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COVID-19 Pandemic

The Importance of Supporting Civilian and Military Transition-to-Practice Programs to Avert Current and Future Nursing Shortages

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Registered nurses (RNs) are national assets who provide quality patient care, especially during the corona virus disease 2019 pandemic. Currently, healthcare organizations are overwhelmed with ill patients who require RNs with specialty experiences. Curtailment and cancellation by healthcare organizations of civilian and military transition-to-practice programs for newly licensed RNs are at risk. If this phenomenon continues, current and future nursing shortages will prevail.

The onset of the corona virus disease 2019 (COVID-19) pandemic created unforeseen havoc to the global delivery of health care because transmission, treatment, and immunization treatment modalities were not fully understood (Busse et al., 2020; Lofti et al., 2020). In 2020, the International Council of Nurses reported that 44 countries experienced the death of over 1,500 nurses from COVID-19 (Jones, 2020). According to the Centers for Disease Control and Prevention (CDC), the United States has dealt with 26,034,475 COVID-19 cases and 439,955 deaths as of February 2, 2021 (CDC, 2020a). As the COVID-19 pandemic lingers, it is important to realize that past, present, and future nurses are notable vanguards who stand ready against public health catastrophes (Jackson et al., 2020; Jones, 2020). The nursing profession is obligated to apply current and historical pandemic lessons learned as strategies to develop future registered nurses (RNs) into practicing clinicians (Labrague et al., 2018). Civilian and military transition-to-practice programs (TPPs) meet this duty by shaping newly licensed RNs into competent RNs (Oblea et al., 2019; Walsh, 2018). The purpose of this article was to explore the evidence about TPPs for newly licensed civilian and military RNs that support averting current and future nursing shortages.

NURSING SHORTAGE IMPACT ON TPPs

U.S. hospitals employ over 3.8 million RNs, whereas newly licensed RNs compose 10% of U.S. civilian hospital nursing staff (American Nurses Credentialing Center, 2020; Hopkins & Bromley, 2016). The influx of severely ill COVID-19 patients created a national shortage of experienced critical care and emergency department RNs (O'Brien, 2020; Veenema et al., 2020). The U.S. Bureau of Labor Statistics (2020) predicts that, by 2026, the demand for 203,700 nurses will be required to fill positions left vacant by nurses who resign or retire. Healthcare leaders must realize that time and resources are required for TPPs to guide newly licensed RNs into competent clinicians (Hofler & Thomas, 2016).

Assuming that RNs remain in their original resident home state, the Health Resources and Services Administration (2017) projected a nationwide surplus of civilian nurses by 2025. This projection is misleading when further analysis is considered. Figure 1 shows an imbalanced distribution phenomenon among 16 states, with Hawaii exhibiting the least anticipated nursing shortage and Arizona having the most predictable nursing shortage. The total nursing shortage sum of these 16 states is 106,602 RNs. Healthcare organizations that offer TPPs must be able to obtain reliable statewide supply and demand information as a way to meet current healthcare consumer demands and forecast future RN attrition rates (Hofler & Thomas, 2016).

THE COVID-19 PANDEMIC INFLUENCE ON TRANSITION-TO-PRACTICE AND NURSING PROGRAMS

The COVID-19 pandemic forced healthcare leaders from U.S. civilian hospitals and military medical treatment facilities (MTFs) to take drastic staffing measures. Article I, Section 8, of the U.S. Constitution allows Congress to determine size of our armed forces (Congressional Research Service, 2016).

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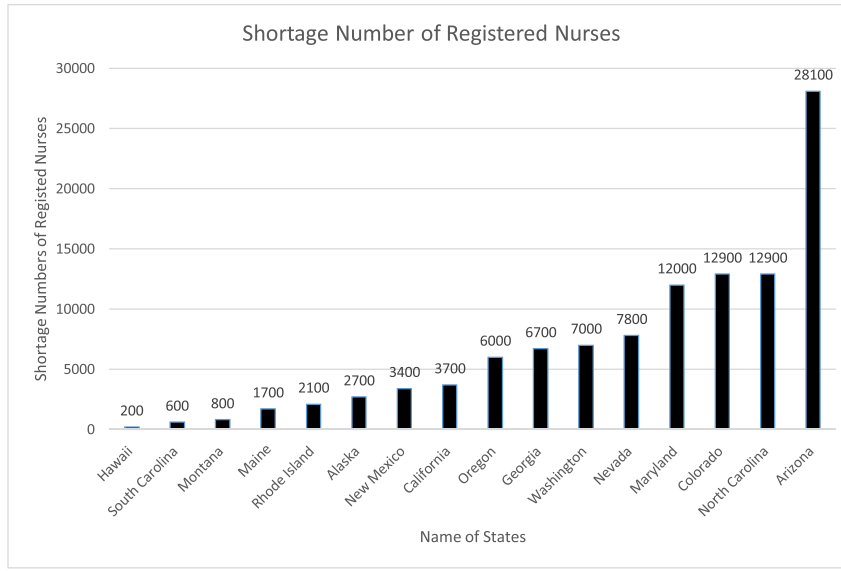

FIGURE 1. 2025 projected shortage numbers of registered nurses for 16 states. This figure is available in color online (www.jnpdonline.com).

