Title: New graduate midwives' experiences of their transition support programs

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student

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ABSTRACT

Background: The transition from student to registered midwife is a critical period for a new graduate. The literature suggests that well-designed 'transition support programs' (TSPs) assist graduates to successfully take up their roles as registered clinicians. While TSPs for midwives exist in NSW, Australia, there appears to be an adhoc approach to their design, implementation and effectiveness.

Aim: To identify the type of support offered to newly graduated midwives during their transition year and to increase knowledge and understanding of new midwives' expectations and experiences of this support.

Method: This descriptive qualitative study was undertaken in three phases. In phase one 14 maternity hospitals within three Sydney Area Health Services (AHS) provided details of their TSPs. In phase two, 31 newly graduated midwives participated in telephone interviews (18 at the beginning of their transition year and 29 at the end). An additional 7 participated in focus groups. In phase three interviews with 16 experienced midwives canvased perceptions of the support their facility offered the new graduates. Latent and manifest content analysis was used to analyse the data.

Findings: The approach to transition support varied across and within AHSs: some sites offered no program. Whilst differences existed between the TSPs they shared common elements such as clinical rotations and study days. At the beginning of their TSP midwives expected that the opportunities provided to them would consolidate their knowledge and clinical skills. In addition they expected to be supported by colleagues to gain confidence. On completion of their transition period, some midwives' experiences were at odds with the details of the programs initially outlined by the AHSs. The discrepancy between the expected and actual program resulted in increased stress and anxiety for midwives, especially in birth suite. Midwives were critical of the lack of promised supernumerary time

as well as limited access to midwifery continuity of care models. While approximately 60% believed that they had met their goals and been well supported more than 16% of the midwives had left their TSP before the end of their first year of clinical practice.

Conclusion: This study has provided a unique insight into the expectations and experiences of midwives as they start their professional careers. It has also provided much needed information on the structure and content of programs offered within three AHSs. It is anticipated that the findings will provide evidence to assist in the development of TSPs that successfully meet the needs of the graduate, the childbearing women they care for and the organisations in which they work.

CHAPTER 1: INTRODUCTION

INTRODUCTION

The transition from student to registered midwife is a critical period in a new graduate's working life (Heath et al. 2002), and an exciting time that represents the successful completion of the graduate's study program. It is during this period that the newly graduated midwife has to undergo significant adjustments in order to become an effective member of the multidisciplinary team (Queensland Nursing Council 2006). This requires the development of existing and sometimes new skills, knowledge, attitudes, values and responsibilities (Begley 2007; Charnley 1999; Queensland Nursing Council 2006; van der Putten 2008). The literature suggests that well-designed transition support programs (TSPs) can play a significant role in assisting graduates to successfully take up their roles as registered clinicians (Department of Health 2004; Fitzgerald et al. 2001; Queensland Nursing Council 2006).

The ability of new midwives to successfully make the transition from student to practitioner has other implications for both the profession of midwifery and the maternity health service as a whole. With the shortage of midwives nationally and internationally (Altier & Krsek 2006; Heath et al. 2002; Sullivan, Lock & Homer 2011), it is essential that existing and newly qualified staff be retained within the profession. This is highly relevant in the Australian context where losses of newly graduated midwives are reported to be high (Heath et al. 2002). In studies of both midwives and nurses, an effective transition program was seen to have a positive effect on the retention of staff (Beecroft, Kunzman & Krozek 2001; Boon et al. 2005; Levett-Jones & Fitzgerald 2005).

The need to retain midwives has a number of ramifications for the profession. The most pertinent perhaps is the ability for future midwives to be able to practice within their full scope of practice and continue to drive the change agenda currently being shaped and promoted by the peak midwifery body, The Australian College of Midwives (ACM)

(Brodie & Barclay 2001; Heath et al. 2002). This is particularly the case in New South Wales (NSW), where maternity health care policy has recognised the need to refocus care on the needs of women using primary health principles and to better utilise the skills and expertise of the midwife (NSW Health 2003, 2010). As a result new models of woman-centred care have emerged such as midwifery-led stand-alone birth centres (Ryde and Belmont hospitals), case load group practices (The Royal Women's Hospital) and the introduction of publicly-funded home birth services (St George Hospital). These new models of care by their very nature enable midwives to practise within the full scope of their role (Australian Nursing & Midwifery Council 2006; Brodie & Barclay 2001).

Carolan and Hodnett (2007) comment, however, that although these changes are certainly in the interest of pregnant women, a challenge exists for midwives who have been working for extended periods of time in a fragmented system of maternity care. While the success and sustainability of these new models depends on a number of factors, the role of the newly graduated midwife in embracing the new models and working within them should not be underestimated. Effective transition programs form a key part of the strategy to ensure this success can be facilitated.

In the Australian context, TSPs are defined as "an individualised, planned education process for licensed nurses and midwives to support a safe and effective transition into a new practice area" (Queensland Nursing Council 2006, p. 1). In the United States of America (USA) such programs are referred to as "orientation programs" (Park & Jones 2010), while the United Kingdom (UK) uses the term "preceptorship programs" (Department of Health 2010). For the purposes of this study, I will be referring to all programs designed to transition newly registered nurses and midwives into practice as TSPs.

While they may not always include a taught or didactic component, most TSPs include a variety of learning strategies such as rotations through different maternity settings, completion of a skills inventory, goal-setting for clinical rotations, provision of a mentor

and opportunities for debriefing (Levett-Jones & Fitzgerald 2005). Despite the recognition that midwifery and nursing transition programs are "essential" (Heath et al. 2002), there remains a lack of commitment by various Australian health authorities to their development, implementation and evaluation.

The state of New South Wales (NSW) is no exception. Each year large numbers of newly graduated midwives, educated via a variety of routes, are employed throughout NSW to work within the maternity health care system. What these midwives are offered as transition programs to support their evolution into professional practice varies greatly in terms of content and duration. Anecdotal reports within three Area Health Services in Sydney would suggest that this support can range from 'a big smile and a welcome back' to a 12-month structured program consisting of study days, rotations through all clinical areas and periods of supported practice. Informal feedback also indicates that there are contested and divergent views on the needs of new midwifery graduates pertaining to their specific education route and qualification.

Whatever the TSP on offer, the effectiveness is unclear and currently under-evaluated in NSW and Australia as a whole. There is also limited understanding of how well these programs build on education, and prepare midwives to work across the full scope of practice and confidently embrace challenges of working within midwifery models of care. Certainly no evaluations of programs in NSW have been published in professional literature. Moreover, international literature on the needs of the newly graduated and the effectiveness of TSPs is almost entirely related to the transition of newly graduated nurses rather than midwives.

SETTING THE CONTEXT FOR THE STUDY

For the first time in 2008, graduates from the Bachelor of Midwifery program at the University of Technology, Sydney (UTS) joined those who qualified as midwives via the postgraduate route following initial registration as nurses (Graduate Diploma or Masters

programs). An opportunity existed to identify what programs were available and explore new graduates' expectations and experiences of the support offered as they transitioned from student to registered midwife status. This study was conceived and commenced as part of an Area Health Service and University collaborative initiative and taken up as my Master of Midwifery (Hons) research.

AIM

The aim of this study was to identify the type of support offered to newly graduated midwives during their transition year, and to increase knowledge and understanding of new midwives' expectations and experiences of this support. The specific ***objectives*** of the study were to:

1. identify and describe the transition support programs offered for newly graduated midwives offered by hospitals within three Sydney Area Health Services [1](AHS)
2. describe newly graduated midwives' expectations and experiences of their transition support programs, and
3. describe experienced midwives' perceptions of the support offered to the newly graduated midwives employed within their organisation.

SIGNPOSTING THE JOURNEY

Chapter 2 presents an overview of the international literature pertaining to the transition of newly graduated nurses and midwives. Nursing literature has been included in the

[1] This research was conducted prior to NSW Health's 2011 restructuring of the state into Local Health Districts.

discussion due to the scarcity of midwifery specific writing. The chapter begins by examining the need for transition support and well-established principles that have been suggested to underpin their development, implementation and evaluation. However the discussion goes on to identify the lack of progress in implementation of these goals in Australian and more specifically a midwifery context. The transition of a newly graduated midwife or nurse can potentially be influenced by a number of factors such as personal expectations, the clinical environment and the level and type of support available. These factors are explored with reference to the literature and the chapter concludes with a brief discussion of the importance of feedback as a supportive mechanism.

Chapter 3 describes the qualitative descriptive methodology used in this study. The methodology and methods used are described along with the rationale for the choice of design. The chapter moves on to further detail the study design under the traditional headings of setting, participants, recruitment, data collection and data analysis. The chapter concludes with a discussion of the ethical considerations.

The findings of the research are presented in Chapters 4 and 5. Chapter 4 begins by describing the elements of the TSPs available to the newly graduated midwives in the three AHSs in 2008. Common elements such as clinical rotations and study days were shared by all the TSPs. However, differences were identified between programs on offer, namely the duration of supernumerary time, opportunities to work within midwifery continuity of care models and formal opportunities for feedback and debriefing. The chapter concludes with a discussion of the newly graduated midwives' expectations of their TSPs. Expectations included a belief that the program would enable them to consolidate their existing skills, gain further experience and develop new clinical skills. Supported clinical rotations and study days that focused on clinical skills acquisition were identified by the newly graduated midwives as elements that would assist them to attain their goals for the year.

In Chapter 5, I report on the newly graduated midwives' experiences as they neared the end or had finished their TSP. It is apparent from their comments that the busy, chaotic clinical

environment where workloads were high and skill mix often poor, impacted on their experience. This information sets the scene and enables an understanding of how the individual elements of the TSPs are provided within this, at times challenging, environment.

Chapter 5 also includes a short section on the views of the experienced clinical midwives who participated in the new graduates' TSPs. The analysis reveals that the experienced midwives in this study believed that all newly graduated midwives, regardless of their previous experience, require a level of transition support as they move from student to registered midwife.

Finally in Chapter 6, I use the relevant literature to contextualise and discuss some of the key findings. The newly graduated midwives' expectations of their TSP are conveyed with a reflection on the advantageous aspects that a positive outlook brings to an individual. A discussion on the value of clinical rotations to enable the development and enhancing of clinical skills is undertaken, although the opportunity to work in midwifery continuity of care models appears to provide the new graduate with the requisite support and skills to commence their professional career.

The programs on offer to the newly graduated midwives, in theory, met the key principles of transition support by including most of the key elements. However, in practice the realities of the clinical environment appear to have disrupted these plans. The experienced midwives' comments articulated these difficulties and clarified the need for all newly graduated midwives to have access to support as they transition from student to midwife.

Chapter 6 concludes with recommendations to promote effective support for all newly graduated midwives. It is hoped this will assist in the creation of TSPs that support newly graduated midwives to develop into strong, competent midwives, confident in working to the International Confederation of Midwives' definition of the midwife. Recommendations are made for education, practice and areas for future research.

SUBJECTIVITY AND LOCALITY OF THE RESEARCHER

My personal motivation for asking undertaking this research

Having followed a direct entry midwifery program[2] in the UK in the early 1990s, on qualifying I found myself working on the Delivery Suite largely unsupported and, frankly, anxious. The huge disparity between being a third-year student and a first-year midwife was one that I was completely unprepared for. Thankfully, much has changed in the intervening years in the UK. Access to transition programs has become the norm for newly graduated midwives as their value and benefit have been identified (Boon et al. 2005; Burke 1994; Maggs 1994; Powell 2005; The North West London Hospitals NHS Trust 2008). Arriving in Australia, to observe newly qualified midwives undergoing similar experiences to my own was concerning. It was disconcerting to find that many students either did not take up a midwifery position on qualification, or left to return to nursing soon afterwards. I could not help but wonder if the support we provided, or perhaps the lack thereof, impacted on each new graduate's decision.

With the registration of the first group of Bachelor of Midwifery students in 2008, there was a sudden 'urgency' within the AHSs to ensure TSPs were in place to meet the graduates' needs. This was in spite of a long history of newly registered midwives (who had been nurses) entering the system. The sudden urgency to develop transition programs appeared to be based on the unsupported assumption and expectations that Bachelor of Midwifery graduates – often referred to as direct entry midwives – would require a far greater level of support than their colleagues who had followed the Graduate Diploma and Masters routes into midwifery. This assumption is contested to some extent in the available literature (Fleming et al. 2001). Certainly, the work of Dreyfus and Dreyfus (2005) provides a conceptual framework to describe the evolutionary nature of professional skills acquisition. This framework leads one to expect all newly graduated midwives, regardless

[2] Similar to the Bachelor of Midwifery my midwifery program did not require me to be a registered nurse.

of their qualification, to have the same need for support (Dreyfus & Dreyfus 2005). Midwives who graduate through Graduate Diploma and Masters programs will have prior experience as qualified nurses on which to draw. In terms of midwifery, however, they are also beginning practitioners.

The importance of supporting new midwifery graduates is a key element to building a sustainable strong, vibrant midwifery workforce. I am therefore highly motivated to explore how all newly graduated midwives can best be supported. This study may provide the opportunity to contribute locally and nationally to the development of quality support and education programs for newly graduated midwives.

CONCLUSION

In NSW there have been significant developments in midwifery education with the commencement of the Bachelor of Midwifery program. However, how to support midwives once they have completed their education leading to registration has not been explored within NSW. In addition the limited national and international research focusing on the specific transition support needs of newly graduated midwives means that we do not have a clear understanding of what newly graduated midwives expect of their TSP, and limited understanding of their experiences within TSPs. With the national and international shortage of midwives it is essential that we understand how to effectively support newly graduated midwives in order to recruit and retain them within the profession. This research aims to contribute to the current knowledge by providing a greater level of understanding of new graduate midwives' experiences. It is hoped that the evidence from this study will provide the foundation on which standards and/or principles can be developed to guide the provision of TSPs for all newly graduated midwives.

The newly graduated midwives in this study generously shared their stories and experiences. I would like to thank them, and hope that this research lives up to the honesty and clarity of their contributions.

The journey now commences with Chapter 2. Here I review the relevant literature providing a context for the study.

CHAPTER 2: LITERATURE REVIEW

INTRODUCTION

The international literature pertaining to the transition of the newly graduated is generally focused on the newly graduated nurse. In this chapter I will discuss some of the limited literature available on the transition of newly graduated midwives, drawing on the nursing literature where appropriate or where gaps exist. The chapter begins by examining the need for transition support and identifies a lack of Australian standards to guide the development of programs, particularly for new graduate midwives. The discussion will move on to identify factors which have the potential to influence the transition of a newly graduated nurse or midwife. Topics such as personal expectations, the clinical environment and the level and type of support available will be explored with reference to the literature. Finally, I will outline the importance of feedback as a supportive mechanism.

BACKGROUND: RHETORIC VERSUS REALITY

When searching for literature regarding the transition from student to midwife and how this may be best supported, one has to almost exclusively turn to New Zealand, the United Kingdom (UK) and Ireland. This may be partly explained by the clearly defined professional role of the midwife in these countries. By contrast, it could be argued that the role of the midwife in the USA and Australia has traditionally been more of an extension of the nursing role and so potentially would not require separate transition to practice. While the literature from outside Australia provides some insight into the issues pertaining to structured support and/or transition support programs (TSPs), one must be mindful of the differences in health care settings, context and funding.

Australian literature relating to the needs of the newly graduated and the effectiveness of TSPs is almost wholly related to the transition of newly graduated nurses rather than midwives (Levett-Jones & Fitzgerald 2005; Parker, Plank & Hegney 2003). Interestingly,

this is also the case in other countries where the discussion of transition programs for newly graduated midwives is limited – and again, the focus is on newly graduated nurses.

Despite the paucity of literature pertaining to the implementation and evaluation of TSPs for new graduates in an Australian context there is little doubt that, at a professional level, the importance of such programs is well recognised and promoted. In 2002 a National Review of Nursing Education was undertaken in Australia (Heath et al. 2002). The resulting report detailed the fundamentals necessary for building a sustainable nursing and midwifery workforce. Transition programs were identified as being of fundamental importance to achieving this goal (Heath et al. 2002). However, whilst these programs were thought essential, the report identified that there were few programs offered, with availability, access, quality and accountability varying greatly from state to state (Heath et al. 2002). At the time, the authors of the report also recommended that the Australian Nursing Council Incorporated (ANCI) – now the Australian Nursing and Midwifery Accreditation Council (ANMAC) – develop minimum standards for transition programs (Heath et al. 2002). They suggested that all programs should "build on entry-level competencies, be competency-based, not replicate content covered through universities, be available in speciality fields, and offer new graduates a range of experiences" (Heath et al. 2002, p. 144).

While ANMAC has not published standards for TSPs, some Australian states and territories have developed discussion papers and position statements regarding their expectations for the transition of newly graduated midwives and nurses. For example, the Queensland Nursing Council (2006) in its position statement recommends that employers use its guidelines as a minimum standard to ensure quality support or a TSP for all newly qualified midwives, nurses and enrolled nurses. Ten guiding principles underpin the document. These include but are not limited to ensuring programs are appropriately resourced, have stakeholder involvement, are individually-focused, provide regular constructive feedback, utilise and support the precentorship role, employ flexible design patterns, and are regularly evaluated and validated (Queensland Nursing Council 2006, p. 2).

Similarly, an earlier South Australian report (Department of Health 2004) identified ten standards to successfully support transition to practice for midwives and nurses. It outlined four principles that the authors believed should guide a TSP:

1. A supportive environment
2. An orientation to corporate knowledge to support the development of positive attributes and attitudes to work
3. The development of clinical confidence, and
4. The preparation for professional responsibilities (Department of Health 2004, p. 7).

In Western Australia, Department of Health new graduate programs are available for enrolled nurses, nurses and midwives (Nursing and Midwifery Office 2011a, 2011b). The aim of these programs is recorded as offering the new graduate the opportunity to consolidate theoretical knowledge while gaining experience and developing clinical skills in a variety of clinical settings (Nursing and Midwifery Office 2011b). From a review of these documents it appears that the structure and content of these programs is set by the individual sites offering the TSP and not by the Department of Health. To date, neither the NSW Nurses and Midwives Board or the NSW Department of Health have published standards or guidance for TSPs for midwives or nurses in NSW.

Some three years after Heath et al's (2002) national report, nursing educators Levett-Jones and Fitzgerald (2005) published a discussion paper that explored and reviewed the evolution of TSPs for nurses following the move to university-based training in 1984. In this paper they provide an overview of the TSPs on offer to newly graduated nurses in Australia in 2003. While the authors caution that direct comparison of programs was difficult due to the differences in terminology used, they discovered a range of formal and informal programs available for newly graduated nurses with wide variation between states in terms of funding, structure and duration (Levett-Jones & Fitzgerald 2005). For example, in NSW $900 of government funding was available for each new graduate nurse whereas in the Northern Territory $4000 was available. In Tasmania a 12-month standardised program

was offered across all hospitals in the state, in contrast to South Australia where the length of program differed between hospitals (Levett-Jones & Fitzgerald 2005).

In reviewing what was available to newly graduated nurses, Levett-Jones and Fitzgerald (2005) aimed to challenge the status quo. They argued that there was little available evidence to inform the content and structure of formal graduate TSPs and questioned whether alternative approaches should be explored (Levett-Jones & Fitzgerald 2005). One alternative they suggested was to focus on developing clinical environments which would enable a culture of supportive practice. They argued that this approach would have the additional benefit of encouraging continuing professional development for the rest of the team (Levett-Jones & Fitzgerald 2005). Whilst their paper is solely focused on nursing, the questions raised have relevance to midwifery as the profession questions how best to support newly graduated midwives.

The lack of a midwifery focus in the literature is particularly significant in the Australian context. Over the last ten years the role of the midwife in Australia has changed significantly, with clear delineation from nursing in regulation, scope of practice and competencies (Australian Nursing & Midwifery Council 2006; Brodie & Barclay 2001; Heath et al. 2002). While there are similarities, significant differences now exist between the professions. Potentially the most considerable of these lies in the way midwives are educated.

Traditionally, midwives entered the profession by undertaking a post-nursing qualification (initially offered through hospital midwifery schools and later at university level). Postgraduate midwifery education is currently offered as either a Graduate Diploma or Masters degree. More recently, there has been the development and implementation of an undergraduate degree, the Bachelor of Midwifery, where participants are not required to hold registration as a nurse. In NSW both undergraduate and postgraduate education routes are now available. Across these education routes, all programs prepare student midwives

for registration and to meet the "National Competency Standards for the Midwife" (Australian Nursing & Midwifery Council 2006).

The multiple education routes add a layer of complexity when discussing TSPs for newly graduated midwives. Consideration also needs to be given to the international literature that debates the effectiveness of preparing midwives through an undergraduate Bachelor of Midwifery program. This will be a topic of debate later in the chapter (Maggs 1994; Panettiere & Cadman 2002). The relative newness of Bachelor of Midwifery programs in Australia means that, whilst already in place, they have not been formally evaluated. Given this ongoing evolution of the profession, it is interesting that more attention has not been given to how newly qualified midwives are supported as they transition from student to registered midwife.

As evidenced above, standards and guiding principles for TSPs for both newly graduated midwives and nurses exist and the importance of this support is not in question. What is unclear, however, is how this 'support' should be structured and delivered to meet both the individual needs of graduates and the employing health service. It is widely acknowledged in the literature that this is an area in need of further research (Charnley 1999; Levett-Jones & Fitzgerald 2005; Parker, Plank & Hegney 2003).

In order to devise TSPs that meet new graduates' needs it is important to have an understanding of the transition process for a newly graduated midwife or nurse. In the next section of the chapter I move on to explore the many factors that can influence the transition of the newly graduated.

FACTORS THAT CAN INFLUENCE THE TRANSITION OF THE NEWLY GRADUATED

A critical appraisal of the available literature reveals a number of reoccurring themes that illuminate the complexities of the transition process for a newly graduated midwife or

nurse. One of the most recent and insightful qualitative nursing studies was undertaken by UK researchers Clark and Holmes (2007). The study was based on the premise that, although at the point of registration newly graduated nurses are expected to be competent and practice autonomously, this is often not the reality. Clark and Holmes sought to identify the factors that influence continuing professional development. Using a series of mixed focus groups, 105 newly graduated nurses, experienced nurses and practice development nurses were interviewed. The analysis revealed eight factors that capture the many constructs that influence the continuing development of a newly qualified nurse. These can be summarised as:

- **expectations** placed on new nurses
- **confidence** new nurses have in themselves, and that placed in them by others
- **context and environment** ability to transfer skills
- **knowledge** underpinning actions
- **effective preceptorship** including both support and challenge
- **time to permit consolidation** and integration of skills and knowledge
- **opportunities** to learn in practice and/or reflect on actions, and
- **acceptance** to the ward team (Clark & Holmes 2007, p. 1218).

In their discussion of limitations the authors suggested that focus groups allowed for a more natural environment, facilitating useful reciprocal participant interaction which they wished to capture (Clark & Holmes 2007). This was intended to counter the claim that newly graduated nurses may have felt some pressure to conform and/or were influenced by the presence of their more experienced peers. Notwithstanding this factor, Clark and Holmes's work does provide insight and a useful framework by which to explore the factors that influence the new graduate's transition and thus their professional development.

Under the four principal headings of expectations and experiences, competence and confidence, context and environment, and provision of effective personal and professional

support, all of the factors identified by Clark and Holmes (2007) will be discussed with reference to the wider available literature.

EXPECTATIONS AND EXPERIENCES

As Clarke and Holmes (2007) argue, a newly graduated midwife's or nurse's expectations and experiences are likely to play a role in how they move through her transition period. Similarly expectations of the new graduate can have an enormous influence on the new practitioner's experience and progress: if expectations are too high inadequate support may result; conversely if they are too low opportunities for development may be withheld. In this section of the chapter I explore the relevant literature from the perspectives of the newly graduated midwife or nurse and the experienced midwives they work with.

The new graduate

There is much written on how the new graduate experiences a sense of unpreparedness at the point of registration (Charnley 1999; Clark & Holmes 2007; Fleming et al. 2001; Gerrish 2000; Jasper 1996; Newton & McKenna 2007). While their education has given them the knowledge to underpin their chosen profession, the reality of putting this knowledge into practice is often challenging and stressful (Charnley 1999; Jasper 1996; Newton & McKenna 2007). It is widely acknowledged in the literature that the new graduate finds the increased level of responsibility and accountability for managing clinical care particularly overwhelming (Fleming et al. 2001; Jasper 1996; Maben & Clark 1998; van der Putten 2008).

The reality of this increased responsibility when moving from student to qualified professional can be confronting for many and the literature identifies that new graduates can experience a form of 'reality or transition shock' (Charnley 1999; Delaney 2003; Duchscher 2009; Evans 2001; van der Putten 2008). This phenomenon is described as occurring when, having studied extensively to qualify in their chosen profession in the

expectation that this will prepare them for the challenges of their new role, the new graduate finds themselves feeling totally unprepared and left 'reeling' from the reality of practice (Charnley 1999; Evans 2001; Gerrish 2000; van der Putten 2008). As a result, the new graduate may experience feelings of fear, apprehension, uncertainty and deficiency as well as insecurity (Charnley 1999; Duchscher 2009; Gerrish 2000).

In her phenomenological study of the lived experience of six newly qualified midwives in Ireland, Van der Putten (2008) identified 'reality shock' and 'living up to expectations' as themes representative of the midwives' experiences (van der Putten 2008, p. 48). The author discusses how newly graduated midwives acclimatising to their new reality of clinical practice also had to 'live up to' the expectations of the women as well as other experienced midwives, adding another level of stress (van der Putten 2008). While the author acknowledges the limitations of the study, in particular the small number of participants, the richness of the data presented and the fact that the themes resonate strongly with other international literature attest to the study's contribution to the literature on this topic.

Further examples of 'reality shock' can be found in the earlier qualitative work of Charnley (1999) and Delaney (2003). Both authors described how new graduates struggled with their changing role and new-found responsibility. Charnley (1999), who undertook a grounded theory study in the UK of 18 newly qualified nurses' experiences, labelled the theme "the reality of practice" (Charnley 1999, p. 34). Under this theme she discussed how they expressed feelings of stress and anxiety regarding their registered nursing role. The new graduates expressed concerns regarding their level of knowledge and skill, but also found the workplace challenging in terms of workload and staff shortages. Many believed they had been sheltered as students from the realities of the nursing role (Charnley 1999).

Similarly to the findings of Charnley, Delaney (2003), who interviewed ten newly qualified nurses in Connecticut USA, described new graduates' feelings of anxiety and insecurity as they took up their new role. In her analysis she clustered a number of concepts under the

pertinent heading of "welcome to the real world" (Delaney 2003, p. 440). Both authors also discuss how the new graduate nurses identified a gap between what they had learned at university and what they witnessed in practice (Charnley 1999; Delaney 2003). This theory practice gap resulted in some experiencing a sense of dissonance as the values they had developed throughout their education were not supported in practice (Delaney 2003). The impact of this perceived 'theory practice gap' on the new graduate cannot be underestimated as it may lead them to doubt and question their training and desire to remain in their chosen profession.

Lange and Kennedy (2006) surveyed a total of 245 newly graduated nurse-midwives in the USA to question if theory practice gaps existed in practice. They used a questionnaire containing the 39 previously identified processes of exemplary midwifery practice as validated by Kennedy in a previous Delphi study (2000). Respondents were asked to rate, using a scale of one to seven, how closely their clinical preceptors' practice compared to these exemplary examples in a number of practice settings. The authors reported that 50% of the nurse-midwives reported differences between actual and exemplary practice (Lange & Kennedy 2006). Lange and Kennedy (2006) note how confronting it can be for newly qualified nurse-midwives when they are exposed to midwifery practice outside the theoretical environment that is at odds with their own philosophy and/or beliefs. For this reason the authors suggest that educators and preceptors need to be cognisant of the theory practice gap when they are planning clinical placements (Lange & Kennedy 2006).

The need for the new graduate to navigate the theory practice gap is also alluded to by Duchscher (2009), who has researched the transition process for nurses over a ten-year period in Canada. In her latest work she confirms the new graduate's experience of "role performance stress, moral distress, discouragement and disillusionment" during the transition period (Duchscher 2009, p. 1104). Whilst appropriate support can assist the new graduate to some extent, Duchscher (2009) argues that this is an inevitable part of transitioning from student to practitioner, and as such senior students should be prepared within their training for this experience.

As highlighted by the literature the expectations and experiences of the new graduate shape their transition from student to registered practitioner. A large part of this experience is the interaction new graduates share with their colleagues. The literature suggests that experienced clinicians thus play a significant role in the transition process (Carolan & Hodnett 2007; Leap, Barclay & Sheehan 2003b; Lobo 2002). In the next section I will discuss the literature pertaining to the experienced midwives expectations' of the newly graduated midwife.

The expectations of experienced midwives

The variety of educational routes into midwifery has generated significant debate on how best to educate midwives (Carolan & Hodnett 2007; Leap 2001, 2006; Maggs 1994). How to support them, if at all, when they are newly graduated is another hotly-contested issue (Carolan & Hodnett 2007; Fleming et al. 2001; Lobo 2002; Panettiere & Cadman 2002). What experienced midwives expect from the newly graduated midwife can have a significant impact on the latter's transition into practice in respect to the opportunities available and the quality of the experience (Carolan & Hodnett 2007; Fleming et al. 2001). Lobo (2002) in her small UK pilot study of newly graduated midwives recounted that, whilst she came across many comments regarding the advantages of holding a nursing registration, these were not qualified with examples as to how or why. Not surprisingly then staff appear to have different expectations of new graduates as a result of the type of midwifery educational preparation undertaken: undergraduate (no previous nursing qualification required) or postgraduate (registered nurses undertaking midwifery as a postgraduate qualification).

In a discussion paper authored by Carolan and Hodnett (2007), it was reported that when UK midwifery undergraduate programs were introduced there was initially a rather negative view of the skills and value of the graduates. The Bachelor-prepared midwives were generally expected to need extensive support, have poor time management skills and be overly confident (Carolan & Hodnett 2007). These findings resonate with the anecdotal

evidence currently available in NSW. Carolan and Hodnett (2007), however, reported that as more midwives have graduated via this undergraduate route it has been acknowledged that they are adequately prepared for midwifery practice and that differences are not apparent between them and their postgraduate peers who are also registered nurses. In contrast, New Zealand authors Panettiere and Cadman (2002) assert that it is unacceptable to expect undergraduate prepared midwives to have all the necessary skills on qualification because they do not have the additional nursing experience or knowledge. In their opinion piece they state that structured transition programs need to be on offer in order to support them safely and effectively into practice (Panettiere & Cadman 2002).

