military nursing practice in the USAF? The additional questions this study seeks to answer include:

1. What does it mean to be a nurse in the USAF?
2. How do new military nurses in the USAF perceive the transition from civilian to military nursing practice?
3. What factors facilitate the transition process?
4. What factors hinder the transition process?

5. What knowledge and skills, brought from civilian practice, are perceived to help the transition to military nursing practice in the USAF?

6. What advice can be shared with other new USAF nurses that could improve the transition process?

**Significance of the Study**

The vision of the AFNC is “a total nursing force delivering evidence-based, patient–centered care to meet global operations” (Siniscalchi, 2009, p. 1). Yet the ability to meet this vision has been impacted by the nursing shortage and the ability of the USAF to recruit and retain experienced nurses (Siniscalchi, 2009). The AFNC established four key priorities which serve to guide nurse leaders in meeting the vision. Two priorities in particular, Force Development and Force Management, may be directly influenced by the transition experiences and outcomes of experienced nurses new to military nursing practice. These priorities seek to enhance professional competencies of nurses through enhanced educational and training opportunities while building and sustaining the AFNC which is capable of meeting healthcare needs at home and abroad (Siniscalchi, 2009). This includes assuring “the right number of people to accomplish the mission” (Siniscalchi, 2009, p. 4).

New Air Force nurses, leaving professional practice in the civilian healthcare environment, are likely to encounter significant role transitions. The role transition process and transition outcomes maintain reaching implications capable of impacting the nurse’s career, the welfare of soldier’s receiving care, the AFNC, and potentially the safety and security of our country. The unique practice environments and role expectations require Air Force nurses be knowledgeable, well-rounded, flexible, and adaptable. According to the nursing literature,
unsuccessful role transitions are associated with role ambiguity, unrealistic role expectations, lack of support, and feelings of unpreparedness for the role (Chang & Hancock, 2003; Clare & van Loon, 2003; Cranford, 2013; Rosser & King, 2003). For Air Force nurses, unsuccessful transitions could result in feelings of depression and anxiety, decreased confidence, and stress leading to loss of duty time or an inability to carry out the mission. Worse yet, negative transitions could cause undue harm and injury to Airmen resulting in loss of life or additional costs to the Air Force.

Understanding the transition process from the perspective of an Air Force nurse is imperative. Although there is a plethora of literature investigating the role transitions of graduate nurses beginning professional nursing practice and minimal research among experienced nurses undergoing role transition, there is no research investigating the transition experiences of civilian staff nurses who move into an Air Force staff nurse role. This study will add to the existing body of knowledge by examining the role transition experiences of new Air Force nurses. It is anticipated that the lived experiences reported by these military nurses will inform senior leaders at the base, command, and Air Force levels of the transition process and influence future efforts aimed at improving role transition experiences for military nurses and the retention of experienced nurses capable of meeting the vision of the AFNC.

**Theoretical Framework**

Meleis, Sawyer, Im, Messias, & Schumacher’s (2000) middle-range theory of transition was chosen to frame the concept of the study and develop interview questions which capture all of the known elements of role transitions in nursing. Believed to result from and result in changes to identity, roles, abilities, health, relationships, behaviors, and environments (Schumacher & Meleis, 1994) transition is defined as the “passage from one life phase,
condition, or status to another” (Chick & Meleis, 1986, p. 239). Decades of empirical work and collaboration with students and other nurse researchers resulted in Meleis et al. (2000) theory of transition which incorporates the types, patterns, and properties of transition in addition to the conditions which facilitate or inhibit the transition process, and finally the patterns of response reflected in process and outcome indicators (Figure 1.1).

Transitions are described by the type, pattern, and essential properties. There are four types of transition in nursing: developmental, situational, health/illness, and organizational (Meleis et al., 2000). Situational transitions are those that involve changes in professional roles or scope of practice (Schumacher & Meleis, 1994); including the transition from civilian to military nursing practice among professional nurses with more than one year of clinical experience. Transitional patterns influence the transition process. Patterns include whether one or more than one transition is occurring, whether these transitions are sequential or simultaneous, and whether transitions are related or unrelated (Meleis et al., 2000). Finally, all transitions, regardless of type or pattern, maintain similar, interrelated properties. Transitional properties include an awareness of the transition experience, engagement in the transition process, changes and differences, movement over time, and critical points which serve as indicators of the transition process (Meleis et al., 2000).

Transition conditions are the elements which facilitate or hinder the transition process and impact the outcomes of transition (Meleis et al., 2000). Meleis et al. (2000) outlined three types of conditions including personal, community, and societal. Personal conditions include the meanings ascribed to the events before and during the transition process, any cultural beliefs attached to the transition event, socioeconomic status, and knowledge of and preparation for the transition (Meleis et al., 2000). Resources in the community include personal and professional
support systems, role models or mentors, and information or advice which is available when needed (Meleis et al., 2000). Societal perceptions, influenced by stereotypes and social stigmas, can also interfere with a person’s ability to achieve a healthy transition.

Healthy transitions are defined by process and outcome indicators. Process indicators are those characteristics which indicate whether a transition process is moving in a positive or negative direction (Meleis et al., 2000). According to the transition theory, the process indicators include feeling connected to new and old contacts, interacting with others so that the meaning of the experience may be uncovered, an environment which supports transition, becoming situated in terms of time or relationships, and developing confidence and coping (Meleis et al., 2000). Outcome indicators are the characteristics which define the outcome of transition. These include role mastery and the reformation of a new identity (Meleis et al., 2000).

Each transition is unique, complex, and multidimensional. While all transitions may increase susceptibility to alterations in health and wellbeing they can also be regarded as opportunities. This study will incorporate concepts from Meleis’ et al. (2000) theory of transitions in the investigation and description of the lived experiences of nurses, with more than one year of clinical experience, who transition from civilian to military nursing practice. It is anticipated that this study will broaden the understanding of transition and applicability of Meleis’ et al. (2000) theory by applying the concepts to a yet unstudied cohort of nurses.
Assumptions

The purpose of this study is to explore and describe the lived experience of transition from civilian staff nurse to an Air Force staff nurse. The methodology chosen for this study is a qualitative, hermeneutic phenomenological approach. The phenomenological method is ideal for studies that seek to explore the experiences that can only be described by those living it. Phenomenological researchers seek to understand lived experiences by using rich descriptions to describe phenomena that are generated through collaborations between researcher and participant (Dowling & Cooney, 2012; Finlay, 2009). Before undertaking this study, it is important to acknowledge any underlying assumptions.
The following list outlines the assumptions related to the chosen methodology and the phenomena of interest to this study:

1. The hermeneutic, phenomenological approach is a useful framework for capturing rich data which may be used to describe and understand role transitions among new Air Force staff nurses.
2. Military nurses are willing to share their role transition experiences.
3. The participants in the study will provide data that is factual and authentic.
4. Role transitions in nursing are stressful.
5. The practice environment influences the transition experience.
6. Past nursing experience influences transition.
7. The role transition in a military setting is vastly different than one in a civilian setting.
8. The researcher’s own professional role transition experiences and knowledge of role transitions will influence the study.

**Definition of Terms**

1. Civilian nursing practice – nursing care provided by nurses outside of a military medical environment, such as a hospital.
2. Experienced nurse – a registered nurse who has at least one year of clinical practice experience
3. Hermeneutic phenomenology – a phenomenological approach, based upon Heidegger’s philosophy, which maintains “that participant’s experiences and interpretation of ‘being-in-the-world’ are embodied in a background of linguistic and cultural traditions that can only be understood and interpreted by another ‘being-in-the-world’ – the researcher” (Lowes & Prowse, 2001, p. 474).
4. Lived experience – “the reciprocal relationship between the respondent and the environment as he or she sees it” (Dombro, 2007, p. 102).

5. Military nurse – a registered nurse that serves in any branch of the U.S. military and holds military rank (Kesler, 2012). Within the context of this study, military nurses will be limited to only Air Force nurses.

6. Military nursing practice – nursing care of active duty, retirees, and dependents which is provided by registered nurses, serving as commissioned officers, practicing within the military medical system, under the direction of the Chief Nurse, Medical Group Commander, and Wing Commander.

7. Nurse Corps – all military services have nursing branches called ‘corps.’ A ‘corps’ is defined as a “semi-independent or independent military command whose members are grouped together because they share a common mission or career path” (Kesler, 2012, ¶ 3). For example: the Air Force Nurse Corps (AFNC).

8. Phenomenology – a philosophy and a research method (Munhall, 2007a) that seeks to understand and describe lived experiences by uncovering the meanings of phenomena (Pringle, Hendry, & McLafferty, 2011; Petty, Thomson, & Stew, 2012). It is broken down into two separate and distinct philosophies: descriptive (or eidetic, which is guided by the ideas of Edmund Husserl) and interpretive or hermeneutic (guided by the ideas of Martin Heidegger).

9. Phenomenon – the central concept of study by phenomenologists and the concept which is experienced by the participant (Creswell, 1998, p. 236).

10. Registered nurse – someone who has graduated from an accredited nursing program and successfully passed the NCLEX exam.
11. Transition - a passage or movement, over time, from one place or state to another that “can produce profound alterations in the lives of individuals and their significant others and have important implications for well-being and health” (Schumacher & Meleis, 1994, p. 119).

12. Work-role transition – the “human experience associated with entering a new community of practice” which has been described as a “dynamic, developmental process with associated emotional work, critical tasks, and a diffusion through role boundaries to assume the new identity, values and knowledge base of the new role” (Anderson, 2009, p. 203).

Summary

This chapter introduced the problem, provided background information about the military healthcare system and military nursing practice, identified the purpose of the study, provided justification for the study, and listed the research questions and assumptions.
Chapter 2: Review of Literature

Chapter two will critically examine the current nursing literature of role transitions in professional practice. The chapter includes a synthesis of the reported experiences, characteristics of work life and the practice environment, and the supports afforded during the transition process which were broken down into two cohorts: new graduates and experienced nurses. A discussion of the similarities and differences between the experiences of each cohort is provided in addition to research implications with possible direction for future research inquiry on the phenomena.

A search of the nursing literature was undertaken to investigate the current state of research regarding role transitions in professional nursing practice for the purpose of identifying future areas of research inquiry on the topic. Electronic databases, including CINAHL, PubMed, ProQuest, OVID, and Science Direct, were explored using the keywords transition, role transition, nursing, novice nurse, and graduate nurse. Additional studies were located following a review of reference lists of relevant articles. Realizing the dynamic nature of the acute care environment, studies related to role transitions in nursing were limited to ten years while no date limitations were placed upon articles which presented or discussed theoretical frameworks or models developed to reflect role transitions in nursing.

Inclusion criteria. To meet inclusion criteria for this literature review, articles must be written in English, the central concept of the study clearly designated as transition, and confined to nursing literature. Because the healthcare system is rapidly evolving and the work environment heavily influences transition experiences, articles that focused on role transitions were limited to publication between 2003-present.
Exclusion criteria. Articles not written in English, did not focus on the concept of transition, or were published before 2003 were excluded from this review. Based upon the inclusion and exclusion criteria, a total of 50 studies investigating the experience of transition were included in addition to four articles which presented theoretical frameworks or models of transition. Finally, an additional five articles, deemed classic to the investigation and understanding of transition were also included.

Analysis method. Articles matching the inclusion and exclusion criteria were organized and evaluated using the Matrix Method (Garrard, 2011). According to the Matrix Method, located articles are organized and summarized in a table format from oldest to most recent with six columns labeled as follows: author, year, purpose, sample, methods, and findings (Garrard, 2011). Once compiled, a critical review of the literature was undertaken to identify themes in transitional research and identify implications to nursing practice and direction for future inquiry.

Findings

Role transitions for new graduates and experienced nurses have the potential to be significantly different. For this reason, findings are reported separately with a synthesis of commonalities and differences presented in the discussion section.

Role Transition for the New Graduate Nurse

Often described as a common rite of passage for nurses, the transition from a student nurse role to a professional nursing role is challenging and complex (Delaney, 2003). With most new graduates beginning professional practice in a hospital setting, characterized by demanding workloads, advancing technologies, and higher patient acuities, it is not surprising that new graduates describe the transition to practice as stressful. Beginning with a formal orientation
period, transition to practice often lasts 12-18 months and requires new graduates to master skills and behaviors inherent to the role of a professional nurse as well as the culture, norms, and values of the profession and the work place (Newton & McKenna, 2007; Pellico, Brewer, & Kovner, 2009).

Before graduation, student nurses draw strength and comfort from nursing faculty, peer support, and protections afforded in the student role (Morrow, 2009). New graduates are excited to begin professional practice (Delaney, 2003) and initially report feeling comfortable and confident in their new role (Casey et al., 2004). However, feelings of shock, stress, and fear quickly beset the new graduate as they realize a sense of unpreparedness for the role due to a lack of knowledge, clinical skill proficiency, and critical thinking skills expected of professional nurses (Casey et al., 2004; Duclos-Miller, 2011). Kramer (1974) initially described the disparity between school-bred values and the reality of practice as reality shock. More recently, Duchscher (2008) used the term transition shock to describe differences between the roles, responsibilities, and expectations of student nurses in undergraduate nursing programs compared to those required of professional practice.

Role stress is a persistent part of reality shock experienced by new graduates in transition (Chang & Hancock, 2003; Kramer, 1974). Role stress is defined as a discrepancy between the perception of a role and the ability to perform the role (Hoffart, Waddell, & Young, 2011). Consistent with findings by Kramer (1974) and Duchscher (2008), role stress results from a lack of self-confidence (Walker, Earl, Costa, & Cuddihy, 2013), role ambiguity and role overload (Chang & Hancock, 2003), limited skill proficiency (Ellerton & Gregor, 2003), differences between expectations of the nursing role and the reality of nursing practice (Duclos-Miller, 2011;
Naydi & Cheri, 2008), and an inability to cope with end-of-life issues (Delaney, 2003; Walker et al., 2013).

Practice readiness is consistently implicated in the negative transition experiences reported by new graduates (Oermann, Poole-Dawkins, Alvarez, Foster, & O’Sullivan, 2010). Clinical preparation during school is insufficient to prepare new graduates to function in the role of a professional nurse (Berkow, Virkstis, Stewart, and Conway, 2008; Romyn et al., 2009). The expectation of new graduates to enter practice as fully capable and functioning registered nurses, in the same environments deemed challenging by experienced nurses, is unrealistic and often leaves the new graduate feeling overwhelmed and isolated (Craig, Moscato, & Moyce, 2012; Dyess & Sherman, 2009; Olson, 2009). New graduates have an intense fear that a lack of experience may contribute to making mistakes, missing important clinical information, or not knowing what to do during an unanticipated crisis all of which have the potential to cause undue patient harm (Craig et al., 2012; Etheridge, 2007; Olson, 2009). New graduates simply do not have the competence and confidence to assume the responsibility and management of patient care expected of professional nurses (Casey et al., 2004). Although new graduates desire autonomous practice, a lack of knowledge and skill proficiency results in an unforeseen dependence on the knowledge and experience of peers and mentors to provide safe care (Casey et al., 2004; Ellerton & Gregor, 2003; Naydi & Cheri, 2008; Romyn et al., 2009; Thrysoe, Hounsgaard, Dohn, & Wagner, 2011). To the new graduate, practice readiness is more than the ability to perform procedures as learned in the academic setting. The essential skills of professional nursing practice include assessment, prioritization, time management, delegation, communication, and critical thinking (Chandler, 2012).
Learning to think critically is a major part of role socialization for new graduates in transition. Critical thinking skills develop through individual problem solving and collaboration with members of the healthcare team and improve with clinical experience suggesting that it is a function of time (Etheridge, 2007). A primary goal of undergraduate nursing education is to develop critical thinking skills through emphasis and application of the nursing process to clinical practice (Duchscher, 2003). However, new graduates report having insufficient clinical opportunities to practice clinical skills and apply textbook standards of care to real world nursing practice (Casey et al., 2004; Clare & van Loon, 2003). New graduates realize that critical thinking is more than the ability to successfully complete nursing skills or procedures. It involves collecting, analyzing, and interpreting multiple pieces of clinical data and individually applying them to a particular patient (Etheridge, 2007). In nursing, the outcome of critical thinking is the ability to make sound clinical judgments.

New graduates struggle when expected to make complex clinical decisions yet feel unqualified to do so. The unexpected amount of responsibility associated with the professional nursing role coupled with the dynamic, fast-pace environment of current nursing practice in the hospital setting often leave new graduates feeling anxious and overwhelmed (Delaney, 2003). A perceived inability to make accurate clinical judgments and competently perform the nursing role is a source of stress consistently described in the literature (Clare & van Loon, 2003).

**Characteristics of Work Life and the Practice Environment.** The chaotic workplace, characteristic of the hospital setting, is influenced by nursing shortages, high patient acuity, technological advancements, and scarce resources all of which impact the transition to practice (Scott et al., 2008). New graduates expect and believe that peers, preceptors, and nurse managers will welcome them into the unit culture and the profession by providing support and a positive
work environment that fosters collaboration and learning. However, the reality encountered is often far different.