The U.S. armed forces are all-volunteer, and it represents 1% of the total U.S. population (GlobalFirePower.com, 2020). To overcome all hazard disasters, Federal Law 10 U.S. Code § 12302 was initiated in 1953 (Absher, 2020). The president can lawfully recall up to 1 million reservists and retirees for up to 2 years. In April 2020, the Department of Defense voluntarily recalled reservists and military retirees to active duty in support of the COVID-19 pandemic. Most of the retiree volunteers were RNs who willingly served in uniform once more at stateside and oversea military MTFs. These military nurses provided world-class direct patient care, hospital education, staff development, and assisted with COVID-19 screenings for both military and civilian patients.

A major recommendation by the CDC is that civilian hospitals plan for staffing shortages during the COVID-19 pandemic and collaborate with their human resource departments to mitigate maximum hospital capacities (CDC, 2020b). Hospital administrators took action by establishing minimal baseline patient to nurse ratios for safety reasons. This required adjusting staffing schedules, canceling elective surgeries, and closing ambulatory care clinics, which affects the health of chronically ill patients. Many hospitals encouraged existing staff nurses to work overtime, monetarily enticed nurses out of retirement, and filled vacant nurse positions with experienced contract and travel nurses at premium pay (Higgins-Dunn, 2020). Other considerations included delaying employee vacations and denying family leave requests, which perpetuated employee absenteeism and low morale (Coombs, 2020).

Similar to the 2008 economic recession, people worldwide are currently experiencing high unemployment rates, loss of income, and unanticipated access barriers to health care because of the COVID-19 pandemic (Catton, 2020). Healthcare consumers in the United States face paying exorbitant out-of-pocket medical expenses because of rising health insurance copayments, which creates financial distress among suppliers and consumers of health care (Zheng et al., 2020). This economic calamity resulted in lessened employment opportunities for newly licensed RNs because of diminished healthcare revenue. Numerous civilian healthcare systems cut operation costs by implementing newly licensed RN hiring freezes, temporarily ceasing TPP offerings or offering virtual TPPs (Balagtas, 2020; Houle et al., 2020).

The COVID-19 pandemic has also affected numerous nursing programs (Shea & Rovera, 2021; Yancey, 2020). The need for most hospitals, during the COVID-19 pandemic, is experienced nurses at the expense of temporally closing clinical sites to nursing programs. This created an abrupt learning gap for many nursing students who had hospital clinical rotations canceled and graduations possibly postponed. Many state governors relaxed their board of nursing rules and allowing for an increase in the use of simulation to provide clinical learning experiences and certain senior nursing students to graduate early. This increase in simulation use allowed nursing schools to utilize virtual classrooms and clinical simulation instead of required hospital clinical hours (Palancia Esposito & Sullivan, 2020). San Francisco State University School of Nursing and Texas A&M University Health Science Center College of Nursing are two academic institutions that adapted to the challenges of the COVID-19 pandemic

(Clark, 2020; Shea & Rovera, 2021). These institutes created virtual clinical settings or experiences that reduced students' potential exposure to COVID-19 and met required clinical objectives so that students graduated on time. Further information sharing by academic nursing programs is highly encouraged as a means to determine best practice outcomes of virtual clinical education during the COVID-19 pandemic.

BACKGROUND OF CIVILIAN/MILITARY TPPs

In 1995, the Northwestern Community Hospital in Arlington Heights, Illinois, established the initial 24-month TPP (Goeddeke, 2009). They reported that the outcome of their TPP was competent practicing nurses, with 30% of the original nurses still employed after 10 years. The Northwestern Community Hospital also noted that retirement among staff nurses was a factor that promoted continuation of their TPP. In 2002, six U.S. hospitals established partnerships with university nursing schools and piloted TPPs (Goode et al., 2013). These actions inspired Hawaii to implement TPPs statewide. By 2004, the American Association of Colleges of Nursing led the way in establishing TPPs for critical care nurses (Barnett et al., 2014).