The differences between the two groups have been the subject of limited research over the last ten years. One study by Fleming et al. (2001), used a self-completing survey and semi-structured interviews to explore the differences between midwives with an undergraduate or postgraduate qualification. A total of 130 newly graduated midwives (95 undergraduate and 35 postgraduate) and 95 supervisors of midwives in Scotland were surveyed using a skills inventory. The newly graduated midwives were asked to assess their level of confidence against the skills inventory and the supervisors to rate their expectations of the newly graduated midwives using the same tool. Semi-structured interviews were conducted with 40 midwives in their first year of practice, 40 midwives with over three years of practice and 12 supervisors of midwives. The focus of the interview was "what are your expectations of newly qualified midwives?" (Fleming et al. 2001, p. 297).

In this comprehensive study, Fleming et al. (2001) reported that the postgraduate midwives rated their skills scores significantly higher than the undergraduate trained midwives in all areas ($p<0.01$). The experienced midwives in the clinical setting judged all newly graduated midwives as being competent to provide 'normal' midwifery care in all areas regardless of qualification. In terms of the graduates' extended skill base and the ability to manage complications, experienced midwives identified that these would develop over time (Fleming et al. 2001). There was a perception by some of the experienced midwifery staff, that undergraduate midwives required greater levels of support while the postgraduate

midwives were expected to have better time management skills and be more comfortable in the ward environment (Fleming et al. 2001). In contrast, the newly graduated midwives' perceptions of their own skills and knowledge were quite different from the experienced midwives' view (Fleming et al. 2001). The experienced midwives consistently scored both groups of newly graduated midwives skill level as lower than their self-assessed scores (Fleming et al. 2001).

Similarly, Begley (1998), in one of a series of studies undertaken in Ireland, found that post-registration midwifery students felt that their previous learning and nursing qualifications were not recognised or utilised and they were given too little responsibility. With this lack of responsibility came a loss of status for many as they moved from qualified nurse back to student midwife (Begley 2007). However, the balance of respecting previous experience whilst supporting new skills acquisition appears difficult to get right, with Begley (2001) later reporting that post-registration students often felt they were given too much responsibility. Whilst Begley's work relates to the experiences of postgraduate student midwives, her findings may resonate with the experiences' of newly graduated midwives whose skills and experiences may be either under or over-valued.

Experienced midwives' expectations of the new graduate may impact on the opportunities and experiences available to them during their transition to practice. At the same time, the new graduates' perceptions of their own level of knowledge, skills and expertise on registration will influence how they approach their transition to practice. In the next section the concepts of competence and confidence will be explored further.

COMPETENCE AND CONFIDENCE

Central to the notion of providing support during the transition from student to registered midwife are the concepts of competence and confidence. These are therefore important concepts to debate when discussing and designing structured support and/or programs. Clark and Holmes (2007), suggest that competence is closely related to confidence in

clinical skills. Situations that build the graduates' confidence will impact positively on their competence. However, perhaps the first question to ask relates to whether new graduates are competent in their clinical knowledge and skills at the point of registration? (Clark & Holmes 2007; Panettiere & Cadman 2002).

Competence

In Australia the definition of the midwife is based on the International Confederations of Midwives' 2005 definition (Australian Nursing & Midwifery Council 2006, p. 1).

> *A midwife is a person who having been regularly admitted to a midwifery educational program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.*
>
> *The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.*
>
> *The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.*
>
> *A midwife may practise in any setting including the home, community, hospitals, clinics or health units (International Confederation of Midwives 2005) .*

This is an important point to make as the definition highlights a well-defined scope of practice for the registered midwife and thus the new graduate.

In 2006, after an extensive process of development, The Australian Nursing & Midwifery Council (ANMC) unveiled the new "National Competency Standards for the Midwife". These woman-centred standards provided an overarching framework by which midwifery performance could be evaluated for the purposes of registration. The standards currently underpin the development, implementation and evaluation of midwifery curricular by Universities across the country. The Nursing and Midwifery Board of Australia also use the competency standards to evaluate a midwife's performance in professional conduct matters.

The standards are organised into four domains central to midwifery practice: legal and professional practice; midwifery knowledge and practice; midwifery as primary healthcare; and reflective and ethical practice. Each domain is then broken down into competencies, which represent aspects of professional performance. There are 14 competencies in total. It is in these nationally agreed standards that a student midwife must demonstrate competence before she/he can register (Australian Nursing & Midwifery Council 2006).

Whilst the competence standards are clear there may be confusion around the issue of competence for the newly graduated midwife. Dictionary definitions of competence portray a sense of certainty which seemingly does not recognise movement or progression. The Macquarie Dictionary defines competence as being "properly qualified, capable, able, adept, adroit, efficient, expert, good at, practical, proficient, resourceful, skilful, skilled, sure, fitting or sufficient for the purpose" (Macquarie 2005, p. 115). Using this definition, some would argue that at the point of registration it is unrealistic to expect the newly graduated midwife, who is a novice, to be expert or adroit in every domain of practice. Our professional definition of competence is therefore at odds with the traditional dictionary definition, as our expectation is that newly graduated midwives will grow into their professional competence as their experience and skills increase. Butler, Fraser and Murphy

(2008, p. 260) refer to midwives on graduation as having "essential competencies": the fundamental skills and knowledge necessary to be able to safely perform their role. Issues concerning competence thus affect program design, as those designing programs grapple with how to achieve an appropriate level of support while optimising opportunities for learning and development.

With regards to ensuring effective transition support, a number of authors debate if newly graduated midwives and nurses are confident enough in their knowledge and skills to practice autonomously (Charnley 1999; Clark & Holmes 2007; Duchscher 2009; Gerrish 2000).

Confidence

Confidence is defined as being "full trust; belief in the reliability of a person or thing; self-reliance, self-assurance" (Macquarie 2005, p. 117). Whilst a newly qualified midwife or nurse can be assumed to be competent in order to register, they may not feel confident in their ability or competence (Charnley 1999).

Maggs and Rapport's (1996) study provides some insight into the scope of the newly graduated midwives confidence. These researchers constructed a self-completion questionnaire for registered midwives prepared through an undergraduate program (non-nurses), who had qualified within the previous year in the UK. The questionnaire asked participants for their biographical and employment details, opinions regarding their midwifery course and their continuing education needs (Maggs & Rapport 1996). Out of a total sample size of 96, 45% (n=43) completed the questionnaire. While the authors caution the reader against making generalisations due to the disappointing sample size, the findings provide some insight into a new graduate midwives' confidence. Maggs and Rapport (1996) revealed that these midwives perceived themselves as confident in providing 'normal' midwifery care though less confident in caring for sick neonates. This outcome may be the result of the reality that whilst it is important that a midwife be skilled at

neonatal resuscitation and identifying a sick neonate, the ongoing provision of care of such infants falls outside the role and scope of midwifery practice. The level of confidence of newly graduated midwives, whether prepared through an undergraduate or postgraduate program, has not been examined previously in NSW.

International nursing literature provides an understanding of the confidence of nurses upon graduation (Clark & Holmes 2007; Delaney 2003; Gerrish 2000; Jasper 1996). It is reported that nurses often identify a lack of confidence related to their feelings of being clinically unprepared for their new role, and that while they have theoretical knowledge they often struggle with the clinical decision-making aspects of care (Gerrish 2000; Jasper 1996). As Clarke and Holmes (2007) report, a lack of confidence may increase the new graduates' level of stress, particularly if ward managers and preceptors put unnecessary restrictions onto their practice in order to evaluate their skills. Rather than building confidence in the new graduate, a lack of confidence is often exacerbated by these restrictions which may leave them feeling exposed and uncertain (Clark & Holmes 2007). On a positive note, however, Clark and Holmes (2007) reported that, although at the point of registration nurses in their study did not feel confident, within six months they felt prepared for practice. This indicates that the first six months is potentially the most critical. Those tasked with the responsibility of coordinating new graduates' transition into practice need to be mindful of this finding when designing support mechanisms and/or programs.

The duration of support provided to ensure that new graduates build confidence and are afforded appropriate time to consolidate their skills appears key to successful transition. However, successful transition is not solely related to time – the relevance of the clinical environment and its' culture play a significant role. In the next section this will be explored within the international literature.

CONTEXT AND ENVIRONMENT

The importance of the environment into which the newly graduated midwife enters cannot

be overstated. A culture that promotes a supportive learning environment where skilled clinicians are able and willing to share their clinical knowledge and expertise is required to create confident practitioners who feel valued and able to start on their professional career (Clare et al. 2003; Clare et al. 2002; Levett-Jones & Fitzgerald 2005). Unfortunately there is evidence that this is often not the case, with the newly graduated repeatedly describing the workplace as a negative environment that is unhelpful, unsupportive, oppressively hierarchical and at times perceived as a bullying culture (Clare et al. 2002; Duchscher 2009; Licqurish & Seibold 2007). Paying attention to the culture of the working environment therefore becomes an essential consideration in terms of providing successful transition support. In this section I canvass the literature on how new graduates' experience and learn within their new working environment.

A workplace learning environment

The clinical environment is an important factor that has the potential to influence a graduate's transition to practice. The new graduate requires 'supported' exposure to relevant clinical experiences in order to develop skills and confidence. Blaka (2006), a Norwegian researcher, stresses how crucial it is for the beginning practitioner to work alongside experienced staff where they are able to watch, listen, learn and practice in an effort to make the most of the learning opportunities available. While Blaka's research focused on the student midwife many of her findings are just as relevant for the new graduate. She contends that skilled practice depends on practical knowledge that can only be learned through active participation (Blaka 2006). However, this active participation must occur in a supportive atmosphere where the new midwife feels confident to take on additional skills and responsibilities. A clinical environment that facilitates this ability to learn is therefore essential.

Similarly, in the Australian context Boud and Middleton (2003) have reported on the importance of 'informal learning' in the workplace. In their cross-discipline and -sector research project titled *Uncovering Learning at Work*, the researchers explored how employees working within different sites in the same organisation acquired the knowledge

and skills they needed to function appropriately. Boud and Middleton (2003) articulated the concept of 'informal learning' as they discovered that people learned the skills/knowledge they required in the workplace from their peers. They purported that within the workplace we learn from all members of the team, even those who do not have an identified role in education (Boud & Middleton 2003).

Informal learning of workplace knowledge and skills is particularly significant within a midwifery context, as highlighted by Cioffi and Markham (1997). In this study, undertaken in Western Sydney NSW, these researches examined the clinical decision-making processes of 30 midwives. They did this by asking the midwives to think aloud while they reached their decisions of simulated clinical cases. Cioffi and Markham found that the midwives used heuristics or 'rules of thumb' in their decision-making processes, and suggested that these were based on the midwives' previous clinical knowledge and experiences (Cioffi & Markham 1997). In a later publication, Cioffi (1998) comments that this learned or 'embodied' knowledge is rarely written in textbooks and questions how best to transmit this to students and/or newly qualified midwives. Providing new midwives with opportunities to work in a variety of clinical environments not only enables them to develop their skills and confidence but increases their exposure to the experienced midwives' 'rules of thumb'.

It would appear from the literature that the skills and knowledge required by the beginning practitioner need to be learned via interaction with, and absorption into, the professional culture along with an understanding and appreciation of the rules that are used within it. To gain confidence, a newly qualified midwife needs to become conversant with the embodied knowledge, which is effectively exemplified and translated into clinical practice by experienced midwives (Blaka 2006; Cioffi 1998). The importance of the new graduate being exposed to this hidden knowledge through effective modeling by experienced midwives cannot be overstated. However, how the new midwife is accepted by the experienced midwives into the team also plays a role in their effective transition to clinical practice.

Wanting to fit in/ being accepted

Wanting to 'fit in' and be 'accepted' as part of the team is a phenomenon that has been commonly reported as an important element of the new nursing graduate's experience (Duchscher 2009; Newton & McKenna 2007). For example, Maben and Clark (1998) conducted in-depth interviews with 10 newly graduated nurses in the South of England while Evans (2001) conducted focus groups with nine newly graduated nurses in London. Both groups of nurses affirmed the importance of being a respected part of a team and how they valued feedback from their colleagues with regard to their actions and progress (Evans 2001; Maben & Clark 1998). Similarly to these UK studies, Blaka (2006) identified feeling 'welcome and accepted' and 'supportive communication' as key themes emerging from her observations and interviews (Blaka 2006, p. 38). She identified that new graduates are not always automatically integrated into the team (Blaka 2006). This lack of integration may result in the new graduate feeling isolated, engendering feelings of rejection.

Kensington's (2006) work undertaken in New Zealand confirms Blaka's findings, revealing a culture whereby newly graduated midwives were expected to actively prove themselves in order to be accepted. Using a feminist phenomenological approach Kensington (2006) undertook in-depth semi-structured interviews with nine graduate midwives in New Zealand. While only a small number of midwives were interviewed the richness of the findings strongly resonates with the international literature. Having to prove oneself to gain acceptance is a daunting challenge and is perhaps indicative of a 'hierarchical' nursing structure that has traditionally emphasised the importance of clinical experience as opposed to theoretical knowledge and research acumen (Kensington 2006). The role of the mentor midwife appeared to be crucial to the new graduates' experiences as they supported and at times protected the new midwives from their unsupportive colleagues.

In the next section I move onto explore the literature surrounding the new graduate's need for personal and professional support along with a discussion of different approaches to support.

PERSONAL AND PROFESSIONAL SUPPORT

Several Australian reports suggest that the level of personal and professional support provided during the transition period can impact on both the retention of graduates in the workforce (Fitzgerald et al. 2001; Heath et al. 2002; Queensland Nursing Council 2006) and the quality of care provided to health care users (Queensland Nursing Council 2006). Parker et al. (2003) argue how "a lack of professional and collegial support during this transition phase can seriously affect both short and long-term performance and, therefore, determine whether or not the graduate remains in the nursing workforce" (p. 301). The importance of getting the right level and type of support is therefore vital to ensure that the new graduate is enabled to make the most of all clinical and learning opportunities.

When reviewing the literature, three person-to-person support concepts frequently appeared: mentorship, preceptorship and supervision. Mills, Francis and Bonner (2005) point out, however, that there remains confusion regarding the definition and meaning of these three terms. Kensington (2006) agrees, stating that there is a high degree of overlap and even interchangeability between the terms in the midwifery and nursing literature. While Table 1 (page 35 of thesis), taken from Mills et al (2005), gives an overview of the key points and differences it is worth discussing each concept in more detail given their potential importance to ensuring adequate 'support' is available. To conclude the chapter I will discuss the value of 'feedback'. The rationale for exploring this concept here is that engaging in critical conversations with new graduates about their learning needs, including strengths and weaknesses, is a fundamental part of providing person-to-person support.

Mentoring

The New Zealand researcher Kensington (2006) notes that the modern English word mentor – or wise advisor – has its provenance in the Greek *mentor,* a character in Homer's *Odyssey,* a friend of Odysseus and advisor of Telemachus. In etymological terms, the name appears to be an agent noun of *mentos* meaning intent, purpose, spirit, passion, arising from the Sanskrit *man-tar-* one who thinks, and/or the Latin *mon-i-tor* one who admonishes.

The role of the mentor is therefore one of support and guidance, enabling the new practitioner to adapt and grow into their professional role (Di Vito-Thomas 1998; Kensington 2006). Kensington (2006) outlines two kinds of mentoring: informal and formal. Informal mentoring entails a naturally occurring partnership based on reciprocal trust, whereas formal or facilitated mentoring is more likely to be determined by an organisation and augmented with a regime of support and development. Both types of mentoring involve a mutually agreed, supportive relationship between two individuals whereby the personalities, philosophical outlook and priorities of each combine to determine the partnership's aims and duration (Kensington 2006).

Richmond (2006), surveyed 270 midwives in the UK about their experiences of midwives as mentors. The author found that the qualities rated most important in a mentor were role modeling, supporting best practice and providing positive feedback. Kensington (2006) suggested that for this to occur it is important that trust is established within a relationship where individual philosophies were aligned. Having a choice of mentor was also noted as important.

UK initiatives like the review of healthcare programs *Making a Difference* (Department of Health 1999) and *Fitness for Practice and Purpose* (UKCC 2001) indicate that practice-based learning is crucial to effective career progression. Mentoring plays a key role in this process with midwives modeling best practice, supporting and giving feedback. In Richmond's (2006) work, mentors who were experienced and confident in their roles were far more effective in enabling the development of knowledge and skills in the mentored.

Having said this, however, the earlier work of Di Vito-Thomas (1998) sounds a cautionary note, suggesting that there are advantages and disadvantages of mentoring. She cites knowledge sharing and motivation as the positives with unconstructive role modeling and overdependence as the negative aspects. Richmond (2006) picks up on this issue and acknowledges the potential for negative outcomes when mentors do not receive adequate training and support. These authors both advocate the need for effective systems that

address these issues, ensuring that disadvantages are limited.

Supervision

The term ‘supervision’ has many definitions and meanings (Mills et al (2005)). Certainly it appears to be interpreted differently between professions and countries. For example, in the UK statutory supervision of midwifery practice has been law since the 1902 Midwives’ Act. The central concept of this model of supervision was initially a desire to ‘protect the public’ but has since incorporated professional development (Mander & Fleming 2002). ‘Supervision’ is achieved through the systematic examination of practice and professional development of the midwives with the mandated requirement that every midwife meet with her/his supervisor annually (Nursing and Midwifery Council 2009). At this meeting a discussion regarding clinical competence, professional development and identified learning needs is held and a mutually agreed action plan is defined.

In recent years concerns over what is termed as ‘policing’ have seen the evolution of the role and a move towards a much more conciliatory and supportive approach (Duerden 2002). However, as Symon (2002) discussed, the role of protecting the public remains central with midwives being accountable for their practice both legally and professionally. The supervisor continues to have responsibility for the statutory reporting of professional misconduct to the Nursing and Midwifery Council (NMC). This model is therefore problematic and often challenging, with the supervisor being asked to play a dual role: supporter and policeman.

In Australia, the term *clinical supervision* has primarily been used within mental health, counseling and social work arenas. In the last few years, however, there has been an increasing appreciation of the benefits of clinical supervision for all areas of nursing and midwifery, due to its success in increasing support for clinical staff, decreasing stress and promoting the development of skills and knowledge (Brunero & Stein-Parbury 2008). Clinical supervision in this context is described as an opportunity for professional support

and education through regular case and/or clinical discussions with peers and other experienced colleagues (Brunero & Stein-Parbury 2008). The practice of reflection is central to clinical supervision with learning resulting from the exploration of the situation that occurred, actions taken and identification of potential areas for personal or group development.

Preceptorship

Preceptorship is defined as being a short-term relationship with the focus on skills acquisition (Kensington 2006; Mills, Francis & Bonner 2005). Kensington (2006) describes the direct teaching and coaching aspects of preceptorship where an experienced practitioner directly instructs and/or supervises clinical activities. Boon et al (2005) see the preceptorship role as helping newly qualified midwives to consolidate their clinical skills, putting theory into practice.

Mills et al (2005) highlight the responsibilities of the preceptor in providing formal feedback on the preceptee to either managers or educators. This is the point at which the concept of preceptorship varies from mentoring and clinical supervision which have confidentiality as a central tenant of the relationship.

Graduates identify that the most important aspect of their graduate year is the level of support provided in the clinical environment (Clare et al. 2003). The literature reviewed demonstrates the importance of effectively supporting new graduates as they make the transition from student to clinician. Preceptorship is potentially an important way to ensure this occurs. How to provide appropriate and relevant feedback is one of the skills that a preceptor must learn in order to provide effective support.

Table 1. Models for professional support

Element	*Mentoring*	*Clinical Supervision*	*Preceptoring*
Context	Outside the immediate work setting	Within the work setting, but away from the immediate work area	Within the work setting
Time	Long time-frame with a progression of relationship phases	Long time-frame with a progression of relationship phases	Short period, usually 2-12 weeks
Relationship reporting	Confidential discussions; minimal reporting on relationship status in a formal setting	Confidential discussions; minimal reporting on relationship status in a formal setting	Formal reporting on the progress of the preceptee
Level of commitment	High level of commitment; many require a time commitment outside of the work setting	High level of commitment; hopefully conducted within working hours, but away from the work setting; may require a time commitment outside of the work setting	Lower level of commitment; conducted solely in the work setting
Outcomes	Broader outcomes that can encompass improved clinical practice, career progression, scholarly endeavor, personal achievement	Improved clinical practice	Clinical skill development

(Mills, Francis & Bonner 2005, p. 6)

Feedback

Feedback has been identified earlier in this chapter as one of the guiding principles of providing effective support and is therefore relevant to any discussion on structured support and/or TSPs (Queensland Nursing Council 2006). Feedback is also covered in this section because it has to take place within the context of an interaction, whether professional or personal.

A large proportion of the evidence and information pertaining to the provision of feedback in a clinical setting such as midwifery is found within the medical literature, where it is widely accepted that feedback is an essential aspect of learning for junior medical officers (Chur-Hansen & McLean 2006; Kilminster, Jolly & van der Vleuten 2002; Rolfe & Sanson-Fisher 2002; Van De Ridder et al. 2008). Effective feedback has been shown to be beneficial to professionals early on in their careers as it provides motivation, reinforces good practice, improves learning outcomes and enhances skill acquisition (Bienstock et al. 2007; Eraut 2006; Eraut 2011; Rolfe & Sanson-Fisher 2002). The benefit of effective feedback for newly graduated midwives at the beginning of their professional career therefore seems quite clear.

Eraut (2006) defines feedback as "any communication that gives some access to other people's opinions, feeling, thoughts or judgements about one's own performance" (p. 114). He explains that feedback can be given in response to a specific event or situation or as part of on-going workplace learning (Eraut 2006). Whilst feedback may be provided formally such as in an appraisal interview, Eraut argues that much feedback is given informally and is cautious as to the effects of such feedback. For example, in a clinical ward environment Eraut suggests that the allocation of workload can be interpreted as a judgement on the nurse's capability or inability to care for the patient (Eraut 2006). The provision of feedback can therefore be multifaceted.

The work of Quilligan (2007) expands on this. From her experiences of working with doctors in the Clinical and Communication Skills Unit at the University of Cambridge she explores the intricacy of providing good feedback. In her 2007 paper she discusses why it is so complex. Feedback involves the thoughts and opinions of the person providing the feedback who has to ensure that the feedback is given in a way so that it is constructively accepted by the recipient. At the same time, the recipient needs to be able to understand the content, reflect upon the issues and ultimately implement change as a result (Quilligan 2007).

Eraut (2006) goes on to distinguish between four types of feedback. These include immediate on-the-job feedback, for example where a mentor may make on-the-spot comments regarding the undertaking of a procedure such as taking blood; informal conversations that occur after an event and take place away from the clinical setting, for example feedback on how the mentee interacted with a patient; formal feedback, such as that provided by a mentor or clinical supervisor with responsibility for the learner's development, and finally, the appraisal process which is more formal and less frequent and usually focuses on long-term development goals and progress. Eraut argues that the types of feedback used will depend upon the clinical situation along with the role and needs of the person providing and receiving the feedback. From the perspective of transition support all four types are feedback are relevant and have value if undertaken in a productive, emotionally sensitive and appropriate way.

Reviewing the work of Dutch researchers Belschak and Den Hartog (2009) is also helpful. They found that the framing of feedback in the positive enhanced the favourable effects such as staff retention. They also found that positive feedback increased staff's commitment and what they referred to as '*Organisational Citizenship Behaviours'*. By this, they referred to actions that went beyond usual workplace activities and promoted the welfare of colleagues and the organisation as a whole. They recommend that wherever possible feedback should be framed in the positive rather than the negative. For example,

where a performance issue is identified it is viewed as a learning opportunity rather than a mistake (Belschak & Den Hartog 2009).

While feedback framed in the positive has organisation benefits, Belschak and Den Hartog (2009) found that negative feedback was linked to high staff turnover, anger, disruptive tendencies and potential damage to the organisation. Quilligan (2007) concurs cautioning that if feedback is judgemental or poorly given it can have negative effects on the recipient, impacting on their level of confidence and may cause them to disengage. To assist clinicians in getting the balance right, Quilligan (2007) asserts her three key points to giving effective feedback: "feedback must be descriptive, comments about what is working and things that could be improved need to be supported and the way feedback is given is more important that what is said" (p. 101).

Learning how to give effective feedback is commonly referred to by doctors who are in teaching roles as their greatest area of need (Quilligan 2007). Quilligan (2007), discusses how many doctors do not have positive experiences of receiving effective feedback themselves and so do not have these encounters to draw upon. For this reason there is often a tendency to focus on the positives rather than aspects requiring attention. In order to assist clinicians in providing effective feedback Chur-Hansen and McLean (2006, p. 69) advocate a "positive-negative-positive" approach. This involves the person providing the feedback starting the conversation with a positive statement about the learner's strengths or the skill undertaken. The issue or area for improvement is then identified. The feedback session is concluded with a motivating or positive statement (Chur-Hansen & McLean 2006). This simple approach is both effective and easy to role model. It enables the recipient to learn in practice providing a starting point for personal reflection.

In order to provide newly graduated midwives with appropriate support the skill of providing effective feedback needs to be valued and understood. Adoption of the positive-negative-positive approach to feedback may be a useful resource for those planning and involved in TSPs for newly graduated midwives.

CONCLUSION

In this chapter, I have discussed and critiqued the relevant literature to contextualise the study. Some form of structured support during the transition period for both midwifery and nursing graduates has been deemed 'essential' for some time and well-established principles have been suggested to underpin the development, implementation and evaluation of formalised support as seen in a TSP. While some states and territories have developed programs to support their new graduates' transition into practice there remains limited progress towards standardising these programs in the Australian context. More specifically, the principles and programs available are generic, covering both nursing and midwifery rather than focusing on the very different needs of each profession. Within NSW no state-wide guidance or standards exist in relation to the content of TSPs. From a midwifery perspective it is unclear what transition support is available across NSW, and it is likely that this is having a significant impact on our ability to adequately support new graduate midwives through their graduate year and beyond. This research aims to provide some insight into the provision and content of TSPs for newly graduated midwives in NSW.

In the next chapter I will outline the methodology and study design chosen along with the motivations for these decisions. The design will be outlined in detail under the traditional headings of setting, participants, recruitment, data collection, data analysis and ethical considerations.

CHAPTER 3: RESEARCH DESIGN

INTRODUCTION

In this chapter I will outline the research design adopted for this study and provide a rationale for choosing a qualitative descriptive approach. In Chapter 2 I alluded to the dearth of evidence concerning how newly graduated Australian midwives experience their transition support programs (TSPs). The use of a descriptive qualitative approach is therefore appropriate as it seeks to increase understanding and knowledge of specific phenomena, rather than testing predetermined hypotheses**.** The chapter begins with a discussion of the methodology and methods used for this study. The design will then be described in more detail under the traditional headings of, setting, participants, recruitment, data collection and data analysis. Finally the chapter concludes with a brief discussion of the ethical considerations of the study.

JUSTIFICATION FOR EMPLOYING A QUALITATIVE DESCRIPTIVE APPROACH

Burns and Grove (2003, p. 493) describe qualitative research as the "systematic, subjective approach used to describe life experiences and give them meaning". In essence, qualitative research is an umbrella term under which a number methodologies and methods sit. These differing approaches may be quite separate or may overlap; however, their common theme is that they all conform to an interpretive methodology (Holloway 1997).

Streubert and Carpenter (1999, p. 15) identify six common characteristics of qualitative research: a belief in multiple realities; an approach to understanding that supports the phenomenon studied; a commitment to understanding the participant's viewpoint; limiting the disruption to the natural context of the phenomena of interest; acknowledging the researcher as part of the research process; and communication of the understanding of the

phenomenon by reporting in a commentary-rich style. These six characteristics informed the development and design of my study and are discussed in more detail below.

The first characteristic outlined by Streubert and Carpenter (1999) is the notion that there is no single truth or reality. Unlike the quantitative paradigm, qualitative research is based on the belief that meaning is created through multiple realities. In other words, individuals understand and experience life differently as a result of finding multiple ways to interpret what happens to and around them (Silverman 2000; Streubert & Carpenter 1999). This concept was considered particularly relevant to the study described in this thesis as first, there is no consistent approach to TSPs for newly graduated midwives; and secondly, within each TSP the midwives will have differing experiences.

To enable multiple levels of understanding to emerge that capture the participant's viewpoint, a qualitative researcher also needs to commit to identifying approaches most suitable to understanding the phenomena under study. In many cases this may mean employing more than one approach and/or data collection tool (Streubert & Carpenter 1999). Collecting participant's verbal accounts is one way of providing an opportunity for exploring subjectivity, which includes participants' sense of self and identity as they construct explanations of their experience. Taking this on board, I took a significant amount of time thinking about what techniques were likely to paint the clearest picture of first, what TSPs offer in NSW; and secondly, the subjective experience of individual midwives within the programs. It was these understandings that unpinned the decision to collect documents and undertake telephone interviews and focus groups with new graduates as well as other midwifery stakeholders.

One of the crucial elements of qualitative inquiry is the researcher's intention to represent the participant's perspective, or emic view, whilst ensuring respect for their personal space and views (Streubert & Carpenter 1999). This can only truly be done by using the individual's own words to describe and explain their experience. The use of quotes and participant stories provides a richness and depth in the understanding of a phenomenon. In

the presentation of the analysis participant's words, phrases and direct quotes are used whenever possible to provide a rich description of both graduate and registered midwives' expectations and experiences of midwifery TSPs.

When undertaking data collection, the qualitative researcher must be mindful of not disturbing or impacting the phenomena being studied (Streubert & Carpenter 1999). Whilst the very fact that the phenomenon is being studied will inevitably have some impact it is the researcher's duty to limit this as much as possible. It was this characteristic of qualitative inquiry that underpinned the decision to ensure participants were interviewed by individuals unknown to them and from outside of their own area health service. Interviews and focus groups were also conducted at a convenient time in the hope that this would minimise any disruption to the graduates' ability to openly share expectations and experiences.

Whilst the researcher strives not to impact or disrupt the natural context under study, qualitative research values the role of the researcher in his or her study (Streubert & Carpenter 1999). The premise that all qualitative research is conducted with subjective bias frees the researcher to embrace this bias and use it advantageously (Streubert & Carpenter 1999). Qualitative researchers believe that this involvement can add additional depth to the data and analysis as the researcher potentially has empathy or further understanding. My previous experience as a newly graduated midwife gave additional understanding to the concepts and experiences reported by the participants and allowed for additional probing questions to clarify and explore themes within the telephone interviews and focus groups.

Nonetheless, it is essential to be reflective as Mulhall and associates (1999) identify. The researcher must acknowledge how their own beliefs, assumptions and actions will inevitably affect the research throughout the entire process. Similarly, Sandelowski (2000, p. 335) points out that "descriptions always depend on the perceptions, inclinations, sensitivities and the sensibilities of the describer". In keeping with this, the text of the study

is written in the first person acknowledging my own judgement on how and why certain conclusions were made.