New graduates not only have to learn how to function in the professional role but also maneuver the healthcare organization and interactions with members of the healthcare team (McKenna & Green, 2004; Wangensteen, Johansson, & Nordström, 2008). Collegial relationships with experienced nurses and physicians are important to new graduates; however, unprofessional behaviors commonly witnessed in the workplace only reinforce traditional hierarchical struggles (Duchscher, 2009; Martin & Wilson, 2011). In fact, 48% of participants in Clare and van Loon’s (2003) study reported witnessing or experiencing unprofessional behavior by members of the healthcare team. Defined as “any act of aggression demonstrated by a colleague, and it is inclusive of emotional, physical, and verbal threats, as well as innuendo or criticism” (Dyess & Sherman, 2009, p. 407) horizontal violence leaves new graduates feeling intimidated and anxious (Andersson & Edberg, 2010). New graduates frequently report that they feel a lack of acceptance, respect, and support from experienced nurses contributing to feelings of disillusionment with the profession (Casey et al., 2004; Pellico et al., 2009). In fact, new graduates often feel that their lack of knowledge and experience is perceived as a weakness rather than an expectation of graduate nurses in transition (Morrow, 2009). Unprofessional workplace behaviors negatively influence new graduate self-confidence that can impact the ability to successfully transition and integrate into the unit culture (Walker et al., 2013).

Workload, expressed as high nurse-to-patient ratios, is a major source of stress to new graduates (Pellico et al., 2009). In a study by Scott et al. (2008), 24% of the new graduates surveyed reported daily nursing shortages which impacted the ability to safely practice. New graduates need stable workloads that provide ample opportunities to practice and master basic
nursing skills (Thomas, Bertram, & Allen, 2012). Ready access to preceptors and other experienced nurses during the first one to four months of practice is imperative (Duchscher, 2009). Realizing student nurses have limited patient care assignments in undergraduate clinical rotations, Duchscher (2009) suggests gradually increasing workload and patient complexity during the transition period. Adjustments to workload should be a collaborative effort between the preceptor and new graduate and should be based on the knowledge and skills acquired through experience and comfort in the role of a professional nurse.

Fitting into the healthcare team and unit culture is important to new graduates but is often challenging (Delaney, 2003; Deppoliti, 2008; Malouf & West, 2011). Eager to “to demonstrate their knowledge and be seen as a professional” new graduates are surprised when they encounter colleagues who do not appreciate their developmental level and the support needed to function effectively in the role (Jewell, 2013, p. 2). Keenly aware of deficits in knowledge and experience, new graduates will go to great lengths to appear confident as a way of fitting in (Duchscher, 2008). In fact new graduates felt that fitting in with staff members was more important than learning about patient conditions or providing patient care (Thrysoe et al., 2011). New graduates believe full acceptance into the unit culture is achieved when colleagues seek help and assistance from them (Duchscher, 2008; Schoessler & Waldo, 2006). The preceptor is often in the best position to facilitate integration of the new graduate into the unit culture and healthcare team (Dyess & Sherman, 2009; Romyn et al., 2009).

Support for the New Graduate Nurse. “The first year in a profession establishes an individual’s career framework and influences long-term professional development and satisfaction” (Scott et al., 2008, p. 75). With more than 10% of a typical hospital workforce staffed by new graduates (Berkow et al., 2008) and approximately 89.2% of new licensed
registered nurses beginning practice in hospital settings (National Council of State Boards of Nursing [NCSBN], 2009), it is vital that they are adequately supported. Unfortunately, nurse managers readily concede that traditional orientation programs, offered by hospitals, are insufficient to fully prepare a new graduate for practice, regardless of the educational program from which they graduated (Oermann et al., 2010). Further, new graduates need support from peers and managers for up to a year after completion of the traditional orientation period. How then are new graduates best supported during the transition from a student to a professional nurse?

Comprehensive orientation programs that foster the development of clinical competencies and positively promote role socialization are essential. Quality orientation programs, that meet new graduate needs, may enhance job satisfaction in the initial transition from student to professional nurse and reduce job turnover (Scott et al., 2008).

Currently, many hospital-based orientation programs combine didactic and precepted practice with an experienced nurse over a period ranging from 2 weeks to 24 weeks (Casey et al., 2004; Delaney, 2003; Ellerton & Gregor, 2003). The quality of these programs is influenced by financial resources, nursing shortages, and staffing patterns. Orientation programs and the transition experiences of new graduates in the United States are variable, leading to calls for yearlong, standardized transition programs based on best practice (Spector & Echternacht, 2010). To be successful, these standardized programs must appreciate the learning needs of new graduates, utilize well-trained nurse preceptors, facilitate strong relationships with colleagues and members of the extended healthcare team, encourage communication, provide timely, constructive feedback, and significantly reduce stress associated with the new role (Hoffart et al., 2011). During transition, Spector & Echternacht (2010) also suggest the inclusion of modules
covering patient-centered care, communication and teamwork, evidenced-based practice, quality improvement, and informatics.

Preceptors significantly influence a new graduates’ perception of transition and are pivotal to success in the professional role (Delaney, 2003; McKenna & Newton, 2008). It has been reported that new graduates need and value well-trained, consistent preceptors in order to build trust and promote a comfortable learning environment whereby the new graduate feels comfortable asking questions (Andersson & Edberg, 2010; Casey et al., 2004). Preceptors can ease stress and enhance self-confidence (Thrysoe et al., 2011) through consistent, constructive feedback (Duchscher, 2009), as well as, provide regular praise and encouragement (Walker et al., 2013; Wangensteen et al., 2008). Unfortunately, experienced nurses often report feeling unprepared and unsupported in the preceptor role (Spector & Echternacht, 2010).

A supportive work environment is directly linked with positive transition experiences (Clare & van Loon, 2003). Realizing that negative transition experiences are linked to job dissatisfaction, poor retention of new graduates, and turnover within and outside of the profession, healthcare organizations and unit based nurse managers are working to reform the practice environment to be more supportive of the needs and expectations of new graduates (Clare & van Loon, 2003). A review of transitional studies spanning more than four decades informed the development of best practice principles which, when implemented, create a supportive environment for graduates nurses in transition. According to Clare and van Loon (2003), the best practice principles for ensuring a supportive work environment for the new graduate in transition include sufficient numbers of qualified preceptors for each new nurse, open patterns of quality communication and feedback, nurse colleagues that maintain positive attitudes and professional standards, and finally ample continuing education opportunities.
A supportive work environment, positive preceptor experiences, a comprehensive orientation, clear role expectations, and self-confidence all contribute to a positive transition experience (Zinsmeister & Schafer, 2009). Successful transition is defined by new graduates as a confidence in the ability to provide safe care, positive feedback from peers, feeling a part of healthcare team, comfort in asking questions, time management skills, self-confidence in the ability to perform the job, and an ability to handle unexpected situations (Craig et al., 2012). The outcomes of negative transition include a lack of retention, increased turnover, increased dissatisfaction by new graduates and employers, increased costs to healthcare organizations, and risks to patient safety (Spector & Echternacht, 2010).

Role Transition for the Experienced Nurse

A work role transition is defined as “the human experience associated with entering a new community of practice” (Anderson, 2009, p. 203). For experienced nurses, role transitions may occur with any change in clinical practice environment, moving into an advanced practice nurse role, or moving out of clinical practice into a nurse educator position in an academic setting. Regardless of practical experience, role transitions are capable of inducing thoughts, feelings, and experiences similar to those of novice nurses beginning professional practice (Cranford, 2013; Manning & Neville, 2009).

Role transitions in nursing are challenging. Just like new graduates, experienced nurses often report a disparity between the expectation of a new role and the reality encountered (Schriner, 2007). Although experienced nurses bring transferrable skills, correlated with time in a professional role and clinical experience, all role transitions involve letting go of previous professional roles and learning new or different knowledge, skills, behaviors, responsibilities, expectations, and norms (Cranford, 2013; Pearson, 2002; Robinson, Kellett, King, & Keating,
2012) in addition to new environments, policies, and hierarchal structures (Anderson, 2009). 
More importantly, nurses must learn “to use their previous knowledge in new ways” (Steiner, 
McLaughlin, Hyde, Brown, & Burman, 2008, p. 441). Nurses felt that prior knowledge and 
xperience would adequately inform and prepare them for the role to the degree that they would 
quickly fit in with colleagues and function autonomously in a short period of time; but were 
surprised when this did not occur (Hartung, 2005).

Experienced nurses commonly report role stress during professional role transition for 
numerous reasons. A lack of role clarity resulting in role ambiguity was reported as a major 
source of role strain significantly contributing to role stress for nurses transitioning from clinical 
practice to academia (Cranford, 2013; Kelly & Mathews, 2001). New nurse educators conceded 
that a previous exposure to the academic role did not equate to a full understanding or 
appreciation of the expectations associated with the role. Further, a lack of explicit role definition 
by academic supervisors resulted in apprehension and confusion for new educators (Manning & 
Neville, 2009; McDermid, Peters, Daly, & Jackson, 2013). New advanced practice nurses 
struggled with an expanded role that afforded increased power in clinical decision making 
abilities that resulted in feelings of isolation, uncertainty, and fear but also contributed to role 
stress (Bombard et al., 2010; Cusson & Strange, 2008; Kelly & Mathews, 2001). Prolonged role 
strain and role stress impacted the physical and mental health of nurses leading to feelings of 
incompetence, weight loss, and exhaustion (Cranford, 2013; Kelly & Mathews, 2001; Manning 
& Neville, 2009). For most nurses, feelings of frustration, anxiety, fear, and inadequacy 
dissipated over time as experience in the new role increased comfort and confidence (Bombard et 
al., 2010).
Role performance is influenced by internal and external factors (Figure 2.1). A lack of educational preparedness was consistently implicated in the inability of new nurse educators to perform the role as anticipated (Dempsey, 2007; Duphily, 2011; Johnson, 2008; Weidman, 2013). In the opinion of new nurse educators, classes did not train future educators how to teach nor provide ample experience teaching in a classroom setting before graduation (Manning & Neville, 2009). The same cannot be said for new advanced practice nurses. Participants in Kelly and Mathews (2001) and Cusson and Strange’s (2008) studies report feeling sufficiently prepared, both academically and clinically, to move into practice in an advanced role. Nurses changing clinical practice environments bring a repertoire of relevant skills and experience to the new role, however, additional education and professional development is often needed (Rosser & King, 2003).

Conflict arises when there is a gap between role expectations and role performance (Pearson, 2002). Unrealistic expectations, held by healthcare organizations, managers, and peers, to fully know how to perform the role and do so independently in a short period of time contributed to role stress (Maxwell, Brigham, Logan, & Smith, 2011) and negatively influenced role performance (Dempsey, 2007; Hartung, 2005). Many times, nurses in role transition used compensatory measures to bridge the gap between the role expectations, colleague’s expectations, and a deficit in knowledge or skills. Schoening (2013) concluded that new nurse educators would frequently over-prepare to prevent appearing incompetent or failing to properly teach nursing students the course content. Participants in the McDermid et al. (2013) study sought outside learning opportunities, in the form of continuing education, which would aid role performance.
**Figure 2.1: Factors Influencing Role Expectations & Performance during Transition**

<table>
<thead>
<tr>
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<th>Role Expectations</th>
<th>Role Performance</th>
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| **External Factors** | • Knowledge of the professional role  
• Exposure to the professional role  
• Clinical experiences  
• Role models  
• Past nursing experience  
• Unrealistic expectations by peers & nurse managers | • Orientation  
• Work environment  
• Workload  
• Mentor/preceptor support  
• Nursing shortages  
• Advanced technologies |
| **Internal Factors**  | • Personal experiences with nurses & professional nursing practice  
• Previous experience as a professional nurse  
• Unclear or unknown expectations  
• Unrealistic expectations of self  
• Reality shock | • Lack of knowledge  
• Lack of skill proficiency  
• Low self-confidence  
• Stress  
• Role overload  
• Feelings of unpreparedness  
• Fear  
• Anxiety |

**Characteristics of Work Life and the Practice Environment.** Many of the same challenges reported in the literature of new graduate transition to practice is applicable to experienced nurses in role transition. The fast-paced work environment, nursing shortages, rapidly advancing technologies, and the expectation of nurses to do more with less continue to influence role transitions. The ability to integrate knowledge, skills, and information gained through experience may ease transitional stresses and struggles (Johnson, 2008).

Heavy workloads in the clinical and academic settings are problematic for experienced nurses during role transition. It was not uncommon, even for experienced nurses, to lack the knowledge and skills needed to wholly perform the new role without additional education and training (Rosser & King, 2003). In addition to minimal teaching requirements, expressed as contact hours, nurse educators maintain additional workload obligations such as membership on
university committees as well as advancing the profession through scholarship (Cranford, 2013). Weidman (2013) suggests a lighter teaching load until new educators are comfortable in a teaching role and balancing other work related responsibilities. In the clinical environment, experienced nurses should have stable workloads commensurate with previous work experience and comfort levels (Zurmehly, 2007). Hartung (2005) also suggests a reduced workload while nurses learn the new role, become familiarized with the organization, and work to fit in with colleagues.

Like new graduate nurses, experienced nurses desire to fit in and become a part of the workplace team (Asselin, Osterman, & Cullen, 2006). Experienced nurses hope that peers appreciate the knowledge and clinical experiences which they bring to the role (McDermid et al., 2013) and desire to “establish their credibility” as well as “demonstrate worth” to the organization (Manning & Neville, 2009, p. 48). This process is made more challenging by colleagues who do not understand the process of transition or offer support to nurses during role transition (Maxwell et al., 2011).

**Support for the Experienced Nurse during Role Transition.** Peer, managerial, and organizational support is essential to the successful role transition of experienced nurses (Asselin et al., 2006). It is crucial that nurses receive multilayer support during all stages of transition (Robinson et al., 2012). Adequate support during role transition is associated with decreased feelings of anxiety, confusion, and stress (Rosser & King, 2003) while a perceived lack of support was associated with feelings of decreased self-confidence (Maxwell et al., 2011). Positive collegial relationships helped to bolster self-confidence and perform the role effectively (Kelly & Mathews, 2001). In fact, participants in Dempsey’s (2007) study affirmed that collegial
support was the most important determinant of a successful role transition from clinical practice to academia.

Orientation to the new work role and the work environment is vital to a successful transition and often influences the tone of the transition experience. Although consistently reported as important and necessary by researchers, orientation programs did not adequately meet nurse’s needs or expectations (Kelly & Mathews, 2001). Currently, orientation programs are not well-defined, maintain variable lengths, and are individualized to healthcare organizations. Recommendations for improving role transitions include formal, defined orientation periods lasting at least one year (Schoening, 2013) which include clearly defined role expectations and a comprehensive orientation to the work environment and the role (McDermid et al., 2013).

Mentors provide significant support to nurses during role transition. According to Rosser and King (2003), mentors help experienced nurses to bridge the gap between what is already known and what needs to be learned. Mentors also serve as expert resource advisors that can guide practice in an unfamiliar environment and answer questions (Hartung, 2005). Further, mentors are in a position to provide interpersonal support to nurses struggling to cope with transition (Cranford, 2013). Lastly, mentors provide consistent, supportive, and immediate feedback that is deemed important to role actualization and building self-confidence (Anderson, 2009). However, due to a generalized lack of training of nurse mentors, recommendations for improving role transition include formal training courses aimed at preparing nurses to assume mentorship positions and additional organizational support for nurses serving in a mentor role (Rosser & King, 2003; Sword, 2012). During the entire transition period, the nurse should have access to a well-trained and experienced mentor (McDermid et al., 2013; Schoening, 2013).
Indicators of successful role transitions among experienced nurses are clearly outlined in the literature. First, nurses must maintain the knowledge and skill proficiency necessary to perform the role as expected by healthcare organizations, academic institutions, and other professional bodies (Bombard et al., 2010). Complete socialization to the role will allow the nurse to practice autonomously and safely (Pearson, 2002; Robinson et al., 2012). Hartung (2005) also suggests that successful role transition involve more than gaining the confidence and competence to function in the role; nurses must also be committed to performing the role to their best ability and derive pleasure and satisfaction in doing so.

Ineffective role transitions are defined as the “difficulty taking on new roles and can be manifested when nurses accommodate to the role, but are unable to influence positive outcomes or experience role conflict” (Pearson, 2002, p. 175-176). A focus on tasks rather than outcomes, burnout, and an over dependence on others for successful role performance are specific indicators of ineffective or unsuccessful transitions (Pearson, 2002). Several barriers to successful role transitions are offered by current nursing literature. First is the inability or resistance to letting go of previously held roles that prevent learning a new role (Pearson, 2002). A lack of support, namely an organized orientation and heavy workloads, significantly contribute to feelings of stress, anxiety, and frustration that can interfere with learning and performing the new role successfully (Dempsey, 2007; Pearson, 2002). Unless barriers to successful role transition are reduced or eliminated, nurse turnover and retention will remain problematic (Asselin et al., 2006).

Synthesis of the Literature

The investigation of role transitions in nursing is evident in the nursing literature for more than forty years. However, far more studies focus on the transition experiences of new graduate
nurses moving from a student to professional nursing role. In fact, among the 50 studies included in this review from current nursing literature, only six studies investigating the transition resulting from a change in practice environments, five studies of nurses transitioning into an advanced practice role, and eleven studies investigating the transition from clinical practice into academia could be located. No studies isolating the role transition resulting from a change in clinical practice unit within the acute-care setting was located. Further, specific nursing cohorts are either under-represented, for example rural and public health nurses, or not represented at all, as is the case for military nurses practicing in the United States. This suggests that while there is a plethora of studies about role transitions in nursing, the subject has not been fully investigated.

A synthesis of current literature reveals that regardless of age, years of clinical experience, or educational preparation, role transitions are challenging for nurses. The transition experiences reported by new graduates and experienced nurses alike are markedly similar. Nurses struggle to define and clarify their new role, learn and integrate new knowledge and skills needed to effectively function within the role, and bridge the gap between personal expectations about the role and the often unrealistic expectations held by peers and managers (Weidman, 2013). The outcomes of transition are influenced by personal and environmental factors and are classified along a continuum ranging from successful and effective to unsuccessful or ineffective. Negative transitional outcomes are repeatedly linked to job dissatisfaction, burnout, and turnover (Chandler, 2012; Duphily, 2011; Manning & Neville, 2009; Scott et al., 2008).