In 2010, a nationwide nursing shortage occurred because of high RN turnover rates and diminished retention rates for newly licensed RNs (Brook et al., 2019; Institute of Medicine, 2011). The Joint Commission recommended that U.S. healthcare facilities offer TPPs as a way to recruit and retain newly licensed RNs. The State of Maryland implemented TPPs statewide in 2016, which reduced newly licensed RNs' resignation rate by 10%, increased newly licensed RNs' retention rate by 96%, and cut hiring costs (Walsh, 2018).

Currently, 40% of TPPs in the United States are 1 year in duration, whereas the remainder of these civilian and military TPPs are 6 months in length (Oblea et al., 2019; Walsh, 2018). These programs are indispensable as transition conduits for newly licensed RNs, yet accreditation requires minimum program length (American Nurses Credentialing Center, 2020). Civilian hospitals that offer TPPs are associated with academic medical centers that nurture rich teaching environments that merit recognition as Magnet status healthcare organizations (Warren et al., 2018). TPPs also act as a catalyst for professional development through organizational membership drives, assist with certifications, and promote advanced education, which is helpful for job advancements. Likewise, military TPPs allow team building by military nurses as they create and present evidence-based projects (Oblea et al., 2019). These activities encourage esprit de corps and promote lifelong learning through pursuit of advanced nursing degrees, which are beneficial for promotions.

Since the early 1990s, the U.S. Air Force Nurse Corps relied on preceptor programs (University of Cincinnati Health, 2020). In 2008, they collaborated with the University of Cincinnati Medical Center to establish the first military–civilian TPP. In 2009, the U.S. Army Nurse Corps (ANC) initiated the Brigadier General Anna Mae Hays Clinical Nurse Transition Program (CNTP) in lieu of the preceptor program (Oblea et al., 2019). This program shapes newly assigned ANC officers into competent clinicians and effective military leaders. Currently, the U.S. Army, the U.S. Air Force, and the U.S. Navy Nurse Corps ensure that their newly commissioned Nurse Corps officers transition into the enterprise analogous to civilian TPPs.

Nursing shortages are not noticeable in our military services; however, many military MTFs are vulnerable to sporadic temporary RN shortages because of contingency operations (Oblea et al., 2019). Military RNs have a unique mission of deploying globally in support of our war fighters, as they quell hostilities or engage in humanitarian missions. This requires both clinical and leadership training to safeguard deployment readiness. If there are episodes of exorbitant exodus of ANC officers, it will harm national security. Nationwide, civilian TPPs consider 12 months with 90% retention as an acceptable retention rate goal (Eckerson, 2018); however, retention rates drop to 70% after 2 years (Akerson & Stiles, 2018).

In comparison, ANC utilize internal reports to establish the efficacy milestone at the fifth year of service (Oblea et al., 2019). This is when military officers can voluntarily resign their commission and exit honorably. From 2009 to 2011, the retention rate for ANC officers was 89.9% at their fifth year of military service. Further comparative retention rate studies at 1, 2, 5, and 10 years post civilian and military TPP will strategically benefit organizational forecasting of nursing shortages.

The COVID-19 pandemic presented significant threats for military healthcare systems' ability to care for an overwhelming influx of critically ill patients. To mitigate this threat, the ANC directed a temporary reduction of the 26-week CNTP to a 14-week CNTP in April 2020 (J. Sabido, personal communication, April 1, 2020) in order to accelerate the availability of nursing workforce to meet the potential workload demands. Table 1 compares the clinical, didactic, case study and group project requirements for the 26-week CNTP versus the 14-week pilot CNTP. Piloting the shorter program reduced length of training for one iteration.

The U.S. Army Medical Center of Excellence applied the military decision by considering benefits versus risks during the COVID-19 pandemic and concluded that it was best to revert to the 26-week CNTP. Evidence supports the decision that the longer program outweighed the gains in workforce availability by ensuring the sustainment of safe nursing care by clinically competent RNs (Rush et al., 2019). Moreover, the American Nurses Credentialing Center for Practice Transition Accreditation Program requires military CNTPs to be a minimum of 6 months in length for pending

TABLE 1 26-Week Versus 14-Week Clinical Nurse Transition Program (CNTP) Required Hours

Requirements	26-Week CNTP	14-Week CNTP (COVID-19)
Supervised clinical hours	860 hours	560 hours
Monthly didactic seminars	48 hours	0 hours
Two case studies	28 hours	28 hours
Evidence-based practice group project	28 hours	0 hours
Total hours	1,040 hours	588 hours

accreditation approval (American Nurses Credentialing Center, 2020).