Additionally, in an effort to approach the study openly and honestly I examined my own thoughts, assumptions and personal biases regarding the topic prior to beginning the research. I believed that most of the newly graduated would have a good understanding of their TSP, that they would be provided with opportunities to work within the full scope of midwifery practice, and that they would be supported during their transition into professional practice. I realised that my previous experience of being a newly graduated midwife and then supporting newly graduated midwives over many years of practice may influence my conclusions. I documented these in a journal as well as discussing with my supervisors. Having done this however I was reassured by Appleton and King's (1997) comment that the interest, experience and knowledge of the investigator can enhance the research findings.

I made the decision to use a descriptive methodology as these types of studies aim to use rich description to "accurately portray the characteristics of people, situations, or groups and/or the frequency with which certain phenomena occur" (Polit & Beck 2006, p. 498). Sandelowski (2000) also suggests that a descriptive methodology is ideal when there is limited information on a topic as it aims to provide an accurate summary of the phenomena. Burns and Grove (2005) echo this statement and argue that descriptive studies provide evidence on which further studies can build. As existing research in the area is limited, this methodology appeared to be most suitable to enhance knowledge and inform further exploration of the phenomenon.

The use of descriptive methodologies that are not unpinned by theoretical frameworks has, however, received some criticism in the literature. Sandelowski (2000), a well-known author and advocate of the descriptive approach, claims descriptive methodologies are often seen as the lowest form of investigation. She suggests this is because qualitative descriptive studies are the least theoretical of all the qualitative methodologies. Sandelowski (2000)

goes on to argue however that this is not necessarily a flaw and can be advantageous, as the researcher is not weighed down by philosophical or theoretical requirements. Sandelowski (2000) explains how the researcher is able to stay closer to their data and have the freedom to allow the words themselves to describe the phenomenon as opposed to the researcher interpreting though a pre-existing frameworks.

By using a descriptive methodology I hoped to be able to fully explore and describe the phenomenon: newly graduated midwives' expectations and experiences of their TSPs. Additionally, I endeavoured to be able to add depth to their personal experiences by reporting on the views and opinions of experienced midwives involved in the transition programs being offered to new midwifery graduates.

AIM

As stated in chapter 1 the aim of this study was to identify the type of support offered to newly graduated midwives during their transition year, and to increase knowledge and understanding of new midwives' expectations and experiences of this support. The specific objectives of the study were to:

1. identify and describe the transition support programs offered for newly graduated midwives offered by hospitals within three Sydney Area Health Services (AHS)
2. describe newly graduated midwives' expectations and experiences of their transition support programs, and
3. describe experienced midwives' perceptions of the support offered to the newly graduated midwives employed within their organisation.

RESEARCH DESIGN

The study was conducted in three phases, each designed to meet an objective of the study. In Phase One a description of the site based TSPs on offer was collated and the population of new graduate midwives defined. Phase Two used qualitative data techniques including interviews at two time points and focus groups to capture the new graduates' expectations and experiences of the support programs offered during their transition from student to graduate. Similarly, in Phase Three qualitative data collection techniques were employed to elicit midwifery stakeholder's views on TSPs in an attempt to confirm and contextualise the new graduates' experience.

Setting

The study was conducted within three NSW area health services. Together these health services have a total of nineteen public maternity hospitals: Area A has six hospitals; Area B seven hospitals; and Area C six hospitals. The three AHSs have a combined birth rate of approximately 36,662 per year. In 2008 these births were distributed between the areas as follows: Area A 11,322, Area B 8,000 and Area C 17,340. Newly graduated midwives were employed at a total of 14 hospitals: all the facilities in Area C and four hospitals in Areas A and B. In 2008 a total of 80 places were offered to newly graduated midwives across the three AHSs.

An expert steering committee consisting of representatives from each area health service was established at the commencement of the study. This steering committee was set up to guide the design of the study and to inform and oversee the development of the data collection tools. Membership of the committee included the AHS/UTS Professors of Midwifery and key midwifery stakeholders from all three Area Health Services involved.

Phase One

Phase One of the study was designed to meet my first objective: to identify and describe existing transition support programs within three Area Health Services. Initial e-mail contact was made with the named person responsible for the coordination of the midwifery TSP at each site within the three area health services where newly graduated midwives were employed (n=14). The aims and objectives of the study were discussed, and coordinators asked to participate by providing a description of TSPs offered at their facility. A template was developed in collaboration with the expert steering group in order to standardise the descriptions given (see Appendix 1). The template addressed questions pertaining to the duration of the program, the documented program outcomes or objectives, the availability of peer support (for example, a named mentor) and the opportunity to experience working within a continuity of midwifery model. In total, twelve questions were asked.

Six completed program templates were returned. In Area A, four were received reflecting the number of hospital sites employing newly graduated midwives in 2008, all of whom offered a TSP. A single template was received from Area B which had devised an area-wide TSP covering all seven sites. In Area C, an area-wide approach was also taken and one template was received which detailed the TSP in place at four of the six sites. The other two sites, although employing newly graduated midwives, did not have a TSP in place.
Once the templates were received analysis began. All hospitals were given a code, a letter and number. The letter identified which area they were located in: for example, Hospital A1 was in Area A. A descriptive mapping exercise was then undertaken to link common aspects of each TSP so that comparisons could be formed and differences identified.

Phase Two

Phase Two of the study aimed to elicit data that would provide increased knowledge and understanding of new graduates expectations and experiences of their TSPs: this was objective two. Individual telephone interviews were conducted with a total of 29 newly

graduated midwives. These were followed by two focus groups involving a total of seven midwives.

Participants

2008

All newly graduated midwives employed within the three AHSs during 2008 were invited to participate in the study (n=80). They included midwives prepared through Bachelor of Midwifery, Graduate Diploma and Master programs.

2010

In 2010, newly graduated midwives employed within Areas B and C were invited to participate in the focus group aspect of the study (n=30). They included midwives prepared through Bachelor of Midwifery, Graduate Diploma and Masters programs.

Recruitment procedure

Time 1 *(beginning of the transition year)*

A number of recruitment strategies were used in the study. First, each of the clinical site coordinators responsible for graduates was given the correct number of study packages for their facilities and asked to disseminate the packages to the new graduates within the first few weeks of their TSP. The study packages included a letter of invitation, a participant information sheet, a consent form for telephone interview, an anonymous demographic questionnaire and two reply envelopes (see Appendices 2, 3 and 4). Participants were told that completing the demographic questionnaire was expected to take no longer than fifteen minutes and that the telephone interview would be approximately 30-45 minutes in length. Participants were encouraged to contact the researcher should they have any questions or queries. If interested, participating graduates were asked to first complete and return the questionnaire via one of the prepaid reply envelopes. Secondly, they were asked to return

the signed consent form with a contact telephone number. Reminder invitations were sent to participants via the site coordinators on up to three occasions.

Consent forms were received from 19 (23.8%) of the newly graduated midwives. Once consent forms were received the newly graduated midwives were contacted by telephone to arrange a convenient time for their 30-45 minute telephone interview. It was not possible to contact one of the newly graduated midwives although several attempts were made.

Eighteen newly registered midwives participated in a telephone interview. Eight (44.4%) midwives were educated in a Bachelor of Midwifery program, seven (38.9%) were Graduate Diploma graduates and three (16.7%) had completed a pre-registration Masters program. The age of midwives ranged from 23 to 55 years and all were female. Ten (55.6%) were working full-time while the remaining eight were working between 20 to 32 hours per week. Ten (55.6%) of the midwives were employed in Area A with the remaining nine (44.4%) employed in Area B. In the event, there were no respondents from Area C. All of the respondents were from sites where a TSP was offered. As a result of participants commencing employment at varying time periods after their graduation, and of some delays in returning consent forms, participants had been working in the clinical environment for on average eight weeks (times ranged from four to 21 weeks) when their telephone interviews were undertaken.

Time 2 *(end of the transition year)*

Midwifery graduates who had completed the Time 1 demographic questionnaire and participated in a telephone interview were sent another pack including a copy of their first telephone interview transcript, the same demographic questionnaire, and another copy of the participant information sheet in the last weeks of their transition year.

The purpose of returning copies of the first interview response to the participants was twofold. First, it allowed participants to check, and if required, amend the original

interview response in order to enhance the validity and reliability of data. Secondly, it provided the opportunity for participants to recall how they had perceived their needs at the start of the transition year. It may otherwise have been difficult for respondents to recall how they felt and what they thought they would need twelve months earlier. It was recognised that newly graduated midwives may be attracted to specific TSPs based on their perceived needs at graduation. Their actual needs may vary from their perceived needs – if this is the case, it represents important information for those developing the TSPs.

Once again, participants were instructed to complete and return the questionnaire via the prepaid envelope. Interview times were organised by telephone using the contact details provided. Sixteen of the original consenting graduates (n=18) participated in a second telephone interview. The remaining two consenting graduates were called on a number of occasions using the phone numbers they had provided; however, in these cases contact could not be made.

In addition, graduate midwives who did not return their study packages at Time 1 were provided, via the clinical site coordinators responsible for graduates, with another copy of the original information pack inviting them to reconsider joining the study at the Time 2 point (n = 54[3]). It was anticipated that there would be a greater response rate at Time 2. This assumption was based on a number of reasons: networks with the clinical site coordinators responsible for graduates had been enhanced over the year; the graduates at the end of the TSP would potentially be less stressed than at the beginning so more inclined to respond; and, having completed their year, they might be motivated to express their more fully-formed views.

As a result, an additional 13 graduates consented to participate in a telephone interview at the Time 2 data collection point. Four newly graduated midwives were educated in a

[3] It was reported by the hospital TSP co-ordinators that eight newly graduated midwives had left their prior to the Time 2 recruitment.

Bachelor of Midwifery program, six were Graduate Diploma graduates and three had completed a pre-registration Masters program. The age of new graduates ranged from 20 to 45 years and all were female. Nine were working full-time while the remaining four worked between 24 to 32 hours per week. Five of the participants were employed in Area A, five in Area B and the remaining three were employed in Area C.

Focus groups

Two focus groups were conducted in early 2010 to confirm the emerging themes elicited from the data analysis process. New graduates in areas B and C (n = 30) were approached via a midwifery educator in each area. The new graduates were invited to participate in a one-hour focus group by members of the expert steering group. In order to maintain the confidentiality of participants' Area A was not targeted as this was the area in which I worked. Midwives were provided with the information sheet and consent form and asked to contact myself if they were interested in being involved in the study (Appendices 5 and 6). Seven midwives from area B and C consented to participate. Table 2 summarises the recruitment of newly graduated midwives in Phase Two.

Table 2. ***A summary of Phase Two new graduate midwife recruitment***

	Bachelor of Midwifery	**Graduate Diploma**	**Master**	***Total***
Time 1 interview	8	7	3	***18***
Time 2 interview	12	12	5	***29***
Focus group	5	2	0	***7***

An overview of participant characteristics for Phase Two can be found in Appendix 7. This summary also includes the new graduates' pseudonyms.

Data collection

Telephone interviews

Once consent was received, participants were contacted and a time suitable to the graduate was made to conduct the telephone interview. Burns and Grove (2005) discuss how interviews represent a useful technique that can allow for a greater exploring of the issues than other data collection methods**.** An interview format allows for the deeper probing of specific issues, and creates the potential for a greater understanding of the issues raised.
This first interview focused on what the new graduates hoped to achieve professionally during the transition year and their expectations of the TSP they were undertaking. The second structured telephone interview asked participants to reflect on the structure of their own TSP, the positives and negatives of the program, their achievements in relation to their expectations for the year, and their thoughts on how programs could be improved. Themes arising from the Time 1 data collection were also discussed with participants. Each interview lasted between 30 and 45 minutes.

Telephone interviews were considered a reliable source of data collection for this study as the interview questions were deemed to be relatively uncomplicated. Telephone interviews have the additional benefit of good response rates while being cost-effective (Polit & Beck 2006). The benefits of this method were many: the 30-45 minutes duration was deemed to be short enough to not overly impact on the busy newly graduated midwives' time; conducting the interview by telephone made it easy to arrange; no travel was necessary, and there was no booking of rooms to arrange. Most important perhaps was the acknowledgment that a telephone interview would be potentially less threatening for the participants. This last consideration was based on the belief that newly graduated midwives may feel more intimidated in a face-to-face interview, particularly if they felt they had negative experiences to share.

To ensure and maintain consistency in approach between interviews and interviewers a pro-forma was designed in consultation with the expert steering group (Creswell & Plano Clark

2007). It consisted of a number of opened questions based on the objectives of the study (See Appendices 8 and 9). Notes and bullet points were taken to capture the key points and themes discussed by the midwives; however, if pertinent quotes were made by the midwives these were written down. Whilst it is acknowledged that the taping and transcribing of interviews can be advantageous, Russell and Gregory (2003) maintain that it is not always necessary. The cost of transcription of audiotapes may also dictate the use of this option when resources are limited.

In total, six experienced midwives conducted the interviews with the overall aim to maintain confidentiality and enhance participate comfort. For this reason experienced midwives did not interview any participants from their AHS. The experienced midwives were either Clinical Midwifery Consultants or Senior Midwifery Educators employed within one of the AHSs. Interviewers were provided with detailed instruction and helpful strategies to employ when interviewing to promote consistency. Two experienced midwives conducted the first 18 interviews and an additional four[4] were recruited for the Time 2 interviews. The members of the interview team met prior to the commencement of interviews and regularly communicated via e-mail and telephone during the interview process to maintain consistency and mitigate issues and concerns. Interviewers were asked to keep field notes and at the completion of the interview came together to discuss the process.

Focus groups

Berg (2001) describes a focus group as an interview for groups where the researcher learns about the phenomena in question via the discussion and interaction within the group. Burns and Grove (2003) state that the strength of a focus groups is its potential to elicit rich data. These authors identify the value of the group dynamic, which they say can encourage

[4] Additional interviews were recruited as the Time 2 interviews were undertaken at the same time as the Phase Three telephone interviews with the experienced midwives.

discussions within the group where participants may be encouraged to express views and opinions stimulated by other participants' comments and actions (Burns & Grove 2003). A focus group thus allows for dynamic interactions which may not be achieved through regular interviews (Haggstrom, Mamhidir & Kihlgren 2010). The advantages are that participants may question one another, share stories and ideas that jog forgotten thoughts, and debate and argue concepts and opinions (Burns & Grove 2003; Holloway 1997). It is also likely that some participants may gain an increased level of confidence as a result of a perception that there is safety in numbers when discussing sensitive issues (Burns & Grove 2003; Holloway 1997).

Berg (2001) advocates the value of focus groups, especially where one-off data collection is required. For these reasons, I considered this method of data collection an ideal way to confirm the initial themes emerging from data analysis.

Focus groups usually consist of a small number of participants with a moderator to guide the session, and can be either guided or un-guided (Berg 2001). Holloway (1997) cautions those using the focus group technique, highlighting that a dominant participant may overtly influence the discussion while more passive members may not feel able to vocalise their ideas. It is important that all members of the group participate in discussions equally (Haggstrom, Mamhidir & Kihlgren 2010). For this reason, Burns and Grove (2003) point out that the moderator must be an impartial skilled facilitator able to extract relevant information from all participants. These authors go on to say that the moderator must remain impartial and needs to have facilitation skills that focus on encouraging and ensuring equitable participation from all members of the group (Burns & Grove 2003). I was mindful of these arguments when I conducted the focus groups; and for these same reasons I did not attempt to facilitate a focus group with graduates in my own area health service who were well-known to me.

At the beginning of each group I made sure that the participants felt comfortable. I re-affirmed that confidentiality would be maintained and that group members should respect

each others' voices – this is where the skill of the moderator in facilitating groups becomes crucial. The complex issue of confidentiality within a focus group is highlighted by Berg (2001), who acknowledges that, whilst the researcher's responsibility is assured, that of the other participants may not be. This uncertainty, if not addressed, can negatively impact upon participants' involvement within the group: discussions may not flow freely and views may not be openly expressed (Berg 2001). Assurance must therefore be given at the commencement of the group to ensure that participants feel secure. Participants in my focus group were provided with information about the focus group and asked to sign consent forms outlining the expectations for the group.

I acted as moderator and guided the discussions in the focus groups. As the aim of the focus groups was to confirm the emerging themes identified in Time Two, a list of questions was devised prior to the groups in consultation with my supervisors (Appendix 10). The focus groups were recorded on an iPod and I subsequently transcribed the discussions into Word document.

Phase Three

Phase Three was designed to address my final objective: to describe experienced midwives' perceptions of the support offered to the newly graduated midwives employed within their organisation. By doing this, I hoped to provide as full a picture as possible of TSPs from all of the stakeholders' perspectives.

Participants

Experienced midwives (n=33) from across the three Area Health Services were invited to participate in Phase Three of the project. They were identified with assistance from the members of the expert steering group. Inclusion in the study was based on roles and responsibility such as clinical midwives assigned one or more of the newly graduated midwives, managers who had overall responsibility for the service and/or ward area

through which the newly graduated midwives rotated, and clinical educators involved in supporting the clinical development of the newly graduated midwives.

Recruitment procedure

Towards the end of the graduates' transition year, the identified experienced midwives were sent an information sheet and consent form inviting them to participate in the study (see Appendices 11 and 12). The experienced midwives were informed that the interviews would last approximately 30 minutes.

Participant characteristics

Sixteen experienced midwives participated in a telephone interview. Seven (43%) of these held a management position, four (25%) worked as an educator and the remaining five (32%) were clinical midwives. Nine (56%) were employed within Area A, four (25%) worked in Area B and the remaining three (19%) were from Area C. Appendix 13 includes the experienced midwives' pseudonyms.

Data collection

Once consent was received from each participant, a time to conduct the one-off telephone interview was organised. Similarly to the data collection for the new graduates, an interview pro-forma was used to enhance the consistency of data collection (Appendix 14). Questions were designed to provide information about the type of experience each interviewee had with the newly graduated midwives. Questions also focused on their perceptions of the new graduates' needs and their reflections on the transition support provided in their area. During the course of the conversations, midwives were reminded to respond to the questions in a general manner and not report on the performance or experiences of individual new graduates.

The six members of the interview team conducted the Phase Three interviews. Similarly to the interviews conducted with the graduate midwives, allocation of interviews was co-ordinated to ensure that the interviewer did not come from the same area health service as the interviewee. This strategy was used to ensure confidentiality and create a sense of ease for the participant.

DATA ANALYSIS

A content analysis approach was used to analyse the data set. Berg (2001) describes content analysis as the process of applying an objective systematic coding scheme to data in order to condense it and make it systematically comparable. Content analysis can be either manifest, interpreting data which is visible, obvious and/or countable; or latent, interpreting the underlying meaning of the data (Berg 2001; Graneheim & Lundman 2004).

Graneheim and Lundman (2004) claim that when designing a study the researcher must first decide if they are using manifest or latent content analysis. However, Berg (2001) argues that there are advantages to using both and advocates that this is done whenever possible. He articulates that stating the frequency of an occurring theme adds weight to the argument whilst the use of latent content analysis will give a deeper interpretation of the theme. For this reason I made the decision to use a mix of manifest and latent content analysis.

Polit and Hungler (1995) highlight how the researchers own subjectivity may be a disadvantage of content analysis. As previously indicated this argument is countered by Graneheim and Lundman (2004) who take the reader back to the basic concepts of qualitative research: the understanding that there are always multiple levels of meaning and understanding that come up from subjective interpretation. What is essential is that processes are objective, systematic and clearly articulated so that others using the same processes would arrive at the same conclusions (Berg 2001).

In Phase One, a mapping exercise was undertaken with the completed program description templates from the participating hospitals. Through this exercise similarities and points of difference were identified.

Data from Phase Two and Three was typed into Word documents. The transcripts were then read several times to allow for familiarisation with the content and to get a sense of the whole. The next step of analysis involved the forming of 'meaning units': the grouping together of words or statements that related to one another by their context or content (Graneheim & Lundman 2004). This was achieved by grouping together all participant responses to the individual questions from the telephone interview pro-forma. Responses from each participant were cut and pasted into a Word document under the question heading, care being taken to ensure that each response was clearly identifiable as being from the pseudonym midwife.

The meaning units were condensed so that the core meaning was retained but responses were shortened (Graneheim & Lundman 2004). The condensed meaning units were then abstracted, or grouped together which allowed for sub-theming. Finally, sub-themes were grouped to generate larger themes. During analysis, I followed Graneheim and Lundman's (2004) advice and strove to ensure that all relevant data was included while excluding irrelevant data. During this process I was also aware of the need to ensure the meaning units were neither so wide that they included too many themes nor so narrow that they became fragmented (Graneheim & Lundman 2004). Figure 1. illustrates the process through which key themes were identified.

Using this process enabled an audit, or decision, trail to be made of how themes were developed. Further examples of my audit trails can be found in Appendix 15. Graneheim and Lundman (2004) identify the importance of illustrating the process of how meaning units, condensing, abstraction and themes are derived in demonstrating credibility of findings. In this way main themes and sub-themes were identified.

Figure 1. Example of emerging theme

What factors do you think will assist you?	*"Cannulation skills"* *"Medication knowledge"* *"Perineal repair"* *"Practical sessions to go over skills drills"*	The need to attain specific clinical skills	Gaining more experience

The focus group data and the experienced registered midwives' data were transcribed into Word documents and treated similarly. However, as the purpose of the focus groups was to validate the emerging themes, meaning units already identified were used as a type of template or analysis framework. The Phase Three data was used in much the same way, the aim being to triangulate the data sets providing a richer picture of the newly graduated midwives' expectations and experiences of the TSPs.

TRUSTWORTHINESS

Qualitative research requires rigour in the form of an accurate representation of participants' experiences (Silverman 2000). Trustworthiness and authenticity are key elements to ensuring rigour within the research process. Polit and Beck (2006) define the criteria for assessing trustworthiness in qualitative research as including "credibility, transferability, dependability and confirmability" (Polit & Beck 2006, p. 511).

Credibility refers to the intended objectives of the research and how well the individual aspects of the study are designed to meet these objectives (Graneheim & Lundman 2004).

For example, when deciding upon recruitment strategies it is optimal to recruit a range of participants who offer a wide and/or varied experience of the phenomena. With these range of experiences the phenomena can be explored from a number of differing viewpoints. By recruiting graduated and experienced midwives from three AHSs and from differing midwifery education programs, my study has been able to benefit from a wide range of opinions, views and experiences. This has given richness to the data.

The second aspect of trustworthiness identified by Polit and Beck (2006) is transferability: how a study's findings can be transferred to other settings or situations (Polit & Beck 2006)**.** Graneheim and Lundman (2004) suggest that while authors can offer proposals as to how their findings may be transferred to other contexts, it is in the end up to the reader to make the decision regarding this potential. The authors can, however, assist the reader by effectively describing in detail the characteristics of the participants, the setting and the findings. Phase One of my study aims to provide the reader with a detailed description of the TSPs available to assist the reader in deciding if the subsequent findings are transferable to their place of work.

Dependability is the third facet of trustworthiness (Polit & Beck 2006). It refers to the consistency and reliability of data collection and analysis processes (Golafshani 2003). Graneheim and Lundman (2004) discuss the conflicting challenges of maintaining consistency over the duration of a study. In designing my study I weighed up the benefits of questioning all participants on the same areas versus allowing evolution to occur as I gained new insights into the phenomena that could prompt further investigation on a specific area (Graneheim & Lundman 2004). As a result of these deliberations I decided to attempt to establish dependability in two ways. First, telephone interview pro-formas were used, to standardise the questions asked of all participants. Notwithstanding this, by undertaking focus groups, after the extraction of themes from the initial analysis the study was able to evolve. Focus group participants were questioned on the identified themes to check for reliability while there was also the opportunity to probe other areas alluded to in the telephone interviews but fell outside of scope of the pro-forma.

Polit and Beck's (2006) final aspect of trustworthiness is confirmability, which includes the verification of themes. Confirmability refers to the extent to which the themes 'ring true' to the reader. Some authors use the term 'verification'. Such a term is believed to be problematic in qualitative research as the starting position is that multiple meaning and realities exist for individuals and so interpretation is subjective (Polit & Beck 2006). Having said this, there are a number of strategies researchers can employ to demonstrate the confirmability of findings. To have credibility therefore one must not only verify themes but also confirm the processes that were gone through to arrive at these themes (Graneheim & Lundman 2004). Russell and Gregory (2003) discuss 'investigator triangulation' as a way of corroborating findings through consensus of investigators. Themes elicited via data analysis were presented to the steering committee with the associated audit trails. The purpose was to check processes and gain consensus.

While the process of gaining consensus is important to ensure the authenticity of data, Silverman (2000) also suggests that the researcher should validate the accuracy of the data with the participants. Conversely, Appleton and King (1997) argue that the individual's reality is fluid and changes with time. They suggest that it may therefore be more realistic to accept that an individual's perception is accurate at the time it is described (Appleton & King 1997). With regard to the newly graduated midwives I subscribe to Appleton and King's (1997) theory. As they move from student to beginning practitioner, the newly graduated midwives' experiences and feelings will inevitably change over the course of their transition year. However, in an attempt to ensure a degree of trustworthiness, the participants were sent the interview transcript of their first telephone interview prior to their second. This allowed them to correct any misunderstandings and also to refresh their memory of their feelings and aspirations at the beginning of their TSP.

Other strategies were employed to ensure the credibility and confirmability of my findings. These included facilitated discussions with my supervisors at all stages of data analysis; discussions with fellow research students of preliminary findings and themes; diagramming and audit trails showing the rationale and justification for analysis decisions; and the use of

focus groups which allowed verification of themes elicited from analysis of the graduates' telephone interviews.

ETHICAL ISSUES AND THE CONSENT PROCESS

Burns and Grove (2005) comment that research necessitates four qualities: "expertise; diligence; honesty and integrity" (p. 207). Human rights must be protected at all times when conducting research, specifically: "self-determination; privacy; anonymity and confidentiality; fair treatment and protection from discomfort and harm" (Burns & Grove 2005, p. 207). The ethics process that any study undertakes ensures that these five concerns are addressed and accounted for.

An application for multi-site ethics approval was submitted to the University of Wollongong's Ethics Committee (Appendices 17 and 18). In addition, site-specific approval was obtained from all of the hospitals involved with the research and from UTS's Ethics Committee (Appendix 16).

Participants received information about the research and were offered an opportunity to discuss the research with the principal researcher. The principal researchers were explicitly not line managers of any participants in this research.

The coordinators of the midwifery TSPs were asked to disseminate invitations, information and consent forms to potential participants. However, all participants were supplied with a reply paid envelope in which they were asked to return consent forms – and demographic questionnaires where appropriate – directly to the principal researchers. The aim was to avoid any potential sense of coercion on the part of the participants as well as to ensure that their colleagues and line managers were not aware of their decision to participate or decline to participate in the research.

To maintain confidentiality, interviews and focus groups were arranged with experienced midwives from outside their AHS. It was acknowledged that some interviewers may have played a role in the TSP at their employing hospital, making them 'interested' researchers. Burns and Grove (2003) acknowledge that researchers may often have a personal interest in the topic under study, and in qualitative research this potential source of bias is acknowledged, though it cannot be eliminated. The use of a structured interview schedule, and of interviewers from different Area Health Services, aimed to reduce the effect of this potential bias.

The demographic questionnaires were anonymous and identifiable interview and focus group data was coded to ensure confidentiality. Participants were informed that participation in the study was voluntary and that they could withdraw from the study at any time without penalty.

The interview data and demographic questionnaire data were entered onto two Excel databases, both of which were password-protected. The de-identified raw data was stored in a locked filing cabinet in the researcher's office for the duration of the study. On completion of the study raw data will be securely stored in a locked filing cabinet at UTS for a period of five years. No identifying information will be used in written reports, presentations or publications. All data will be managed in accordance with the National Health and Medical Research Council's guidelines.

CONCLUSION

Given the lack of evidence concerning how newly graduated Australian midwives experience their TSPs, a descriptive qualitative approach was considered the best approach to increase knowledge and understanding of this under-researched area. In this chapter I have detailed the design of the study including, setting, participants, recruitment, data collection, analysis and ethical considerations.

Taking a descriptive qualitative approach firstly facilitated a description of the structure and identification of the core elements of the different TSPs offered with the three AHS. Secondly this method allowed the exploration of the newly graduated midwives' expectations and experiences of their TSPs. In reporting the findings manifest, content analysis was used to quantify the regularity with which themes occurred and latent content analysis enabled the interpretation and understanding of the themes.

In the next chapter I will present the findings of the Phase One scoping exercise undertaken to identify the structure and elements of the TSPs on offer to the newly graduated midwives. The chapter concludes with the presentation of the findings that describe newly graduated midwives' expectations of their TSP.

Chapter 4: Exploration and Discussion of Transition Support Programs for Newly Graduated Midwives in three Area Health Services

INTRODUCTION

This chapter is the first of two that present the findings of this study. As previously outlined the study was undertaken in a number of phases with multiple data collection points. In this chapter I will initially present the findings of the Phase One scoping exercise undertaken to identify the structure and elements of the Transition Support Programs (TSPs) newly graduated midwives were offered within three Area Health Services (AHSs) in NSW, Australia. The chapter concludes with an exploration of the findings of Phase Two Time 1: the newly graduated midwives' expectations of the TSPs they were entering. These findings will be discussed under three main headings: the midwives' understanding of their TSPs, desired goals during the program, and requirements of the TSP to assist in meeting their goals. In Chapter 5 I will present the findings related to the midwives experiences (Time 2). This will also include data collected from experienced midwives.

For the purposes of identification, the newly graduated midwives will be referred to in this chapter as the 'midwives'. Other midwives – that is, those not in their first year of practice – will be referred to as 'experienced midwives' or by their job title, for example 'midwifery manager' or 'educator'.

OVERVIEW OF THE TRANSITION SUPPORT PROGRAMS ON OFFER WITHIN THE THREE AREA HEALTH SERVICES

As outlined in the previous chapter, a representative from each hospital within the three AHSs was asked to complete a template outlining the elements of their TSPs for newly

graduated midwives. The three AHSs were all located within the Sydney metropolitan area. Area A included six hospitals, four of which provided a TSP. Area B included seven hospitals, four of which provided TSPs a standardised area-wide TSP was offered in these facilities. In Area C there were six maternity hospitals, all of which employed newly graduated midwives; however, only three of these institutions had a TSP. Similarly to Area B, Area C ran a standardised TSP in the four sites who offered a program. In total there were 80 newly graduated midwives employed across the three AHS in 2008. Table 3 provides a breakdown of newly graduated midwives per AHS and hospital as well as the availability of TSPs. For ease of analysis only those hospitals employing midwives in 2008 are discussed.