Recommendations aimed at easing the struggles commonly associated with transition are widely reported and maintain consistent themes across nursing literature. According to McDermid et al. (2013) and Pellico et al. (2009), formal mentoring programs, clearly defined role expectations, and programs aimed at orienting nurses to both the role and the environment
are needed. The formal orientation period may last as long as one year to achieve comfort in the new role and ensure a successful transition (Anderson, 2009; Casey et al., 2004; Duchscher, 2008; Schoening, 2013). For nurses transitioning from a clinical to educator role, support from colleagues was identified as the most important factor to successful transition (Dempsey, 2007). Researchers caution that mentors and preceptors should be adequately trained before assuming the additional role (Naydi & Cheri, 2008; Sword, 2012; Zinsmeister & Schafer, 2009). Further, professional development opportunities focused around education and training were also deemed useful by nurses in transition (Schriner, 2007). Without attention to personal and professional recommendations role transitions in nursing will continue to remain problematic.

The nursing literature is replete with research investigating the new graduate transition to professional practice through Benner’s novice to expert lens. Benner (1984) defined a novice as anyone that is new to a setting in which roles are different and previous experience is lacking. Clinical experiences in the academic setting provide just enough experience from which new graduates are capable of making basic clinical decisions at the advanced beginner level (Benner, 1984). Experienced nurses who leave a comfortable, well-known role in favor of a new role or new practice environment are likely to temporarily return to a novice level of performance. In fact, nurses in Sword’s study reported feeling like “a new nurse all over again” as they tried to learn and define their new role as a nurse educator (2012, p. 269). Nurses may find themselves at a novice performance level more than one time during their professional careers. Feelings of uncertainty, frustration, fear, stress, anxiety, and decreased self-confidence are inextricably linked to the novice position and the transitions surrounding it (Cusson & Strange, 2008; Duchscher, 2008; Hartung, 2005; Olson, 2009). Healthcare organizations need to implement
strategies that better support nurses at a novice level, regardless of clinical practice experience and knowledge level.

An analysis of current literature reveals strengths and weaknesses in recent studies investigating role transitions in nursing. Qualitative methodologies are commonly employed when little was known about a phenomena (Munhall, 2007a). Research on role transitions in nursing evolved from traditional qualitative approaches aimed at describing the experience of transition, to grounded theory designs that generated models and theories, and later to hybrid approaches which measure constructs commonly reported in previous studies. Over time, studies also incorporated more longitudinal approaches that helped nurses better understand the relationship between time and the transition process. Finally, research investigating specific interventions, such as residency programs for new graduates, were undertaken. Recommendations derived from the transitional literature provide direction and insight to nursing leaders seeking to ease stress during role transitions.

While plentiful in number, current research on role transitions in nursing limit understanding and applicability outside the confines of the particular study. Consistent with qualitative methodologies, study samples are often small and homogenous. While it is realized that conclusions derived from qualitative research studies may not be generalized beyond the study sample, it should be noted that the lack of variation in the samples prevents readers from understanding how different variables may influence the perception and outcomes of role transition. For example, a majority of samples included in this review of literature were largely comprised of young, female, Caucasian nurses. The underrepresentation of male nurses or nurses of different ethnic backgrounds does not allow for a holistic understanding of role transition.
Further, studies often combine multiple variables, capable of impacting role transitions, into one sample. One of the most common are samples in which nurses graduated from different pre-licensure programs. For example, participants in Zinsmeister and Schafer’s (2009) study graduated from associate degree (ADN), Diploma, and baccalaureate degree (BSN) programs while Olson (2009) was the only researcher to deliberately separate the sample into two subgroups based on the degree attained. Without specifically isolating each program it is difficult for the reader to ascertain whether one program better prepares nurses for role transition. In addition, many studies fail to adequately describe and report the practice environments in which the role transition occurred. Nursing literature has consistently implicated the work environment in negative transition experiences, unsuccessful transition outcomes, burnout, and nursing turnover (Kovner et al., 2007; Pellico et al., 2009). Typically, nurse researchers describe the work environment using vague terms such as acute care (Ellerton & Gregor, 2003; Thomas et al., 2012) but rarely provide specific details such as patient population or the number of beds in the unit. In other studies, multiple practice environments are grouped together (Casey et al., 2004; Dyess & Sherman, 2009; Martin & Wilson, 2011). The inattention to detail precludes the reader from understanding the environmental elements which may have contributed to the reported transition experiences.

**Gaps in the Literature**

While there is a plethora of literature investigating role transitions in nursing, a synthesis of current literature revealed limitations which provide direction for future research inquiry. These limitations are discussed below.

**Expand the scope of transitional nursing research to include military nurses.** While military nurses graduate from the same undergraduate programs described in the nursing
literature on role transitions, the similarities end there. The practice environment, nursing role, and job expectations of military nurses are different from their civilian counterparts such that drawing parallels between the two cohorts are not appropriate nor the recommendations derived from the research relevant. “The requirement for well-trained military medical personnel at all levels is imperative” (Derr et al., 2008, p. 203). Missions at home and abroad require well-sustained skills particularly trauma response. “Depending on the base of assignment, exposure to adequate volumes of patients with acute injuries is diminishing” (p. 200). There is currently no research on the role transition from civilian to military nursing practice. Furthermore, it would be imprudent to generalize findings from transitional studies of nurses practicing in a civilian environment onto this small, unique cohort of nurses.

Research of military nurses and their practice is often retrospective and focused almost exclusively on the experiences during war in the combat environment. A total of six studies about military nurses were located of which 4 focused exclusively on the experience of nursing in a combat or humanitarian environment (Agazio, 2010; Brewer & Ryan-Wenger, 2009; Griffiths & Jasper, 2008; Scannell-Desch & Doherty, 2010), one focused on military nurse stress (Kashani et al., 2010) and one investigated the training of military nurses in Sweden (Johansson et al., 2007). The focus of future studies on role transitions in nursing should be expanded to include military nursing practice of service members, their families, and military retirees stationed in the United States, away from the combat environment. Further, differences in expectations of military nurses and practice environments may have a substantial impact on the transition of nurses moving from civilian to military nursing practice. Studies should be undertaken to determine if military nurses maintain the same or similar struggles during transition as described in the current literature of civilian nurses. From there, studies which seek
to describe the similarities and differences in transition experiences across the different branches of the armed forces could help expand the understanding of role transitions in military nursing practice.

**Isolate and compare specific demographic variables in transitional research.** Future transitional studies should isolate demographic variables, such as gender and nursing degree attained, to better understand their individualized influence on transition. Commonly, samples in role transition studies will include both males and females and include more than one degree program (Chandler, 2012; Delaney, 2003; Duclos-Miller, 2011; Dyess & Sherman, 2009; Ellerton & Gregor, 2003; Olson, 2009; Thomas et al., 2012). In order to fully describe and understand the transition experiences for new graduate nurses, it would be beneficial to isolate more homogenous samples and compare across like variables. Etheridge (2007) had the most homogenous sample: all female, graduated with bachelor’s degree, and worked on a medical-surgical unit. However, a lack of similar studies prevent readers from comparing results.

**More focus on the role of different units on transition.** It is widely recognized that the work environment influences the role transition for nurses in a clinical setting. Among studies investigating new graduate nurse transition to practice, only two studies explicitly described the specific units where the role transition occurred (Etheridge, 2007; Martin & Wilson, 2011). Future studies should investigate the role that specific units, such as medical-surgical or critical care, have on transition. Are there elements of these particular environments that influence transition? Do nurses struggle more in one care area more than another? In the case of the new graduate nurse, is one care area, perhaps critical care, so stressful and challenging that professional practice should not begin there?
Summary

This chapter critically examined the current nursing literature of role transitions in professional practice including a synthesis of the reported experiences, characteristics of work life and the practice environment, and the supports afforded during the transition process. The chapter highlighted trends and identified directions for future inquiry; most notably the inclusion of military nurses in studies which investigate the experiences of nurses in transition.
Chapter 3: Methodology

Chapter three describes the research design, sampling method, recruitment of participants, and the data collection process as well as methods used to ensure rigor in the study.

Purpose

The purpose of the study was to explore and describe the lived experience of transition from a civilian staff nurse role to an Air Force staff nurse role.

Research Questions

The central question guiding this study was: What is the lived experience of civilian registered nurses, with more than one year of clinical experience, who undergo a role transition to military nursing practice in the USAF? The additional questions this study sought to answer included:

1. What does it mean to be a nurse in the USAF?
2. How do new military nurses in the USAF perceive the transition from civilian to military nursing practice?
3. What factors facilitate the transition process?
4. What factors hinder the transition process?
5. What knowledge and skills, brought from civilian practice, are perceived to help the transition to military nursing practice in the USAF?
6. What advice can be shared with other new USAF nurses that could improve the transition process?
Research Design

A qualitative, interpretative phenomenological method was chosen to guide this study. The phenomenological method provides a framework by which researchers can describe and interpret the perceptions and meanings of lived experiences associated with a particular phenomenon (Nicholls, 2009a; Welford, Murphy, & Casey, 2012). The role transition of registered nurses, with greater than one year of clinical experience, moving from a civilian to an Air Force staff nurse position is the phenomena of interest. Appendix A provides a detailed discussion of phenomenological approaches commonly used in nursing research with associated philosophical assumptions and includes a rationale for the choice to employ an interpretative phenomenological method for this study.

Recruitment and Sampling

Recruitment of participants began at a 65 bed, multi-specialty, trauma center, located in the Midwestern United States, which is accredited by The Joint Commission on Accreditation of Healthcare Organizations. At this facility, more than 300,000 active duty, retired, and dependent family members receive medical care each year by 2100 military and civilian employees, the majority of which (more than two thirds) are active duty (Barber, 2013). Following approval from the Institutional Review Board at the University of Hawai‘i at Mānoa (Appendix B), nurses meeting the following inclusion criteria were invited to participate:

1. Graduated from an accredited baccalaureate nursing program within the last five years
2. Commissioned officers in the United States Air Force (USAF) employed as registered nurses in a staff nurse role working on an in-patient unit.
3. Maintain between one and five years of nursing experience in a civilian healthcare setting before transition to the USAF
4. Maintain less than two years of clinical experience as a registered nurse in the USAF
5. Did not attend the Air Force Nurse Transition Program (NTP)
6. Willing to voluntarily participate in one, audiotaped interview
7. English speaking

The following exclusion criteria precluded nurses from participating in the study:
1. Currently practicing in an advanced practice nurse (APN) role in the USAF
2. Currently serving in the Air Force Reserves
3. Previously served as an enlisted Airmen in the USAF before becoming a commissioned officer
4. Previously deployed as a registered nurse in the military

**Sampling and Sample Size**

Qualitative research, and more specifically, phenomenology, appreciates the uniqueness of participants and the ways in which meanings are constructed (Nicholls, 2009b). Therefore, samples in phenomenology are not intended to represent the general population, but rather provide insight into a phenomenon through rich descriptions which are based upon personal experience (Nicholls, 2009b; Sandelowski, 1995). While there is no set sample size in qualitative research, Crist and Tanner (2003) argue an adequate sample is achieved when “interpretations are visible and clear, new informants reveal no new findings, and meanings from all previous narratives become redundant” (p. 203). Further, Sandelowski (1986) argues that a predetermination of sample size is not possible because it depends on the data collected and the outcome of data analysis which may lead the study in a different direction. Nicholls
(2009b) notes that in phenomenological studies it is not uncommon to have samples with five to eight participants.

Sampling procedures in qualitative research are less demarcated and rigid as those described in quantitative research (Coyne, 1997). According to Morse (1991), qualitative samples should maintain “appropriateness that requires purposeful sampling and a ‘good’ informant (i.e. one who is articulate, reflective, and willing to share with the interviewer)” (p. 127). A purposive sample is defined as one in which participants with meaningful insight into a particular phenomenon are chosen because of their willingness to talk about their experiences (Haber, 2010; Nicholls, 2009b).

Beginning with a personal contact assigned to an Air Force medical center in the Midwestern United States, participants were recruited using a snowball sampling method. Snowball sampling is a recruitment technique whereby current participants assist the researcher to identify other potential participants meeting the inclusion criteria (Haber, 2010). Interested participants were referred to the principal investigator for additional study-related information. Potential participants were contacted, by e-mail, to introduce the study, outline inclusion criteria, and ascertain interest in participation. Participants were encouraged to contact the researcher for any questions or clarification of the research purpose, aims, or procedures.

**Measures**

**Interview**

Data was collected using semi-structured, face-to-face or telephone interviews. To facilitate timely gathering of the data, semi-structured, face-to-face focus groups were considered
if the researcher encountered constraints related to scheduling of the interviews. Interviews were
conducted by telephone or Skype if additional participants were stationed at other Air Force
bases around the United States or abroad. Situated between the rigid, paternalistic style of the
structured interview and the open, uncontrolled style of an unstructured interview, the semi-
structured interview or focus group balances researcher flexibility and control which assure the
aims of the study can be achieved (Walker, 2011). Nicholls (2009b) advocates the use of guiding
questions as a means of meeting and reaching the aims. The interview (Appendix C) began with
a broad, introductory (“grand tour”) 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. The questions following the first
question on the written interview guide served as probes, as needed, to assure all relevant aspects
of transition were addressed (Turner, 2010). The follow-up questions were developed from
themes emerging from a critical review of literature. A semi-structured interview encourages the
active involvement of both the researcher and participant. Further, validation of participant
descriptions of the experience occurred at the end of each interview to assure congruency
between the researcher’s understandings of participant lived experiences. It was expected that the
interview would provide insight and understanding into the transition experience from the
perspective of the participants in the study. Interviews were conducted in a private, mutually
agreed upon setting, during off-duty hours. Each interview lasted approximately one (1) hour.

**Demographic Questionnaire**

Before each interview, participants completed a demographic questionnaire which
provided insight into their previous civilian clinical experience and current Air Force nursing
role. The demographic information collected included (a) age, (b) gender, (c) race, (d) year of
graduation from BSN program, (e) the year of commissioning into the USAF, (f) years of professional nursing practice in a civilian setting before commissioning, (g) the civilian clinical units worked and (h) whether the current duty assignment is the first since commissioning. To assure participant confidentiality and privacy no identifying information was collected on the demographic questionnaire.

**Data Collection Process**

A letter of invitation was e-mailed to potential participants (Appendix D). Prior to the start of the data collection process, informed consent was obtained. Further, participant rights, including methods used to ensure confidentiality and that participation is voluntary and could be withdrawn at any time without retribution, were discussed with each participant. All participants were asked to read and sign an informed consent to participate in the study (Appendix E). Written permission to audiotape the interview was also obtained. Upon completion of the consenting process, an explanation of the procedures for data collection, analysis, use, and possible publication were reviewed with each participant. Each participant was asked to complete a written demographic questionnaire (Appendix F) prior to their interview. The signed informed consent, completed demographic questionnaire, audiotapes, and transcripts were secured in a locked file in the researcher’s office for the duration of the study. Data collection continued until saturation occurred, that is, no new themes emerged from the data.

**Data Collection**

Data was collected using a semi-structured interview until data saturation was achieved. Interviews began with a broad, introductory question asking participants to describe their transition from civilian to military nursing practice in the USAF. Additional probing questions were used to clarify and further elucidate the transition experience. Periodically during the
interview, validation of participant experiences, descriptions, and feelings occurred to verify congruency between participant’s perceptions and researcher’s understanding. Three interviews were conducted in person at a time and place of the participants’ choice, three interviews were conducted by telephone due to geographical separation between participant and researcher, and 1 interview was conducted via Skype. Careful attention was paid to providing ample time for participants to describe their transition experience before follow-up questions were asked. All of the interviews were audio recorded for accuracy. Individual interviews ranged from 60 to 90 minutes in length and were recorded using both digital and taped recording devices. Each interview was transcribed verbatim by the researcher and verified for accuracy. All personal information, with the exception of the participant ID number, known only to the researcher, was excluded from the transcript to protect participant confidentiality. All recordings and transcribed interviews were maintained in a locked filing cabinet in the researcher’s office.

**Demonstrating Trustworthiness**

“Without rigor, research is worthless, becomes fiction, and loses its utility” (Morse, Barrett, Mayan, Olson, & Spiers, 2002, p. 14). In the naturalistic paradigm, trustworthiness is a means of establishing worth and demonstrating rigor which is demonstrated by four criterion: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). These criteria are parallel equivalents to internal validity, external validity, reliability, and objectivity traditionally employed to ensure rigor in quantitative research. According to Lincoln and Guba (1985), qualitative research is worthwhile when truth value, applicability, consistency, and neutrality are demonstrated. Morse et al. (2002) suggested that ensuring rigor should be the responsibility of the researcher, and not the reader or reviewer, and should be attained at all levels of the study and not just the conclusion.
**Credibility.** Credibility, as a means of demonstrating truth value, is established when phenomena are accurately identified and described and the interpretation of meaning is derived from the depiction of multiple realities discovered during the study (Lincoln & Guba, 1985). In this study, member checks, systematic data analysis procedures consistent with the principles of the hermeneutic method, a decision trail outlined in a reflexive journal, conclusions (themes) that are grounded in the data, and a rich, thick description of the transition experience were used to demonstrate credibility.