CONSEQUENCES OF CURTAILING OR ELIMINATING TPP

The consequences of curtailing or eliminating TPPs will decimate the future of health care because a new cohort of competent contemporary RNs will not be available to replenish the attrition of proficient baby boomer nurses (Rush et al., 2019). Prior to the establishment of TPPs, many hospitals reported 50% decrease in retention rates at 1 year (Akerson & Stiles, 2018). In addition, newly licensed RNs are more apt to leave the nursing profession within 2 years of practice because of toxic work environments, clinical unpreparedness, and overwhelming workloads (Webb & Kohi, 2019). TPPs are essential in closing the gap between expected clinical performance and the harsh reality that 65% of newly licensed RNs are not fully ready to undertake entry-level clinical positions (Rush et al., 2019). This creates an unsafe clinical setting for newly licensed RNs who are prone to committing patient safety errors.

It is common for newly hired RNs to articulate that their undergraduate academic experiences lacked practical clinical skill opportunities (Aldridge & Hummel, 2019). Rush et al. (2019) reported that 95% of newly hired contemporary RNs perceive lack of preparation in performing clinical skills and procedures. It is beneficial for TPPs to utilize assorted approaches to structure training and orientation for newly licensed RNs (Dang et al., 2018). If not, current and future generations of RNs will learn by trial and error, which results in negative patient safety outcomes.

Numerous hospitals in the United States are unable to fill 20% of their nursing positions because of attrition and toxic work environments (Evans et al., 2020; Taylor et al., 2019; Webb & Kohi, 2019). One-way TPPs can fill this void is by recruiting experienced preceptors and mentors who are personable and approachable with newly licensed RNs. Mentors, such as nursing professional development (NPD) leaders, provide professional development support for newly licensed RNs (Kiss & Smith, 2018).

The role of preceptors are to diminish perceived disparities of newly licensed RNs between expectations and reality (Taylor et al., 2019). Preceptors, such as experienced clinical staff nurses, ensure that newly licensed RNs are skillful, are adequately trained, and maintain behavioral composure while under stress. Unfortunately, some healthcare professionals, like newly licensed RNs, experience toxic behaviors from others in the workplace (Webb & Kohi, 2019). This leads to high employee turnover rates, increased patient safety incidents, and decreased work performance. TPPs that are multidimensional by using didactic, simulation, and clinical preceptors (Pertiwi & Hariyati, 2019) can monitor and sustain a positive culture through education, reporting blatant toxic behaviors and mentoring clinical preceptors as positive role models (Webb & Kohi, 2019).

Utilization of quality preceptors and mentors are key components to successful TPP (Spiva et al., 2017; Taylor et al., 2019). The selection process for preceptors is imperative for the development of newly licensed RNs. Preceptees will benefit immensely from experienced preceptors who exhibit positive attitudes because this is a key human factor for promoting a conducive culture for clinical teaching (Pertiwi & Hariyati, 2019). There is a need for further studies about best preceptorship and mentorship development training program practices that foster constructive interpersonal relationships.

Another tactic offered by TPPs is clinical skills laboratories. This venue is essential for verifying delivery of safe patient care (Aldridge & Hummel, 2019; Rush et al., 2019). Table 2 compares the top nine clinical skills perceived as uncomfortable after pretraining and posttraining by newly licensed civilian and military RNs (Goode et al., 2013; Oblea et al., 2019). The top problematic skill for civilian nurses was rapid response/codes, and the top challenging skill for military nurses was thoracostomy care. Assessment skills for both civilian and military nurses did not appear in the pretraining uncomfortable skills list but was listed number nine for posttraining. This is worth mentioning because assessment skills are the cornerstones of patient safety (Billings & Halsted, 2019). Formative evaluations during simulation and skills training are means to provide constructive feedback that enhances professional growth of newly licensed RNs. Because both cited civilian and military studies were conducted unilaterally (Goode et al., 2013; Oblea et al., 2019), further collaborative studies are needed to determine whether or not there are admitted uncomfortable skill changes between newly licensed civilian and military RNs.

IMPLICATIONS FOR NPD LEADERS

Accountability of positive patient outcomes are interweaved with transformational leadership and evidence-based nursing

TABLE 2 Top Nine Pretraining and Posttraining Skills for Civilian Transition-to-Practice Program and Military Clinical Nurse Transition Program Participants Reported as Being Uncomfortable Performing Autonomously After Pretraining and Postraining