Table 3. Number of midwives employed in 2008 and availability of transition support programs

		No. of newly graduated midwives employed in 2008 (n=80)	Qualification of the midwives employed			
	Hospital		*GD**	*BM***	*M****	TSP available
Area A	A1	12	√	√	√	√
	A2	9	√	√		√
	A3	4	√	√	√	√
	A4	5			√	√
Area B	B5	2	√			√
	B6	8	√			√
	B7	8	√	√		√
	B8	3	√			√
Area C	C9	12	√	√		√
	C10	3	√			√
	C11	3	√	√		√
	C12	2	√			
	C13	8	√			
	C14	1	√			√

* Graduate Diploma, **Bachelor of Midwifery, ***Masters

The template sent to each facility within the three AHSs requested information on 12 elements of their TSPs: duration of the program, overview of the program, time allocated for learning, documented program outcomes or objectives, information provided to the participant, degree of flexibility eg. part-time positions, experiences with continuity of midwifery practice, support provided by clinical or mentoring experienced midwives, peer support, debriefing opportunities, opportunities for midwife participant to provide feedback and required assessments or credentialing exercises.

The sites were also invited to supply any other supporting documentation regarding their individual TSP. The information provided has been used to develop this summary of the TSPs available to midwives employed within the three AHSs included in this study during 2008. Responses are grouped and discussed under the headings of the 12 elements previously identified.

Documented objectives of the Transition Support Program

Representatives at each hospital were asked to report on the documented outcomes of their TSPs. The degree of formal structure and detail provided regarding these outcomes varied considerably between the 12 TSPs offered. Staff responsible for the program at Hospital A1 provided an overarching aim for their TSP. They stated their TSP would:

> *Facilitate newly graduated midwives to develop skills and knowledge in the provision of midwifery care, in order to meet specific outcomes in a defined timeframe. A period of orientation, supervised practice and clinical support was designed to progressively enable the midwife to develop autonomous practice.*

This overarching aim was reported to be supported by a number of specific objectives and outcomes for the midwife in each clinical area; the detail of which was not supplied. Similarly to the program at hospital A1, representatives at hospital A4 stated that they had detailed objectives for each ward area. These objectives were, however, not specific to the

midwives' TSPs, but the same as in the general orientation program provided to all new staff.

Unlike hospital A1, an overarching aim of the TSP was not provided for the programs at hospitals A2 and A3. Instead ten principal objectives were outlined which related to professional and personal responsibilities. Examples included responsibility for continuing professional development, the use of hospital policies and appropriate consultation and referral. Further detail on how the midwives would meet these objectives was not reported.

The four hospitals in Area C offering TSP all had clear learning objectives documented. The overarching aim was stated as:

> *To consolidate clinical midwifery practice, transform new graduate midwives into competent beginner-level midwives and demonstrate an increasing level of midwifery skills and knowledge.*

In this area it was reported that the midwives met, discussed and identified their individual learning objectives with the clinical midwifery educator and/or identified preceptor at the beginning of their TSP. These learning objectives then formed part of an ongoing review and performance process to ensure they were supported and facilitated to meet their identified objectives. Area C was the only area to formally evaluate its programs.

In Area B there were no overarching goals or formal program objectives provided.

Information provided to the midwives

The amount of information provided to the midwives about their TSPs varied considerably between all the hospitals. For example in Area C (hospitals 9, 10, 11 and 14) a comprehensive package was provided for each midwife. This package included a welcome letter, information booklet, education plan, evaluation document, group clinical supervision fact sheet, and rotation details for the 12-month period. In contrast, at hospitals A2 and A3 it was stated that the TSPs were verbally discussed with the new midwives. No written

material was provided although a policy document was accessed for this study. This appeared, however, to be in draft form and was readily available to midwives entering the TSP. At the other sites in Area A and those in Area B the only information given to the midwives appeared to be related, in the most part, to two specific program elements: the plan for the clinical rotations and the study days available. The individual elements of the TSPs designed to support the midwives will now be described.

Elements of the transition support programs

Although the standard duration of all 12 TSPs was one year, there was wide variety in the level, intensity and type of support available to the midwives. The nature and scope of the TSP offered depended largely on the AHS and the hospital at which it was offered. Table 4 (page 70) provides an overview of the approach to clinical rotations and provision of study days at each hospital. The differences in the three major elements of the TSP – clinical rotations, supernumerary time and study days – will now be discussed in more detail.

Clinical rotations, supernumerary time and study days

Area A

Individual hospitals within Area A offered a range of programs. At hospital A1, 2008 was the first year that midwives from the Bachelor of Midwifery program joined their counterparts from the Graduate Diploma program. All the midwives were offered a clinical rotation with time allocated to antenatal clinic, birthing services, antenatal ward, postnatal and the home postnatal midwifery service. There was an individualised supernumerary period in each clinical area: antenatal clinics one to three weeks, antenatal ward two days, birthing suite three days, and between one to two weeks on the postnatal ward. Study days were available but only offered to the Bachelor of Midwifery midwives. These consisted of three days, where the midwives joined with the newly graduated nurses. These study days were reported by A1 representatives as focusing on 'basic nursing skills' and so had no midwifery content. 'Basic nursing skills' were not defined; however, further information

was elicited from the midwifery educators who were interviewed by telephone as part of Phase Three. It was reported that these 'basic nursing skills' days covered subjects such as: the working of infusion pumps, drug calculations, management of drains and fluid balance charts.

Hospitals A2 and A3's programs included supported clinical rotations to all areas with supernumerary orientation on the initial rotation to a new area. The midwives were offered two weeks working alongside the midwifery educator on the delivery suite. Four study days were available for all midwives. Similarly to hospitals A1, 2 and 3, hospital A4 offered a three-monthly clinical rotation with a week supernumerary at the beginning of each new rotation, along with seven study days available for all midwives.

Area B

Somewhat differently to Area A, Area B offered an area-wide TSP to all its midwives. This program included a planned rotation to all clinical areas with two supernumerary days at the start of each new rotation. Five study days were available for all midwives with the Bachelor of Midwifery graduates able to access an additional four days. One of these additional days was stated by Area B to be a skills day to meet 'identified requirements'; details of which requirements were not provided. The three remaining days were designed to be used by midwives to attend conferences or seminars of their choice, or to participate in a supernumerary capacity in a clinical area of interest.

Area C

As stated previously, within Area C only four of the six hospitals employing the midwives had a TSP. Similarly to Area B these four hospitals, C9, 10, 11 and 14, offered the same TSP. The TSP included a three-to-four monthly clinical rotation to the birthing unit, postnatal and antenatal wards, antenatal clinic and newborn care along with three study days. Supernumerary time was only available to those who were new to the hospital.

Table 4. Allocation of clinical rotations and study days for the midwives.

Hospital	Clinical Rotations (weeks)	Supernumerary Time	No of Study Days	Study Days Available	Study Day Subjects
A1	10 to 16	√	3	*Bachelor of Midwifery only*	Basic nursing skills
A2	8	√	4	*All new grads*	FONT[5], midwifery skills, reflective practice, breastfeeding education
A3	8	√	4	*All new grads*	FONT, midwifery skills, reflective practice, breastfeeding education
A4	12	√	7	*All new grads*	FONT, midwifery skills, reflective practice, breastfeeding education, child protection
Area B	Duration not specified	√	5 9	*Graduate Diploma* *Bachelor of Midwifery*	FONT, breastfeeding education, midwifery skills
C9,10, 11, 14	Dec-16	Only if new to Hospital	3	*All new grads*	FONT, midwifery skills
C12, 13*	No		No	No	No

* TSP not available

[5] NSW Health mandated training. Fetal welfare, Obstetric emergency and Neonatal resuscitation Training (FONT)

Summary of study day topics

Information provided by representatives at all hospitals on the subjects for the study days showed many similarities although as identified above the number of sessions on offer varied considerably. All programs included the two FONT days, breastfeeding education, a 'midwifery skills' day as well as opportunities for debriefing and reflection. The 'midwifery skills' day typically covered topics such as, fetal scalp electrode application, vaginal examination and discussion and case studies around the management of complex clinical cases.

Flexibility of the Transition Support Program and the opportunity to work within midwifery continuity of care models

The degree of flexibility, or customisation, of the TSPs to meet the needs of individual midwives, along with opportunities to work within midwifery continuity of care models[6], was a domain that generated a range of options. Opportunities to work within midwifery continuity of care models were not widely available to all. Table 5 provides an overview of the flexibility of the TSPs and opportunities to experience midwifery continuity of care models.

Area A

At hospital A1, only full-time programs were offered; however, the hospital reported that it considered the individual's interests and rotation preferences where possible. This included a limited opportunity to work within a midwifery continuity of care model with a small number of spaces available in either the birth centre or the caseload midwifery team.

Part-time programs were featured at hospitals A2 and A3, with an initial rotation of eight weeks to each clinical area. This was followed by a rotation wherever possible to the

[6] Midwifery continuity of care models were models of care where midwives provided continuity to a caseload of women during their antenatal, intrapartum and in some instances early postnatal periods.

midwives' area of preference although this was not assured. Experience with midwifery continuity of care models could be arranged by discussion with managers after the initial rotation period at hospital A2 only. Although the number of places available limited opportunities to work in different models of care, a small number of midwives successfully transferred into a midwifery continuity of care model – some within their TSPs, while others had to leave the program to enter the model. Hospital A4 offered flexibility in the form of part-time rotation and extended rotation in a ward area. However, the midwives were not offered an opportunity to gain experience in a midwifery continuity of care model.

Table 5. Flexibility of TSPs and opportunities to work in midwifery continuity of care models

Hospital	Flexibility of the program		Experience offered in midwifery continuity of care models
	Part time available	***Options to choose rotations***	
A1		Possible	Limited opportunities
A2	√	Yes in second half of year	Limited opportunities
A3	√	Yes in second half of year	
A4	√	Opportunity to extend rotations	
B5, 6, 8	√		
B7	√		Available to all midwives
C9, 10, 11, 14	√	Opportunities to rotate within Area C and to neonatal care.	
C12*, 13*	√		

*TSP not available

Area B

Within Area B, full-time and 0.7FTE part-time options were available but there was no option for midwives to extend or give a preference for their clinical rotation. Hospital B7

was the only institution to provide all the midwives with an opportunity to rotate to a midwifery continuity of care model.

Area C

In the four hospitals in Area C that offered TSPs (9, 10, 11, 14), part-time options were available despite full-time options being encouraged. The midwives were provided with the opportunity to rotate to other hospitals within Area C to gain different experiences. Newborn care was included as an optional rotation for those midwives requesting the experience.

Support from experienced midwives

One element common to all TSPs was the provision of clinical support. As detailed in Chapter 2, 'support' can have different meanings to different people. For example, it may be hands-on clinical support as would be the case in a preceptorship arrangement, or clinical advice or guidance more suited to a mentorship role. Representatives from each hospital site were asked to nominate what type of support was available as part of their TSP. The response to this question was mixed. There appeared to be a level of confusion as to the terminology and definition of support mechanisms on offer. For example, terms such as mentoring, buddying and preceptor were all used interchangeably. While all the responses provided will be discussed, it was difficult to ascertain the level of support on offer, as a result of this confusion.

The degree and frequency with which a named 'mentor, preceptor or buddy' was provided to the midwives varied between sites. However, all sites appeared to have some system in place to ensure that the midwife had a level of clinical support although this was often not the same person from shift to shift. In the postnatal service at hospital A1, an identified 'buddy/preceptor' or resource person was provided for each shift for the first month. Although the buddy/preceptor might sometimes differ with each shift, wherever possible the same midwife acted in this role. Within birthing services after the initial supernumerary

period the midwives worked with the 'clinical support midwife': usually identified as being the clinical midwifery educator for a period of time depending on the individual's needs. In antenatal clinics each midwife had their own identified 'preceptor' who was there as a resource.

At hospitals A2 and A3, whilst support with a clinical 'mentor or buddy' was encouraged it was not mandated. The midwives at hospital A4 retained the 'mentor' they had as a student, to preserve ongoing continuity of learning and support.

In area B support for the midwives varied for each hospital. Hospital B7 allocated a clinical midwifery consultant[7] to the midwives to provide formal 'mentoring' throughout the year. Other facilities provided support in a less structured or formal way. These arrangements appeared to be more 'ad hoc' and informal with the midwives having to identify their own supports as required.

In Area C, the midwives had a list of 'mentors' from which to choose in each clinical area. It was reported that the midwifery unit managers preferred this method rather than attempting to match a mentor with a midwife as they believed this would achieve greater operational flexibility. Overall in Area C they reported that they had 'good support' for the midwives, however, they did not give any indication as to how this level of support was achieved.

Access to clinical supervision

Whether midwives had access to clinical supervision sessions appeared to be more consistently reported than other forms of support. Certainly it was seen as separate to support provided in the clinical environment. Clinical supervision as defined in Chapter 2 is

[7] In the Australian context a clinical midwifery consultant's role encompasses four specific domains: clinical practice and support, education, research and policy.

the opportunity for professional support and education through regular case and/or clinical discussion with peers and other experienced colleagues (Brunero & Stein-Parbury 2008). Hospital A1 reported that clinical supervision was available to the midwives in each clinical rotation. Representatives from hospitals A2 and A3 reported that monthly clinical supervision sessions were planned for the future but had not yet commenced at the time of data collection. Representatives at hospital A4 and Area B made no comment on access to clinical supervision.

The most widespread access to clinical supervision was reported to be within Area C. Hospitals C9, 10, 11 and 14 offered monthly group clinical supervision to all midwives.

Training on offer for experienced midwives to prepare them for supportive roles

Whilst all sites, with the exception of C12 and 13, offered the midwives some level of support from clinical midwifery educators, midwifery educators, clinical midwifery consultants or other experienced clinical midwives, the support offered to these 'preceptor' or 'mentoring' experienced midwives themselves varied greatly. Some sites provided preceptor workshops to prepare the experienced midwives, while others made midwifery educators or clinical midwifery consultants available to the experienced midwives for advice and support. For example, all mentor/preceptor experienced midwives at hospital A1 attended a two-day 'Preceptor Workshop'. Following the workshop a midwifery educator was available in each clinical area for the mentor/preceptor experienced midwife for on-going support and advice. However, this support was reported as being informal and relatively brief in duration.

In contrast to hospital A1, hospital A2 and 3 representatives did not identify any support for their mentoring experienced midwives. The representative at hospital A4 reported that an initial mentoring workshop had been held in 1999 at a local university; however, there had been no subsequent support or training for mentoring experienced midwives since. Area B stated that it was the expectation that all experienced midwives undertaking a

mentoring/preceptoring role attend a ‘Preceptorship Workshop’. However, after training no formal process of support for mentoring/preceptorship-trained experienced midwives was in place. Similarly, there appeared to be no formal support for mentoring/preceptorship-trained experienced midwives in hospitals C9, 10, 11 and 14.

Formal assessment and credentialing exercises

Only hospitals in Area C (C9, 10, 11 and 14) had identified formal processes for assessing the midwives. In these hospitals, formal appraisals were stated to be undertaken at the end of each clinical rotation, at the end of the 12 months and then three months into their second year of practice. The Australian Nursing and Midwifery Council’s (2006) competencies were utilised to review the midwife’s clinical practice at regular appraisals and meetings.

In the other areas, assessments were solely related to ‘new’ midwifery skills or were only for the Bachelor of Midwifery midwives in order to assess their basic ‘nursing’ skills. For example, hospital A1 only assessed the midwives within birthing services. Here they had to undertake what was called an "extended roles" assessment which covered skills such as performance of artificial rupture of membranes, perineal repair, venepuncture, cannulation and fetal scalp electrode application. Conversely, in hospitals A2 and A3 there were no specific TSP assessments required for the Graduate Diploma or Masters prepared midwives. Bachelor of Midwifery midwives, however, were expected to attend and be assessed at a medication workshop that was offered during their orientation. At hospital A2, an introduction to the credentialing[8] process was available but not required until the midwives wished to work in a midwifery continuity of care model.

[8] Credentialing at this time was a process mandated by NSW Health (PD2005_615) to ensure that midwives possessed certain credentials prior to working within midwifery continuity of care models.

Representatives at hospital A4 reported that no assessments or credentialing exercises were required. Likewise, Area B had no formal assessments. However, Area B's representatives did report that the midwives' study days were developed to provide intensive hands-on supervised learning. Within this strategy was an informal system whereby if learning needs were identified for a midwife, this information was shared with the educators to enable them to provide additional support/education as required.

Sharing experiences: opportunities for midwives to debrief and feedback

Debriefing opportunities

Each hospital had some system in place to allow the midwives the chance to debrief[9]. Some sites had regular structured sessions in place whereas others appeared to be more ad hoc. For example, for the first few weeks the midwives at hospital A1 were able to debrief at the end of each day with their educator or preceptor. After this time debriefing was more informal, occurring as and when an issue arose or at the end of the study days provided to the Bachelor of Midwifery midwives. In hospitals A2 and 3, debriefing occurred on demand although it was noted that originally this had been arranged on a weekly basis. In most of Area B debriefing was only included in the study days. The one exception was hospital B7 whose representative stated that they provided regular formal debriefing. Within Area C, hospitals C9, 10, 11 and 14 debriefing occurred within the monthly group clinical supervision offered to the midwives.

Feedback / evaluation

Almost all sites asked the midwives to feedback their thoughts and comments on the study days provided. In general, however, the majority did not seek opinions specific to the TSP. There were some notable differences nonetheless. At hospital A1, feedback on the TSP was

[9] From the information given it appears that the term 'debrief' referred to giving the newly graduated midwives the opportunity to discuss and reflect upon cases, events and experiences with their peers and/or an experienced midwife, educator or manager.

facilitated formally through appraisals at the end of each clinical rotation, and occurred informally with educators throughout clinical rotations. This provided the midwives with the opportunity to give and receive feedback. At the end of each study day for the Bachelor of Midwifery midwives, they were required to provide a formal evaluation. Likewise, hospitals A2 and 3 requested written evaluation of study days. They also reported that the midwives were encouraged to have informal discussion with the clinical midwifery educators, who co-ordinated the TSP, and managers throughout their TSP. In contrast, hospital A4's representative reported no formal process by which the midwives could provide or receive feedback on their TSP.

In Area B it was reported that the feedback and evaluations from the midwives regarding their study days was valued by the clinical midwifery consultant and educators. This feedback provided the basis for any modifications required to the study days in terms of content or structure. However, no structured processes were in place to allow the midwives to formally give or receive feedback on their TSP. Having said this, representatives reported that midwives were encouraged to provide informal evaluations to the clinical midwifery consultant and/or educators on any areas of concern or commendation throughout the year.

Unlike Areas A and B, the hospitals in Area C were the only ones to have comprehensive formal feedback processes in place to provide feedback and to elicit the midwives' thoughts and opinions of every aspect of their TSP. At the end of each clinical rotation there was a formative follow-up with a clinical midwifery educator. In addition a summative follow-up was undertaken with the midwifery unit manager at the end of the twelve-month program along with a performance review. There also was an 'impact evaluation' three months after completion of the program to evaluate its impact and any new developments for the midwife. Table 6 summarises the opportunities provided for the midwives to debrief and exchange feedback on their TSPs.

Table 6 Summary of the debriefing and feedback opportunities provided to the midwives

Hospital	Debriefing opportunities	Opportunity for feedback	
		TSP evaluation	*Study day evaluation*
A1	Initially after each shift then on demand. Clinical supervision available	Formal appraisals and informal feedback	√
A2	On demand	Informal only	√
A3	On demand	Informal only	√
A4	Informally with managers or educator. At study days		
B5, 6, 8	At study days	Informal only	√
B7	Regular formal debriefs arranged also at study days	Informal only	√
C9, 10, 11, 14	Monthly clinical supervision for all midwives	Formal appraisals and formal and informal feedback	√
C12*, 13*			

*TSP not available

SUMMARY

So far in this chapter, I have outlined the structure and common elements of the TSPs offered to midwives in three AHSs of NSW. The approach to transition support varied across and within AHSs with some sites offering no program at all. Two of the areas had opted to develop an area-wide program while in the remaining AHS different programs

were offered at each site. Whilst it was evident that the TSPs all shared common elements such as clinical rotations and study days, differences existed between the programs on offer. The key areas of difference were in the provision and duration of supernumerary time, opportunities to work within midwifery continuity of care models and formal opportunities for feedback and debriefing.

In the next section of the chapter, I will present the midwives' expectations as they commenced their TSPs. The findings are discussed under three main headings: midwives' understanding of their TSPs, their desired goals during the program and how the midwives considered the TSP would assist them to meet their goals.

MIDWIVES' EXPECTATIONS OF THEIR TRANSITION SUPPORT PROGRAMS

As previously described in Chapter 3, a total of 25 midwives contributed data before commencing, or early in their TSP (Phase Two, Time 1). Both the telephone interviews and focus groups were designed to elicit the midwives' understanding of their TSPs, their desired goals during the program and how they considered the TSP would assist them to meet their goals. The findings are thus described under these three headings and where appropriate also include a number of subheadings.

What I understand about my Transition Support Program

The majority of the midwives (n=19) reported that the information provided about their TSP was either limited or in some cases non-existent. Bina's comment, *"it all appears hazy",* is reminiscent of most midwives' response to this question. Others reported that they did not even know there was a program.

While some of the midwives reported receiving snippets of information about their TSP, others expressed how on commencing their program there appeared to be "*nothing set up*" *(Rose),* which resulted in a sense of frustration for many. For example, one midwife said *"we keep getting told different things and no-one appears to be leading the program. We are marked on the rosters as 'beginners' but that doesn't seem to make any difference…"* (*Nancy*). Comments such as "*there is no transition from student to midwife" (Gaye*) and *"I'm just working like everyone else"* (*Anna*) effectively summed up many of the midwives' experiences.

Whilst some of the midwives reported not having a clear understanding of their program, this was not always indicative of a negative experience. For example Lea, who had already commenced her TSP, answered that although she did not have a clear understanding of her TSP at the beginning it was "*working well"*. She did acknowledge however, that "*there was*

always room for improvement". This possibly indicates the level of confusion surrounding the TSP at her hospital.

Only six of the midwives interviewed felt they had a clear understanding of the TSP at commencement (the six were located across four different hospitals). These midwives were able to articulate the aspects of the TSPs they were entering including the duration and venue for their clinical rotations and the opportunities to attend study days. Interestingly, this feedback was contradicted by others: the hospitals where the six midwives worked also employed at least one other midwife who reported less clarity in their understanding of the program. It is worth noting that even those reporting no or limited information about their TSP were able to recount specific aspects of their hospital's TSP such as study days, rotations and a period of support.

What I want to achieve from my Transition Support Program

Participants were asked what they wanted to achieve during their TSP. The midwives' responses were grouped into four overarching themes: gaining confidence; consolidating what I know; gaining 'more' experience and beginning my professional career. These themes are detailed below.

Gaining confidence

The midwives' desire for 'confidence' was clearly evident in the data set with 21 of the 25 making reference to this concept. Overall, the comments related to the general concept of increasing or gaining confidence in their skills and knowledge. One midwife, like many of her fellow graduates, expressed her aspiration to feel comfortable in "*all*" areas. She provided some insight into what this meant when she added, "*I want to feel that the questions I ask are the same as those that a midwife would ask rather than a student midwife" (Bina).*

For others the focus appeared to be their confidence in the delivery or birth suite. The midwives talked about wanting to feel that they were able to cope and make clinical decisions to effectively deal with any situation they were faced with. One participant summed this up when she related her desire to *"feel confident managing what walks through the door" (Anna).* For others the birth/delivery suite experience was framed in the negative. Kim, for example, said she wanted:

> T*o be less scared in Delivery Suite. I am very scared at the moment I get palpitations and chest pain when I am there or just thinking about it. I want to enjoy going to work and not feel overwhelmed.*

This was not an uncommon experience and many of the midwives talked about their level of confidence in making clinical decisions in the birthing area and their fear of *"making mistakes" (Suzie).*

Consolidating what I know

Over 60% of participants (n=15) stated that they wanted to consolidate the skills and knowledge they had acquired throughout their midwifery education. The desire to put their new skills into practice was a priority; however, the need to build upon these skills was also highlighted. One midwife articulated her thoughts in the following way:

> *We need to refresh things that we have done as students but there is no point just keeping us at that level we need to be learning things that are a little more advanced. Encouraging us to think in a more advanced way…we've got this knowledge…this amount of knowledge and skills that we learnt as students and we are consolidating them but have got to be able to be more forward and become more advanced in practice, otherwise you are going to stay at the same level* (*Mandy*).

Whilst midwives clearly verbalised the need to build their clinical skills and knowledge, one participant also introduced the idea of the midwife having to learn and understand *"the system" (Nancy*). She stated that this was because it was *"different when you (were) a*

student." On further questioning it became apparent that there were two distinct aspects to learning the system.

The first related to the 'hierarchical' systems midwives perceived were in place to ensure the work '*got done*' in the clinical area. For example, as students they had observed the experienced midwives, in their role as care givers and advocates for women, consulting and at times negotiating with more senior midwives or medical staff. Now as newly registered midwives they had to utilise their knowledge and skills to decide when and with whom to consult/negotiate. The reality of having to do this posed challenges for some of the midwives as they perceived their status as being at the "*bottom of the ladder" (Tina)*'. Midwives commonly talked about feeling a lack of respect and being "*treated like a schoolgirl" (Fay).* In these situations it was very difficult for the midwives to feel able to navigate the system on behalf of themselves and the women for whom they were caring.

The second aspect articulated by the midwives was related to the realisation that they were now the ones responsible for the woman and her care. As students they were not required to make decisions; as new graduates they were. For most this perceived new responsibility and accountability was significant, with many reporting that it carried a level of "*burden*" and "*stress*" *(Diane)*. Sam shared her concerns:

> *It's just so different now…we provided care (as students) but the buck didn't stop with us…now I am going to have to make decisions and you know I am scared…really scared…the buck now stops with me and I don't think I am ready… you know it is all a bit scary…*

Gaining more experience

Leading on from their expressed need to consolidate their knowledge, the midwives voiced their objective to "*build upon*" and further "*develop" (Quinn)* their clinical skills. For the majority, the gaining of experience in the clinical environment was fundamental to their aspirations for the year. This was expressed well by one of the midwives when she

remarked, "*Experience, Experience, Experience, Experience*" (*Mina*). Central to this was an understanding that their midwifery education had given them the '*basics*'. One midwife clearly articulated this as she explained:

> *When you are a beginning learner you take in what you can, but when you are confident in the basics you can take in more and achieve a deeper knowledge and understanding (Quinn).*

Being exposed to new experiences and having the opportunity to work in different areas was raised by many as being important during their first year. However, it was the opportunity for the acquisition and development of new skills that midwives expected would be the most valuable aspect of their TSP (n=20). The data suggests that the midwives were primarily focused on gaining specific clinical skills such as cannulation, perineal suturing, attachment of fetal scalp electrodes and the performing of artificial rupture of membranes. The midwives considered these skills to be a '*necessity*' as well as representative of being '*a midwife*'. The skills therefore needed '*ticking off*' as soon as possible. One of the Bachelor of Midwifery graduates, however, put this within the context of providing woman-centred care when she commented:

> *I am hoping that the program will include practical skills like cannulation that will enable me to provide total care to women without having to go out of the room and ask for help, for silly things like a line (IV cannula) (Mina).*

The idea of 'skills days' where the midwives had the opportunity to learn new skills and have hands-on practice in emergency scenarios such as shoulder dystocia and neonatal resuscitation was also a popular concept. These days also provided the midwives with the opportunity to further explore subjects such as postpartum haemorrhage and the use and interpretation of electronic fetal monitoring which was seen as advantageous. The enthusiasm of some of the midwives' was evident:

> *I really want to further my knowledge and get some practice…practicing where it doesn't matter if I do something that's not right…things like PPH (postpartum haemorrhage) and shoulder dystocia…don't really think these were well covered in*

my course only really had one and a half hour sessions which was OK for the theory but not enough for me to feel like I could do it properly (Bernie).

Beginning my professional career

Many of the midwives discussed the transitional aspect of the program that would frame and guide their first year as registered midwives and the beginning of their professional careers. Midwives believed their TSP would provide the opportunity for them to explore possibilities that could inform their choices regarding their '*future career paths'*. The comments of one midwife exemplified this desire: "*an opportunity to go and try everything and to see where I fit best in terms of clinical areas*" (*Nancy*).

Several midwives considered the implications of moving from student to midwife. As mentioned above this was often discussed in relation to the increased level of accountability and decision making responsibilities. By the end of their first twelve months many expressed a desire to attain a level of autonomy in their practice: "*by end of the year I want to feel independent as a midwife*" (*Penny*). In this context, independence was defined as being able to provide and make the decisions regarding a woman's care with less reliance on additional support. For example, one of the participants expressed her wish "*to feel competent in the decision making process, to work independently and confidently look after a case*" *(Jane).*

Whilst level of accountability and responsibility was uppermost in many of the midwives' minds the transition from student to midwife was also mentioned in relation to outlook. For example, one midwife summarised her hopes in the following way: *"to be able to work as a midwife and to keep the un-cynical view that I had as a student - to keep the whole joy of the process" (Bina).* Helen told of her wish to *"keep the woman as her focus"* and Suzie spoke of wanting to *"enjoy being a real midwife".*

What I need in a Transition Support Program to achieve my goals

Midwives were asked to identify what factors they believed would assist them during their TSPs. Again their responses can be grouped into three overarching themes: being in a supportive environment, the opportunity to develop new clinical skills and a positive personal attitude. These three themes will now be discussed in more detail.

Being in a supportive environment

Without exception, the midwives all commented on the importance of a 'supportive environment' in assisting them to achieve their goals. This was described by midwives as one where education and learning were valued. It was also seen as beneficial, not just for the midwives but for the unit as a whole. Midwives used words and/or phrases such as '*providing guidance'*, '*advice'*, '*positive culture'*, '*understanding*', '*a willingness to help*' and '*developing relationships*' to describe the elements of positive support.

A proportion of the midwives also believed that having hands-on clinical support and guidance from the experienced midwives and educators was important. These midwives were keen to have someone to physically work alongside, particularly at the beginning of a rotation to a new clinical area. This type of support was generally highly valued.

For others, however, just knowing someone would have the 'time' to be there should they need it was enough and considered to provide a general sense of security. The midwives wanted to know that when they had questions or problems they could go to someone who was willing to spend time with them. For example, one midwife talked about having *"back-up if (I) am out of my depth…I need to know that I can talk over the case with the in-charge (experienced midwife)"* (*Penny*).

The midwives expressed their expectations and desire to be part of the team and establish professional relationships that would endure over time. They specifically expressed their expectation to receive positive support and encouragement from the experienced midwives,

educators and midwifery managers. This support included recognition from experienced staff and managers that the midwives were beginning practitioners – this was particularly pertinent when it came to the developing of clinical skills.