Soliciting participant feedback, through member checks, is a widely debated topic for researchers employing an interpretative phenomenological study. Lincoln and Guba (1985) believe that member checks are the best way to establish credibility because it provides an opportunity for participants to clarify or amend interpretations, add additional information, and assure participants won’t feel misunderstood. McConnell-Henry et al. (2011) argue that performing member checks is inconsistent with the underlying philosophies, a potential threat to rigor, and therefore should not be used. According to Heidegger, lived experiences and their assigned meanings are contextual and may change each time the experience is revisited. Member checks provide additional opportunities for participants to revisit the experience and potentially alter the perception and meaning of the experience based upon changing realities (Bradbury-Jones, Irvine, & Sambrook, 2010; Sandelowski, 1993). The concern is deciphering “how the researcher will know when the ‘right’ interpretation has surfaced” (McConnell-Henry et al., 2011, p. 30). In order to provide the opportunity to clarify initial interpretations of data and provide additional information while remaining true to the Heideggerian philosophy and increasing the credibility of the study, member checks occurred immediately following the
interview in the form of a verbal summary. No additional efforts to return transcribed transcripts or interpretations derived from data analysis to the participants were undertaken.

**Transferability.** Transferability refers to the reader’s ability to discern contextual similarities between the phenomena of interest and their own lived experiences with the same situation (Lincoln & Guba, 1985). Sandelowski (1986) also asserts that the findings should be meaningful and relevant to the reader’s experiences with the phenomena. This is best achieved through a thick, rich description which includes a thorough elucidation of the context, such as the physical environment, organizational structures, daily routines, staffing, and work relationships (Koch, 1994; Lincoln & Guba, 1985). This study previously described the hierarchical structure of the military medical system, the role of the military nurse, and the work environment. The findings of this study integrated these contextual elements with the shared experiences described by new military nurses to identify the meaning of transition for nurses moving from civilian to military practice in the USAF.

**Dependability.** Dependability focuses on the research process ensuring each step is “logical, traceable, and clearly documented” (Tobin & Begley, 2004, p. 392). Lincoln & Guba (1985) argue that there cannot be credibility without dependability so by demonstrating one the researcher has essentially demonstrated both. An audit trail is one method, advocated by Lincoln & Guba (1985), of establishing dependability. Defined as a “residue of records stemming from inquiry,” an audit trail will be used in this study to demonstrate dependability (Lincoln & Guba, 1985, p. 319). Koch (1994) also advocates for a clear decision trail which serve to bridge links within the audit trail. Tobin and Begley (2004) stress the importance of reflexivity, a process which “inquirers keep a self-critical account of the research process, including their internal and external dialogue,” in the audit trail process (p. 392). Reflexivity was achieved with the use of a
reflexive journal during the entire research process. Sandelowski (1986) states auditability is demonstrated when a description, explanation, and justification of the researcher’s personal interest in the study, assumptions related to the topic of inquiry, the purpose, sample selection, the relationship between researcher and participant, data collection procedures and length, the setting of data collection, how data is analyzed and interpreted, the creation of categories and themes from the data, and the determination of truth value is outlined.

**Confirmability.** Confirmability assumes the conclusions and interpretations presented are derived from the data (Tobin & Begley, 2004). An audit trail and reflexive journaling are two techniques which can establish confirmability and both were used in this study (Lincoln & Guba, 1985). Further, demonstrating credibility, transferability, and dependability will thus confirm that the data, interpretation, and conclusions were derived from the interview of new military nurses in the USAF.

**Ethical Considerations**

Ethical considerations, in qualitative research, involve both the participant and the researcher (Klopper, 2008; Munhall, 2007b). Protecting participants rights include “the right to self-determination, right to privacy, right to autonomy and confidentiality, right to fair treatment, and the right to protection from discomfort and harm” (Klopper, 2008, p. 71). To assure these rights in this study, each participant signed an informed consent following a verbal explanation of the study and their rights with ample time to ask questions (Appendix E). The consent included an explanation of procedures and information about the risks associated with participation, benefits, confidentiality, and withdrawal without prejudice. While the anticipated risk to study participants was minimal, recalling experiences related to transition to an Air Force staff nurse role could invoke psychological distress including anxiety or depression. Clinical
psychologists, on staff at each base hospital, were available to study participants if needed. Each participant was assured that participation is voluntary with the right to withdraw at any time without retribution or impact on their military nursing career. Finally, efforts to ensure the privacy and confidentiality of the participants included securing all study related materials in a locked drawer in the researcher’s office as well as the use of a participant ID number in the written research report. Additionally, any additional identifying information from the interview transcript and report of findings which could link the participants to their reported experiences was removed.

Nurse researchers have an ethical obligation to accurately describe lived experiences of others. The researcher’s role is to “describe and report in the most authentic manner possible the experience that unfolds, even if it is contrary to your aims” (Munhall, 2007b, p. 504). This, at times, is challenging due to the evolving relationship between researcher and participant which can interfere with the objective research process and the idea that the researcher is often the study instrument in qualitative research (Barroso, 2010). Efforts including the use of a reflexive journal and an audit trail were employed as additional means of assuring the researcher’s ethical obligation.

Summary

Chapter three provided a description of the research design, methods of sampling and recruiting participants, as well as data collection procedures. Additionally a discussion of the methods that were used to ensure rigor in the study was presented. Finally, the chapter concluded with a review of the ethical considerations including participant rights, privacy, and confidentiality.
Chapter 4: Presentation of the Findings

Chapter four describes the sample, data analysis procedures, and presents the findings derived from interviews with new Air Force nurses. A thematic map of the findings is presented. The chapter concludes with an exhaustive description of the transition experience.

Description of the Sample

In total, 16 possible participants were identified through personal Air Force contacts. Of the 16 potential participants, 14 responded to email or phone inquiries to participate. A total of six nurses did not meet all of the inclusion criteria: 4 nurses currently practice in a clinic setting, 1 nurse attended the Nurse Transition Program, and 1 nurse was previously enlisted. In addition, one nurse initially responded to the email inquiry and confirmed meeting all inclusion criteria but later could not be reached to schedule the interview. A final sample of seven Air Force nurses consented to participate in the study.

Demographic Questions

A summary of the demographic characteristics of the sample is presented in Table 4.1.
Table 4.1: Demographic Characteristics of the Sample (N = 7)

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
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<tbody>
<tr>
<td><strong>Age (years)</strong></td>
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<tr>
<td>24 – 26 years</td>
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<td>57</td>
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<tr>
<td>27 – 29 years</td>
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<td>14</td>
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<tr>
<td>30 – 33 years</td>
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<td>29</td>
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<tr>
<td><strong>Gender</strong></td>
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<td><strong>Race</strong></td>
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<tr>
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<tr>
<td><strong>Years of Civilian Clinical Practice</strong></td>
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<td></td>
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<tr>
<td>1 - 2 years</td>
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<td>71</td>
</tr>
<tr>
<td>3 – 4 years</td>
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<td>29</td>
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<tr>
<td><strong>Civilian Clinical Experience (Unit)</strong></td>
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<tr>
<td>Other Inpatient Unit</td>
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<tr>
<td><strong>Years of Air Force experience</strong></td>
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<tr>
<td><strong>Currently at First Air Force Duty Assignment</strong></td>
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<td>100</td>
</tr>
</tbody>
</table>

* Note: some participants worked in multiple civilian care units before commissioning.

Data Analysis

“The purpose of data analysis is to organize, provide structure to, and elicit meaning from research data” (Polit & Beck, 2008, p. 556). The simultaneous collection and analysis of data in qualitative research is a characteristic which differentiates it from other research paradigms (Polit & Beck, 2008). To the phenomenological researcher, data analysis is a process of moving from a single participant’s description of a lived experience to the synthesis of all participant descriptions in order to reveal the essence, or meaning, of that experience (Barroso, 2010).

This study employed an interpretative phenomenological approach to describe the experience and uncover the meaning of role transitions for new Air Force nurses. Central to the
phenomenological approach is the close engagement between the researcher and participant whereby the co-construction of meanings, based upon personal and contextual influences, may be achieved (Flood, 2010). While there is no concrete method for data analysis within hermeneutic phenomenology, Kafle (2011) recommends six interrelated research activities which may serve as a guideline: “commitment to an abiding concern, oriented stance toward the question, investigating the experience as it is lived, describing the phenomenon through writing and rewriting, and consideration of parts and whole” (p. 191).

Hermeneutic phenomenology seeks to investigate phenomena that are perceived or experienced and to elucidate the meanings of those experiences (Flood, 2010). “To achieve this, the researcher has to select a method for data analysis congruent with the philosophical underpinnings of the study” (Flood, 2010, p. 11). Colaizzi’s (1978) method was chosen to guide data analysis in this study for a few reasons. This data analysis procedure is well defined and clear yet flexible enough to allow for adjustments based on a researcher’s approach to investigating a phenomena.

Commonly used data analysis methods in nursing research subscribe to the assumptions of descriptive phenomenology and in doing so are inconsistent with the assumptions of interpretative phenomenology (Appendix G). Colaizzi’s (1978) method is one of them. The final step requires validation of the descriptions provided by participants which violates the assumption that contextual variables, such as time and environment, influence the description and meanings of a lived experience. And each time a particular experience is revisited these descriptions and meanings may change, making the act of returning to study participants to validate the synthesis of descriptions and initial formulation of meanings illogical and inappropriate (McConnell-Henry et al., 2011). However, assuring congruency between a
researcher’s understandings of participant lived experiences is important. To avoid this issue, validation of descriptions of the experience and themes was verified immediately following the conclusion of the interview so as to not distort the data secondary to the changing realities of the participant while still providing opportunities for participants to clarify descriptions and interpretations and contribute additional information deemed important (Figure 4.1).

*Figure 4.1: Colaizzi’s (1978) Method*

1. Read transcripts
2. Extract significant statements
3. Formulate meanings
4. Cluster meanings into themes
5. Integrate results into an exhaustive description
6. Use exhaustive description to capture the essence
7. Validate participant descriptions *

* Colaizzi’s (1978) method indicates a validation of participant descriptions should be the last step in data analysis, however, in this study validation will occur at the end of each interview to account for contextual influences which may alter the perception of the lived experience.

Data was analyzed using a tiered approach, according to the seven steps outlined in Colaizzi’s (1978) method. First, each audio-recorded interview was reviewed one additional time before transcription began. A manual review of each transcript followed the verbatim transcription of the taped interview. The researcher compared the recorded interviews and transcripts at least one more time before any formal analysis was undertaken. The purpose was to
gain a familiarity with the content, word choice, and tone of each participant’s responses. Next significant statements from the transcript were identified, meanings formulated and clustered, and themes developed. Each transcript was compared to the others to identify commonalities among the themes. Direct quotes were extracted to reflect each theme. Finally, the themes were integrated into an exhaustive description that captures the essence of the transition experience for new Air Force nurses. A total of three themes and 13 subthemes were generated from the data.

**Findings**

The analysis of 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 officer role. All participants indicated numerous times that the transition experiences described have little to do with the professional nursing role but rather are the result of a lack of familiarity with the military way of life.

NAFN 2 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.

**Theme 1: Learning the Military Culture.** The military environment is different. Governed by rules and order, military culture is characterized by social and professional traditions which influence every facet of daily life. Learning the Air Force culture proved to be the biggest challenge to these new nurses.
NAFN3 commented, “The lack of knowledge. The lack of knowledge of Air
Force stuff because our training to get into the Air Force, our training from
civilian to Air Force is only four weeks.”

Phrases like “sink or swim,” “fake it till you make it,” “learn as you go,” “trial and error,” and
“gray area” were used to describe their lack of knowledge of the military and their feelings of
apprehension to assuming the Officer role.

NAFN 4 stated, “It was a bit stressful and frustrating with not knowing some of
the stuff and getting stuff in order and learning, um, the sink or swim method –
fake it till you make it. So that was kind of frustrating and with everything being
new and not having the support out here that I had back home – that made it a
little more emotional, I guess.”

NAFN 3 noted, “The first year was very difficult because I had no idea what any
of that stuff was.”

The first theme reflects the steep learning curve encountered by the participants as they began
learning about and integrating into the military culture. The participants reported feeling
overwhelmed by the volume of new information they were required to learn, frustrated by a
general lack of instruction of military policies, and fearful of missing a detail or making a
mistake. The elements of the military culture that were particularly cumbersome to learn are
reflected as six sub-themes including customs and courtesies, rank and respect, the chain of
command, the military uniform, redefining professional boundaries, and the military lifestyle.

**Theme 1.1: Customs and Courtesies.** Resulting from a need to establish order, discipline, and
respect, Air Force customs and courtesies extend basic principles of politeness by outlining the
expected behaviors of its members in personal and professional situations. In the Air Force, established customs and courtesies include, among others, saluting and respecting rank.

A salute is a formal greeting rendered as a sign of respect between enlisted personnel and Officers. It is expected that Airmen of all ranks recognize when a salute is required or prepare to return a salute at all times. The guidelines for properly saluting are taught to all new Airmen and are consistently reinforced throughout their career. Airmen are also expected to show respect for members of a higher rank. This is accomplished by standing at attention when a senior ranking Officer enters a room and addressing fellow Airmen by their name and rank.

NAFN 6 commented, “Another challenge was just learning the military customs and courtesies. As a civilian nurse you – you didn’t stand when your nurse manager came onto the floor – when your commander comes in to your unit you – you respect them and stand to attention. … And then learning … saying Sir or Ma’am or the military rank and then when you’re outside saluting a superior officer – that was just something I was – a bit different.”

And NAFN 4 recalled:

“I know one of the first times leadership came through, it was a Lieutenant Colonel (LTC), I just turned to him and I was like ‘hey’ and they [peers] were like ‘you really should kind of stand up.’”

Despite talking with Air Force recruiters and attending Commissioned Officer Training (COT) for four weeks in-between commissioning and reporting to their first duty assignment, the participants felt unprepared for the Officer role. Participants expected to be taught what they needed to know before arriving at their first base and became frustrated when this did not occur.
NAFN 6 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 be, what to expect and really didn’t get that much – that training that I thought was going to happen there.”

NAFN 4 agreed stating:

“I kind of wished they would have stuck a little bit 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 the military aspect.”

Although two of the participants acknowledged growing up in a military family, all of the participants conceded that learning and integrating the specific rules which comprise Air Force customs and courtesies was challenging. Nurses appreciated “having peers that supported and kind of showed me the way the Air Force runs” (NAFN 4). They looked to their peers and to more senior Officers for help in recognizing and correctly executing many of these customs and courtesies.

NAFN 1 stated, “I would kind of follow everyone else’s guide, you had to like stand up and you weren’t supposed to sit down until they said ‘at ease,’ …. some things are still not perfectly clear to me but as I go along it gets better.”

**Theme 1.2: Rank and Respect.** The hierarchical system in the military is based solely on the rank of its members. The rank structure in the Air Force is broken down into two groups: enlisted and Officer; with 9 and 11 ranks within each, respectively. Insignia indicating an Airmen’s rank
is visibility worn on the upper sleeve of enlisted Airmen uniforms or the collars of Officers to allow for easy recognition and rendering a salute, when indicated. Promotion to a higher rank is linked to increased privileges, responsibilities, and authority within a given unit or group. All of the participants were commissioned as Officers at the rank of 1st or 2nd Lieutenant, depending on years of prior nursing experience in the civilian workforce.

The nurses appreciate the respect and professionalism that stems from the rank structure in the Air Force. NAFN 1 stated, "I did like the respect level. It was nice to transition from civilian to military – that was something that was good – the respect levels were really high." But the additional element of rank impacted the communication between peers and friends. NAFN1 also recalled the challenge of "calling my colleagues, that are my friends, by their last names and rank."

As compared to working in the civilian workforce, NAFN 2 commented, "I would say that, you know, more respect is given in the military versus the civilian side." Rank, and the respect associated with it, were connected with professional accountability.

NAFN 2 also stated, "The rank system, um, just more respect in general. And you like being held accountable for your actions. Like I’ve seen nurses in a civilian hospital who do a horrible job, horrible, and nothing is ever said or done. And in the military hospital, if you are not doing a good job you are getting counseled about it, which I like."

**Theme 1.3: The Chain of Command.** The chain of command is directly linked to the rank structure and dictates patterns of communication within the Air Force. Adhering to the lengthy
chain of command was new to the nurses and created frustration when they attempted to communicate and complete required tasks.

NAFN4 stated, “Now instead of having just one boss, um, I have a supervisor that also – so it goes supervisor, then our flight commander, then the squadron commander, and then the medical group commander. So that’s a bit different. … I was used to being able to just drop into my boss’s office and be like, ‘hey, there’s a problem with this,’ … whereas now there is a whole chain of command and it goes all the way up.”

NAFN 5 agreed stating:

“You have to go through your chain of command. You have to go through your flight commander to get to your squadron commander.”

The participants recognized that skipping around the chain of command is not allowed and carried with it the potential for harsh penalties. NAFN 2 commented, “The chain of command … you can’t just jump … So I can’t go to him [the Element Leader] and then go to our squadron commander, which is a Colonel. I can’t do that.” NAFN 4 agreed with NAFN 2 stating, “There’s no jumping the chain of command. It’s a major no-no.”

NAFN 4 also described the situation she encountered when trying to obtain a signature on some tuition reimbursement paperwork. Attempts to “go around” the flight commander in an effort to expedite the process were criticized and a verbal reprimand received. She stated, “if you need a signature you know you can’t just go straight to that person.”
Participants readily admitted making mistakes when following the chain of command soon after commissioning. Participants felt that supervisors and flight commanders were patient and understanding while they learned their role and how it fit into the larger chain of command.

NAFN 6 shared, “I have a really good supervisor so it’s, it’s been good. Like he’s very patient with us – the Lieutenants. You know, he’ll nicely correct us about sending emails and the chain of command and stuff I’ve definitely screwed up on when I first got here.”