Civilian Transition-to-Practice Program		Military Clinical Nurse Transition Program	
Pretraining Skills	**Posttraining Skills**	**Pretraining Skills**	**Posttraining Skills**
Rapid response/codes	Rapid response/codes	Thoracostomy care	Thoracostomy care
Thoracostomy care	Thoracostomy care	Nasogastric tube/Dobhoff care	Tracheostomy care
Mechanical ventilator management	Palliative care	Central line care	Rapid response/codes
Blood product Administration	Mechanical ventilator management	Tracheostomy care	Nasogastric tube/Dobhoff care
Phlebotomy	Tracheostomy care	Intravenous cannulation	Central line care
Intravenous cannulation	Phlebotomy	Rapid response/codes	Electrocardiogram interpretation
Interprofessional communication	Blood product administration	Electrocardiogram interpretation	Wound care
Time management	Intravenous cannulation	Bladder catheter insertion	Intravenous infusion pumps
Palliative care	Assessment skills	Documentation	Assessment skills

interventions (Dang et al., 2018; Spencer et al., 2018). The concept of transformational leadership practiced by NPD leaders has the potential to produce positive outcomes that are conducive to strengthening the bridge between academia and clinical delivery of evidence-based nursing care. Because nurses are the largest stakeholder in health care, it is imperative that NPD leaders be mentors, authentic leaders, and empowered to engage with organizational decisions (Institute of Medicine, 2011; Kiss & Smith, 2018).

The main aspect of NPD leaders is to utilize multiple orientation strategies (Karnish et al., 2019; Oblea et al., 2019; Pertiwi & Hariyati, 2019; Walsh, 2018). This strategy combines didactic clinical preceptorship, socialization, and simulation/skills laboratories into comprehensive professional development programs. NPD leaders are instrumental in providing human resource management, design position descriptions, and utilize socialization (Kiss & Smith, 2018). This allows professional development for onboarding newly licensed RNs as a means to strengthen clinical competencies and ensure patient safety. There are factors to consider that influence the onboarding process of newly licensed RNs. These newly licensed RNs have limited nursing experience in the academic realm but have previous lifelong experiences that can contribute unique outlooks to a healthcare organization. Socialization through interprofessional clinical simulation activities are optimal opportunities for sharing ideas and promoting innovative collaboration (Krueger et al., 2017). Further research is required to determine whether multiple orientation strategies advance long-term clinical competencies, patient safety, and socialization for newly licensed RNs.

RECOMMENDATIONS

The analysis of this article identified eight pertinent themes that influence the future trajectory of the nursing shortage. First, there is a basic need for future collaborative research between civilian and military NPD leaders to strengthen TPPs. Currently, comparative civilian and military TPPs studies do not exist. Second, there is a necessity for further collaborative qualitative and quantitative studies between civilian and military NPD leaders to determine whether there are admitted uncomfortable skill changes for newly licensed RNs. Third, additional consensus research addressing consistent duration and its effect on outcomes of civilian and military TPPs is required to support accreditation benchmarks. Fourth, collaboration between civilian and military TPPs in conducting comparative studies for RN retention rates at 1, 2, 5, and 10 years is a way to forecast pending nursing shortages. Fifth, further body of evidence supports identifying ideal preceptors who contribute to positive retention rates and improved competency levels of newly licensed RNs. Sixth, additional qualitative research is necessary to identify the organizational benefits of TPPs in promoting positive organizational culture.

Seventh, added studies examine whether multiple orientation strategies promote long-term clinical competencies, patient safety, and socialization for newly licensed RNs after completion of TPPs. Lastly, university nursing programs must share their best practice clinical alterations used during the COVID-19 pandemic to ensure safe and competent nursing practice.

CONCLUSION

The COVID-19 pandemic played havoc on the healthcare industry, yet healthcare consumers still hold RNs accountable for safe competent health care (Busse et al., 2020; Dang et al., 2018; Spencer et al., 2018). Once the COVID-19 pandemic resolves, it is imperative not to lose sight of the importance of TPPs as a means to address current and projected nursing shortages in years to come (CDC, 2020b; Hofler & Thomas, 2016; Lofti et al., 2020). TPPs provides active learning experiences and NPD leadership support for newly licensed civilian and military RNs as they progress from an academic environment into the healthcare workforce (American Nurses Credentialing Center, 2020; Kiss & Smith, 2018). If shortsightedness of resource management prevails, our national healthcare system will implode as qualified nurses leave the profession, while availability of newly licensed RNs lessen (Brook et al., 2019; Institute of Medicine, 2011).

Note. This bar graph exhibits the 2025 projected shortage numbers of Registered Nurses for 16 states.

Note. This comparison table represents the required clinical, didactic, case study, and group project hours required for completion of the 26-Week or and 14-week clinical nurse transition programs.

Note. This table demonstrates pre and post nursing skills reported by Nurse Residency Program and clinical nurse transition program participants as being uncomfortable performing autonomously after pre and post training.

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