Opportunities to develop clinical skills

As previously alluded to, the opportunity to gain clinical experience was considered by midwives to be paramount in their quest to achieve their first-year goals. Midwives talked of wanting variety in practice in order to develop broad clinical skills. Rotating through the different practice areas was therefore considered an important aspect of their TSP:

> *I want to consolidate the skills I learnt while I was a student…gain experience in all the areas and be allowed to rotate through all the areas in a 12-month period… I want to spend time in (the) birth unit, special care baby unit, antenatal and postnatal. (Mandy)*

Some of the midwives viewed the clinical rotations as an opportunity to experience different aspects of the midwifery role, which would ultimately help them decide where they wanted to practice following their TSP. In this vein, a number mentioned their desire to rotate into midwifery continuity of care models as their career goals were focused on working within these models: *"(I) really want to get some experience in the MGP (midwifery group practice) as that is where I want to end up" (Gaye).*

Along with variety of practice environment, the duration of the rotation was considered an essential component. Midwives associated the length of time in a particular area of practice with the ability to consolidate and develop clinical skills and expertise. As Suzie highlighted,

> *I don't want to just get 3 months on the delivery suite and then the rest of the year on postnatal…I want to get to the end of the year and know that I have developed skills in every area.*

Having the time and opportunity to consolidate and develop clinical skills was expected by many to have a positive impact on their levels of confidence by the end of their TSP.

Given the participants' desire to consolidate and build their skill base, it is perhaps not surprising that more than half of the midwives (n=18) also identified practically-orientated clinical skills and study days as components of a program that would assist them in meeting their goals. Certainly the data suggested that they were all keen to attend such days. Jo in particular discussed how important she thought the study days would be for her to refresh her skills and knowledge in preparation for her clinical rotations. She commented that she *"would like the education days to inject (her) with IV confidence".*

It became clear that the majority of midwives identified a set of specific subject areas and clinical skills that they considered would assist them in their transition year. These commonly included cannulation, perineal repair, emergency skills drills, and K2 (on-line fetal welfare package). Pharmacology knowledge was also identified as a significant learning need by some midwives. This was a result of midwives perceiving that some midwifery curriculums covered this area poorly.

Positive personal attitude

Whilst clinical support and skills development were essential, the midwives also identified that their own attitude would play a role in helping them to achieve their goals. Maintaining a positive personal attitude, whilst only mentioned by a few of the midwives, was an important and interesting concept. Having '*enthusiasm and drive*', '*being positive*' and wanting to '*get on with it (TSP)…it's all up to me*' were comments that clearly conveyed a level of commitment and sense of ownership on the part of the midwives. Kim expressed her personal philosophy as wanting to "*make the most of the opportunity. To be assertive regarding my learning needs with other midwives. Being responsible for my own learning/development".*

Likewise, Jo talked about "*getting out what you put in*" and expressed her desire to get involved in the unit by participating in activities such as "*writing of local policies*". Jo considered this a good way to help the unit she was working in whilst simultaneously enhancing her own education and knowledge.

Summary

The findings presented in this section of the chapter have indicated that midwives entered their TSP with an expectation that the program would enable them to consolidate their existing skills, gain further experience and develop new clinical skills. They believed that supported clinical rotations and study days that focused on clinical skills acquisition would be invaluable in assisting them to attain their goals for the year.

CONCLUSION

In this first findings chapter I have outlined the structure and common elements of the TSP offered to midwives in three AHSs in NSW, along with the expectations of the midwives entering the programs. The approach to transition support varied across and within AHSs with some sites offering no program at all. Whilst difference existed between the TSPs on offer they all shared many common elements. From the midwives' expectations it would appear that the elements of TSPs on offer were germane to meeting their expressed needs. All TSPs offered opportunities for clinical rotation to consolidate and provide diverse clinical experience and study days to assist in new skills acquisition.

In the next chapter I will describe the midwives' experiences of their TSPs elicited from data collected at the end of their transition year. Where relevant these findings will be supported by data collected from the midwifery managers, educators and experienced clinical midwives.

Chapter 5: The Newly Graduated Midwives' Experiences of Their Transition Support Programs

INTRODUCTION

Chapter 5 is the second findings chapter in which I will present the findings of the content analysis of interview and focus group data collected from 38 newly graduated midwives about their experiences of their transition support programs (TSPs). I describe the midwives' actual experiences as they neared the end or had finished their TSP. Where relevant, these findings are supported by the analysis of telephone interview data collected from 16 experienced midwives. Juxtaposing data in this way adds a further dimension in understanding to the new graduate's experiences.

When analysing the data it became apparent that many of the midwives made reference to the clinical practice environment in which they entered as new graduates. This data 'sets the scene' and provides an understanding of how the context of maternity care provision was perceived and experienced by the midwives during their TSP. The maternity care context will therefore be discussed first. I then move on to describe the midwives' experiences of the individual elements of their TSPs. Comments from the experienced midwives' are woven through the discussion where relevant. This section of the chapter concludes with a brief commentary of the experienced midwives' perceptions of the differences between new graduates educated through undergraduate and postgraduate programs.

In the final section of the chapter I describe midwives' overall satisfaction of their TSP in regards to support and achievement of personal goals.

THE MATERNITY CARE CONTEXT

The midwives described the clinical environment as busy and often extremely chaotic. Midwives commonly commented on the lack of staff and/or poor skill mix. Working in these circumstances left many participants feeling stressed and overworked. They also perceived that their midwifery colleagues were also suffering a level of stress as a result of this situation. Morale was reported as being low in many of the units. These aspects were commented on: "*I know it's going to be a long day when I'm the most experienced midwife on the shift"* (*Quinn*). Another midwife, Xena, said that she had not been able to access any one-to-one support herself but had in fact "*mentored a student*". While some may have found this daunting Xena expressed this to be a positive experience and identified it as one of the highlights of her year.

Workloads were reported to be heavy in all clinical areas and the midwives were often expected, despite promises of supernumerary time and/or reduced workloads, to take a full clinical load early in their TSP rotations. The heavy workload and lack of senior staff often affected the availability and were identified by the midwives as impacting on the level of support and experience they were able to access and time permitted for the provision of education and professional development. The midwives felt this situation not only impacted further on their own stress levels but again vibrated across all maternity staff and their working environment as a whole. Cindy commented that: "*it is just crazy busy all the time … no time to catch your breath…no time for anything extra…it's just let's get the work done and go home*". Similarly Lea expressed her frustration at the skill mix stating "[I] *am on with one other midwife…not much more experienced than me…is really scary…how is that support for either of us?"*

These observations were confirmed by a number of the experienced midwives in their telephone interviews, who also alluded to clinical environments that were busy and under pressure and therefore not always suited to provide the level of support and guidance required: "*Support could have been better (but) everyone is very busy.*" (Ester); "*We have*

poor staffing…everyone has to pitch in." (Danni); "*They (midwives) were well supported…but it did depend on skill mix, staff numbers and workload.*" (Isla); "*We do what we can but it is difficult when you are running between rooms… you can only do so much*" (Lena).

Some midwives found themselves in an environment described as a multidisciplinary hierarchy where rules, status and power were valued. The midwives perceived that many of the '*rules*' and '*structures*' they came across were instigated by experienced midwives to control and manipulate the environment on behalf of themselves and the women. The midwives felt under pressure to learn the rules so that they could navigate the system themselves. This appeared to be particularly important for the Bachelor of Midwifery midwives who did not have prior experience of working within a nursing hierarchy. One of the Bachelor of Midwifery midwives commented that she felt "*institutionally disadvantaged*" *(Bina),* while another commented:

> *It's procedures…as a midwife you have the necessary skills already there; but then we also have to learn procedures and corporate culture…how to get around the systems that are in place to be able to practice as midwives and support the women* (*Jo*).

In environments described as hierarchical, the midwives perceived there to be a '*pecking orde*r' that placed them near the bottom, assigning them little or no status or power. Their perception that this was indeed a reality was reinforced in a number of ways. For example, many commented on how they were the ones required to fill staff shortages and/or move to other areas when busy because the more experienced midwives either did not want to, or could not because of their lack of skills: *"We get moved because of staff shortages…other midwives are not skilled in birthing…or they (the experienced midwives) refuse to go." (Kim).* As a result, the new midwives felt that their 'learning needs' were ranked below those of the other experienced midwives and/or the organisation.

In addition to their unmet learning needs, some midwives reported a working environment dominated by fear and intimidation. Midwives considered that they were continually under surveillance from experienced midwives. Feeling '*watched*' and under '*constant monitoring*' represented an additional level of pressure for the midwives, accompanied by the threat of disapproval should they '*step out of line'*. One Bachelor of Midwifery midwife described her experience in the following way:

> *They (the experienced midwives) are just looking at me waiting, waiting for me to make a mistake, waiting for me to step one foot out of line and they are just going to hammer me something shocking. You know, and how do you work like that? (Suzie).*

Whilst there were negative reports of the working environment, there were also comments by midwives verifying that though the clinical environment was busy they were still offered a level of support that assisted them meet their learning needs. For example, one midwife commented that she *"never felt that there was ever a time when I couldn't get help; even when the ward was at its busiest they were always happy to help me" (Mina).*

The TSPs were embedded within these clinical environments. It is not surprising therefore that the environmental characteristics described influenced the midwives' experiences of the individual components of the TSPs. The midwives' experiences and perceptions of the different components or elements of their TSPs will now be presented in greater detail.

THE ELEMENTS OF THE TRANSITION SUPPORT PROGRAM

Of the 38 midwives interviewed at the end of their first year of practice, 36 were at facilities where a TSP was available (a TSP was not available at hospital C12). While these midwives in theory did not have access to a program when they were interviewed their perception was that they were on a TSP. They recounted their experience of being able to access many of the common elements such as clinical rotations and study days. For this reason their data has been included in the analysis.

When midwives were asked to comment on the specific elements of their TSP it was apparent – as the Chapter 4 scoping exercise identified – that the programs differed. What also became obvious was that midwives were not always offered or able to access all aspects of the TSP as detailed in the scoping exercise. For example, the information provided by the hospitals records may have indicated that the midwives had access to four study days although in reality the midwives may only have been able to access two.

As discussed in Chapter 4, the hospitals were asked to detail 12 generic elements of their TSPs. Some of these elements were organisational (duration of the program, documented outcomes, information provided to participants and flexibility of the program), whereas others were more clinically focused (clinical rotations, supernumerary time and study days). While the organisational aspects are important they were not identified as significant for the midwives entering the programs. To gain a deeper understanding of the midwives' experience of their TSPs, the midwives were asked to comment specifically upon the eight generic elements they considered important to TSP: clinical rotations, study days, supernumerary time, opportunities to work in continuity of care models, preceptorship, mentoring, clinical supervision and formal assessments. Table 7 provides of an overview of reported access to these eight elements.

With the exception of formal assessments, the midwives' experiences of each of the TSP elements will be discussed further in this chapter. Formal assessments cannot be explored in any depth as only five midwives reported formal assessments as part of their TSP. This is not surprising given the discussions in Chapter 4 that identified only Area C had formalised assessment processes for the midwives.

Overall, the midwives reported similar opportunities within their TSPs with the exception of supernumerary time (37% reported no access) and access to continuity models of care (58% reported no access); and these opportunities will be discussed in more detail below.

Table 7. The elements of transition support programs experienced by the midwives

Elements of TSP	No. of midwives who reported access to individual elements N=38	% of midwives who reported access to individual elements
Clinical Rotations	35	92
Study Days	33	87
Supernumerary Time	25	66
Opportunity to Work in a Continuity of Midwifery Care Model[10]	16	42
Preceptorship	9	24
Mentoring	4	11
Clinical Supervision	4	11
Formal Assessments	5	13

It is interesting to note that there were conflicting responses from midwives employed within the same facility. For example, some reported access to certain elements such as access to supernumerary time while others mentioned no or limited access. It is impossible to judge if these midwives were treated differently by the facilities or if their perceptions of the situation were altered for some reason. Still more perplexing was the recounting of access to elements such as structured clinical rotations and study days from midwives at facilities where a TSP was not reported to be offered. Again, this may be the perception of the midwives involved or perhaps reflects an underreporting of transition support at these

[10] Usually a Midwifery Group Practice (MGP) consisting of a number of midwives (commonly four to six)) who provide continuity of antenatal, intrapartum and postnatal care to a defined caseload of women.

facilities. However, it may perhaps illustrate a level of confusion in relation to their TSPs as approximately one third of midwives (n=12) expressed that they did not believe there was a TSP at all.

For those who considered themselves on a TSP there was divided opinion. Some remarked upon the lack of clarity, structure and organisation. As one midwife summarised, "(*the TSP) was a disappointment: (I) expected more. We were left to our own devices a lot, there was no organisation and we had no direction or feedback." (Sally*). Whilst some of the midwives agreed, saying they felt as if they had been "*thrown in at the deep end*", others reported that they had found the programs to be well organised with *"everything we needed*." One aspect of 'need' identified by many of the midwives was access to clinical rotations.

Clinical rotations: difficult when the plan was changed

As identified in Chapter 4, all TSPs offered a planned clinical rotation. These ranged from 8 – 16 weeks. Whilst 92% (n=35) of the midwives reported having access to clinical rotations, the duration and variety of experiences offered differed greatly between sites and, for some, within facilities. Some midwives recounted being offered a comprehensive rotation plan that included birth suite, postnatal ward, maternity support program[11], antenatal clinic, antenatal ward and midwifery continuity of care models. Others, however, appeared to have only been offered birth suite and postnatal wards.

Whatever the rotation plan on offer, when the plan was 'known' by the midwife in advance she/he felt able to adapt, pre-empt and prepare for their next challenge. The opportunity to have a pre-planned rotation provided the midwives with a sense of familiarity and left them

[11] Maternity Support Program relates to the provision of postnatal care and support once the woman has been discharged home. The midwives visit the women in their homes to provide postnatal care and advice and may also offer additional support over the telephone.

feeling *"in control" (Mandy*) of their own professional development. This appeared to positively affect their level of confidence. One of the midwives articulated this relationship when she said:

> *Control is central. If I felt in control of the situation I felt confident. When I knew where I was rotating to I had time to plan…I came up with time management strategies for myself to feel in control (Bina).*

Although the midwives were positive about rotation plans, and were happy to have been given a clear plan at the beginning of the year, the reality was that their rotation experience was more often related to clinical activity or staffing issues than their learning needs. The frequent interruption of their rotation plan left midwives feeling like *"gap-fillers" (Bina)* on the roster. Certainly there was evidence in the interviews with experienced clinicians that this was indeed a reality. For example, Doris commented on the *"ad hoc approach"* to clinical rotations at her hospital, while Gloria remarked on how staffing the clinical area was often difficult: *"Sometimes I just can't cover the roster…it's not ideal to always move them (midwives) about…but the area has to be safe".*

A consequence of this lack of structure was a heightened sense of "*distress*" and "*anxiety*". Midwives described losing a sense of control over their working life and being unable to mentally prepare for the experience:

> *You get pulled out to work in other areas when other areas are short… there is never any notice that you will not be in the area you expected…[It] can be very stressful as [there is] no warning or time to prepare for the situation… transitional midwives get used in this way all the time as they are the ones that can work in all areas…our needs are secondary to the needs of the other staff and the student midwives (Gladys).*

The duration of the clinical placement or rotation was another aspect that midwives frequently commented upon. On the whole, most midwives would have liked to have spent longer in each area, and particularly in birth suite:

I had minimal time on the delivery suite … didn't get many births as they went to the students. It would have been better to have more even distribution of time in each area ... I need more experience in birthing (Xena).

Despite some negative aspects, overall the clinical rotations were rated very positively by the midwives. A structured period of time in each clinical area enabled them to develop some level of clinical skill in which they could feel confident. The clinical rotations provided the opportunity to keep their "*skills current*", while developing a further appreciation of the clinical pressures in each area. This allowed them to become a "*flexible member of the team*" *(Mina)* who was valued because they could work in all areas: *"a prized resource" (Mandy).* Many commented on the networking opportunities provided by rotating through the units; the ability to build peer supports in each clinical area was highly valued. What appeared to further assist many in their adaptation to a new clinical area was the availability of a period of supernumerary time.

Supernumerary time: highly valued but not always available

Providing newly qualified midwives with an opportunity to be 'supernumerary' (extra to the normal staffing level) where they are able to work alongside an experienced midwife or clinical educator was a component of most TSPs. Just over 66% (n=25) of the midwives reported being afforded some supernumerary time. However, based on the findings in Chapter 4, 80% (n= 29) should have had access to supernumerary time as only in Area C did the scoping exercise identify that no supernumerary time was provided. When it was available, midwives reported that supernumerary time provided them with an opportunity to be *"eased" (Elle)* into the clinical area rather than being *"chucked into the deep end" (Carla).* It presented midwives with space and time to ask questions, orientate and adjust to their new role without the pressure of taking on a full clinical load. As one participant explained:

Being supernumerary really allowed me to acclimatise, it is so different when you are no longer a student…having to make decisions for yourself… you know it is all

up to you...having someone with me those first few days… you know, to bounce ideas off etc…well, it just made me feel like 'You know, I can do this' (Tina.)

On average, supernumerary experience was fairly minimal. One to two days when a midwife entered a 'new' clinical area was the standard. In most instances, this total was at odds with the evidence provided during the scoping exercise, as outlined in Chapter 4. However, some notable exceptions were reported with some midwives afforded supernumerary periods of between two and four weeks, the latter at one site where the midwives spent four weeks in a continuity of midwifery carer model in a supernumerary role.

As well as receiving reduced time, some of the midwives reported that during their supernumerary day/s the educator or Clinical Midwifery Consultant assigned to them either got called away or "*just left (them) to get on with it*" *(Daisy).* For the most part this did not appear to be perceived negatively, with midwives commenting; *"It was just enough to allow me to be orientated to the ward"* (*Gladys*) and *"It was as much as I needed to get me started." (Bernie).*

Those midwives who were not allocated supernumerary time, however, viewed this extremely negatively. Midwives used words such as "*abandonment" (Sally)*, "*disinterest*" (*Zara)* and "*disappointment" (Elle)* to articulate their feelings. One of the participants, educated through a Masters program, commented:

(I) had no supernumerary time…even though we were promised supernumerary time and an orientation in every area…but (I was) just left to get on with it…(I) was just counted in the numbers…I don't know why, probably staffing problems…but it just wasn't fair…it was really stressful, (and I) thought I didn't want to carry on but I'm OK now (Una.).

These types of feelings were particularly common when midwives discussed their rotation to birth suite.

The birth suite: a stressful experience

Even with supernumerary support, feelings of "*stress*" *(Nancy)*, "*discomfort*" *(Sam)* and "*anxiety*" *(Suzie)* were reported most frequently in relation to the birth suite rotation. The midwives reported that their new-found level of responsibility in this distinct area of practice was particularly overwhelming and difficult to cope with. One of the Graduate Diploma-prepared midwives summed it up by describing birth suite as the "*scariest and most daunting experience because of the intensity of the work and just how much you need to know" (Carla).*

For a few participants, conquering their high levels of distress and anxiety became insurmountable. By the time of the second interview, one participant had made a decision to leave the public hospital system. She stated that the "*level of responsibility is too high. (I) can't come to work with this level of stress and anxiety*" (*Nancy*). This participant opted to go to a private hospital where she considered she would have less responsibility and thus be able to reduce her stress. Another midwife reported not being able to complete her birth suite rotation because of the stress and having to access the staff counsellor to help her cope with coming to work.

The stress experienced by the midwives, particularly around birth suite, was seemingly linked to what participants described as "*their new reality" (Mandy)*: being responsible for making decisions regarding a woman's labour and birth care. The midwives considered this to be a new experience because "*as a student you never have to make a decision on your own" (Bina).*This was something that they did not necessarily feel prepared for. Feelings of apprehension about decision-making were compounded by the "*fear" (Suzie)* of making a mistake. Feeling "*scared*" *(Kim)* about making an error was common among all the participants. Not unlike her colleagues, the midwife in the following scenario expressed her worries as: "*If there is nobody there to ask what do you do?…you've got very little expertise or experience in this area and you know if something goes wrong you're responsible" (Mandy*). Her anxiety was real and she went on to talk about her fear of losing

her registration over *"a mistake" (Mandy)*. Sadly, by the time of the focus group these pressures and fears had led to Mandy's decision to leave midwifery and return to her previous area of work.

One of the strategies to better support midwives in their birth suite rotation was to offer study days that specifically focused on the knowledge and skills required for clinical practice in this setting, for example perineal repair and maternity emergencies. Given the level of anxiety that working in birth suite caused, it is not perhaps surprising that the provision of such study days was highly regarded.

Study days: a popular aspect of the program

Thirty-one midwives (87%) stated they had access to study days. The midwives reported the number of study days on offer ranged from one to seven with the majority attending between two and four study days. These figures are somewhat different to the three to nine stated during the scoping exercise set out in Chapter 4. Confirmation that not all planned study days went ahead was provided by one of the experienced midwives, Ester, who during her interview acknowledged this to be a common occurrence. It is reassuring to note that the midwives did not appear to have difficulty in being allocated time by their managers to attend the study days on offer.

The study days most commonly accessed by the midwives were the two mandatory NSW Health FONT[12] workshops. These were followed in popularity by 'midwifery skills days' which included skills such as the application of a fetal scalp electrode and how to perform artificial rupture of membranes. Breastfeeding, venepuncture and cannulation were also highly rated, with perineal repair workshops only being accessed by a few.

[12] Fetal welfare, Obstetric emergency and Neonatal resuscitation Training

While developing new skills and knowledge at the study days was highly valued, so too was the opportunity to share experiences. Where study days were held exclusively for the midwives the opportunity to spend time with their peers and '*debrief*' was greatly appreciated. When the midwives talked about debriefing they referred to the opportunity of being able to discuss and share their experiences, talk though clinical cases and reflect on their practice in the safe environment of their peer group. One midwife described this experience: *"In the group you learn together; if something didn't go perfectly everyone can talk about it…that way we all learn from the experience"* (*Carla*). Another midwife referred to the level of support and safety she felt: *"You can talk about anything you need to…you don't feel stupid…you don't feel judged."* (Sam).

Whilst attendance at study days provided the opportunity to gain further knowledge and practice skills and facilitated a sense of sharing, it was the 'support' provided by midwifery colleagues that enabled the midwives to consolidate their learning in the clinical area.

Support: the importance of relationships with colleagues

In their telephone interviews, the midwives were asked specifically to comment on three common concepts of support: mentoring, preceptorship and clinical supervision. However, in the dialogue there appeared to be confusion amongst the midwives regarding these three models. In general, the midwives used the terms interchangeably and were not able to articulate any difference between each model. This confusion is not surprising given the similar level of confusion demonstrated by the hospitals in the scoping exercise, as mentioned in Chapter 4. While the midwives' overall experiences of support will be discussed, it is difficult to ascertain whether they accessed support though a specific model – be it mentoring, preceptorship or clinical supervision – as a result of this lack of clarity.

The findings presented in Chapter 4 identified that midwives expected to be *'supported'* throughout their TSP. They used words and phrases such as "*providing guidance"'*, "*having time"*, "*advice"*, "*positive culture*", "*understanding*", "*a willingness to help*" and "*developing relationships*" to describe what they thought support should look like. At the

end of their TSP midwives used similar words and phrases to describe their perceptions of a supportive environment. However, at this time point there was a realisation of needing to have their level of "*newness"* readily accepted and nurtured by managers and staff. In addition, support was discussed as having a working environment where education and learning were valued. This learning culture was seen as being beneficial, not just for themselves, but for the maternity units as a whole. Nonetheless, the focus was very much on the relationships the midwives shared with colleagues. For example, when Kim was asked what support meant for her she answered, *"having someone to go to with a problem, who has the time to spend with you to work through and discuss with you*". Below I will discuss the participants' experiences of support in the first year as midwives.

Midwifery managers: mixed messages

The feedback from the midwives regarding the level of support provided by the midwifery managers was mixed. While some commented that they received a great deal of their support from managers, others reported them as being *"distant", "disinterested" and "unhelpful"*. The managers were perceived as being constantly busy, juggling high clinical workloads along with either a lack of staff or a poor skill mix.

When asked what would you like from the managers, the midwives talked about those in "*positions of authority*" recognising the importance of ensuring clinically appropriate workloads were allocated to them when they were just "*starting out*". Suggestions such as being given a reduced work-load for one week rather than one supernumerary day to acclimatise were common. One midwife summarised for many when she commented that it is useful if the "*midwifery manager and other midwives are understanding and remember what it is like to be a beginner" (Gaye).*

Midwives articulated the importance of having the acknowledgement from the managers that they were still learning. However, there was evidence that some midwives were left in charge of a clinical area, most commonly the postnatal ward, well before they felt ready for this responsibility. Mandy recounted her experience which was similar to others:

> *After three months I was left in charge of the ward as the only midwife and when I questioned it I was told (by the manager) "Oh, you can manage an area 'cause you've got experience as a nurse"…I can manage an area…but I don't have the midwifery knowledge and skills that I feel I should have to be in charge.*

This lack of support was distressing for the midwives and added a further level of stress. Not only did they experience the stress of being in a situation they did not feel prepared for, but they were also stressed by the potential of letting down the already busy manager.

> *On one hand you think "Oh they think I can do this"…gives you a lift…but on the other you are thinking "I can't do this"…You know, it is difficult because if you say "I can't" they (the manager) will have to find someone else* (Tina).

The midwifery educators were also seen as being in a position under pressure.

Midwifery educators: essential but in demand

The role of the midwifery educator was acknowledged and recognised as an important one to the midwives. Some of the midwives related how their allocated educator had worked with them on the first day of each new clinical rotation. This was reported very positively as it provided the midwives with one-on-one time where they did not feel rushed. During the interviews, however, many made reference to the amount of time they had with the educator as well as the availability of the educators. In general, midwives expressed the opinion that there was a lack of midwifery educator positions and as a result they were often not available, or if they were their time had to be specifically requested. The perception appeared to be as far as support from the educators was concerned that *"It is there if you want it but not routinely in place: you have to ask" (Mina).*

Compounding the lack of midwifery educator positions to support learning and development in clinical areas, these positions (where they existed) were often reported as having to take on a clinical workload in addition to their supervisory/mentoring role. The

midwives also articulated their perception that in some units it was the expected norm that the educators' primary focus was the student midwives, not the midwives. Consequently, the midwives felt sidelined and this added to their perceptions of being unimportant. Confirmation of these experiences was again evident in the data collected from experienced midwives. For example, Pearl commented that: "*sometimes there is student overload … so they (midwives) are encouraged to contact the educator once their orientation is complete rather than the educator chasing them*".

There were, however, positive examples of where educators had made individualised plans to support particular needs. For example, Kim reported that she had two rotations to the delivery suite. The first she found very anxiety-provoking and she required additional support. Prior to her second rotation, the educator ensured that she was "*buddied up"* with an experienced midwife and when she rotated onto nights a supernumerary educator was initially rostered on to support her. Vicky reported how her educator when requested "*had spent time to do a couple of case reviews with me about cases I had but was uncertain about."* Another shared Nancy's experience, commenting "*[The] educator [is] fantastic, always available for support*".

With both the midwifery managers and educators under pressure it fell to the experienced midwives to provide support and guidance to the midwives.

Experienced midwives: a lifeline

The midwives considered their relationships with their experienced peers as very important and of significance in terms of development. Most reported that it was the experienced midwives who in fact provided them with the most support and from whom they learned the most. Support appeared to be multifaceted. For some, it was very much about having someone physically present that could "*answer a question*", "*provide guidance in a difficult situation*" or "*check an examination*". For example, Quinn described support as:

> *Being able to utilise their (the experienced midwives') experience…to use the team around you to ask about anything I am unsure of…knowing they are there.*

For others, it was simply about making them feel welcome and part of the team. As one midwife expressed:

> *(To) feel like I belong…like I can ask for help like the other (experienced) midwives without them (experienced midwives) thinking 'Oh, there she goes again asking something stupid'* (Bernie).

The experienced midwives' ability to make the working environment enjoyable was also an aspect of support that midwives valued. One midwife's comment is reflective of many when she said that *"support from midwives makes a huge difference … can make a shift fabulous"* (Nancy).

The importance of belonging was something that the experienced midwives also articulated in their interviews. They stated that one of their roles was to accommodate and integrate the new midwives into their teams. At times they considered this difficult as a result of some clinical rotations where the midwives were frequently moving. Gloria, a midwifery manager, commented:

> *With rotations sometimes they (the midwives) felt like they didn't belong…we tried to give support as best we could…[we] included them whenever possible in the unit's activities, things like meetings etc…*

Sometimes the level of support provided by the experienced midwives was associated with a sense of internal conflict. Whilst the midwives were reliant on support, they simultaneously experienced a sense of guilt for potentially increasing the experienced midwives' workload in the context of already overworked and stressed staff. For example, Dianne said *"I felt the burden on senior staff".* Similarly, Helen identified her appreciation of this additional demand on staff: *"All the midwives have been so fantastic and it is just luck that they are all willing to work so hard"*.

While there were many positive examples in the data set, there were also a number of reported interactions with experienced staff that were considered as negative and

unsupportive. In the earlier section outlining the maternity care context, there was evidence that in some environments experienced midwives fostered a sense of fear and intimidation in the midwives:

> *Some midwives are much more supportive than others. Some were very unhelpful, when you would go to them with a problem they would undermine your confidence (Kim).*

These experienced midwives often added to the midwives' anxiety and impacted their ongoing development. *"I did not achieve what I wanted to…I do not feel confident…it was hopeless…they treated me like a schoolgirl." (Fay).* Once again there was evidence in the interviews conducted with experienced midwives that this was indeed a reality. For example, Ester commented: *"Staff's attitudes could be improved",* while another experienced midwife, Claudia, acknowledged that *"We sometimes are not as supportive as we could be … [It's] difficult to always help when we are all so busy."*

It should be stressed however that, while some experiences were negative, the overall impression was that it was the experienced midwives who offered the most comprehensive clinical support to the midwives, for which they in turn were grateful. The final source of support mentioned by the midwives came from their peers.

Peer support: sharing together

Many of the midwives identified the value of peer support. They appreciated the aspects of their shared experience where they were all trying to consolidate their skills and knowledge in the same challenging environments. As such, many felt able to share their "*ups and downs*" with each other. This provided a level of support that assisted them during their TSP. For example, Sam stated:

> *We have each other…we all know how hard it is…it is so good to be able to say 'Hey, you know this happened today and I feel …', they just get what you mean 'cause they are going through it too.*

The expressed value of the organised 'debriefs' held within the study days has already been mentioned above. These debrief sessions, usually facilitated by the midwifery educator, provided the midwives with the opportunity to reflect on their practice in a supported non-threatening environment. They reported that they learnt much from the opportunity to talk though real cases and explore the clinical scenario with each other. However, many reported that these sessions were not regular enough. Kim expressed her desire for *"more support"* in the form of:

> *Weekly or fortnightly sessions with the educators when you can go and discuss topics, issues and concerns with other TSP midwives and sometimes include all staff – especially if there has been an incident where there needs to be a debrief or opportunity for discussion (Kim).*

At some hospitals informal 'debriefing' sessions (outside of the allocated study days) where the midwives could regularly come together with an experienced midwife to discuss cases and experiences were an identified aspect of the TSP on offer. However, in practice these sessions often did not happen: the busy clinical environments taking priority for the midwives and their managers.