**Theme 1.4: The Military Uniform.** Four of the seven participants described the challenges associated with learning about and correctly wearing the different military uniforms. The nurses expected to receive information about properly assembling and wearing the uniform but when little or no instruction was received they were left to seek out alternative sources of information which contributed to increased feelings of stress and frustration during transition.

NAFN 6 found it was challenging “Not really getting any instruction on military dress and appearance. … I mostly had to learn all this on my own as far as …having to get instructed on when you’re wearing your blues – where you are putting all of your different symbols and identifiers of your military rank – having to kind of learn that on my own.”

NAFN 4 agreed stating, “At COT, um, you don’t get taught everything. You just come in and expected, like – they didn’t even teach us how to wear a uniform.”

The nurses were overwhelmed by the number of rules that pertained to the military uniform and found it hard to keep them straight at first.
NAFN 3 stated, “You wear your ABUs there [hospital] and then you change into your scrubs. You can wear your PT gear one way and that’s only if you come straight from PT or you’re going to PT. But it’s only one way; you can’t wear your PT gear in and out. You have to wear your ABUs. Um, so then you have to have a separate pair of shoes and everything.”

NAFN 1 also shared, “It was very stressful … figuring out how my uniform needed to be at work, how to put pins on by myself, how to, that I needed to wear the same colored socks as my shoes. Just the little stuff like that was stressful.”

The lack of instruction related to military dress and appearance during COT meant that the nurses had to either learn it on their own or seek out resources which could provide adequate direction. Participants often relied on their peers or “prior enlisted personnel who had been in the military before” (NAFN 6) to answer questions and aid in compliance with the rules.

**Theme 1.5: Redefining Professional Boundaries.** In the civilian workforce, participants acknowledged close friendships with peers and unlicensed assistive personnel (UAP). Based on previous experience, the participants linked these relationships with co-workers to better communication and improved patient care. But in the military, and the Air Force specifically, personal and professional boundaries are clearly demarcated and blurring these lines is not permitted.

NAFN 4 commented, “There’s a boundary now that we absolutely have to abide by because there is no fraternization.”

NAFN 3 echoed a similar sentiment, “And there’s a totally different environment because I cannot be friends with those techs [enlisted medical technicians]. I’m
not allowed to be friends with them. I can’t hang out with them outside of work. Um, we can’t even give the impression because it’s not even just if you’re friends with them or have a special relationship because if somebody can perceive it as you’re having a special relationship with that enlisted person – you can get in trouble.”

Regardless of years of clinical practice or length of Air Force service, enlisted medical technicians provide patient care under the leadership and direction of Officers; both nurses and physicians. Friendships, beyond professional working relationships, between Airmen belonging to different rank groups, detracts from established order and discipline and may jeopardize the mission.

**Theme 1.6: The Military Lifestyle.** The military maintains unique challenges intrinsic to the military way of life. These include frequent relocations to often unfamiliar geographical places, locating alternative sources of support, and separation from family. All of the participants identified their current duty assignment as their first and as being away from known support systems.

NAFN 4 discussed choosing her first assignment based upon a local organization that could be a potential source of support in the area, “…Because I am from PA and it’s so far away. I didn’t have any support system here so they kind of became my support system when I first got here and that’s helped the transition.”

But nurses also realized the importance of looking out for one another – identifying with what it felt like to be new and the desire to make connections with others on the unit while attempting to build lasting relationships. NAFN 3 stated, “I feel like little things like just including people in,
and maybe not everyone becomes friends. Just coming to a place, you know nobody. You have nothing to do, you have no friends, no family.”

NAFN 7 also commented that the two civilian nurses working in the unit “have been pretty good about, you know, every couple of weeks or so making sure that the three of us go out somewhere and do something and, um, and they’re always giving me suggestions of things to do, places to go … they are very knowledgeable about the area so they’re trying to help me acclimate in that way too.”

Initially, the single greatest source of information and support for the participants was their assigned sponsor. The role of the sponsor is to provide support to the incoming service member by answering questions, helping to in-process (check-in) to the base, and providing guidance about the local area.

NAFN 5 stated, “The piece that I found helpful was my sponsor. I think I got lucky that I was given a particularly awesome and enthusiastic sponsor. … So she was just that constant person that was always there helping me with the nursing aspect, with the moving from stateside to overseas aspect. Just always there.”

The quality and helpfulness of the sponsors assigned to the participants varied greatly. 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.

Three participants described a positive experience with their assigned sponsor; finding them helpful to the transition to their first duty assignment and a new base.
NAFN 6: “In general, my sponsor was able to, you know, help me in-process into the base. … So my sponsor was helpful there and helpful with directing me to travel offices, financial offices, so, in general, it was just a basic orientation.”

NAFN 5 concurred saying, “But as far as bridging the gap for like in-patient nursing, um, it was definitely my sponsor. You know, she was really great, I asked her like a million and a half questions, um, and she was able to give me all of the answers.”

Participants appreciated proactive sponsors that took measures to welcome and help them feel comfortable because they were new to the Air Force, had never experienced a permanent change of station (PCS) [relocation to a new base] before, and may not have been aware of available resources.

NAFN 7 noted that upon arrival to the base for the first time, “I drove straight to the hospital and met him. He made sure to give me a tour of the hospital. He made sure, because I couldn’t get into my apartment until the next day, so he made sure that I had a place to stay that night on base…”

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 assimilating into the military culture with inadequate support and assistance from a sponsor.

NAFN 1 stated, “My sponsor didn’t tell me a lot when I talked to her on the phone, she worked night shift so she just didn’t have, give me the time I really wanted. … I kind of would have liked to have someone be there at the hospital, or um, meet me there at the base, or meet me at the hospital to kind of show me
around a little bit more because I was completely by myself when I got there. Like, nobody was here with me so I had to go to the base by myself. I had no idea where it was and you know it’s not on GPS. Like the stuff around the base. So, it was very stressful just direction wise. Um, just to be there by myself…”

NAFN 4 agreed with NAFN 1 stating:

“Well she didn’t meet me on base so I was coming in base kind of blind and not knowing where to go and I didn’t know I should set up a hotel or with TLF [temporary lodging facility] prior to coming…”

NAFN 3 also shared a desire to have more help from sponsors who could find her places to stay or to share knowledge about the area and the Air Force. She stated, “She ended up being on night shift so she showed me around a little bit so I could get my signatures, my checklists, and my badges … and I didn’t know where anything was so she helped me out a little bit in maybe the first couple of days but then she got to transition to night shift. So then I kind of lost her.”

One of the participants initially felt supported by the assigned sponsor but after arrival to the base, the sponsor was less supportive to the new nurse due to personal circumstances.

Initially NAFN 7 felt the assigned sponsor was accessible, attentive, and knowledgeable stating, “…he was awesome before I got there. When I was in COT I was emailing him all the time asking him tons of questions and he was really good about getting back with me right away with answers to all of my questions.”
After arriving on base NAFN 7 found the sponsor to be less supportive than before saying: “But he was in the process of getting out of the Air Force at the time and not, I don’t want to say not on good terms, but he wanted out. So he was more focused on – okay, I’m going to give you the bare minimum because I’m working on getting myself out.”

NAFN 1 summed up the role of the sponsor by saying, “A sponsor makes the biggest difference. I’ve noticed that not everybody gets a good sponsor and that’ll truly make the difference.”

**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 begin. Elements which bridge the gap between the two roles are described in four sub-themes including orientation, preceptor support, peer and managerial support, and the work environment. Each of sub-themes contributed to the formation of the military nurse identity.

**Theme 2.1: Orientation.** The orientation period provided an opportunity for participants to further define and clarify their new professional role by integrating information learned in COT with additional base specific knowledge. Owing to their previous civilian experience, the participants had both competence and confidence in their ability to perform the nursing role which meant that they could focus their attention on learning the Officer role.

NAFN 3 stated, “But for me it was all of the Air Force stuff. That’s what I needed to focus on.”
NAFN 6 agreed saying, “With the orientation process I felt I had to do a lot of work – because I mean I was deficient in knowledge and lack of knowledge of the military … so I felt that most of my orientation was me asking several questions to bring me up to speed on those things.”

The participants felt overwhelmed by the amount of new information they were expected to know and immediately integrate into their daily work practice.

NAFN 2 stated, “Just learning all of that Air Force stuff all at once – it’s so much information, between that and the clinical stuff – it’s too much to remember all at once.”

NAFN 3 reported a similar feeling saying, “It’s kind of a haze. It was kind of a blur. It was all a blur – a lot of it was a blur. Orientation. Because there was just so much information all at once.”

For most participants, attendance at three separate orientations were required: the base level, medical group level, and unit level. Base level orientation largely included briefings by senior leaders which sought to introduce Airmen to base resources and the surrounding area. Having moved to an unfamiliar place, NAFN 7 appreciated the “base specific” information provided during the base level orientation because it helped with the transition into the military culture. In addition, NAFN 7 stated, “I wouldn’t say it helped with necessarily being an Officer but it helped with understanding the military.”

The medical group orientation focused more on patient care resources and healthcare policies. But there did not appear to be consistency across the participant’s assigned bases with regard to the content and mode of delivery of the information in these orientations. NAFN 6
described the medical group orientation as a “brief orientation as to where different departments were within the medical group” while other participants were assigned computer based training modules to complete. NAFN 5 stated, “They gave this humongous list of all of these CBTs, computer based training modules, that I had to get done. The list is very long and a lot of them were annual.” Inexperienced in the military role made it challenging to relate to the content in the training modules and even harder to determine the relative importance of the information to the nurse’s role.

NAFN 3 stated, “So it’s very hard to even realize what it is. And what it’s exactly for because we do so many online learnings and you’re like, when am I actually going to use it? How serious do I need to take some of these or should I click through and try and get it done as quickly as I can because I have to do this? Do I need it?”

Participants expressed frustration over a redundancy of information and a lack of time provided to complete the required trainings at the base and medical group levels. NAFN 1 stated, “I mean we had to go through this whole in-processing where you sit through the base wing orientation, when you sit through the medical group orientation, where you have a lot of orientation. Like, a lot. Some of the things were helpful but a lot of it was redundant, boring, not necessary.” Another participant struggled to complete the required trainings due to short staffing on the unit causing additional stress. NAFN 5 stated, “And I felt like that was frustrating to me - that I wasn’t given time to get things settled before I was expected to be on the floor.”

Yet it was an impersonalized unit level orientation that was identified as a factor which most impacted the transition to the military nursing role. Although 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. NAFN 2 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.”

NAFN 1 likened the orientation to that of a new graduate saying “It was just him following me around – it was an orientation I got as – the same orientation I got as a new graduate. At first I observed and then I started doing things or I took 1 patient or took two patients and three patients…”

NAFN 3 also said, “And it was frustrating because also they’re acting like you’re a brand new nurse.”

Other participants reported a very different orientation experience stating:

“I don’t want to say that they just threw me in but it wasn’t super structured as far as – here is the list of things that we need to make sure you learn, and here’s the things you need to be able to do and all of that – it was more like – you’re just going to be in with another nurse and learn as much as you can” (NAFN 7).

NAFN 4 felt like the orientation period was “predetermined” and did not appreciate the learning needs or comfort level of the new nurse. In fact, NAFN 4 stated that “they never talked with me about my comfort level” in the role and I only learned the orientation timeline “when the schedule came out I was like ‘Oh, I guess I’m off orientation now.’”

Participants reported spending between six weeks to three and one half months in orientation on the unit but in some cases the length did not match the nurse’s learning needs.
NAFN 3 said, “We did a lot of training but that stuff I’ve done forever so that’s not what I really felt like I needed training on. I felt like I needed more hospital specific – what they expect of me.”

While some participants felt the unit orientation was too long others longed for additional time to learn the role.

NAFN 1 stated, “I don’t think six weeks is necessary for me to take care of these patients. Quite frankly, it could have been two to three weeks because it’s not like I needed to learn skills.”

Conversely, NAFN 5 stated, “So staffing was limited so my orientation was cut short. They were like, ‘Oh, you’ve got some experience under your belt, we’re cutting short your orientation process because we really need you on the floor. That was difficult. I didn’t necessarily feel 100% comfortable being set free on my own.”

Additionally, the participants identified two specific challenges that they encountered during their unit orientation: deciphering the multitude of policies governing patient care (Air Force Instructions [AFIs] versus medical group policies [MDGIs]) and learning the computer system. NAFN 3 stated, “They have so many MDGIs and so many AFIs and so many rules but they are so thick. I mean we have three books this big – we can’t read all these.” NAFN 1 felt that “a lot of the policies are a little gray” because sometimes the broad Air Force policies did not match the more narrow medical group policies (MDGIs) leaving nurses confused over which policy should be followed. NAFN 2 said, “There’s a policy for everything. So there’s an Air Force policy and then there’s an MDGI policy which is the med group policy. So you have to think – is
this Air Force or is there an MDGI? … So that’s stressful … Because you have to ping pong back and forth.”

The computer systems also proved to be a challenge to learn for the participants. NAFN 6 stated, “Navigating through the different software systems that the military, the Air Force, or DOD (Department of Defense) have. There’s a steep learning curve there too.”

NAFN 2 agreed saying, “Probably the hardest part for me was the computer system. … Keeping up with all the different passwords and all the different log-ins for all the systems that they want you to use.”

NAFN 1 described using a computer system with charting technologies “that just didn’t seem very effective” and a “surprising” lack of medication scanning capabilities which proved to be a difficult adjustment since technologies in the civilian workplace were perceived as more advanced and user friendly.

**Theme 2.2: 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. NAFN 3 commented on the expectations she had of the preceptor relationship:

“\[I\] felt like if I’m coming in with experience it needs to be a different sort of precepting. It needs to be more hospital centered because we have the skills.”

In some cases, preceptors had similar, or even less, clinical experience than the participants they were assigned to mentor which was surprising to the new nurses.
NAFN 3 stated “I had more experience than some of the nurses that were precepting me.”

NAFN 1 agreed saying, “So I felt like I had more to offer to teach him about medical patients because I felt like I was used to taking care of a lot of very sick patient at the same time …”

All seven participants acknowledged the assignment of multiple preceptors during their orientation to the unit. The participants were frustrated by a lack of transitional continuity and interrupted learning this created. Several rationales for this practice were offered by participants.

NAFN 6 believed scheduling influenced the assignment of preceptors saying, “I didn’t have one specific preceptor – it was several different preceptors because it’s hard to schedule the same preceptor with the same nurse coming on each shift.”

NAFN 4 agreed saying, “I don’t know if it was just schedules and the way it worked out, um, my thought is kind of poor planning.”

Other participants believed the rationale for assignment of multiple preceptors included providing alternate views of the role and an opportunity for nurses to learn different ways to do things.

NAFN 3 states, “I didn’t just have one, so it was a 6 week orientation and it switched off, I think I had two maybe three. … They tried to make it where I would have one preceptor for three weeks and then another preceptor for the other three weeks” and it was helpful because “learning different ways to do things – so
I definitely learned some things from them or maybe some things that I haven’t experienced.”

NAFN 4 felt similarly stating, “It was good to see the different ways each of the nurses organized their day or would take care of their patients.”

NAFN 2 found that the training responsibilities and turnover due to changes in duty locations impacted the availability of preceptors.

She said, “Changing preceptors … that’s because the leaving and the constant training that you have to go to that’s off base and things like that.”

NAFN 5 agreed stating, “I didn’t have, I wasn’t assigned one single preceptor. It was ‘okay, who wasn’t an orientee today?’”

Regardless of the reasons behind the assignment of multiple preceptors, the participants generally disliked the disruption. A comment from NAFN 4 illustrates this point:

“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.”

With each change in preceptor, NAFN 3 found that “it went right back to the beginning. ‘I don’t know what you can do, I’m going to have to watch you’ and we kind of went not very far with that.”

Perhaps one benefit of changing preceptors during orientation is the opportunity to evaluate their preceptor(s) and discuss qualities which are both helpful and detrimental to the transition process. Participants valued preceptors who were role models (NAFN 1), followed
established rules (NAFN 1), were present (NAFN 2), maintained open channels of communication (NAFN 2), were knowledgeable (NAFN 3), provided timely feedback (NAFN 5), took the preceptor role seriously (NAFN 5), shared knowledge (NAFN 5 & 6), shared military experience (NAFN 6), a good leader (NAFN 6), and answered questions (NAFN 6 & 7).

NAFN 5 summed it up by saying, “One of the biggest things that made her such a great preceptor is that she wanted to be one. You know, she requested, ‘Can I precept the new nurse?’ I think that’s the big thing – is that she wasn’t volun-told to do it – she volunteered for it.”

NAFN 7 shared that her preceptor believed new nurses should receive as much hands experience as possible during orientation. She stated, “So one of the first things she did was ask me ‘How do you learn? How do you want me to orient you? Do you want to just follow me for a while or do you want to start doing stuff right away?’ And she always asked me, ‘How much do you want me to do?’ And I think that really helped a lot.”

On the other hand, preceptors that were untrained or otherwise unprepared for the role (NAFN 5), unhelpful (NAFN 4 & 5), didn’t respect or appreciate the knowledge and skills learned in civilian practice (NAFN 1 & 2), unavailable or too busy (NAFN 2 & 5), inflexible (NAFN 1), or who didn’t trust the participant’s ability to safely care for a patient despite sufficient opportunities to demonstrate skill proficiency (NAFN 1) were not valued by participants.

NAFN 1 commented, “When I got there they treated me like a brand new nurse. … Standing over my shoulder … and I’m like, ‘okay, I’m an RN, I’m legally able to do this’ but they treated me like a brand new nurse because that is what
generally comes in. So that was frustrating to have someone be right behind me and just kind of, in a sense, wait for me to make a mistake.”

Participants expressed frustration with preceptors that did not meet their needs. NAFN 1 went so far as to say, “I despised going to work for the first month and then after he knew I was a good nurse and I was doing the right thing, … it was a lot better.”

Overall, the participants felt that they had a positive preceptor relationship and that they received what they needed from their preceptor and the unit orientation.

**Theme 2.3: Peer and Managerial Support.** All seven of the participants identified support from peers and immediate supervisors as helpful to their transition into the military.

NAFN 6 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.”

Participants felt connected to and supported by their immediate supervisor. Working closely with nurse managers allowed participants to build rapport and develop professional relationships that helped to foster a positive work environment. Two participants felt that their Air Force nurse managers were “better than” their previous civilian nurse managers because they had a genuine interest in the nursing staff and the welfare of the unit.

NAFN 2 stated, “He’s great. He has an open door policy – you can go and talk to him, you can text him, he’s wonderful. He’s the very first one I ever had in the military. I can compare to civilian ones – he’s good. He answers questions, he
helps guide you, you know, the right way. He constantly asks you what you want to do with your career. So, he’s good.”

Morale on the unit was directly linked with a positive relationship between staff and manager. This was best acknowledged by NAFN 1:

“He’s very good about leave. He knows it’s important. So he gives us – he tries everything he can to give us leave we want. He makes sure the new people are taken care of and doesn’t leave us out in the dust. … And he’s very big about morale.”

Nurse managers were in an ideal position to provide support to the new nurses. Participants appreciated managers who were accessible, knowledgeable, and who readily communicated with staff.

NAFN 5 stated, “She was very friendly, very outgoing – ‘Welcome to the unit – this is where you need to go. Do you need a map of the base – let me help you.’ She was just really supportive. … I immediately felt comfortable with her, going to her with questions about different things – she made it easy to go to her when I needed something.

However, a majority of participants reported little interaction with their squadron commanders, thought to be because of the chain of command, and as a result did not feel that they knew them well or that they could identify any support received from them.

NAFN 5 stated, “The squadron commander – I knew her name, I knew where her office was located because my preceptor took me to her office and said, ‘Hey, this
is our new 2nd LT’ but other than that you couldn’t easily go to her. You have to go through your chain of command.”

NAFN 6 agreed saying, “And I feel a lot of what they know about me is what is presented on paper. And from, you know, the feedback forms that they get from their subordinates – so they’re commanders – they get it from those people who are under them.”

Peers assigned to the same unit were an additional source of valuable support to the participants. Often nurses and medical technicians work closely as a team which the participants found helpful to their transition.

   NAFN 1 stated, “We’re such a small unit so it’s very – everybody is very helpful. We kind of work as a team so if you ask for help you’re going to get it.”

   NAFN 4 shared a similar experience saying, “I do know that the nurses I came in with were extremely helpful and – this is what we do and how we do it.”

Having both nursing and military experience, peers were able to provide invaluable guidance to participants. In general, peers were welcoming and understood the learning needs of the new nurses and as a result, participants felt comfortable asking questions and clarifying military procedures. Role socialization was supported by the positive interactions with peers.

   NAFN 5 shared, “I knew who I could go to and say ‘This is a stupid question but can you help me?’ I never felt stupid asking a question, if I had one. I always knew there was at least one nurse working with me that I could go to and say, ‘Run this through with me really quick before I go and do it.’”
NAFN 7 also said, “They have been really good at just trying to help me get used to everything there and as far as it being the military thing, like, being a military nurse, specifically. I would have to say my co-workers have been helpful in that situation. Just me adjusting to nursing but also all of the other things I have to do associated with the military.”

NAFN 6 summed up the support received from peers and managers by saying:

“I had a very good peer support – whether it be navigating through computer systems, whether it be me with my lack of knowledge, and the dynamic of caring for postpartum or labor and delivery patients, they’re able to help me – or bring me up to speed. … They knew the military life and the lifestyle. I was able to be very inquisitive and inquire of them and be able to ask them to share their experiences and they were open to that.”

**Theme 2.4: The Work Environment.** Used to working in a fast-paced unit caring for clinically complex patients with numerous chronic and co-morbid conditions, four of the seven participants were surprised by the smaller size of the units, significantly smaller patient assignments, and lower patient acuity for the same diagnosis. NAFN4 stated, “Military hospitals are smaller, um, so you’re not doing quite as much.” NAFN7 concurred stating, “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, in-patient units averaged 13 beds with a typical staffing pattern of three to four registered nurses and one or two medical technicians per shift. If a unit was full, participants were assigned between two and four patients per shift. But participants noted that units are rarely full yet staffing remains unchanged resulting in less patient contact and decreased opportunities to use nursing skills.
NAFN4 commented: “…the lack of patients. It’s been frustrating because I feel like I’m losing nursing experience.”

NAFN2 felt similarly, “I kind of felt like I was losing my skills.”

One participant commented that the age of a typical patient in an Air Force hospital was at least 30 to 40 years younger than those typically seen in civilian practice. Nurses believed that patient acuity among patients in an Air Force hospital were less than that of civilian patients with the same diagnosis.

NAFN3 stated, “We don’t have the patient load that I had as a civilian, the patients seem to be a lot more healthy.”

NAFN2 noted, “It seems like I do a lot more care in the civilian side than I do on the military side.”

Decreased patient care assignments coupled with low patient acuities meant that this element of transition was deemed easier. NAFN1 states, “The patients were a lot less sick, I got less patients, it was… it wasn’t hard to transition… to be a nurse in the military hospital.”

However, one participant, working on a labor and delivery unit in a geographically separated location, felt that the patients were just as sick and required just as much, if not more, care as the patients encountered in civilian practice. NAFN5 goes on to say, “My civilian job was kind of like your run of the mill med-surg … much sicker patients in labor and delivery than on my med-surg floor.”

In general, clinical units that were smaller and where staff functioned as a cohesive group seemed to support the participants during transition and create an environment whereby they
could 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 transition from civilian to military nursing practice and being a military nurse.

NAFN 5 stated, “It’s just very tense. Everyone’s always stressed out that there are not enough nurses to go around, that there’s more patients than we can handle. My work environment has not made the transition as easy as it could be because I’m only a year in and I’m already really tired of it.”

**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 contributed to the formation of a new professional military nurse identity. Participants now had a working knowledge of the Air Force health care system and could recognize their role within it. 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 encountered are reflected as three sub-themes including juggling dual roles, role expectations, and scope of practice.

**Theme 3.1: Juggling Dual Roles.** Upon commissioning, military nurses assume dual roles: that of an Officer and a registered nurse. Simultaneous membership in two, often competing professions, mean that military nurses must maintain competencies for both (Griffiths & Jasper, 2007). A statement by NAFN 2 illustrates this new realization and the perceived challenge it presents, “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.”
NAFN 3 agreed saying, “You’re an Airmen first, before anything, you’re in the Air Force and you’re an Officer.”

And while the nursing role ceases with the completion of patient care at the end of an assigned shift, the Officer role continues as long as an Airmen is on active duty status.

NAFN 6 stated, “It’s just a different dynamic than okay you’re employer expects you to be here at seven o’clock and you’re done at seven – you can go home. The military is different – you’re basically – even if you’re off duty you’re still – you’re still an active duty personnel. You’re active duty 24 – 7.”

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.

NAFN 6 shared, “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.”

NAFN 7 also stated, “In the military, you’re an Airmen first and you’re a nurse second. … It’s a hard concept to grasp, to say, ‘I can’t be … there because I have to go to this Air Force thing.’ … I’ve always been a nurse first so now – that’s a hard transition.”

NAFN 2 explained the relationship between the two roles by saying “You’re an Officer before you’re a nurse.” 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 a registered nurse, could be anything other than caring for a patient.

NAFN 2 commented, “But the patient, to me, I look at it – the patient is the mission.”

NAFN 6 agreed stating, “But when it comes down to it – when we’re providing care to our patients, I mean, you’re going to be a doctor first. You’re going to be a doctor first and a nurse first when your patient needs you.”

The participants acknowledged the benefit of the various trainings, offered by the Air Force, to prepare them for being an Officer and the expectations of the role. All new Air Force nurses attend Commissioned Officer Training, COT, before arriving at their first assignment. Here nurses receive information about the Air Force and learn to be leaders. Additional base level trainings are provided upon arrival and reinforced yearly to ensure competence. NAFN 2 stated that she also attended specific training aimed at preparing nurses for deployment including, “Aeromedical Patient Staging (AEPS) and Emergency Medical Disaster Staging (E-MDS).” NAFN 2 felt that the training content and frequency, provided by the Air Force, sufficiently prepared her for both the Officer and military nursing roles.

**Theme 3.2: Role Expectations**

Nurses in transition need clear role and performance expectations as role ambiguity has been linked with job dissatisfaction and low morale (Chang & Hancock, 2003; Clare & van Loon, 2003; Duchscher & Myrick, 2008). Most participants describe receiving little or no clarification of the nursing role expectations within their assigned unit and the medical group during orientation leading to feelings of stress and frustration.
NAFN 3 stated, “Whenever I did travel nursing, they told me right away – this is what we need from you, this is what you need to do – get it done. When I started in the Air Force it was different. It was like, ‘okay, you’re a nurse … and we’re going to take care of patients – but there wasn’t really a set, like, this is what we expect from you this shift. I felt like there was no guideline.”

NAFN 5 commented that the fast pace of the unit coupled with short staffing left little time for defining role responsibilities and expectations. She said, “We were so busy – no one’s fault but there wasn’t a lot of extra time for people to kind of hold my hand …. [to explain] now that you’re in the military you have to do X,Y,Z requirements. I had a list but I didn’t have anyone to explain that list to me just because there simply wasn’t the time or a free hand to explain that list to me.”

Only one participant explicitly conveyed that the role expectations were clearly communicated during orientation saying “being instructed on what was expected of me as a nurse and an Officer helped out quite a bit” (NAFN 6).

This lack of clarity left participants surprised by the assignment of extra tasks on top of their staff nurse responsibilities. NAFN 2 explained this requirement by saying, “You get additional duties – everyone does.” NAFN 7 agreed stating that even civilian contract nurses, working in Air Force hospitals, have extra duties but that “the civilian’s extra duties are not necessarily military related.” Some examples of extra assigned jobs, described by participants, included infection control nurse, crash cart coordinator, staff educator, and physical training leader (PTL). Most of the participants admitted that they were expected to begin performing their extra duties once orientation to the base, medical group, and unit was completed. Only one
participant acknowledged a different experience saying, “My supervisor gives us time to adjust before he assigns us additional responsibilities” (NAFN 1).

NAFN 3 highlighted the challenges resulting from the multitude of role responsibilities by saying, “It’s very difficult to get a grasp on what it is that you need to do on a day to day basis. And what is expected of you because there’s a lot.”

Mandatory attendance at staff meetings, commander’s calls, unit physical training (PT) and completion of annual military trainings were other role expectations mentioned by participants. NAFN 6 voiced understanding for and yet frustration with the relative inflexibility of scheduling these required elements because it was challenging for in-patient staff nurses to attend saying,

“The idea that us, as shift workers, were expected to be in the same things as folks who were in the clinics. So we as shift workers were working hours but were expected to be doing the same things as the clinic workers who were the Monday thru Friday 8 to 5 or 0730 to 1630 jobs. … If we worked Monday and Tuesday night shift and we were back on Friday, Saturday, and Sunday but there was training that needed to be Wednesday or Thursday we were having to come in on our day off.”

In addition to the challenge of balancing the assigned tasks with patient care responsibilities NAFN 2 expressed frustration with the lack of compensation for the added time and work required of Air Force nurses. She stated, “I’m salary … Sometimes it’s frustrating but sometimes in a pay period, because we keep up with our hours, it could be a 100 hours. But your pay doesn’t say 100 hours. So, it gets frustrating sometimes.” Frustration over the imbalance
between work load and salary coupled with the loss of overtime and shift differential pay, characteristic of civilian pay standards, was echoed by NAFN 7 who said, “I’ve had a really hard time coping with the hours, the leave, the pay, like everything is just kind of a little bit less than it was for me on the civilian side.”

Participants emphasized the importance of learning and correctly executing the expectations of the Officer and military nursing roles quickly. In the Air Force, nurses commonly provide patient care in a hospital or clinic setting for a short period of time before they are required to take on additional leadership and administrative roles which are linked to a promotion to the rank of Captain. NAFN 2 noted, “You also have to be prepared to be pulled off the floor into the administration side. … I’ve seen it happen. Captains get pulled off the floor. I’ve seen it.”

NAFN 3 agreed saying, “Once you get to Captain they’re starting to throw you up into leadership and that’s – say you started as a brand new nurse – two years till you’re a 1st LT and two years to Captain, automatic, so that’s four years then you’re up in leadership. It’s not a lot of experience to base things off of.”

Problems arise, however, for experienced nurses who receive credit for previous civilian experience which reduces the length of military experience before promotion to Captain. For example, NAFN 3 received one year of military service credit because she had two years of civilian clinical experience. This meant that the participant would only be a 2nd LT for one year, instead of two, before promoting to 1st LT.

NAFN 3 explained, “It’s been a year and I feel like I’ve learned a lot in that year but also I’m a 1st LT now and in less than 2 years I’ll be pining on Captain –
they’re going to want to start pushing me up through the leadership ranks. I need
to make sure that I know all that.”

The desire of the participants to be seen a knowledgeable and proficient in both roles prompted
them to take active measures to learn the role. All seven participants stated that they learned
about their new role by talking with other Air Force nurses and asking questions.

NAFN 3 also commented, “I don’t want to be that person that doesn’t know. So
on my off time I’ll research stuff. I’ll look at things. I’ll go to the Lunch and
Learns. Even just throw my face out there. Just to meet people and then they’ll
give me information.”

**Theme 3.3: 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. In the civilian healthcare
environment doctors round on patients daily, write orders, and rarely, if ever, participate in direct
patient care. Conversely, unlicensed assistive personnel (UAP) are responsible for assisting
patients to complete activities of daily living (ADLs) as well as delegated tasks, assigned by the
nurse, within the confines of established laws and hospital policies. The role responsibilities of
the registered nurse fall in the middle. Nurses collaborate with members of the healthcare team to
provide holistic, evidence-based care to patients based upon written direction (orders) from the
physician.

Medical technicians work alongside registered nurses in Air Force hospitals to provide
patient care. But unlike UAPs, “the technicians can do so much more than anyone you would
work with in the civilian world. Like, any nursing assistant or anything like that. Our techs can do more than they can” (NAFN 7).

NAFN 1 agreed by saying, “they are EMTs so they have a lot more responsibility. They can put in IVs, Foleys, they can do a lot of technical skills. … They have a greater scope of practice. And so you’re in charge of giving them responsibilities and making sure they do it.”

NAFN 6 admits 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, NAFN 4 noted the expanded practice roles meant less opportunities for nurses to provide care and left NAFN 1 often wondering, “‘when was the last time I did this [a particular skill]?’”

Other, more complex skills, traditionally performed by registered nurses in civilian hospitals, are now the responsibility of Air Force physicians.

NAFN 2 stated, “Like there’s some stuff you can do on the civilian side you can’t do on the military side. So you had to know that boundary. Like for PICC lines – on the civilian side you’re able to take care of them, um, remove them, without any, no problem but on the military side the doctor has to remove them.”

NAFN 3 echoed a similar experience stating, “I’ve taken out tons of PICC lines and central lines but here I was surprised to find that I was not allowed to do that. So that was very surprising to me.”
Changes in scope of practice limit the opportunities for nurses to perform basic nursing skills. NAFN2 commented that the result of the change in practice between civilian and military made it “seem like you’re losing some of your skills.”

All seven of the participants believed that they brought valuable professional experience from the civilian environment that helped them transition to the military nursing role. A sound base of nursing knowledge and clinical skill proficiency allowed the participants to focus their transition on learning the military culture and the Officer role.

NAFN 3 stated that the transition was “overwhelming and I couldn’t imagine coming in as a new nurse and a new Airmen. I feel like I would have been completely overwhelmed. Lost.”

In fact, two participants believed that “everything” from their civilian practice was essential to the successful transition into the military. More specifically, participants felt that time management, the ability to deal with unanticipated crises, familiarity with different diagnoses and the nursing care of each, physical assessment, prioritizing, delegation, time management, and feeling comfortable calling and communicating with doctors were all essential skills that were needed by military nurses. NAFN 1 summarized it by saying, “I just couldn’t imagine coming to this unit – with having to get used to the military – without knowing the skills I already knew.”

Finally, participants were asked to share advice from their own transition which could help improve the transition experience for future Air Force nurses.

NAFN 5 stated, “I wish I would have kind of known what I was getting myself into. I think that would have helped me better prepare myself. And I think that’s
something that needs to be fixed …providing some sort of window into, this is what the Air Force looks like – Is this something you want to get into?”

All of the participants agreed that nurses considering a professional nursing career in the military should take active measures to learn about the USAF, the military nursing role, and the role expectations so that the decision to join is a well-informed one. NAFN 4 suggested, “I would tell them to definitely look into military procedures and policies - just to kind of get a good grasp on what you’re getting into.” NAFN 5 recommended, “My number one thing would be to say, if at all possible, get to a military hospital and shadow a nurse for a shift or two. Get in there and see what they do. Don’t listen to a recruiter because they don’t know.” This becomes important as commissioned nurses are contractually bound to fulfill a pre-determined length of time on active duty status.

NAFN 2 stated, “Because you don’t want to get in and then you realize that it’s not cut out for you and you still have to be there four more years. That can make your life nerve wracking.”

NAFN 3 also stated, “You’re stuck. You’re here. You’re doing something. No matter what, maybe you’re not on the floor, maybe you’re doing admin but you are here. Four years of whatever you signed up for – and we’re going to use you.”