While opportunities for the midwives to get together were considered infrequent, the midwives reported how they maintained communication in order to "*be there"* for each other. *"We always make time to see each other…to debrief if needed…keeping in contact…making sure we are all OK"* (*Nancy*).

The sense of camaraderie and support that the midwives felt with one another was evident in many of their comments.

> *When we're in a clinical area we text message when things had gone wrong…like when you make mistakes with VEs etc…sharing this made us realise that everyone was in the same boat…the shared experience is so important (Bina).*

Whilst all the graduate midwives were, in theory, able to benefit from the support of their peers and experienced midwives, those who were provided with the opportunity to rotate

into midwifery continuity of care models were fortunate to receive an additional avenue of support. The support obtained within the continuity of care models was highly valued and had a positive impact on their confidence.

Midwifery continuity of care models: an added bonus for some

The midwives who were given the option to rotate into, or work within, a midwifery continuity of care model rated the encounter highly. The opportunity appeared to provide the midwives with a level of support not always experienced in their other clinical rotations. From the data it is not possible to say definitively what aspect of the model engendered these feelings of support. It may have been the shared philosophy of care that the experienced midwives working within the model demonstrated, or perhaps the environment of the model that fostered a supportive atmosphere.

> *Being part of a group that was much less hierarchical than the hospital… It was all about the women…They (MGP midwives) were open to teaching me…there was much more time to be reflective on what you were learning (Bina).*

What is clear from the data is that the midwives reported feeling extremely supported within the midwifery continuity of care models. The consequence of this level of support was an increase in their learning, clinical confidence and competence. Mina expressed this when she commented:

> *(I) loved it because in the continuity of care model as a midwife it enabled you to really work within your scope of practice…made you think about safe practice…quite challenging. (I) learnt so much.*

Whilst often only a short clinical rotation (at an average time of four weeks), the time spent within the model appeared to enhance the midwives' level of confidence in the long term and stayed with them into other clinical rotations. For example, one midwife reported that:

As a TSP midwife [it's] great to have that one-to-one support from the midwives…the four weeks in Midwifery Group Practice (MGP)[13] *was fantastic and helped with my anxiety on the delivery suite (Tracey).*

The midwives valued how the midwifery continuity of care midwives focused on their relationships with the women and supporting normality. Bina expressed how working within the midwifery continuity of care model was like *"an injection of normality".* This sentiment was repeated by others working in the continuity of carer models as it appeared to provide a sense of what 'being a midwife' was all about. As one midwife described:

The relationships built between the midwives and the women are so much better…the woman is supported much better…(the women) seem happier regardless of outcomes...normal birth is encouraged…(I) have seen lots of water births...it's what midwifery is (Kim).

No midwife reported feeling stressed or anxious when working in a midwifery continuity of care model. Sadly, as identified in the scoping exercise, these opportunities were extremely limited with only one site offering all midwives a rotation into midwifery continuity of care model. Despite this, it is interesting to note that 16 midwives (44%) reported that they did have access to a continuity of midwifery carer model. It appears that rather than being offered the rotation these midwives were able to apply for positions within the models when vacancies became available.

Whilst having access to continuity of care models was advantageous for the successful midwives, it had the potential to frustrate their peers who were not as fortunate. Across all hospitals there were midwives who expressed their dissatisfaction at the limited opportunities to work within a midwifery continuity of care model. Midwives reported how they were leaving their organisation and TSP in order to access models elsewhere. For

[13] MGP at these sites was the name given to the Midwifery Continuity of Care model.

some, missing out on this experience was believed to have impacted on their professional development and future career. Elle for example said:

> *I want to go to the group practice but have only been able to get experience in the hospital…now I will have to unlearn things as it is a different focus.*

Similarly Zara explained*:*

> *I feel professionally disadvantaged as the opportunity to work in a group was taken away from me…without this experience (I) think it will be difficult for me to get employment in a midwifery model.*

The level of support that the midwives received from their rotation into a midwifery continuity of care model is evident. One other aspect of support not yet addressed in this section is that of the provision and receiving of regular feedback.

Receiving feedback: a supportive interaction

When reflecting on their experiences of their TSPs, midwives expressed how important receiving feedback was to them. It was considered an essential element of support that ought to be integrated into all TSPs. Midwives verbalised that without comment, reaction or criticism on their performance they were unable to gauge their progress and/or refine their on-going learning needs. However, despite this articulated need, many of the midwives reported a lack of both formal and informal feedback. The statement from Bina below conveys this point well:

> *I felt like a rabbit in headlights with no direction or feedback…not even from the managers…(I had) no sense of what is normal…didn't know if I was asking too many questions…I just wanted someone to say "This is what you are doing well and this is what you need to* work *on"*

The limited feedback reported by the midwives is perhaps not surprising given the responses from the hospitals outlined in Chapter 4. In the scoping exercise hospitals

reported that, for the most part, feedback mechanisms were informal and typically related to the opportunity to feedback on the content of study days only. The opportunity for the midwives to receive regular formal feedback on their performance and progress was limited and was an aspect of the TSP that many articulated as being in need of improvement.

The desire to receive commentary on their clinical performance was so strong that any feedback was generally considered worthwhile. Having said this, the midwives did state that negative feedback should be provided in an empathetic, supportive manner:

> *I am not adverse to getting criticism if it is given to you in the right way…if you are in a supportive environment you can cope when someone comes to you and says "You did such and such…let's fix that", but if you're not feeling supported you just feel like you're under attack (Suzie).*

When midwives received regular, positive and/or negative feedback they were able to feel confident about the care they were providing. They were reassured that they would know if they were doing something wrong. Jo shared how getting positive feedback made her feel:

> *When you receive that feedback you know I must be doing something right… a personal pat on the back…it makes your day a little brighter.*

It is not difficult to see how this would increase a midwife's confidence. The midwives appreciated feedback from all avenues: from their peers, the experienced midwives, midwifery managers, midwifery educators and particularly from the women they cared for. Vicky discussed how it was important to her to get *"a woman's feedback following care: I always go and see women after their birth and I always get feedback which (gives me) more of an insight."*

In this chapter I have outlined the midwives' experiences of the specific elements of their TSPs. Some elements of the programs appear to be more highly valued than others; however, each unquestionably affected their overall experience of their program. Nonetheless, while a midwife may have been disappointed with one or more aspects of the

program, it does not follow from an objective standpoint that the program failed to meet her overall needs. Therefore, whilst individual experiences are relevant one must view the TSP as a whole in order to assess its success in meeting the needs of the midwives.

DID THE TRANSITION SUPPORT PROGRAMS MEET THE MIDWIVES' NEEDS?

In their pre-program telephone interviews midwives articulated their expectation that the TSP would provide support to enable them to achieve their goals. To ascertain if the TSP had met these expectations, the midwives were asked at the end of their year if they felt supported in their program and if they had achieved their personal goals. The responses to these questions will now be reported.

As outlined earlier in this chapter, the midwives' experiences of support were wide-ranging. Support was attained from many sources and individuals potentially required different levels of support at different times of their TSPs. For example, it is evident from the data that the clinical rotation to birthing services was one where the midwives required high levels of practical support. Support also came in many different guises from hands-on clinical support and guidance to formal educational sessions. That the midwives expected and required support is indisputable; answering the question of whether the midwives felt supported by their programs in general is therefore the next most pertinent step. Table 8 provides a summary of the midwives' responses.

Table 8. Did the midwives feel supported in their Transition Support Programs?

	Yes		*No*		*'Sort of'*	
All Midwives	22	58%	13	34%	3	8%
Postgraduate Midwives (Grad Dip and Masters)	11	52%	9	43%	1	5%
Bachelor of Midwifery Midwives	11	65%	4	24%	2	12%

Whilst over half of the all midwives interviewed said they felt supported, it is interesting to note that the Bachelor of Midwifery midwives felt more so than their postgraduate colleagues. Although a slight difference was noticeable as to the perceived level of support provided, when asked if they had achieved what they wanted to from their TSPs the two groups similarly expressed that they had achieved their personal goals by the end of their TSP (Table 9).

One quarter of the midwives, however, stated that they did not achieve their goals. Typically these were the midwives who were dissatisfied with aspects of their TSP such as; lack of one to one support in the clinical area, limited duration of birthing suite rotation and no opportunity to rotate into continuity of care models.

Table 9. Did the midwives feel they had achieved their goals through their Transition Support Program?

	Yes		*No*		*'Sort of'*	
All Midwives	23	61%	9	23%	6	16%
Postgraduate Midwives (Grad Dip and Masters)	13	62%	4	19%	4	19%
Bachelor of Midwifery Midwives	10	59%	5	29%	2	12%

The effectiveness of the TSP could be viewed in terms of both the level of support the midwives reported and the achievement of goals. The retention of the midwives at the end of the transition year could also be another measure of the relevance and importance of TSPs.

During the recruitment phase of the study the midwifery educators in each facility were asked to provide the numbers of newly graduated midwives employed within their unit. From this data (collected at Time 1 and Time 2) it is possible to gain an insight into retention rates of this cohort of midwives.

A total of 16.3% of the midwives left during their transition year. The reasons for the midwives' departures were not collected as this fell outside the remit of this study. However, from those who took part in the telephone interviews and focus groups, the data suggests that it was either the desire to seek opportunities in midwifery continuity of care models or the decision to leave the midwifery profession that prompted these resignations. Table 10 details the number of midwives leaving their hospitals of initial employment.

As demonstrated above there did not appear to be major differences identified between the Bachelor of Midwifery midwives and their postgraduate colleagues in relation to their overall experiences of their TSPs. In analysing the data regarding their experiences of each element of the TSPs; again, no real differences were evident. It was surprising therefore to find that the experienced midwives commented upon dissimilarities in the two groups of midwives.

Table 10. Number of midwives leaving hospital of employment during transition year

	At the beginning of the 2008 Transition Year	Left before second interview (Time 2)	Left after second interview (Time 2)	Total
Bachelor of Midwifery	17	0	2 (11.8%)	2 (11.8%)
Post Graduate*	63	8 (12.7%)	3 (4.7%)	11 (17.5%)
Total	***80***	***8 (10%)***	***5 (6%)***	***13 (16.3%)***

* Graduate Diploma and Masters

EXPERIENCED MIDWIVES' PERCEPTIONS OF THE DIFFERENCES BETWEEN THE BACHELOR OF MIDWIFERY AND POSTGRADUATE MIDWIVES

In their telephone interviews, the experienced midwives were not asked to comment upon their personal comparisons of the midwives educated though different programs: the Bachelor of Midwifery graduates who had no prior nursing experience, and the Graduate

Diploma and Masters graduates who were previously nurses. However, more than half of the experienced clinicians (n=11) made reference to perceived differences between the Bachelor of Midwifery graduates and their postgraduate colleagues.

Interestingly, amongst those clinicians who mentioned a 'difference' there was no consensus of opinion. Approximately half (n=6) believed that there was no difference between the two groups and they all required the same level of support as 'beginning practitioners'.

> *Once they are qualified I don't like to differentiate between Grad Dips and B-Mids although other staff might. I did not find great differences between Grad dips and B-Mids* (Doris).

The remaining experienced midwives (n=7) believed there were differences necessitating additional supports. Surprisingly, it was not only the Bachelor of Midwifery graduates that were seen to require additional support.

It was acknowledged that Bachelor of Midwifery graduates did not have prior nursing skills to draw upon and this was seen as a hindrance by some. Areas such as *"time management", "awareness of policies and procedures"* and *"knowledge and dispensing of medications"* were identified by educators and managers as priorities for additional development and support. Gloria believed that the Bachelor of Midwifery graduates *"needed more support through an extended orientation program … but the postgraduate midwives needed less support overall because they were RNs 'in a previous life'".* Although it would be interesting to enquire if the postgraduate midwives themselves believed this, certainly the experiences of some of the postgraduate midwives as detailed above would not support this view.

Whilst it is true that the Bachelor of Midwifery graduates did not have prior nursing experience, this was not always seen as a negative. Many discussed how the Bachelor of Midwifery graduates had a different approach to their postgraduate colleagues and this was viewed as advantageous. Isla's comment that *"(Bachelor of Midwifery midwives) were*

more mature age with children themselves so they knew about childbirth. Some of the postgrads were medicalised" was similar to that of Esther who explained her thoughts further:

> *It is easier for the BMs (Bachelor of Midwifery midwives) to adapt to the midwifery philosophy compared to the others (postgraduates)…they have a nursing background and are task-oriented.*

In Danni's opinion a positive aspect of the Bachelor of Midwifery graduates was that they did not have a nursing background first; she felt that this *"made it easier for them to learn new things rather than unlearn old habits*". As such, there was a belief that the postgraduate midwives also required additional support to *"help them to identify the normal versus the abnormal" (Claudia).*

It would appear that it was the experienced midwives' belief that, regardless of the program of education undertaken, newly graduated midwives all benefit from some level of support and guidance as they transition into working life as midwifery professionals.

CONCLUSION

In this chapter I have reported on the midwives' experiences as they neared the end or had completed their TSP. The findings suggest that the busy, chaotic clinical environment where workloads were high and skill mix often poor, impacted on participants' experiences of their TSPs. This information sets the scene and enables an understanding of how the individual elements of the TSPs are provided within, what is at times, a challenging environment.

The midwives' recounted experience of the elements of their TSPs was often at odds with the details of their programs as outlined in Chapter 4. For example, clinical rotations were often changed at short notice and supernumerary time was regularly reduced. The discrepancy between the expected and actual program resulted in increased stress and

anxiety for some midwives. The birthing environment was identified as the clinical area which elicited the greatest level of apprehension for the midwives whilst those with the opportunity to rotate into a midwifery continuity of care model rated the experience positively. More than half of the midwives believed that they had met their goals and been supported by their TSP. Whilst this is a positive finding, given the challenges of the clinical environment, it is of concern that more than 16% of the midwives had left their TSP before the end of their first year of clinical practice.

Chapter 5 also included a short section on the views of the experienced clinical midwives who participated in the new graduates' TSPs. It is evident that they believed all newly graduated midwives, regardless of their previous experience, required a level of transition support as they moved from student to registered midwife.

In Chapter 6, I will bring together the findings of both Chapters 4 and 5 discussing both in relation to the available international literature. I will conclude by making recommendations for education, practice and further research based on the findings and associated discussions.

Chapter 6: Discussion

INTRODUCTION

Supporting newly graduated midwives to make the transition from student and beginning practitioner to qualified, confident midwife is essential to the quality and safety of maternity services. There is, however, limited national and international research focusing on the specific transition support needs of the newly graduated midwife. As a result we do not have a clear understanding of what newly graduated midwives expect of their transition support programs and we have limited understanding of their experiences within programs. This study was undertaken to provide additional knowledge and understanding in this under-researched area. It aimed to firstly identify and describe the transition support programs (TSPs) for newly graduated midwives offered by hospitals within three Area Health Services (AHSs)[14] . Subsequently, the study aimed to describe 38 newly graduated midwives' expectations and experiences of their TSPs. Lastly, it elicited the perceptions of 16 experienced midwives regarding the support offered to the newly graduated midwives employed within their organisations. This data was collected in an attempt to further understand the new graduates' experiences of their transition support programs.

In this chapter I will discuss and explore the study's findings in relation to the contemporary literature on the topic. In the first section I will consider the expectations of the newly graduated midwives of their transition support programs. As part of this review I will reflect on the consequence of one's attitude and the benefits of possessing a positive outlook. This will lead onto a discussion of the availability of programs to support transition, specifically looking at access to and standardisation of programs. Subsequently, the newly graduated midwives perceptions and experiences of their TSPs will be examined in relation to the evidence currently available. The value of clinical rotations will be explored along with the impact and influence of differing clinical environments on the new

[14] This research was conducted prior to NSW Health's restructuring of the state into Local Health Districts.

graduates' development. The many aspects of support will then be examined. Finally, based on the study's findings and related literature, I will identify recommendations for education and practice along with suggested areas for future research.

NEWLY GRADUATED MIDWIVES' EXPECTATIONS OF TRANSITION SUPPORT PROGRAMS: THE IMPORTANCE OF ATTITUDE

The expectations which newly graduated midwives held of their TSP resonate strongly with those expressed in the international literature. In common with their nursing and midwifery peers, the newly graduated midwives in this study identified that they expected their TSP to assist them to gain confidence, consolidate their knowledge and skills and provide them with relevant clinical experience (English National Board for Nursing and Midwifery 1998; McKenna & Green 2004; Mosley 2000; Wangensteen, Johansson & Nordstrom 2008). In addition, and similar to the reported literature, the newly graduated midwives also believed that a supportive environment within which they had the opportunity to develop and expand their skill base was essential in helping them to meet their goals (Deasy, Doody & Tuohy 2011; Johnstone, Kanitsaki & Currie 2007; McKenna & Green 2004; Wangensteen, Johansson & Nordstrom 2008).

One of the goals expressed by many of the newly graduated midwives related to their vision of themselves as professionals. Entering a TSP was expressed as a major milestone for participants as it marked the beginning of their professional career. The findings support the notion that newly graduated midwives expected their TSP to assist them to become autonomous and able to make decisions independently. This concept was explored by Maben and Clark (1998), who similarly identified that new graduate nurses considered the progression from having to ask for help or guidance to an autonomous state as a "significant rite of passage" (p. 152). When achieved, this progression signified that a successful transition had occurred.

The findings of the study reported in this thesis also suggest that some of the newly graduated midwives acknowledged and recognised the way in which they approached their TSP was likely to be a factor in achieving their goals. For example, having a positive personal attitude was considered important to achieving a successful transition. Interestingly, this is not an element that has attracted a great deal of attention in existing TSP literature. The recent work of Butler, Fraser and Murphy (2008), however, sheds more light on this aspect and supports the findings of the study presented in this thesis. When investigating the concept of confidence at the point of registration with 39 newly qualified and 20 experienced midwives in Ireland, the researchers identified three essential competency categories for newly graduated midwives. One of these was specifically focused on the importance of the new graduate having the "right attitude" (Butler, Fraser & Murphy 2008, p. 263).

The midwives in Butler and associates' (2008) study emphasised the importance of having a positive attitude and being motivated, particularly at the point of registration. Similarly Johnstone, Kanitsaki and Currie (2007), in their year-long study of Victorian newly graduated nurses, identified attitude and motivation as moderating the experience of the nurses' transition year. They found that high levels of 'self-support', which they defined as the new graduates ability to be proactive in seeking experiences and support, was associated with more positive assessment and experience of the new graduates' TSP (Johnstone, Kanitsaki & Currie 2007).

Understanding of the potential importance of one's own attitude and motivation on successful transiting can be gleaned from reviewing the psychology literature. Here there is a large body of evidence that clearly demonstrates a correlation between a person's career success and their personality traits (Gelissen & de Graaf 2006; Groves 2005; Judge et al. 1995; Judge et al. 1999; Mohanty 2010). For example, Judge, Higgins, Thoresen and Barrick (1999) used data from three longitudinal studies commissioned by the Institute of Human Development at the University of California, to examine the relationship between personality traits and career success. The researchers used the well evaluated 5-factor

model of personality which categorises almost all aspects of personality (Judge et al. 1999). The dimensions of the 5-factor model include: neuroticism, extraversion, openness to experience, agreeableness and conscientiousness. Judge et al (1999) found that having a negative outlook on life, categorised under the dimension of neuroticism[15], was negatively related to career success. In an earlier study undertaken with over 1,000 US executives Judge, Cable, Boudreau and Bretz (1995) describe how participants who demonstrated motivation were more likely to succeed. Gerber and Saiki's (2010) recent work supports these findings. Using a qualitative methodology these authors sought the opinions of 31 US fashion industry professionals regarding their definitions of career success and what they considered to be the influencing factors to attain success. Participants identified motivation and a positive attitude as two of the attributes required for success.

Reviewing the psychology literature highlights the importance of new graduates maintaining a positive attitude, and level of enthusiasm for their new career, on entry to and throughout their transition year. How to ensure that these are maintained for the duration of their TSP is less evident. However, Yongmei, Jun and Weitz's (2011) recent study may provide some further insight. Yongmei et al (2011) surveyed 129 retail industry interns in the US following the completion of their internship. They found that the level of support and the knowledge gained as a result of their internship was directly related to their level of satisfaction with their roles and their overall attitude towards their career (Yongmei, Jun & Weitz 2011). Not surprisingly, the greater the support, the more interns learned, the higher reported satisfaction with the internship organisation and their career path (Yongmei, Jun & Weitz 2011). Whilst it is acknowledged that the retail industry is very different from a health services environment, one can draw important parallels to the benefits of providing inexperienced staff with support and access to learning. Support and access to learning are the fundamental ingredients of a TSP. In the next section, I will outline the conflicts in relation to the availability of TSPs against the rhetoric.

[15]Neuroticism is defined here as including factors such as self-pity, victimisation and a having a tendency to feel cheated (Judge et al. 1999).

AVAILABILITY OF TRANSITION SUPPORT PROGRAMS: THE RHETORIC

In this section of the chapter I explore two concepts related to the availability of TSPs: access and standardisation. With reference to Australian and international literature, I will outline the value of access to programs for all newly graduated midwives and the need for a standardised approach to ensure quality and consistency.

Accessing transition support

The findings of this study, which included a scoping exercise of the availability and content of TSPs in three AHSs in NSW, identified that not all newly graduated midwives employed in 2008 had access to such a program. This was despite the evidence clearly demonstrating the benefits of providing new graduates with structured support as they make the transition from student to registered practitioner (Clark & Holmes 2007; Department of Health 2004; Fleming et al. 2001; Heath et al. 2002).

As outlined in Chapter 2, well-planned and implemented TSPs increase confidence, enhance clinical competencies and improve retention rates of newly graduated staff (Altier & Krsek 2006; Beecroft, Kunzman & Krozek 2001; Boon et al. 2005; Heath et al. 2002; Park & Jones 2010). In addition, Hughes and Fraser (2011) argue strongly that TSPs should commence as soon as possible following graduation. In their UK study a delay in commencing a TSP was shown to result in increased levels of stress in the new graduates (Hughes & Fraser 2011).

While the value of ensuring new graduates have access to a TSP has been acknowledged for some time, there is limited literature pertaining to the needs of newly graduated midwives. This is particularly the case for those who are nurses and have undertaken a postgraduate course to register as midwives. One might question why this is the case. I would suggest that it might be due to the belief that as registered nurses the postgraduates do not require the same level of support as their non-nursing colleagues. This assumption is

substantiated by the work of Begley, who found that staff had high expectations of student midwives who were also registered nurses. Ultimately this resulted in students' feeling burdened with too much responsibility (Begley 2001).

Further research is required to explore the level and value of support for this group of newly graduated midwives. However, the opinion of the experienced midwives reported in this study was that all newly graduated midwives, regardless of the education program undertaken, would benefit from some level of support and guidance as they transitioned into working life as registered midwives. This belief is supported by the available literature, which suggests that as all newly graduated midwives are beginning practitioners they correspondingly require a level of initial support (English National Board for Nursing and Midwifery 1998; Fleming et al. 2001). Given the strength of the evidence now available it seems clear that all newly graduated midwives should have access to a TSP.

Ensuring the quality of transition support programs: the need for standardisation

As previously stated in the literature review, Heath et al (2002) in their National Review of Nursing Education made three recommendations to provide a standardised approach to the development of transition support programs across Australia:

1. "A national framework should be developed for the transition programs to provide guidelines and standards for institutions;
2. State and Territory nursing (*and midwifery*) registration boards should accredit transition programs; and
3. Employing institutions should be responsible for meeting the standards" (p. 144).

Some eight years later the Australian Nursing Federation (which also represents midwives), in its 2010 policy on midwifery education, stated that both nurses and midwives require "support when making the transition from education to practice…this support includes transition to practice programs…" (Australian Nursing Federation 2010a, p. 2, 2010b).

Despite these recommendations there remains no Australian national framework to provide standards regarding the transition of the new graduate.

Although ensuring access to standardised TSPs for new graduates appears not to have been high on the Australian health agenda, the United Kingdom (UK) Department of Health has recognised the invaluable contribution that TSPs make to graduate experiences (known as preceptorship programs in the UK). In 2010 the UK Department of Health released its *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals.* This practical guide outlines the standards that underpin effective transition for newly registered clinicians to ensure quality and equity of access across England (Department of Health 2010). The definition of preceptorship used within the document asserts:

> *A foundation period … for practitioners at the start of their careers will help them begin the journey from novice to expert. This will enable them to apply knowledge, skills and competences acquired as students, into their area of practice, laying a solid foundation for life-long learning* (Department of Health 2010, p. 8).

The framework suggests a six-to-twelve month program and provides outcome measures to assist organisations monitor the success of their programs. Outcomes include evidence that all newly registered staff have access to a program, retention rates of new graduates, numbers of related clinical incidents reported and new graduate sick leave rates (Department of Health 2010). The suggested duration of TSPs varies in the literature from four months to the end of the first year of professional practice (Altier & Krsek 2006; Begley 2007; Department of Health 2010; Levett-Jones & Fitzgerald 2005; Park & Jones 2010). However, it is suggested that the first four to six months are the most stressful for the new graduate and represents the period during which they require the most support (Duchscher 2009; Schoessler & Waldo 2006).

The framework also asserts that programs should be individualised to meet the needs each practitioner, a strategy recognised to be effective in assisting new graduates to meet their

goals (Hughes & Fraser 2011; Parker, Plank & Hegney 2003). Acknowledging the need for individualisation, the framework nonetheless provides core elements to be included in the design of programs to enhance learning and consolidation (Department of Health 2010). These core elements include: one-to-one support, opportunities to use and develop clinical skills and knowledge (gained through clinical rotations), theoretical/clinical study days (four to six in total), opportunities for group discussion and reflection, goal-setting and regular feedback from preceptors (Department of Health 2010).

Like the UK the New Zealand College of Midwives' promotes an individualised approach to transitional support. The *Midwifery first year of practice program* first piloted in 2007, provides flexibility whilst supporting the new graduate with clinical practice support, education and professional development the participant is able to define their own learning and development needs (New Zealand College of Midwives 2011).

Many of the core elements recommended in the UK and New Zealand models were available within the different programs offered across the three AHSs researched in this study. For example, all programs offered the opportunity for clinical support, teaching and learning and the opportunity to attend educational or study days. However, the findings of this study clearly identified that there was no capacity to personalise the programs to meet individual needs of graduates, nor were there opportunities for the new midwives to set individualised goals. Additionally, the programs offered limited opportunities for the provision of feedback to the newly graduated midwife. The impact of these shortfalls will be discussed later in this chapter as the experiences of the new graduate midwives are explored.

Given the lack of national and NSW guidelines or standards concerning the transition of newly graduated midwives and nurses, it is to be commended that Areas A and B – and for the most part C – recognised the importance of offering a TSP to their newly graduated midwives. The development of national standards to formalise the provision of TSPs for all newly graduated staff is essential, as it will safeguard equity of access to TSPs and regulate

the content and ensure quality of these programs. National standards require outcome measures similar to those identified in the UK framework to enable individual hospitals both public and private, Local Health Districts and Departments of Health to review and monitor the provision and success of TSPs.

THE REALITY OF TRANSITION SUPPORT PROGRAMS: NEWLY GRADUATED MIDWIVES' DESCRIPTIONS AND EXPERIENCES OF THE CORE ELEMENTS

What newly graduated midwives expected was often at odds to what they experienced although this was not always identified in the negative. In this next section, I will focus on certain core elements of the new midwives transition programs specifically: on the aspects which appear to hold the greatest significance namely, the provision of clinical experiences, clinical environments and the concept of support.

The programs – an overview

As described in Chapter 4 TSPs were available at 12 of the 14 hospitals included in this study. However, exploring midwives experiences revealed that the content and outline of the individual TSPs were often not clearly articulated to the newly graduated midwives participating in these programs. At the beginning of their programs many of the newly graduated midwives had a limited understanding of their TSP. This lack of clarity commonly persisted for the duration of their programs. For example, when asked approximately one third of midwives commented that they had not felt they were even on a TSP. This situation is not uncommon. A number of studies of new graduate midwives and nurses transition experiences have reported their TSPs to be ad hoc, ill-defined, unclear and/or non-existent (Holland 1999; Maben & Clark 1998; Nursing and Midwifery Council 2010).

The findings of this study reveal that the newly graduated midwives' descriptions and experiences of programs often did not match the structure outlined by the hospital. Davies

and Mason (2009) in their discussion paper cite similar experiences for newly graduated midwives in the UK. In keeping with the expressed experience of many participants in this study, Davies and Mason (2009) report that their UK counterparts often describe their TSP as merely a clinical rotation plan with little support, no formal assessments or feedback, and one that provides limited opportunities for further education. The provision of clinical experience through clinical rotations was an area on which the newly graduated midwives reflected considerably during their interview.

Clinical rotations: providing adequate clinical experience for midwives?

As previously described, clinical rotations are designed to offer the new graduate an opportunity to consolidate their practice. In the study presented in this thesis, the new graduate midwives valued the opportunity to rotate to all clinical areas. This is at odds with the findings of Australian nurse researchers McKenna, Newton and Green who have written extensively on the subject of the graduate nurse's experience of transition to practice (McKenna & Newton 2008; McKenna & Green 2004; Newton & McKenna 2007). Tracking new graduated nurses over the first 18 months of practice, these authors cautioned against the negative impacts of numerous and sometimes short clinical rotations. The Victorian nurses struggled to 'fit in' and develop enough skills to be able to positively contribute to the workload. Accordingly, Newton and McKenna (McKenna & Newton 2008; 2007) conclude that new graduate nurses should be offered only one clinical rotation. These recommendations are in line with other Australian research by Evans, Boxer and Sanber (2008) and the more recent work of Malouf and West (2011) both of whom reported similar experiences highlighting the potentially detrimental effects on the new graduate.

Unlike their nursing counterparts it appears that the midwives in this study found their clinical rotations enabling. The findings suggest that rotating allowed the new graduate midwife to build-up professional networks in each clinical setting whilst developing skills and experience across all aspects of midwifery care. Comparable findings have been reported by van der Putten (2008), whose qualitative phenomenological study explored the

lived experience of six newly graduated midwives in Ireland. The newly graduated midwives in van der Putten's study also valued the opportunity to develop skills across the full scope of midwifery practice and acquire skills from a variety of experienced midwives. Given the midwives unique scope of practice, which is substantially different from that of a nurse, it's likely that the new graduate midwife feels the need to further develop skills and confidence in all clinical areas to ensure the ability to provide care to women across the entire childbearing experience (Australian Nursing & Midwifery Council 2006; International Confederation of Midwives 2011).