Additional advice offered by participants included: gaining as much civilian clinical experience as possible before joining (NAFN 1), prepare for commissioning early (NAFN 7), master a skill set that will be useful to other nurses as a way of fitting into the unit (NAFN 3), and find a mentor and learn from their knowledge and experience (NAFN 3). Above all, the participants
advise new nurses be flexible and well prepared for change since there are a number of differences between civilian and military nursing practice (NAFN 2).

Figure 4.2 provides a visual depiction of the themes generated from the interviews of seven new Air Force nurses.

*Figure 4.2: The Transition from Civilian to Air Force Staff Nurse*

**The Essence of the Experience of Transition from Civilian to Military Nursing Practice**

Role transitions in nursing have consistently been described as difficult, stressful, and overwhelming. To the participants, registered nurses with previous civilian clinical experience, the transition to military nursing practice in the United States Air Force was no different.
Colaizzi’s method (1978) helped isolate three major themes and 13 sub-themes from the data and uncover the essence, or meaning, of the transition experience.

The data suggests 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 challenging, stressful, and frustrating. While the participants felt that it took a few months to learn the new role becoming confident and comfortable in their ability to consistently perform Officer role independently took significantly longer.

NAFN 3 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 Commissioned Officer Training (COT), a four 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 lead to role confusion and stress as participants learned to realign professional priorities. Based on self-identified learning needs, transition largely focused on learning about and integrating into the military culture with participants expending 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, were willing to share knowledge and experience and who appropriately modeled both roles were beneficial to the participants and quickly became trusted sources of support. In the future, as more experienced nurse’s commission into the United States Air Force, 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 and to have access to knowledgeable, well-trained sources of support during that transition.

Summary

Chapter four presented the findings generated from the semi-structured interviews of seven new Air Force nurses with previous civilian clinical experience. A total of three themes and 13 sub-themes helped to elucidate the essence of transition from their perspective.
Chapter 5: Discussion, Limitations, and Implications

Chapter five presents a discussion of the study’s findings in relation to existing literature on transitions in professional nursing. Study limitations and implications in addition to recommendations for future research inquiry are described.

The purpose of this study was to explore and describe the lived experience of transition from civilian to Air Force staff nurse in order to reveal the essence of that experience. A qualitative, interpretative phenomenological method was used as a framework for understanding and interpreting the lived experience of role transition for new Air Force nurses with more than one year of clinical experience before commissioning. A total of seven participants were recruited using a snowball sampling method. Air Force nurses meeting inclusion criteria participated in one semi-structured interview with validation of responses occurring at the end of each interview. A total of three themes and thirteen sub-themes were generated from the data.

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 for both new graduates and experienced nurses. A discussion of the findings are presented by answering the research questions outlined at the beginning of the study.

The first research question sought to describe what it means to be a military nurse. 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. The 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 soldiers and that there was an unforeseen prioritization of these roles within the Air Force hierarchy. The participants struggled to make sense of the mutually exclusive nature of the dual roles that seemed to place greater importance on the soldiering role as compared to the nursing role. While they acknowledged why the soldier role existed they had trouble understanding how the mission could be anything other than patient care for members of the AFNC. Despite all of this, the participants are proud to be military nurses who provide evidence-based care to Airmen, their families, and retirees at home and abroad.

Surprisingly the participants did not discuss deployment or the risk of deployment as a challenge or stressor. Perhaps this is due to the short length of active duty service and the fact that none of the participants have deployed; although one participant was tasked to deploy only to have the order rescinded two days before leaving. As the new Air Force nurses remain on active duty status and move up in rank, the chance of deploying increases significantly. Although the literature reveals that deployments to combat areas in support of wartime missions are stressful for nurses, this did not appear to be an issue for the participants at this point in their military nursing careers (Scannell-Desch & Doherty, 2010).

The second research question aimed to describe the participant’s perception of the transition experience. Existing studies have revealed recurrent challenges to the transition process including a lack of preparedness (Casey et al., 2004 & Dempsey, 2007), lack of knowledge (Duclos-Miller, 2011), fitting in to a new culture (Asselin et al., 2006 & Delaney, 2003), and unrealistic expectations (Craig et al., 2012). This study uncovered similar challenges. 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 third research question related to the factors which were perceived to facilitate the transition from civilian to military nursing practice. This study supported previous findings that supportive work environments, which foster collaboration and learning, were helpful to nurses in transition (Clare & van Loon, 2003). Unlike a typical civilian work setting where new nurses are often unwelcomed (Casey et al., 2004 & Pellico et al., 2009), all military nurses have experienced being new at some point and because of this the unit and its staff are generally more accepting of new members of the health care team. Staff and unit managers were patient as the participants learned the military nurse role and they helped the new nurses realize their contribution to the unit which not only facilitated integration into the unit culture but helped them feel like they were fitting in.

Adequate support and positive experiences with preceptors and mentors help to ease feelings of stress and are vital to a successful role transition (Zinsmeister & Schafer, 2009). According to the participants, the single greatest factor which facilitated the transition process was the support received from peers, mentors, and nurse managers. The participants appreciated
the willingness of more experienced military nurses to share their own transition experiences as well as answer questions that helped close the perceived gap in knowledge. 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 & Ross & King, 2003). But more than that, mentors can provide interpersonal support to nurses struggling to manage multiple simultaneous demands and cope with unfamiliar surroundings (Cranford, 2013). Separated from known and trusted support systems, the new Air Force nurses in this study struggled to manage moving to a new geographical location, learning a new culture, and beginning a new nursing role in an unknown environment. Valuing the knowledge, experience, and support provided by unit staff and mentors, the participants conceded the importance of support to their overall transition experience.

All of the participants reported taking part in a unit based orientation, whether formal or informal, at their first duty 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 six weeks to more than three months with some bases requiring completion of computer based training (CBT) modules and others not. 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 (McDermid et al., 2013 & Schoening, 2013). Though not often well defined, the participants generally felt that their orientation sufficiently met their learning and transitional needs.
The fourth research question sought to understand the factors which were thought to hinder transition. First and foremost the participants in this study felt like they initially lacked the knowledge needed to meet established officer and nurse role expectations held by the Air Force. Civilian nursing literature often links role unpreparedness to inadequate academic preparation (Berkow et al., 2008; Duphily, 2007; Romyn et al., 2009). In this study, the platform, developed by the Air Force, to prepare new officers to assume the role did not sufficiently meet the learning needs of the participants thus leaving them ill prepared to take on the new role after arriving at the first duty station. The COT course largely focused on leadership without due consideration of 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. The participants feared making a mistake or missing essential expectations thus being accused of insubordination and enduring any associated punishments. They depended on role modeling and ready access to information from peers and mentors to learn the role.

Role ambiguity is a common source of role stress for nurses in transition (Chang & Hancock, 2003; Kelly & Mathews, 2001). According to Duclos-Miller (2011), role ambiguity is defined as having insufficient information needed to clarify the work role. Poorly defined roles and associated expectations result in confusion and anxiety as experienced nurses attempt to conceptualize the new role within a professional nursing framework based on previous clinical experience (Steiner et al., 2008). Unfamiliarity with the military culture and work environment only exacerbated feelings of anxiety and stress for the participants. Only one participant revealed that role expectations were clearly articulated during the unit orientation and consistently reinforced by the assigned preceptor. The rest of the participants relied on observation of peer’s practice and professional interactions as a starting point to understanding the role. Later, as
comfort with peers and mentors increased, participants felt more comfortable asking questions to elicit the information needed to further clarify the role.

Several studies have shown that preceptors influence the perception and outcome of transition (Delaney, 2003; McKenna & Newton, 2008). Ready access to well-trained, experienced, and consistent preceptors during transition is vital (Andersson & Edburg, 2010; Casey et al., 2004; Schoening, 2013). Research by Oermann and Mooffitt-Wolf (1997) as well the NCSBN (2004) support 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 and 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 at the new Air Force nurse rather than formally choosing a well-matched preceptor who would work the same schedule. 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. Attempts to streamline the unit orientation and consciously assign a single, well-qualified preceptor should be seriously considered by Air Force leaders.

The fifth research question encouraged participants to discuss the knowledge and skills, brought from civilian practice, which were perceived to help the transition to military nursing practice in the USAF. Existing studies have isolated essential skills which was been reported to impact transition including physical assessment, time management, delegation, prioritization, communication, and critical thinking (Berkow et al., 2009; 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; Pearson, 2002; Robinson et al., 2012; Steiner et al., 2008). 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.

Finally, the sixth research question invited participants to share advice with other new USAF nurses that could improve the transition process. Resoundingly, the participants felt that nurses considering a career in the USAF should be armed with the information needed to make an informed decision. Information that to some participants, was not readily available nor accurately disseminated prior to their own commissioning. Due to the uniqueness of the role, the expectations, and the practice environment, the participants suggested talking with or even shadowing a current Air Force nurse working in both the clinic and hospital environments. Further, the participants recommend others seek out multiple sources of information, such as the internet and Air Force recruiters, and then encourage corroboration of information between sources. Going into the new role with a clear understanding will likely lessen the transitional challenges related to a lack of knowledge.
Limitations

There are a number of limitations which must be acknowledged. Qualitative, phenomenological research seeks to uncover the meaning or essence of phenomena derived from the perspective of those who lived it. The lived experience therefore represents the subjective reality of the participant. The findings of this study represent the lived experience of transition from the perspective of the seven participants at a specific point in time, which cannot be generalized to all new Air Force nurses with previous civilian experience. Although the sample was small, and data saturation was achieved, the inclusion of more participants could enhance the richness of data and influence the comprehensive understanding of transition by uncovering additional themes. Recruitment of participants was directly impacted by a lack of formal endorsement of the study, by the USAF, which prevented the use of official resources, including military email addresses. The study depended on known personal contacts and the active involvement of participants to recruit additional informants using a snowball sampling method. Further, some of the participants were recruited by a personal contact and others by the researcher which could have influenced participant responses and behaviors. An inability to identify all Air Force nurses meeting the inclusion criteria using military resources limited the sample size considerably. Further, due to geographical separation, three of the interviews were conducted by telephone which introduces the possibility of missed nonverbal cues. Finally, qualitative data analysis largely depends on the judgments and interpretations of the researcher which may be inadvertently influenced by researcher bias. The researcher maintained a reflexive journal during the study as a means of acknowledging and addressing any potential biases.
Implications

This study sought to describe and understand the role transition from a civilian staff nurse to an Air Force staff nurse using an interpretative, phenomenological method. And while the essence of that experience was uncovered from an analysis of the data derived from the interviews of seven new Air Force nurses, failure to implicate these findings beyond the study itself would be imprudent.

A majority of the participants found that Commissioned Officer Training, COT, failed to meet their perceived learning needs. According to the participants, COT focused more on developing leadership capabilities and less on learning the Officer role and integrating into the military culture. While it is recognized that these views represent only a small percentage of new Air Force officers attending COT, it is no less important to address the discrepancy. It is therefore suggested that heightened efforts to include more detailed Air Force related information, such as assembling and wearing the military uniform, be integrated into the COT curriculum. Further, feedback during and after COT should include opportunities to assess whether the content and curriculum of the program met the anticipated and expected learning needs of the participants. Until the content of COT reflects, at least in part, the learning needs of its attendees, the transition to the military Officer role will remain challenging, stressful, and problematic.

Negatively perceived role transitions are linked to job dissatisfaction (Pellico et al., 2009), turnover (Clare & van Loon, 2003; Pellico, Djukic, Kovner, & Brewer, 2010), and a failure to retain quality nurses within the civilian workforce. Although no link between the transition to military nursing practice and job dissatisfaction has been established in the existing literature, job satisfaction among military nurses has been associated with the degree of
professional status, pay, resource adequacy, and perceived support at the unit and base level (Allgood, O’Rouke, VanDerslice, & Hardy, 2000; Zangaro & Johantgen, 2009). The participants in this study reported various challenges which have influenced their perception of the transition experience, reported role satisfaction, and the intent to stay. Two participants in the study expressed an intent to stay in the Air Force, one participant was on the fence, and four participants stated they planned to get out of the Air Force once their service commitment was fulfilled. Rationales for the decision to leave the Air Force included a discrepancy between the expectation of military nursing practice and the reality encountered, feelings of role unpreparedness secondary to a lack of information from recruiters and COT, and finally a lack of opportunities to perform complex nursing skills due to low patient census and even lower patient acuities. The ability to accomplish the mission at home and abroad depends upon the retention of recruited nurses. To that end, efforts and resources must be dedicated to assuring a positive transition experience. These include, but are not limited to, education and training of nurse preceptors, uninterrupted time to complete base and group level training, and a stable unit orientation in which new Air Force nurses are matched with one single preceptor. According to Scott et al. (2008), “The first year in a profession establishes an individual’s career framework and influences long-term professional development and satisfaction” (p. 75). It can be argued that a nurse’s first year in the Air Force has the potential to influence their military career, satisfaction in the role, and the intent to stay.

**Recommendations for Future Research**

The investigation of transition among military nurses remains in its infancy. This study serves as a starting point for understanding the experience from the perspective of new Air Force nurses. But there are additional elements, related to the military culture and working
environment, which are capable of influencing the transition process and therefore should be investigated in their own right and integrated within reported experiences to further elucidate the lived experience of transition.

Consistent with the trend to move health care services to a community setting, the Air Force health care system maintains more outpatient clinics than acute care hospitals. In fact, clinics are postured at each Air Force installation worldwide while there are only a handful of hospitals. This means that newly commissioned Air Force nurses are more likely to be stationed in a clinic setting. The work environment, role expectations, and clinical expertise are likely to be vastly different between the two settings. This study focused on new Air Force nurses currently working in an acute care setting. But it becomes important to acknowledge the transition experiences of nurses who begin their Air Force nursing career in a clinic setting. The results of which should be compared to the findings of this study to identify similarities and differences as well as common elements which could be improved.

Future research inquiry focusing on the role transitions of military nurses should seek to isolate and compare demographic variables which could influence the transition experience. Such variables could include length of time spent in civilian clinical practice prior to commissioning, specific civilian clinical units worked, age at commissioning, gender, or an association with another family member in the military. Often studies investigating role transitions in nursing include samples with numerous demographic variables which prevent comparisons across existing literature. This study is no exception. Only when samples are homogenous can clear analogies be made and true recommendations aimed at improving the experience be developed. A mixed-method approach which links demographic variables to the informant’s perception of the transition experience is needed.
Finally, newly commissioned graduate nurses beginning professional practice in the Air Force are required to attend the Nurse Transition Program (NTP). There is no such transition program in place for newly commissioned nurses with previous civilian experience. As a means of evaluating the effectiveness of NTP and to help ascertain whether a similar program for experienced nurses is needed; a study which compares the reported transition experiences of new graduate Air Force nurses who receive additional training and support through the NTP against new, yet experienced, nurses is needed.

Summary

Chapter five presented a discussion of the results of the study by answering each of the six research questions. The study limitations and research implications were also offered. Finally, recommendations for future research inquiry on military nurse transition was provided.

Conclusion

The role transition from civilian to military nursing practice has the potential to be significantly different. The literature is replete with studies investigating the experience of transition from the perspective of nurses employed in civilian health care settings. The purpose of this study was to explore and describe the lived experience of transition for registered nurses moving from a civilian staff nurse to an Air Force staff nurse position. The results indicated that while both civilian and new Air Force nurses encountered struggles during transition, the characteristics of these struggles were different. Challenges related to a lack of knowledge and role preparedness 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. The current findings need to be compared against the
transition experiences reported by new Air Force nurses working in ambulatory clinic settings. Efforts to reduce the perceived lack of knowledge through improvements to the COT program are recommended for all new AF nurses – not solely new graduates.
References


doi: 10.1111/j.1440-172X.2010.01826.x


http://access.afpc.af.mil/vbinDMZ/broker.exe?_program=DEMOGPK.static_reports.sas

&_service=pZ1pub1&_debug=0


www.aacn.nche.edu/government-affairs/archives/2008/08TNT_FS.pdf


http://www.aha.org/content/00-10/100524-thschartpk.pdf


doi: 10.1097/NND.0b013e31825514e


Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle


doi: 10.2202/1548-923X.1381


Dowling, M., & Cooney, A. (2012). Research approaches related to phenomenology:


doi: 10.1111/j.1365-2648.2008.04898.x


doi: 10.3928/00220124-20090824-03


_The Journal of Continuing Education in Nursing, 38_(1), 24-30.


at 3 months. _The Journal of Continuing Education in Nursing, 34_(3), 103-107.


Duquesne University Press.


doi: 10.1111/j.1365-2648.2007.04469.x


doi: 10.1177/1084822304272944


doi: 10.3912/OJIN.Vol12No03Man04


doi: 10.1016/j.nepr.2004.01.004


Munhall, P. (2007b). Ethical considerations in qualitative research. In P. Munhall (Eds.), *Nursing research: A qualitative perspective* (pp. 501-513). Sudbury, MA: Jones and


doi: 10.1016/j.ijnurstu.2006.05.017


Therapy and Rehabilitation, 16(12), 638-647.


doi: 10.3928/00220124-20100601-01


doi: 10.1016/j.outlook.2008.06.001


doi: 10.1016/j.injury.2008.03.028


Robinson, S., Kellett, S., King, I., & Keating, V. (2012). Role transition from mental health
nurse to IAPT high intensity psychological therapist. *Behavioural and Cognitive Psychotherapy, 40*, 351-366. doi: 10.1017/S1352465811000683


[http://healthcareers.about.com/od/healthcareerprofiles/a/militarymedicaljobs.htm](http://healthcareers.about.com/od/healthcareerprofiles/a/militarymedicaljobs.htm)


Walker, A., Earl, C., Costa, B., & Cuddihy, L. (2013). Graduate nurses’ transition and integration into the workplace: A qualitative comparison of graduate nurses’ and

doi: 10.1016/j.nedt.2012.06.005


doi: 10.1111/j.1365-2702.2007.02229.x


Zadlo, B. (2014, March 12). Email response to FOIA request. [Email to Katie Chargualaf].