The midwife's ability to work to her full scope of practice is a subject of continued debate within the Australian midwifery profession. In a recent Australian study by Davis, Foureur, Clements, Brodie and Herbison (2011), undertaken to assess the level of confidence of newly graduated midwives at the beginning and end of their TSPs, all participants rated their confidence in working to the International Confederation of Midwives' (2011) definition of the midwife as low. The authors suggest that this is a result of the scarcity of opportunities for midwives to work across the full scope of practice. As a result students and qualified midwives alike lack exposure to, and are limited in, providing all aspects of care (Davis et al. 2011). This is despite the introduction of the student 'follow-through'[16] experience. Davis et al (2011) acknowledge the importance of this type of learning experience, stating that it provides students with valuable insight into the benefits of continuity of care. However, given the limited opportunities for students to be placed in continuity of care models (such as caseload) the 'follow throughs' are, more often than not, within fragmented models of care where women see different midwives at each point of their care. So while the student is able to have a level of continuity of care with the woman she/he is not being given the opportunity to observe how the same, or small group of midwives, provide care across the childbirth continuum. As a result, students are not

[16] A 'follow-through' experience is one where a student midwife follows the experience of a pregnant woman from the first antenatal booking appointment through labour, birth and the postnatal period. The woman is not necessarily within a continuity of care model so may see a number of midwives during her care.

exposed to what it means to work to the full International Confederation of Midwives' definition of midwifery practice.

While the profession and many health care providers are committed to introducing new models of maternity care based on the principle of continuity of care in the short term the majority of care will continue to be provided within a fragmented model (Australian Health Ministers' Conference 2011; NSW Health 2010). In this context regular clinical rotations thus become an important strategy to ensure new graduates can consolidate and continue to develop their clinical skill base. The UK's Nursing and Midwifery Council in its 2010 *MINT (Midwives IN Teaching)* report supports the practice of clinical rotations but clearly states that organisations need to be aware of the impact of the frequency and timing of rotations on the new graduate midwives' confidence (Nursing and Midwifery Council 2010). The reports' authors caution that, if rotations are too frequent and for a short duration the potential for the new midwife to become stressed, as they adapt to the new area, is high. On the other hand, extended durations in clinical areas lead to loss of clinical skill and confidence in other areas (Nursing and Midwifery Council 2010).

As previously mentioned, the newly graduated midwives in this study welcomed the opportunity to rotate; however, problems arose when the pre-defined rotations were changed. The newly graduated midwives reported that they were often moved between clinical areas at short notice to cover shortfalls in staffing. The resultant effect was two-fold. Firstly anxiety and stress levels increased as the newly graduated midwives were unable to adequately prepare for the clinical challenge. Secondly they felt undervalued as they perceived others regarded them solely as 'gap-fillers' and not part of the team. The concept of being a valuable team member will be explored later in this chapter when issues pertaining to the hierarchical nature of the clinical environment are discussed.

Duchscher (2009), a Canadian researcher, strongly advocates that new graduates should have access to well-planned and organised clinical rotations. This recommendation is based on over ten years research that has focused on exploring the transition of newly graduated

nurses. Comparable to the newly graduated midwives in this study, new graduate nurses in Canada were often used to cover shortfalls or gaps in the roster. This resulted in similar feelings of stress due to the unpredictability of the situation and limited time to prepare for the change (Duchscher 2009). The new graduate nurses believed that these experiences delayed their development (Duchscher 2009). Whilst the possible impact on newly graduated midwives and nurses of having to cover gaps in the roster is of note, perhaps of greater concern is the potential for adverse clinical events where new graduates may not have the required level of skill or expertise. The recent NSW Clinical Excellence Commissions' Patient Safety Team (2011) report, focusing on the supervision of junior staff at the point of care, identified the challenges and associated risks of replacing experienced staff at short notice. Where skill mix is not optimal the report notes that it is often inexperienced members of staff who are required to fill the gaps.

In this thesis, further exploring graduates perceptions and experiences of clinical rotations revealed two specific areas for notable discussion: the intensity of the birthing suite experience and the overwhelmingly positive experience of rotations within continuity of care models.

The intensity of the birthing suite experience

In 1998 the UK's English National Board for Nursing and Midwifery identified the birthing environment as the clinical area where newly graduated midwives require the most support (English National Board for Nursing and Midwifery 1998). It is not surprising then that with few exceptions the newly graduated midwives in this study found their experience of rotating to the birthing suite to be the most challenging and anxiety-provoking. This finding is supported by international literature (Hughes & Fraser 2011; Nursing and Midwifery Council 2010). The fear is captured in a quote from one of the participants in the MINT study who said, "I feel going to labour ward is going to kill me" (Nursing and Midwifery Council 2010, p. 63). Hughes and Fraser (2011) held focus groups with a total of 62 newly graduated midwives and experienced midwives in the UK. They identified that the labour

ward (birthing suite) was the most stressful environment for newly graduated midwives(Hughes & Fraser 2011).

The timing of when newly graduated midwives first rotation to the birthing suite also appears to be important. Hughes and Fraser (2011) and the Nursing and Midwifery Council (2010) both link newly graduated midwives' frustrations and concerns with delays in their rotations to the birthing environment, with some recommending that it should be a new graduate's first clinical rotation as delays needlessly increase stress and anxiety. For example, a newly graduated midwife in the MINT study expressed her concerns when she said "there is another new midwife who started the same day as me, she went straight to the labour ward and we compare experiences and I am very, very worried" (Nursing and Midwifery Council 2010, p. 63)

The findings of this study highlight a number of reasons why newly graduated midwives find the birthing environment stressful and anxiety-provoking. Firstly, it appears that the graduates' new-found sense of responsibility and need to make decisions around women's care potentially heightens their anxiety. Compounding this is the participant's fear of missing something and/or making a mistake in this clinically critical area. Again, this discovery is consistent with the existing midwifery and nursing literature. Higgins, Spencer and Kane's (2010) systematic review of the experiences and perceptions of newly graduated nurses in the UK is particularly helpful and relevant. From their critical appraisal of 17 articles they were able to construct a comprehensive picture of new graduate nurses' transition into practice. They highlight and discuss the anxiety that newly graduated nurses experience as a result of their increased level of responsibility and autonomy (Clark & Holmes 2007; Gerrish 2000; Higgins, Spencer & Kane 2010; Jasper 1996; Maben & Clark 1998). Similar experiences are noted with graduate midwives. Van der Putten (2008), for example, found Irish midwives readily expressed uncertainty and fear as a result of their heightened awareness of their new professional responsibility and accountability (van der Putten 2008). This was illustrated by one participant's comment on the responsibility of

having to sign clinical discharges as the registered midwife and responsible for the woman's care (van der Putten 2008).

Critiquing the literature on new graduate nurses highlighted a number of other areas of responsibility that are particularly stressful for the new graduate nurse. These included drug administration, time management, organisation of workload and decision-making (Clark & Holmes 2007; Higgins, Spencer & Kane 2010). Likewise, the MINT report (Nursing and Midwifery Council 2010) identifies time management, ability to prioritise workload, drug administration and decision-making skills as pressure points for new graduate midwives (Nursing and Midwifery Council 2010). However, unlike the new graduate nurses there appears to be a dichotomy for the new midwifery graduates in their relationship towards decision-making. The new midwives emerge as prepared for the responsibility of planning and managing care that sits within the parameters of normal labour and birth (Nursing and Midwifery Council 2010). However, it appears that increased levels of anxiety in the newly graduated midwives, are closely associated with caring for women who are deemed to be high-risk or have complex needs (Nursing and Midwifery Council 2010). This aspect of decision-making in the birthing environment was not remarked on by the participants studied in this thesis. Further research in this area would be of benefit to explore the issue in greater depth.

The stress associated with the increased sense of responsibility and autonomy appears to be further exacerbated by the fear of making a mistake (Gerrish 2000; Higgins, Spencer & Kane 2010; Maben & Clark 1998). Again, the new graduate midwives in van der Putten's (2008) study articulated their concern that they 'might miss' something. Higgins et al (2010) discuss the new graduate's concern of litigation and loss of registration as the ultimate outcomes of errors in clinical practice. This resonates with comments made by newly graduated midwives in this study who expressed their real concerns with losing their registration.

In sharp contrast to the newly graduated midwives' experiences of the hospital birthing environment were the reported encounters of rotations into midwifery continuity of care models.

Midwifery continuity of care models: the perfect environment for transition?

Whilst only a few midwives had access to midwifery continuity of care models during their TSP, the experience is worthy of note given the overwhelmingly positive effect on the new graduates. Clinical rotations into continuity of care models were seen as an opportunity to witness normality and midwives creating positive relationships with women – this was commonly viewed as providing mutual satisfaction for both the woman and midwives involved (Sullivan, Lock & Homer 2011). Of particular note was the level of positive support the newly graduated midwives reported that they received during this type of experience. The support not only increased their confidence while in the model but appeared to have an important lasting influence when they rotated back into the hospital environment. One reason for the positive experiences of working within the continuity of care models may have been the new graduates' exposure and observation of midwives working autonomously, away from the medicalised environment of the hospital.

Baird (2007) discusses how, if students and newly graduated midwives do not have the opportunity to watch and observe experienced midwives role modelling autonomous decision-making, they cannot be expected to develop the skills themselves. Baird (2007) goes on to caution that the dominant medical culture within the birthing environment impacts on decision-making even during normal labour and birth, resulting in fewer opportunities for students and midwives to hone their skills and confidence in this area. Drawing on this work, one can conclude that exposure to midwives working within the full scope of midwifery enabled graduates to feel confident in their own ability to make decisions. That the new graduate midwives felt able to maintain some confidence in this area when they rotated back to the hospital environment is, in itself, valuable.

Another reason for the positive reflections of their time in a midwifery continuity of care models may be related to the more egalitarian nature of these modes. Continuity of care models are underpinned by the principles of woman-centred care and the partnership with the woman and midwives (Hunter 2006; Sullivan, Lock & Homer 2011). These models often have a fairly 'flat' management structure as everyone is expected to self-manage their time and workload. The newly graduated midwives commented that this less hierarchical structure fostered a supportive environment where the focus of attention was on the woman and her care. This woman-focused philosophy appears to have been shared by the new graduates and the midwives working in these models, and resulted in a sense of belonging which seems to have been absent within the hospital environment for some of the newly graduated midwives. Hunter (2004) provides some insight as to why this may have been important for the newly graduated midwives.

In her UK ethnographic study Hunter explored midwives managed and experienced emotion at work. She found that the hospital and community environments provided very different work settings and associated ideological values. For example, hospital-based midwives aligned themselves with the institution while those working in community were "with woman" (Hunter 2004, p. 267). She suggests that there should be an acceptance that midwives can thrive in these different environments. Hunter argues that conflict and stress occurs when organisations fail to develop appropriate strategies to support midwives, particularly the newly qualified midwife. She goes on to comment on the importance of preserving the ideals whilst recognising the realities of today's clinical environment (Hunter 2004).

The contrasting findings between the midwives positive experiences in continuity of care and the hospital environment are notable and need further exploration. The findings of this study suggest that many midwives experienced the hospital environment as hierarchical, with many perceiving that as new graduates that they ranked low in the order. The newly graduated midwives' sense of being positioned low in the hierarchy is similar to the documented experiences of midwifery and nursing students at the end of their training

(Begley 2001; Bluff & Holloway 2008). Whilst it is accepted that the participants in this study were no longer students, it is of note that the majority had previously been in the midwifery student role within the hospitals where they undertook their TSP. As such, their place in the hierarchy could be perceived as pre-existing. Johnstone, Kanitsake and Currie's (2007) study of 11 new graduate nurses and 34 key stakeholders (including nurse unit managers, clinical teachers and senior nurse administrators) highlighted this issue, demonstrating how staff continued to regard and behave as if the new graduates were students. In their interviews and focus groups key stakeholders were often noted as referring to the new graduates as students. Johnstone et al (2007) cite this as an example of how staff viewed new graduates as inferior to other experienced staff . With this insight into the workplace it may not be surprising that the new graduate midwives in this study believed themselves to be placed low in the 'pecking order'.

The findings presented in this thesis also suggest that the newly graduated midwives often found it difficult to ascertain their position in the hierarchy, as they perceived they were treated differently to other groups of midwifery staff. The student midwives were observed to be the focus of the midwifery educators' time, with their exposure to clinical experiences taking priority because of the university requirements of their courses. Accordingly, the newly graduated midwives' clinical needs seemingly took second place. In addition, the participants perceived that experienced midwives' work area preferences, were given priority, with the newly graduated midwives expected to fill gaps in the roster and rotate, at short notice to clinical areas where other staff either did not want to or could not go. Similarly, in their small qualitative study to describe the strengths and weaknesses of TPSs for newly registered nurses in Sydney, Evans, Boxer and Sanber (2008) found their participants also perceived they were treated differently to other nurses. In this example, the new graduate nurses believed that they were often given the unpopular shifts that the other staff did not want (Evans, Boxer & Sanber 2008).

The graduates' judgment that they were treated differently in the hospital environment had the potential to impact on their sense of being valued and belonging to the team. The need

to feel accepted by and included in the team has been identified as an important aspect of transition into practice for both midwives (Blaka 2006; Steele 2009) and nurses (Duchscher 2009; Evans, Boxer & Sanber 2008). A sense of belonging to the team promotes confidence, enhances clinical experiences and increases knowledge retention (Blaka 2006; Duchscher 2009; Evans, Boxer & Sanber 2008; Steele 2009). Malouf and West's (2011) in-depth study of nine newly graduated nurses in Sydney suggests that the importance of being accepted as a member of the team cannot be underestimated in relation to the professional development of a new graduate. These authors discussed how the forming of social relationships was central to the new graduates' development and related to their sense of belonging and ability to perform their nursing duties. Blaka (2006), acknowledges the need for social inclusion into the team but also makes the distinction of the need for professional acceptance. The latter needs to be developed over time as the new graduate demonstrates clinical knowledge and skill (Blaka 2006). The design and duration of a TSP should thus enable the new graduate to attain social and professional acceptance.

The findings of the study reported in this thesis suggest that the newly graduated midwives felt a sense of social and professional belonging to the midwifery continuity of care models in which they worked. Certainly these experiences were reported more favourably with no references to stress or anxiety, in contrast to the experiences reported within the hierarchical hospital environment. While further research is warranted, the evidence from this study clearly indicates that newly graduated midwives should be able to access a clinical rotation within a midwifery continuity of care models at the start of their TSP. This would enable them to consolidate and gain experience in all aspects of midwifery care simultaneously.

The realities of the clinical environment: poor skill mix, high workload

It is clear from the international literature that the newly graduated nurse or midwife's experience of the clinical environment is significantly impacted by their organisation's ability to provide adequate support and fulfil the expectations of the TSPs outlined (Davies

& Mason 2009; Evans, Boxer & Sanber 2008; Johnstone, Kanitsaki & Currie 2007; Leap, Barclay & Sheehan 2003a). The findings of this study continue to lend support to the reality that clinical environments are chaotic with chronic understaffing, poor skill mixes and excessively high workloads. In this environment, the difficulty of ensuring graduates work within a supportive teaching and learning culture is well-documented (Davies & Mason 2009; Johnstone, Kanitsaki & Currie 2007; Leap, Barclay & Sheehan 2003a). Some years ago Charnley (1999) noted that managers report a sense of frustration in being unable to provide new graduate nurses sufficient support due to financial limitations. Ten years later, Davies and Mason (2009) draw attention to the ongoing tension between governmental and professional bodies' affirmation of support and endorsement of transition programs for new graduates, and the lack of funding made available to ensure this happens.

The desire to save money by not funding TSPs may well be a false economy. It is a well-established fact that attrition rates for newly graduated nurses and midwives are high (Kovner et al. 2007; Leap, Barclay & Sheehan 2003b; Pine & Tart 2007). Pine and Tart (2007), nursing researchers in the USA, cite attrition rates for newly graduated nurses as between 35 and 61%. Kovner, Brewer, Fairchild, Poornima, Kim and Djukic (2007), in their survey of newly graduated nurses in 35 USA states, reported a lower attrition rate of 13%. However, they caution that 37% of respondents indicated their intention to resign from their positions in the short term.

In Leap, Barclay and Sheehan's (2003b) report of the Australian Midwifery Action Project Education Survey, the authors stated that attrition of newly graduated midwives in NSW was linked to a lack of support and stress. Similar findings are reported in the USA nursing literature where studies have been undertaken to explore how to improve the new graduate's experience (Bowles & Candela 2005; Mathews & Nunley 1992). The aim of TSPs is to support the effective transition of newly graduated staff by offering support and education to enable the new graduate to become a confident, competent and safe practitioner (Park & Jones 2010). Park and Jones (2010) recently reviewed 17 published

reports on TSPs to provide a comprehensive overview of literature relating to the effects of programs to support the transition of newly graduated nurses. These authors reported that the available literature emphasised that TSPs were not only effective in elevating confidence and competency in newly graduated nurses, but also in increasing retention rates (Park & Jones 2010). Of particular note was the fact that TSPs have been demonstrated to be cost-effective (Beecroft, Kunzman & Krozek 2001; Kovner et al. 2007; Park & Jones 2010; Pine & Tart 2007).

Beecroft, Kunzman and Krozek (2001) evaluated a one-year pilot paediatric internship for new graduate nurses in the USA. As part of their evaluation they undertook a return on investment (ROI) comparison which sought to identify the cost-effectiveness of the program. The ROI calculation uses the costs benefits of the program (for example, reduction in recruitment fees, cost of temporary staff to fill vacancies, orientation) divided by the cost of the program. In keeping with the research identified above, the authors found that the program was successful in retaining newly graduated nurses and transitioning them into confident, competent paediatric nurses (Beecroft, Kunzman & Krozek 2001). Of particular interest was their finding that offering an 'internship' saved the organisation money that would previously have been spent on recruitment and other related expenses such as the cost of temporary staff to fill vacancies (Beecroft, Kunzman & Krozek 2001). Pine and Tart (2007) also undertook a ROI on the transition program for newly graduated nurses at a hospital in Texas, USA. Similarly to the findings of Beecroft, Kunzman and Krozek they found their program to be cost-effective (Pine & Tart 2007).

The recent Australian work of Davis et al (2011) calls for an urgent review of midwifery TSPs as they suggest the current ad-hoc approach to TSP tends to focus on the needs of the institution rather than of the individual. This assertion is supported in the literature. For example, Evans, Boxer and Sanber (2008), who interviewed newly graduated nurses in NSW, found that nurses considered their TSP to be more about ensuring staffing of the hospital than a program designed to support transition to practice. As a result many

inexperienced nurses were often rostered to a shift which limited the opportunities for them to access advice from more experienced nurses (Evans, Boxer & Sanber 2008).

The work of Evans et al (2008) also resonates on a number of other levels. Similar to their nursing counterparts, many newly graduated midwives in this study reported that they had to take on full clinical load, were often left in charge of the clinical area and/or were required to provide support and guidance to student midwives. This is seemly not an uncommon experience for newly graduated nurses (Begley 2007; Deasy, Doody & Tuohy 2011; Evans, Boxer & Sanber 2008; Maben & Clark 1998). In addition, this situation does not come without its clinical risks. The recent NSW Clinical Excellence Commission's Patient Safety Team (2011) report focusing on the supervision of junior staff at the point of care identifies that staff shortages may impact on the safety of clinical care, particularly around the supervision of junior staff. When senior staff have to take a clinical load this situation is further compounded, with their availability to provide guidance and support vastly reduced (Clinical Excellence Commission 2011). Again this effectively portrays the experience of many of the newly graduated midwives in this study who reported that the midwifery educators often had clinical loads. With the clinical educators' focus on students and their own clinical workload, the newly graduated midwives were required to seek support from other sources.

Support: a multifaceted concept

The newly graduated midwives at the beginning of their TSP held an expectation that their work colleagues would provide them with an appropriate level of support as they progressed through their year. There was also an expectation, espoused by the hospitals, that a period of supernumerary time would be provided during the TSP, to assist in orientation and acclimatisation to the new role. In the next section I will discuss the realities of support as experienced by the newly graduated midwives.

Supernumerary time: a chance to acclimatise

Providing the new graduate with an opportunity to orientate and become familiar with the clinical environment is a fundamental aspect of a TSP (Department of Health 2010; Queensland Nursing Council 2006). Being able to afford this to graduates without the burden of carrying a clinical workload (in other words being 'supernumerary' to the establised staff numbers), has become recognised as an essential core element of a TSP. The findings presented in Chapter 4 identified that eight of the 12 hospitals offering a TSP included periods of supernumerary time. However, the analysis of the data collected from midwives at the end of their programs highlighted a number of inconsistencies between promised supernumerary time and what the midwives actually experienced. The discord between the rhetoric and reality is common to other reports in the literature on this subject (Hughes & Fraser 2011; Nursing and Midwifery Council 2010).

Hughes and Fraser (2011), in their UK study of newly graduated midwives and their preceptors, found variances between what newly graduated midwives were told would be on offer and the reality of their experience. They found that the allocation of supernumerary time was either shorter than expected or not available at all (Hughes & Fraser 2011). The repercussion of this discrepancy was a sense of abandonment which, perhaps not surprisingly, added to the stress levels of the new graduates (Hughes & Fraser 2011). It may perhaps be the discrepancy between what is expected by the graduate and what is actually available in terms of a supportive environment that causes this sense of abandonment. For example, newly graduated midwives in the MINT report remarked that though supernumerary time was not available, they were able to positively seek support from the experienced midwives in the team (Nursing and Midwifery Council 2010).

Support from the experienced midwifery team

Graduate midwives in this study expected to receive 'support' from a number of different people during their transition year. Over half of the participants reported that they had adequate or good support, a finding that is in keeping with data reported on during a UK

evaluation of the effectiveness of pre-registration programs (English National Board for Nursing and Midwifery 1998). On further exploration, while managers and educators were afforded a mention, it became clear that the 'experienced' clinical midwife was the person most often sought out to provide assistance. This was also a consistent finding of the earlier UK evaluation work (English National Board for Nursing and Midwifery 1998) and indeed remains so with the more recently released MINT report (Nursing and Midwifery Council 2010). The MINT report (2010) notes that newly graduated midwives are most likely to identify experienced midwifery colleagues and senior members of the maternity care team as their most significant support .

Boud and Middleton (2003) in their discussion paper of workplace learning review the prevalence of peer-to-peer learning in workplaces. They draw attention to the diversity of experience and knowledge that is held by individuals within an organisation who do not have traditionally accepted educational roles and argue the value of learning from these individuals (Boud & Middleton 2003). The newly graduated midwives under investigation in this thesis strongly support Boud and Middleton's (2003) assertion. Their experiences suggest that the experienced midwives were the ones from whom they learned the most and from whom they gained the greatest support. The newly graduated midwives reported feeling reassured knowing that they had someone to go to with their problems or question, who had time to spend with them, and who most importantly, would not make them feel inadequate. These are all aspects of supportive relationships that have been reported elsewhere (English National Board for Nursing and Midwifery 1998; Hughes & Fraser 2011; Johnstone, Kanitsaki & Currie 2007; Maben & Clark 1998).

There were of course exceptions. Whilst many newly graduated midwives reported positive experiences, the findings also indicate that, at times, the graduates refrained from seeking advice or guidance from the experienced staff. The motives for this reticence are consistent with other studies of new graduate experiences. Duchscher (2009), a Canadian nursing researcher who has published widely in this area, contends that on one hand the new graduate does not want to add to the workload and burden of the already overworked staff,

and on the other does not want to appear lacking in knowledge or competency. Correspondingly, Malouf and West (2011) report that the new graduate nurses in their study expressed reluctance to ask for assistance for fear of being regarded by staff as incompetent or ignorant and as a result unsafe. Some of the new graduate nurses stated they were hesitant to ask questions or tried to problem-solve and find solutions without support or guidance from the senior clinicians (Malouf & West 2011). The consequence for patient care cannot be understated. The NSW Clinical Excellence Commission (2011) has recently produced a report aimed at raising experienced staff awareness of this issue and encouraging them to be mindful that inexperienced clinicians may be reluctant to seek guidance if they are concerned about being treated unfairly and/ or labelled incapable.

One strategy for mitigating the reluctance of new graduates to look for guidance and support is to provide them with a named preceptor during their TSP with whom they are able to develop a professional relationship of mutual respect and trust (Department of Health 2010; Steele 2009).

Preceptor: providing a point of contact

Although the newly graduated midwives in this study reported a good level of support from the experienced midwives, the data indicates that they were not provided with a named preceptor for the duration of their programs. The value to the new midwifery graduate of having a preceptor has been well established in the literature. Steele (2009), an education consultant and fellow of the UK's higher education academy, outlines how a named preceptor reduces stress, increases confidence and competence, facilitates personal and professional growth and increases job satisfaction. She also suggests that there are tangible and worthwhile benefits for both the preceptor and the organisation (Steele 2009). Preceptors have been shown to have increased self-esteem as a result of role modelling. Subsequently this benefits their professional and personal development. From an organisational perspective, employing a preceptor model for midwives has been shown to

increase rates of retention and recruitment and improve the safety and quality of care (Department of Health 2010; Steele 2009).

Successful preceptor models must have the support of midwifery managers who can overtly demonstrate the value of the preceptor role in supporting the new graduate. Hughes and Fraser (2011) advocate strongly for new midwives and preceptors to be given time to meet at the beginning and/or end of a shift and to ensure rostering patterns regularly facilitate the two working together. Preceptors should also be well-supported in their role and afforded appropriate training opportunities (Hughes & Fraser 2011; Steele 2009). This includes learning how to provide effective feedback to new graduates (Department of Health 2010).

Feedback: keeping them on track

Consistent with the available evidence, the findings reported in this thesis strongly indicate the value of regular formal and informal feedback for the newly graduated midwife (Blaka 2006; Deasy, Doody & Tuohy 2011; Duchscher 2009; Wangensteen, Johansson & Nordstrom 2008). Feedback on performance enabled the midwives to ascertain their progress and identify their learning needs. Without this the graduates reported feeling like they were left floundering. Newly graduated midwives expressed how feedback positively influenced their confidence and skills development. This was particularly evident when the feedback was provided by the women they were caring for (Maben & Clark 1998; Steele 2009).

Whilst the value of feedback was clearly understood by the new graduates, the scoping exercise suggests that it was not highly valued by the hospitals providing the TSPs. Only half of the hospitals had formal feedback processes in place, and even when they did these processes were often inadequate or not followed. As a result new midwives in this study rarely received regular feedback. This finding is not dissimilar to that of Duchscher (2009) who reported the inadequacy of both positive and negative feedback to newly graduated nurses. Wangensteen, Johansson and Nordstrom (2008) concluded from their study that

receiving feedback was so essential and critical to nurses' development that even negative feedback is better than none at all.

Clearly TSPs need clear and consistent mechanisms to facilitate both formal and informal feedback in place. However, given the lack of feedback reported it is likely that experienced clinical staff may need additional support and education on how best to provide effective feedback. From their review of the literature Chur-Hansen and McLean (2006) suggest four points for enhancing the provision of feedback.

- Feedback should be given as soon as possible.
- A standardised model for providing feedback could be used such as the "positive-negative-positive" identified in Chapter 2 (p. 69). In this model the person providing feedback first says something positive about the learner's strengths, the issue or area for improvement is then identified and the process is concluded by a motivating or positive statement.
- Feedback should include practice comments and advice on how to improve performance.
- Information as to where to access further help, information advice or assistance should be provided.

The need for further assistance and information is not uncommon for the newly graduated clinician. For this reason a valuable resource of TSPs is the provision of education sessions within the programs.

Support networks: a valued addition

As reported, offering new graduates the opportunity to attend educational days during their TSP is strongly recommended (Department of Health 2010). The value of such days was clearly evident in the findings, both from a content perspective and in bringing the newly graduated midwives together to facilitate a shared learning environment. However, as with other aspects of the newly graduated midwives' TSPs there were discrepancies with regards

to the number of study days offered at the beginning of the year and those the graduates actually received. While the educational content of study days was valued in enabling the new midwives to gain prized skills and knowledge, this was not the only consequence.

The findings suggest that attendance at these study days also offered the newly graduated midwives the opportunity to network and debrief with their new graduate peers. As described in the literature the importance of these opportunities to reflect and share their experiences was appreciated and had a positive effect on their learning, confidence and ongoing professional development (Blaka 2006; Duchscher 2009). As such they served to build new midwives' professional support network.

Steele (2009) highlights the essential nature of professional networks in maintaining high quality up-to-date clinical care. By providing opportunities for formal and informal reflection and information sharing, practitioners are able to develop personally and professionally in a supported environment (Steele 2009). Furthermore, the positive effect of setting up networking opportunities for the newly graduated as part of their TSPs is well-evaluated in the literature (Delaney 2003; Duchscher 2009; Park & Jones 2010). Park and Jones (2010) outline the benefits of new graduates being able to share their problems and stresses and as a group define strategies to manage and move forward. Duchscher (2009) notes that support networks were well-regarded by the newly graduated nurses in her studies as they provided links to on-going professional development even when opportunities to access these networks were minimal. Providing an opportunity for the newly graduated to regularly meet in a supported environment also mitigates the danger of the new graduates' feelings of isolation as some experience the loss of the supportive networks they had as students (Deasy, Doody & Tuohy 2011).

In this chapter I have explored the findings of this study in order to meet the articulated aims. The newly graduated midwives' expectations of their TSP have been addressed with a reflection on the advantageous aspects that possession of a positive outlook brings to an individual. Examining the newly graduated midwives' experiences it became clear that –

while clinical rotations are valued to enable the development and enhancement of clinical skills – it is the chance to work in midwifery continuity of care models that appears to provide the new graduate with the support and skills needed to start their professional career.

It is widely accepted that TSPs are cost effective, improve recruitment and retention and promote confidence and competence in the new graduate. Despite this knowledge not all newly graduated midwives had access to a TSP. The programs on offer, in theory, met the key principles of transition support by including most of the key elements. However, in practice the realities of the clinical environment appear to have disrupted these plans. The experienced midwives' comments articulated these difficulties. They also threw light on the reality of all newly graduated midwives requiring a level of support as they transition from student to midwife.

In response to the findings and subsequent discussion in the next section of this chapter I will identify recommendations for education and practice along with suggest areas for further research.

RECOMMENDATIONS

The Australian and international literature suggests that TPSs or some form of structured support for all newly graduated midwives is essential. Transition support programs have been demonstrated in the nursing and midwifery literature to be cost-effective, improve recruitment and retention and promote confidence and competence in the new graduate. It is therefore a recommendation of this study that state and national standards be developed that can underpin or inform how organisations provide structured support to newly graduated midwives.