Zinsmeister, L., & Schafer, D. (2009). The exploration of the lived experience of the graduate nurse making the transition to registered nurse during the first year of practice. *Journal*
Appendix A: Phenomenological Approaches & Philosophical Assumptions

Phenomenology is both a philosophy and a research method (Munhall, 2007a). Derived from Greek origins meaning “to bring to light,” phenomenology seeks to understand lived experiences by uncovering the meanings of phenomena (Pringle et al., 2011; Petty et al., 2012). Phenomenologists believe that each person is unique and self-determining; capable of interpreting the world and constructing reality (Welford et al., 2012; Nicholls, 2009a). In essence, phenomenology seeks to “study the meaning of reality” (Nicholls, 2009a, p. 587). Originally conceived by Edmund Husserl, the phenomenological method developed from a belief that experimental research failed to capture the internal and interpersonal perceptions and assigned meanings surrounding phenomena (Crotty, 1998). Over time, differing views of the phenomenological philosophy emerged which influenced several variations in the method that impact current phenomenological research.

There are two distinct phenomenological approaches used in nursing research. The first, descriptive phenomenology, or edetic, is guided by the ideas of Edmund Husserl (Dowling & Cooney, 2012; Flood, 2010). Husserl sought to “study phenomena as they appeared through the consciousness” (Koch, 1996, p. 175) believing mental and physical phenomena to be mutually exclusive (or intentionality) (Dowling & Cooney, 2012). A belief that “there is no real existence outside of the mind” (Dowling & Cooney, 2012, p. 23) meant that all knowledge originates from conscious awareness (McConnell-Henry, Chapman, & Francis, 2011). However, Converse (2012) argues that Husserl’s belief in intentionality essentially removes the person from phenomena and the understanding of that phenomenon. Reality, then, was assumed to be the life experience (McConnell-Henry et al., 2011) and the goal was to uncover the essence, or true meaning, of that reality by describing the lived experience (Dowling & Cooney, 2012).
According to Husserl, the only way to accurately identify the essence of a lived experience is to bracket, also known as the phenomenological *epoché*, one’s own knowledge and beliefs about the phenomena (Dowling & Cooney, 2012; Jones, Rodger, Ziviani, & Boyd, 2012).

Guided by the ideas of Martin Heidegger, the second approach is interpretative phenomenology or hermeneutics. Moving beyond description, hermeneutics seeks to understand lived experiences through clarification and interpretation (Flood, 2010; Welford et al., 2012). Heidegger suggested shifting the focus of study away from the person or phenomena to the exploration of the meaning of being situated in the world, or *dasein* (Dowling & Cooney, 2012; Flood, 2010). The term *life-world* was developed by Heidegger to describe how the realities of being are influenced by the world in which it is occurring (Finlay, 2009). Heidegger rejected the separation of mind and body (*intentionality*) believing that lived experiences are linked to social, cultural, and political contexts which influence the perception and meanings of these experiences (McConnell-Henry et al., 2011; Jones et al., 2012). Unlike Husserl, Heidegger valued the knowledge and experience of researchers and advocated for co-constitutionality or the co-creation of meanings resulting from a “blend of those articulated by participants and researcher” (Flood, 2010, p. 10).

The distinguishing characteristic of descriptive phenomenology is phenomenological reduction, or bracketing (*epoche*). Husserl believed that assumptions, or the “unquestioned meanings about phenomena,” develop from interpreted life experiences which are handed down through generations and contribute to the formulation of a perceived reality which he called ‘natural attitude’ (Munhall, 2007a, p. 161). In order to reach the essence of a lived experience the researcher must suspend their own natural attitude, or their own perceived reality of the world which are influenced by “prejudices, preconceptions, and beliefs” (Dowling & Cooney,
2012, p. 23). The purpose of bracketing is to eliminate any chance that personal beliefs and values, held by the researcher, would influence the description of the experience by the participant (Petty et al., 2012; Roberts, 2013).

While both phenomenological approaches maintain similar goals, to explore lived experiences, there are pronounced differences in the philosophical assumptions which influence the investigation of role transitions in professional nursing practice (McConnell-Henry et al., 2011). The first major difference lies in the relationship between meanings and truths. Husserl believed that there exists one truth about a phenomena and that only a single, correct interpretation of a lived experience can reveal this truth (Dowling & Cooney, 2012; Flood, 2010; Pringle et al., 2011). Conversely, Heidegger asserted that meanings are not fixed but rather co-created through the description of the experience by the participant and the interpretation of the experience by the researcher, co-constitutionality (Flood, 2010; Petty et al., 2012). The influence of culture, society, and politics on the perception of lived experiences and their meanings constitutes the second major difference between the phenomenological approaches. Heidegger believed that reality is influenced by the surrounding world whereas Husserl did not ascribe to such contextual influences (Flood, 2010). The third major difference lies in the topic of bracketing. Descriptive phenomenologists believe bracketing is essential whereas interpretative phenomenologists value the knowledge and presuppositions of the researcher believing it impossible to temporarily set aside presuppositions as they are an integral part of being-in-the world (Dowling & Cooney, 2012).

This study seeks to understand and interpret the lived experience of role transition from civilian to military nursing practice among registered nurses with more than one year of clinical experience. Every nurse will undergo a role transition at some point during their professional
career, and, according to nursing literature, these transitions are influenced by educational preparation, the work environment, availability of support, the culture of nursing practice, and political directives. Further, role transitions are highly individualized and therefore capable of multiple truths. Husserl’s belief in the existence of a single truth which is revealed through a single interpretation of a lived experience is inconsistent with what is known about role transitions in nursing (Dowling & Cooney, 2012; Flood, 2010; & Pringle et al., 2011). Finally, a researcher’s knowledge of and experience with transition make phenomenological reduction a challenge, if not impossible. Heidegger argued that a “researcher’s ability to interpret the data was reliant on previous knowledge and understanding” because a purely objective understanding of phenomena is not possible (McConnell-Henry et al., 2011, p. 9). Further complicating the issue is a lack of clear guidelines regarding the proper method to achieve complete reduction which could threaten a study’s rigor (Converse, 2012). For these reasons, a hermeneutic phenomenological approach was chosen to guide this study.
Appendix B: IRB Approval Letter

April 15, 2014

TO: Katie A. Chargualaf  
Principal Investigator  
School of Nursing & Dental Hygiene  

FROM: Denise A. Lin-DeShetler, MPH, MA  
Director  

Re: CHS #22047 - "The Experiences of Transition from a Civilian Staff Nurse to an Air Force Staff Nurse: A Phenomenological Study"  

This letter is your record of the Human Studies Program approval of this study as exempt.  

On April 15, 2014, the University of Hawai‘i (UH) Human Studies Program approved this study as exempt from federal regulations pertaining to the protection of human research participants. The authority for the exemption applicable to your study is documented in the Code of Federal Regulations at 45 CFR 46.101(b)(2).  

Exempt studies are subject to the ethical principles articulated in The Belmont Report, found at http://www.hawaii.edu/irb/html/manual/appendices/A/belmont.html  

Exempt studies do not require regular continuing review by the Human Studies Program. However, if you propose to modify your study, you must receive approval from the Human Studies Program prior to implementing any changes. You can submit your proposed changes via email at uhirb@hawaii.edu. (The subject line should read: Exempt Study Modification.) The Human Studies Program may review the exempt status at that time and request an application for approval as non-exempt research.  

In order to protect the confidentiality of research participants, we encourage you to destroy private information which can be linked to the identities of individuals as soon as it is reasonable to do so. Signed consent forms, as applicable to your study, should be maintained for at least the duration of your project.  

This approval does not expire. However, please notify the Human Studies Program when your study is complete. Upon notification, we will close our files pertaining to your study.  

If you have any questions relating to the protection of human research participants, please contact the Human Studies Program at 956-5007 or uhirb@hawaii.edu. We wish you success in carrying out your research project.
Appendix C: Interview Questions

1. Tell me about your first staff nurse position in the military.

   PROBES:

   a) Describe the elements you found helpful during your transition?

   b) Describe some challenges you faced during your first year of practice in the military.

   c) What elements, if any, hindered your transition?

   d) Describe the orientation that you received at your first duty assignment.

   e) Describe your assigned mentor during your transition.

   f) Describe the peer support, if any, you received during your first year of nursing practice in the military.

   g) Describe any institutional support that you received during your transition.

   h) How has the work environment influenced your transition to military nursing practice?

   i) What knowledge or skills, from your civilian nursing practice, do you think are essential to the successful transition to military nursing practice?

   j) What, if anything, would you change about your transition from civilian to military nursing practice?

   k) Based on your own transition experience, what advice, if any, would you offer other registered nurses considering a transition from civilian to military nursing practice?
Appendix D: Letter of Invitation to Participate

1607 Beaumont St.
Sheppard AFB, TX 76311

[date]

[Name]
XXXX AFB Medical Center
Street Address
XXXX AFB, XX 12345

Dear [name],

I am a registered nurse, an Air Force spouse, and a PhD student in Nursing at the University of Hawai‘i at Mānoa School of Nursing and Dental Hygiene in Honolulu, Hawai‘i. I am currently conducting a study which seeks to describe the lived experiences of registered nurses, with more than one year of practical experience, who transition from civilian to military nursing practice in the United States Air Force (USAF).

Each year registered nurses, with significant clinical knowledge and experience, transition from civilian to military nursing practice. Yet, there is no research which describes this unique process from the perspective of Air Force nurses. Your experience, as a new Air Force nurse, is valuable and important. Sharing your experience can inform future military nurses, physicians, and military leadership regarding successful transition to military nursing practice and contribute toward efforts aimed at improving the transition.

You have been identified as a potential candidate for this study. Please contact me within the next week if you meet the following study criteria and would be interested in participating. Participation is completely voluntary and your identity will remain confidential. The study is limited to registered nurses who meet the following criteria:

1. Graduated from an accredited baccalaureate nursing program within the last five (5) years
2. Commissioned officers in the United States Air Force (USAF) employed as registered nurses
3. Maintain between one and five years of nursing experience in a civilian healthcare setting before transition to the USAF
4. Maintain less than two years of clinical experience as a registered nurse in the USAF
5. Willing to voluntarily participate in one, audiotaped interview
6. English speaking

If you are interested in participating in this study, please contact me at your earliest
convenience. I may be reached using the following email address katie4@hawaii.edu. I may also be reached by phone (505) 710 – 3083 to answer any questions you may have regarding this study. Thank you for your consideration in participating in this research study.
Sincerely,

Katie A. Chargualaf, RN, MSN/ED, CMSRN
PhD Student
University of Hawai‘i at Mānoa,
School of Nursing and Dental Hygiene, Department of Nursing
Appendix E: Informed Consent

University of Hawai‘i

Consent to Participate in Research Project:

The Experience of Transition from a Civilian Staff Nurse to an Air Force Staff Nurse: A Phenomenological Study

My name is Katie Chargualaf. I am a graduate student at the University of Hawai‘i at Mānoa in the School of Nursing and Dental Hygiene. As part of the requirements for earning my graduate degree, I am doing a research project as a requirement for earning my graduate degree. The purpose of my project is to explore and describe the experiences of registered nurses who transitioned from a staff nurse position in a civilian setting to a staff nurse position in the United States Air Force. I am asking you to participate because you are a registered nurse who recently transitioned into a staff nurse role in the United States Air Force.

What activities will you do in the study and how long will the activities last? If you participate in this project, I will meet with you for an interview or focus group at a location and time convenient for you. The interview will consist of 12 - 15 open ended questions. It will take 45 minutes to an hour. Interview questions will include questions like, “Tell me about your first staff nurse position in the military” and “Describe some challenges you faced during your first year of practice in the military.” Only you and I will be present during the interview. I will audio-record the interview so that I can later transcribe the interview and analyze the responses. You will be one of about 10 people whom I will interview for this study. If you would like to see a copy of all of the questions that I will ask you, please let me know now.

Benefits and Risks: There may be no direct benefits to you in participating in my research project. The results of this project may help improve the role transition experiences of future United States Air Force nurses. I believe there is little or no risk to you in participating in this project. There is a possibility you may become uncomfortable or stressed by answering an interview question or questions. If that happens, we will skip the question, or take a break, or stop the interview. You may also withdraw from the project altogether. Clinical psychologists, assigned to the military health clinic on the Air Force base will be available to you, if needed.

Confidentiality and Privacy: I will keep all information from the interviews in a safe place. Only my University of Hawaii advisor and I will have access to the information. Other agencies that have legal permission have the right to review research records. The University of Hawaii Human Studies Program has the right to review research records for this study.

After I write down the interviews, I will destroy the audio-recordings. When I report the results of my research project, I will not use your name or any other personal information that would
identify you. Instead, I will use a pseudonym (fake name) for your name. If you would like a copy of my final report, please contact me at the number listed near the end of this consent form.

**Voluntary Participation:** Participation in this research project is voluntary. You are free to choose to participate or not to participate in this project. At any point during this project, you can withdraw your permission without any loss of benefits. Your choice to participate or not participate will not affect your position as a registered nurse in the United States Air Force.

**Questions:** If you have any questions about this project, please contact me at via phone (505) 710-3083 or e-mail (katie4@hawaii.edu).

If you have any questions about your rights in this project, you can contact the University of Hawaii, Human Studies Program, by phone at (808) 956-5007 or by e-mail at uhirb@hawaii.edu.

Please keep the section above for your records.

If you agree to participate in this project, please sign the following signature portion of this consent form and return it to Katie Chargualaf.

**Signature(s) for Consent:**

I agree to join in the research project entitled, “The Experience of Transition from a Civilian Staff Nurse to an Air Force Staff Nurse: A Phenomenological Study.” I understand that I can change my mind about being in this project, at any time, by notifying the researcher.

**Your Name (Print):** __________________________________________________________

**Your Signature:** __________________________________________________________

**Date:** __________________________________________________________

**Do you consent to audio-recording of our interview today?** Yes ____ No ____
Appendix F: Demographic Questionnaire

Title of Study: The Experience of Transition from a Civilian Staff Nurse to an Air Force Staff Nurse: A Phenomenological Study

Principal Investigator: Katie Chargualaf, RN, MSN, CMSRN

Participant ID Number: _____________

Age: ________________ Gender: Male Female

Race: __________________________

What year did you graduate from nursing school (BSN program)? ______

Nursing School: ________________________________

What year were you commissioned into the USAF? ______

How many years did you practice as a professional nurse in a civilian healthcare setting before you were commissioned into the USAF? ______

What clinical units did you work on in the civilian healthcare setting?

____________________________________________________________________________

____________________________________________________________________________

Is this your first active duty assignment in the USAF? ______
Appendix G: Data Analysis and the Interpretative Phenomenological Research Method

Nurse researchers often use frameworks, which were developed for and within the field of psychology, to guide data analysis (Colaizzi, 1978; Giorgi, 1985; van Kaam, 1966). All of these methods subscribe to Husserl’s philosophy and contain within it, elements which are inconsistent with Heidegger’s interpretative philosophies. Colaizzi (1978) and Giorgi’s (1985) methods require participant validation at one or more points after the initial interview, a form of member-checking, which fails to acknowledge the contextual influences on the interpretation of lived experiences. It is argued that using member checks in interpretative phenomenology may be a threat to rigor rather than a means of demonstrating it (McConnell-Henry et al., 2011). Van Kaam’s (1966) method requires intersubjective agreement among experts in both the research method and, in this case, nurse transition. McConnell-Henry et al. (2011) assert only the participant and the researcher are experts because together they have co-constructed meanings of the lived experience. Further, all three methods incorporate bracketing, or reduction, as a means of setting aside prior beliefs and knowledge so that the objective reality of the experience may be described (Wojnar & Swanson, 2007). Researchers using an interpretative phenomenological approach, based upon the philosophies of Heidegger, “acknowledge that they can only interpret something according to their own beliefs, experiences, and preconceptions, which are a legitimate part of the research process” (Lowes & Prowse, 2001, p. 474).

Additional methods were also considered as possible frameworks that could guide data analysis for this study. Diekelmann, Allen & Tanner (1989) developed a method of data analysis which is founded on the Heideggerian philosophy and the interpretative phenomenological method. The seven step method includes a validation of results by persons outside of the research team who are familiar with the phenomena of interest as well as interpretative phenomenological research. This step, according to Diekelmann, Allen, & Tanner (1989), provides the assurance
that the interpretations are “true and objective” (Ortiz, 2009, para. 6). According to the assumptions of interpretative phenomenology, it is impossible to validate an interpretation by anyone other than the participant and the researcher as the meanings & interpretations were co-created (McConnell- Henry et al, 2011).

Finally, Van Manen’s (1990) method is another method used by nurse researchers to analyze data which was considered for use in this study. Based upon the philosophies of both Husserl and Heidegger, this method allows the researcher to choose one method, among three, to isolate themes in the data. The three methods which may be used to extract themes from participant descriptions include holistic approach, selective approach, and detailed approach (van Manen, 1990). Although van Manen (1990) believed complete reduction impossible, he argued that a “pre-understanding” of a phenomena could interfere with or influence the interpretation of the lived experience. Therefore, the second step of this method advocates for researcher bracketing to the extent possible. The integration of processes which violate hermeneutic philosophies will not be employed in this study so van Manen’s (1990) method was not chosen to guide data analysis.