The findings of this study suggest that, while the hospitals studied had the intention to support their newly graduated midwives, the reality was often not ideal due to organisation and financial constraints. To promote effective support for all newly graduated midwives this study's findings lead to the following recommendations for education, practice and further research.

Recommendations for education

- Universities need to develop programs to effectively educate and support experienced midwives, to enable them to fulfil the role of preceptor. This training should include how to provide feedback, active listening, goal-setting, problem-solving and role modelling (Department of Health 2010).
- Tertiary pre-registration midwifery programs should include an opportunity to discuss the realities of the transition year to prepare the new graduate for the realities of practice.
- Tertiary education facilities offering pre-registration programs should work with industry to investigate the possibility of working together to provide a structured transition period during the first months of clinical practice. For example the co-facilitating of new graduate support sessions.

Recommendations for practice

- Newly graduated midwives should be offered structured support during their transition. Properly designed and implemented TSPs are an ideal way to do this.
- Thought needs to be given to how TSPs are designed. The evidence would suggest that the first months of the transition year are critical to the newly qualified midwife. A well-structured and supported four-month[17] intensive period offered to the new midwife, as soon as possible following graduation, may be more

[17] It should be noted that those in longer clinical rotations (eg. greater than two months in one area) may need additional time to enable them the opportunity to transition into each clinical area

appropriate than a uniform12-month program (Charnley 1999; Duchscher 2009; Schoessler & Waldo 2006). This period should provide the new midwife with supported clinical rotations, skills educations days, a named preceptor, opportunities for debriefing and regular formal and informal feedback. It is suggested that after this initial period new midwives should be offered structured support that is tailored to their own individual learning needs.

- Where possible newly graduated midwives should be offered a period of time in a midwifery continuity of care/r model. Ideally this should take place during the early months of their transition period.
- All newly graduated midwives require an identified point of contact (or preceptor) for the first year.
- Preceptors require appropriate training and education to support them in their role.
- Midwifery managers need to support the role of the preceptor in time allocation and rostering patterns. This would ensure the preceptor and preceptee have time to meet and to work together as much as possible.
- Formal and informal feedback processes are essential for the new midwife's growth and development. Feedback to the new graduate midwife needs to be on-going and staff require appropriate training to be able to provide this effectively. The positive-negative-positive approach to feedback should be encouraged.
- Formal and informal 'support networks' (peer to peer; preceptor to midwives; educator to midwife) are an important component of support. Newly graduated midwives need to be provided with an opportunity to meet regularly in a safe professional environment with the opportunity for reflection and the sharing of experiences.
- Peer support networks need to be recognised as an important part of the new midwives experience and as such opportunities to attend and/or interact with peers needs to be prioritised and facilitated.

Recommendations for future research

- Further research is required to identify the specific needs of newly graduated midwives and how we can best support them to develop into strong, competent midwives confident in working to the International Confederation of Midwives' definition of the midwife.
- Additional research is needed to explore the specific transition needs of newly graduated midwives who have followed a postgraduate course leading to registration as a midwife.
- Research to explore new graduate and students midwives' experiences in midwifery continuity of care models.
- Further study to explore from an organisational view point how to coordinate and support new graduate and student midwives' rotations into midwifery continuity of care models.
- This study was undertaken in the public hospital system in mainly metropolitan areas. Further research to explore the experiences of newly graduated midwives within rural and remote areas, as well as the private hospital system, would contribute to our understanding of the needs of the newly graduated midwife
- Finally, with attrition rates of newly graduated midwives and nurses reported as high, it would be advantageous to undertake research to explore why newly graduated midwives decide to leave the profession.

LIMITATIONS OF THIS STUDY

This study has limitations that require consideration when interpreting its findings. The relatively small sample size in 2008 which equates to a 23% response rate in the pre-program interviews and a 36% response rate in the post-program interviews was disappointing. Additional focus groups held in 2010 were designed to check and validate the emerging themes. However, caution must be taken in making any generalisations based on the findings of this research.

The study was undertaken in three AHSs in mainly metropolitan hospitals. As such, it is not possible to generalise the findings to rural and remote situations where the transition support for newly graduated midwives may well be different. Similarly, the study was conducted only in the public hospital system and therefore its findings may not be transferable to the private hospital setting.

The use of interview proformas was included to ensure inter-interview consistency. However, whilst the proformas were completed for each telephone interview recordings and direct transcripts were not made. It is acknowledged that as they were not directly transcribed meaning many have been lost due to interviewer interpretation; however, the decision was made in-view of resource and time constraints.

CONCLUSION

This study used a qualitative descriptive approach to describe the transition support programs on offer in three Area Health Services (AHSs) in NSW, and to explore the expectations and experiences of 38 newly graduated Australian midwives. The perceptions of 16 experienced midwives were also elicited in an attempt to enhance the findings developed from the new midwives' data set. A phased approach was employed and data was collected using a number of different techniques (questionnaires, telephone interviewers, focus groups). Latent and manifest content analysis was used to analyse the data sets the study collected.

The findings of Phase One identified that common core elements such as clinical rotations and study days that were shared by all the TSPs. However, differences were identified between programs on offer, namely the duration of supernumerary time, opportunities to work within midwifery continuity of care models and formal opportunities for feedback and debriefing. Newly qualified midwives looked forward to and expected a period of

structured support which would help them to consolidate and build their skills as well as confidence and competence as a registered midwife. They also expected to be welcomed and supported by their midwifery colleagues.

The findings from data collected at the completion of the transition year revealed that the busy, chaotic clinical environment where workloads were high and skill mix often poor impacted on the new midwives' experience. While core elements such as clinical rotations, study days and supernumerary time were rated highly, when these components were unexpectedly changed or not offered as planned midwives struggled to cope. Birth suite was deemed the most stressful environment, where support from colleagues was paramount. Opportunities to rotate into models of care that provided continuity of midwifery care/r were greatly valued and appeared to have a significant positive impact on the new graduate. Data collected from experienced midwives supported the findings and demonstrated that, regardless of pre-registration preparation, there was a common belief that all new midwives should be offered formalised structured support.

Transition support programs are cost effective, improve recruitment and retention and promote confidence and competence in the new graduate. The study findings demonstrate that structured support, which included a number of core elements, is highly valued by new midwives and plays a role in assisting them to successfully make the transition from student to registered practitioner. This study has provided a unique insight into the expectations and experiences of midwives as they start their professional careers. It has also provided much needed information on the structure and content of programs offered within three AHSs in NSW.

The findings from the study add to the existing literature, and it is hoped they will assist in the development of standards and/or principles to inform how organisations support newly graduated midwives. It is critical that the newly graduated midwives are confident in working to the International Confederation of Midwives' definition of the midwife and supported to develop into strong, competent midwives.

Appendix 1

Evaluating Existing Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW

Program Description Template

Area Health Service:……
Name of Site:……

Named coordinator/contact person (designation and contact details):……

Duration of Program	Overview of program	Documented program outcomes or objectives (detail)	Information provided to participant (list and provide copies)	Degree of flexibility? (is there opportunity for flexibility e.g. part time, or rotations that meet specific needs/interests of midwife?)	Does program include experience with continuity of midwifery practice?
Detail support provided to clinical or mentoring midwives	Time allocated for learning? (hours/days and type of learning supported)	Peer support? (eg named mentor provided)	Debriefing opportunities?	Describe required assessments or credentialing exercises	Opportunity for midwife participant to provide feedback on program?

Appendix 2

Evaluating Existing Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW Participation Information Sheet for New Graduate Midwives

PURPOSE OF THE RESEARCH

This is an invitation to participate in a study conducted by researchers at the University of Technology, Sydney (UTS), South Eastern Sydney and Illawarra Area Health Service (SESIAHS), Northern Sydney Central Coast Area Health Service (NSCCAHS) and Sydney South West Area Health Service(SSWAHS).

The purpose of the research is to describe and evaluate the existing transition support programs for new midwifery graduates within these area health services. As graduates from the Bachelor of Midwifery program at the University of Technology, Sydney will be joining the workforce for the first time in 2008, the researchers are also interested in whether their needs for support are different from the graduate diploma or masters graduates. This research will inform the development of graduate transition programs in these Area Health Services that meet the needs of the graduate and the health service.

INVESTIGATORS

Vanessa Clements (Masters Student)	Dr Maralyn Foureur	Dr Pat Brodie
UTS and SESIAHS	UTS and NSCCAHS	UTS and SSWAHS

METHOD AND DEMANDS ON PARTICIPANTS

If you choose to be included, you will be asked to participate in two telephone interviews of up to 30 minutes duration (one in February 2008 and one in February 2009) and to complete two anonymous questionnaires (one in February 2008 and one in February 2009). The telephone interviews will not be audio taped but the interviewer will write notes on your responses. The interview will be conducted at a time that suits you. Typical questions in the interview will include; (February 2009) what sort of qualification you hold, what is your understanding and expectations of the transition support program you are embarking on and (February 2009), what is your experience of the transition support program you are completing and what factors supported or hindered your transition to professional practice. The questionnaire will ask you to rate your level of confidence in the Australian Nursing and Midwifery Council Competencies for a Midwife (in February 2008 and then again in February 2009).

POSSIBLE RISKS, INCONVENIENCES AND DISCOMFORTS

Apart from the 30 minutes of your time for each interview and the time taken to complete the questionnaires (10-15minutes), we can foresee no risks for you. Your involvement in the study is voluntary and you may withdraw your participation from the study at any time and withdraw any data that you have provided to that point. Refusal to participate in the study will not affect your relationship with the Area Health Service, your employing hospital or your transition support program in any way.

FUNDING AND BENEFITS OF THE RESEARCH

This study has received no funding at this time but funding will be sought through 2008. This research will inform the development of transition support programs for midwives in these area health services in the future. Findings from the study will be published in a report and possibly published in professional journals and presented at professional conferences. Confidentiality is assured and you will not be identified in any part of the research.

ETHICS REVIEW AND COMPLAINTS

This study has been reviewed by the Human Research Ethics Committee (Social Science, Humanities and Behavioural Science) of the University of Wollongong. If you have any concerns or complaints regarding the way this research has been conducted, you can contact the UoW Ethics Officer on (02) .

Thank you for your interest in this study.

Appendix 3

Evaluating Existing Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW

Consent form for new graduates

Vanessa Clements (South Eastern Sydney and Illawarra Area Health Service)
Maralyn Foureur (Northern Sydney Central Coast Area Health Service)
Pat Brodie (Sydney South West Area Health Service)

I have been given information about the research titled "Evaluating Existing Transition Support Programs for Graduate Midwives in Three Area Health Services in NSW" and offered the opportunity to discuss the research project with Vanessa Clements (South Eastern Sydney and Illawarra Area Health Service), Maralyn Foureur (Northern Sydney Central Coast Area Health Service) or Pat Brodie (Sydney South West Area Health Service) who are conducting this research.

I have been advised of the potential risks and burdens associated with this research, which include the potential for feeling obliged to participate and taking time to complete two questionnaires and participate in two phone interviews, and have had an opportunity to ask Vanessa Clements, Maralyn Foureur or Pat Brodie any questions I may have about the research and my participation.

I understand that my participation in this research is voluntary, I am free to refuse to participate and I am free to withdraw from the research at any time. My refusal to participate or withdrawal of consent will not affect my relationship with the Area Health Service, my employment or my transition support program in any way.

If I have any enquiries about the research, I can contact Vanessa Clements , Maralyn Foureur or Pat Brodie or if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on.

By signing below I am indicating my consent to;
• participate in up to two telephone interviews of approximately 30 minutes duration (one in February 2008 and one in February 2009)
• completing two anonymous questionnaires (one in February 2008 and one in February 2009)

I understand that the data collected from my participation will be used for preparing a report on the research, a professional journal publication and a conference presentation. The findings of this research will also be used to inform the development of graduate transitions support programs in the future, and I consent for it to be used in that manner.

Signed Date

..../...../.....
Name (please print)

Phone contact for telephone interviews:

Land line:…… Mobile phone:……

Appendix 4

An Evaluation of Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW

Questionnaire

<table>
<tr><td>What is your age in years?
_____</td><td rowspan="2">Is English your first language?
❒ Yes
❒ No</td></tr>
<tr><td>What is your gender?
❒ Male
❒ Female</td></tr>
<tr><td colspan="2">What type of midwifery qualification do you hold?
❒ Graduate Diploma
❒ Bachelors Degree
❒ Masters Degree</td></tr>
<tr><td colspan="2">At which hospital are you employed? _____</td></tr>
<tr><td colspan="2">Are you employed full or part time?
❒ Full time
❒ Part time (if part time, how many hours per week?_____)</td></tr>
<tr><td colspan="2">What is your employment start date (dd/mm/yy)?_____</td></tr>
<tr><td colspan="2">Survey completion date (dd/mm/yy): _____</td></tr>
</table>

Appendix 5

Evaluation of Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW

Focus Group Participant Information Sheet

Purpose of the Research
The purpose of the research is to describe and evaluate the transition support programs for new midwifery graduates within South East Sydney and Illawarra Area Health Service (SESIAHS), North Sydney Central Coast Area Health Service (NSCCAHS) and Sydney South West Area Health Service (SSWAHS). This research will inform the development of future transition support programs in these Area Health Services.

Principal Investigators

Ass. Prof. Deborah Davis (Team Leader)	Prof. Maralyn Foureur	Prof. Pat Brodie
UTS and SESIAHS	UTS and NSCCAHS	UTS and SSWAHS

Please feel free to contact any of the researchers if you would like to discuss this project further.

Methods and Demands on Participants
If you choose to be included, you will be asked to participate in one focus group meeting of up to 60 minutes duration. Sample questions in the focus group will include: what are your expectations of the transition support program you are undertaking, and what factors do you think might support or hinder your transition to professional practice? The focus group will be run by Deborah Davies and Vanessa Clements (a UTS Masters research student). A light snack and refreshments will be provided. The focus group will be tape recorded and transcribed verbatim.

Consent Process
If you would like to participate please complete the enclosed consent form and return this directly to Deborah Davis in the reply paid envelope enclosed. You may also rsvp by email and complete the consent form prior to the focus group meeting. A researcher or research assistant will make contact with you prior to the focus group to confirm your attendance and answer any questions you may have.

Possible Risks, Inconveniences and Discomforts
Apart from the 60 minutes of your time for the focus group we can foresee no risks for you. Your involvement in this study is voluntary and you may withdraw your participation at any time without consequence. If you decide to withdraw participation after the focus group has commenced however, we will not be able to delete the comments that you have made to that point as the transcript of the focus group will represent a group discussion. Declining to participate in the study will not affect your relationship with the Area Health Service, your employing hospital or your transition support program in any way. The principal researchers will be the only people who are aware of your identity and all published data will be in an anonymous form. Only the researchers will have access to raw data and this will be stored in a secure office and password protected computer files.

Funding and Benefits of the Research
This study has received no funding at this time. This research will inform the development of transition support programs for midwives in these Area Health Services in the future. Findings from

the study will be published in a report and possibly published in professional journals and presented at professional conferences. Anonymity is assured and you will not be identified in any part of the research.

Ethics Review and Complaints
This study has been reviewed by the Human Research Ethics Committee (Social Science, Humanities and Behavioural Science) of the University of Wollongong. If you have any concerns or complaints regarding the way this research has been conducted, you can contact the UoW Ethics Officer on (02).

Thank you for your interest in this study.

Appendix 6

Evaluation of Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW

Consent Form for Focus Group

Principal Researchers
Deborah Davis (South Eastern Sydney and Illawarra Area Health Service)
Maralyn Foureur (Northern Sydney Central Coast Area Health Service)
Pat Brodie (Sydney South West Area Health Service)

I have been given information about the research titled "Evaluation of Transition Support Programs for Graduate Midwives in Three Area Health Services in NSW" and offered the opportunity to discuss the research project with Deborah Davis (South Eastern Sydney and Illawarra Area Health Service), Maralyn Foureur (Northern Sydney Central Coast Area Health Service) or Pat Brodie (Sydney South West Area Health Service) who are conducting this research.

I have been advised of the potential risks and burdens associated with this research, which include taking time to attend one focus group of up to 60 minutes duration, and have had an opportunity to ask Deborah Davis, Maralyn Foureur or Pat Brodie any questions I may have about the research and my participation.

I understand that my participation in this research is voluntary, I am free to refuse to participate and I am free to withdraw from the research at any time. If I decide to withdraw my participation during the focus group however, I realise that the information I have provided up to that point will not be able to be deleted from the transcript. My refusal to participate or withdrawal of consent will not affect my relationship with the Area Health Service, my employment or my transition support program in any way.

If I have any enquiries about the research, I can contact Deborah Davis (Phone:), Maralyn Foureur (phone: or Pat Brodie (phone:) or if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on.

By signing below I am indicating my consent to;
• *one focus group of up to 60 minutes duration*

I understand that the data collected from my participation will be used for preparing a report on the research, a professional journal publication and a conference presentation. The findings of this research will also be used to inform the development of graduate transitions support programs in the future, and I consent for it to be used in that manner.

Signed Date

..../...../.....

Name (please print):.....
Phone contact for telephone interviews:
Land line:…… Mobile phone:……

Appendix 7

New graduate participants with pseudonyms

"Name"	Qualification	Age	Full time / Part time	Hours worked	Interview 1	Interview 2	Focus Group
Anna	BM	36	PT	32	✔	✔	X
Cindy	BM	27	FT	40	✔	✔	X
Fay	BM	43	PT	24	✔	✔	X
Lea	BM	55	FT	40	✔	✔	X
Rose	BM	31	FT	40	✔	✔	X
Elle	BM	45	FT	40	X	✔	X
Mina	BM	45	PT	32	✔	✔	X
Nancy	BM	46	PT	32	✔	✔	X
Sally	BM	42	PT	32	X	✔	X
Bina	BM	32	PT	32	✔	✔	X
Yoko	BM	23	FT	40	X	✔	X
Betty	BM	20	FT	40	X	✔	X
Carla	BM	n/a	n/a	n/a	X	X	✔
Suzie	BM	n/a	n/a	n/a	X	X	✔
Jo	BM	n/a	n/a	n/a	X	X	✔
Vicky	BM	n/a	n/a	n/a	X	X	✔
Bernie	BM	n/a	n/a	n/a	X	X	✔
Diane	GD	32	PT	32	✔	✔	X
Irene	GD	23	FT	40	✔	✔	X
Zara	GD	33	FT	40	X	✔	X
Eva	GD	27	FT	40	✔	X	X
Helen	GD	41	PT	24	✔	✔	X
Jane	GD	40	FT	40	✔	✔	X
Kim	GD	23	FT	40	✔	✔	X
Quinn	GD	38	FT	40	✔	✔	X
Gladys	GD	n/a	PT	n/a	X	✔	X
Xena	GD	n/a	PT	n/a	X	✔	X
Amy	GD	24	FT	40	X	✔	X
Tina	GD	n/a	FT	n/a	X	✔	X
Wanda	GD	n/a	FT	40	X	✔	X
Sam	GD	n/a	n/a	n/a	X	X	✔
Mandy	GD	n/a	n/a	n/a	X	X	✔
Gaye	M	35	PT	24	✔	✔	X
Olivia	M	24	FT	40	✔	X	X
Penny	M	31	PT	20	✔	✔	X
Tracey	M	26	FT	40	X	✔	X
Una	M	24	FT	40	X	✔	X
Daisy	M	34	PT	24	X	✔	X

BM: Bachelor of Midwifery, GD: Graduate Diploma, M: Masters

n/a - information not available

Appendix 8

New Graduates' **Pre Program** Telephone Interview Pro Forma

Interviewee's Code: **Date of Interview:**

Name of interviewer: **Interviewer's Contact details:**

What midwifery qualification do you hold?
At what hospital are you undertaking your transition support program?
Do you have a clear understanding of the transition support program you are commencing?
What do you want to achieve professionally in the next 12 months?
What do you hope to gain from this transition support program?
What factors do you think will assist you to achieve what you want to achieve from this program?
Do you have any other comments to make?

Appendix 9

New Graduates' **Post Program** Telephone Interview Pro Forma

Interviewee's Code: **Date of Interview:**

Name of interviewer: **Interviewer contact details:**

What midwifery qualification do you hold?
At what hospital are you/did you undertake your transition support program?
Can you describe the elements of your transition support program?
• ***Rotations*** • ***Supernumerary time*** • ***Study Days*** • ***Mentoring*** • ***Clinical supervision*** • ***Preceptorship*** • ***Opportunity to work in continuity of care models*** • ***Assessments***
What has been your experience of the transition support program?
Did you achieve what you wanted to achieve in this program?
What factors assisted you to achieve what you wanted to achieve?

What factors hindered?
What was the best thing about your transition support program?
What changes would you recommend to the program?
Do you have any other comments to make?
Do you mind if we ask if there was a reason why you didn't participate in the study at the beginning of your transition support program?
Did you receive an information pack? (optional prompt)

Appendix 10

Focus Group Plan and Questions

1. Set ground rules:
    - Don't speak over each other
    - Safe environment
    - Circle of confidence
    - Respecting each other's opinion
    - Can leave at any time but can't delete what you have said

2. Introduction: go around the group and choose a name for themselves and introduce themselves on tape.

3. Questions:

    - What do you want to achieve in the next 12 months?

    - What does consolidation mean:
        - How exactly do you do this?

    - What does competence mean to you?

    - What does confidence mean to you?

    - What is support?
        - What does it look like for you?
        - How does it make you feel?

    - Specific skills and knowledge:
        - Why is this important?
        - Why is this a focus?
        - Is this more important than other things?
        - How will you feel when you are skilled in this technique?
        - Do you feel that people will look and/or treat you differently when you are skilled in this area?

    How are you going to be different by the end of the year?

    - Becoming professional

    - Independence

Appendix 11

Evaluating Existing Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW Participation Information Sheet for Midwifery Managers, Educators and Mentors

PURPOSE OF THE RESEARCH

This is an invitation to participate in a study conducted by researchers at the University of Technology, Sydney (UTS), South Eastern Sydney and Illawarra Area Health Service (SESIAHS), Northern Sydney Central Coast Area Health Service (NSCCAHS) and Sydney South West Area Health Service (SSWAHS).

The purpose of the research is to describe and evaluate the existing transition support programs for new midwifery graduates within these area health services. As graduates from the Bachelor of Midwifery program at the University of Technology, Sydney will be joining the workforce for the first time in 2008, the researchers are also interested in whether their needs for support are different from the graduate diploma or masters graduates. This research will inform the development of future transition support programs in these Area Health Services.

INVESTIGATORS

Vanessa Clements (Masters Student)	Dr Maralyn Foureur	Dr Pat Brodie
UTS and SESIAHS	UTS and NSCCAHS	UTS and SSWAHS

METHOD AND DEMANDS ON PARTICIPANTS

If you choose to be included, you will be asked to participate in one telephone interview of up to 30 minutes duration (in February 2009). The telephone interview will not be audio taped but the interviewer will write notes on your responses. The interview will be conducted at a time that suits you. Typical questions in the interview will include; what is your role and what experience have you had with new graduate midwives in the past year, what do you think are the needs of new graduates and what is your impression of the transition support program in place at your hospital and in what ways could it be improved.

POSSIBLE RISKS, INCONVENIENCES AND DISCOMFORTS

Apart from the 30 minutes of your time for the interview we can foresee no risks for you. Your involvement in the study is voluntary and you may withdraw your participation from the study at any time and withdraw any data that you have provided to that point. Refusal to participate in the study will not affect your relationship with the Area Health Service or your employing hospital in any way.

FUNDING AND BENEFITS OF THE RESEARCH

This study has received no funding at this time but funding will be sought through 2008. This research will inform the development of transition support programs for midwives in these area health services in the future. Findings from the study will be published in a report and possibly published in professional journals and presented at professional conferences. Confidentiality is assured and you will not be identified in any part of the research.

ETHICS REVIEW AND COMPLAINTS

This study has been reviewed by the Human Research Ethics Committee (Social Science, Humanities and Behavioural Science) of the University of Wollongong. If you have any concerns or complaints regarding the way this research has been conducted, you can contact the UoW Ethics Officer on (02).

Thank you for your interest in this study.

Appendix 12

Evaluating Existing Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW Consent form for midwifery managers, educators and mentors

Vanessa Clements(South Eastern Sydney and Illawarra Area Health Service)
Maralyn Foureur (Northern Sydney Central Coast Area Health Service)
Pat Brodie (Sydney South West Area Health Service)

I have been given information about the research titled "Evaluating Existing Transition Support Programs for Graduate Midwives in Three Area Health Services in NSW" and offered the opportunity to discuss the research project with Vanessa Clements (South Eastern Sydney and Illawarra Area Health Service), Maralyn Foureur (Northern Sydney Central Coast Area Health Service) or Pat Brodie (Sydney South West Area Health Service) who are conducting this research.

I have been advised of the potential risks and burdens associated with this research, which include taking time to participate in one phone interview, and have had an opportunity to ask Vanessa Clements, Maralyn Foureur or Pat Brodie any questions I may have about the research and my participation.

I understand that my participation in this research is voluntary, I am free to refuse to participate and I am free to withdraw from the research at any time. My refusal to participate or withdrawal of consent will not affect my relationship with the Area Health Service, or my employment in any way.

If I have any enquiries about the research, I can contact Vanessa Clements (Phone:), Maralyn Foureur (phone:) or Pat Brodie (phone:) or if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on.

By signing below I am indicating my consent to participate in one telephone interview of approximately 30 minutes duration (in February 2009)

I understand that the data collected from my participation will be used for preparing a report on the research, a professional journal publication and a conference presentation. The findings of this research will also be used to inform the development of graduate transitions support programs in the future, and I consent for it to be used in that manner.

Signed Date

..../...../.....

Name (please print)

Phone contact for telephone interviews:

Appendix 13

Experienced midwife participants pseudonyms

Midwifery Managers	Midwifery Educators	Clinical Midwives
Astra	Ester	Bea
Isla	Cate	Eve
Gloria	Gale	Mary
Donna	Doris	Claudia
Pam		Lena
Danni		
Lyn		

Appendix 14

Managers' and Educators' Post Program Telephone Interview Pro Forma

Interviewee's Code: **Date of Interview:**

Name of interviewer: **Interviewer's Contact details:**

What is your role?
What is the name of the hospital you are employed by?
What experiences did you have with new graduate midwives in the past year?
From your perspective, what sort of support did these new graduates require?
What support was provided in your area?
How was this support provided in your area?
What is your impression of the transition support program provided in your area?
In what ways could it be improved?
Do you have any other comments to make?

Appendix 15

Examples of data analysis audit trails

Meaning Unit	Condensed Meaning Unit	Sub-Theme	Theme
What factors do you think will assist you?	*"Cannulation skills"* *"Medication knowledge"* *"Perineal repair"* *"Practical sessions to go over skills drills"*	The need to attain specific clinical skills	Gaining more experience
What do you want to achieve professionally in the next 12 months?	*"Managing what comes in through the door"* *"Feel comfortable in all areas"*	The need to know what to do	Gaining confidence
What factors assisted you to achieve what you wanted to achieve?	*"Didn't know if I was asking too many questions"* *"I am not adverse to getting criticism"* *"I always go to see a woman after their birth and I always get feedback"*	The need to know if they were doing ok	Feedback as a supportive interaction

Appendix 16

17 June 2008

Associate Professor Deborah Davis
CB10.07.207
Faculty of Nursing, Midwifery & Health
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Deborah,

UTS HREC 2008-154 - DAVIS, BRODIE, FOUREUR, ADAMS, MARTIN, GILFILLAN(for CLEMENT - Master Nursing student) -"Evaluation of Transition Support Programs for Newly Qualified Midwives in Three Area Health Services in NSW"

[*External Ratification: University of Wollongong Human Research Ethics Committee HREC approval - HE08/007 23/04/08 to 28/09/09].*

At its meeting held on 10/06/2008, the UTS Human Research Ethics Committee considered the above application, and I am pleased to inform you that your external ethics clearance has been ratified.

Your UTS clearance number is UTS HREC REF NO. 2008-154R

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02.

Yours sincerely,

Dr Chris Zaslawski
(Acting) Chairperson, UTS Human Research Ethics Committee

Appendix 17

INITIAL APPLICATION APPROVAL

In reply please quote: HE08/007
Further Enquiries Phone:

22 February 2008

A/Professor Deborah Davis
PO Box 123
Broadway NSW 2007

Dear A/Professor Davis,

Thank you for your response of 20th February 2008 to the HREC review comments on the application below. I am pleased to advise that the application has been **approved**.

Ethics Number:	HE08/007
Project Title:	Evaluation of Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW.
Name of Researchers:	A/Professor Deborah Davis, Professor Maralyn Foureur, Professor Patricia Brodie, Ms Cathy Adams, Ms Vanessa Clements, Ms Margaret Martin, Mr Richard Gilfillan
Documents Approved:	NEAF application
	Letter of Invitation
	Participant Information Sheet for Newly Graduated Midwives
	Participant Information Sheet for Midwifery Managers, Educators and Mentors
	Consent form for Midwifery Managers, Educators and Mentors
	Consent form for new graduates
	Questionnaire: Evaluation of Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW, as revised in the response of 20/2/08
	Structured Interview Questions, as revised in the response of 20/2/08
Approval Date:	21 February 2008

Expiry Date: 20 February 2009

The University of Wollongong/SESIAHS Health and Medical HREC is constituted and functions in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research.* The HREC has reviewed the research proposal for compliance with the *National Statement* and approval of this project is conditional upon your continuing compliance with this document. As evidence of continuing compliance, the Human Research Ethics Committee requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforseen events that might affect continued ethical acceptability of the project.

You are also required to complete monitoring reports annually and at the end of your project. These reports are sent out approximately 6 weeks prior to the date your ethics approval expires. The reports must be completed, signed by the appropriate Head of Unit, and returned to the Research Services Office prior to the expiry date.

This certificate is approval of the proposal by an HREC, you will require governance approval from individual sites before commencing research. If you have not already done so a site specific assessment form should be lodged with the Governance Officer responsible for each site (see http://www.health.nsw.gov.au/healthethics/researchers.html for more information).

Yours Sincerely,

A/Professor Arthur Jenkins
Chairperson
Human Research Ethics Committee

Appendix 18 University of Wollongong Ethics Renewal

University of Wollongong

RENEWAL APPROVAL – SES&IAHS
In reply please quote: HE08/007
Further Enquiries Ph: 4221 4457

12 March 2010

A/Professor Deborah Davis
PO Box 123
Broadway NSW 2007

Dear Associate Professor Davis,

I am pleased to advise that renewal of the following Human Research Ethics application has been approved. A copy of this advice has been forwarded to the SES&IAHS for their records.

Please note further renewal will need to be applied for in your next annual report.

Ethics Number:	HE08/007
AuRED No:	08/WGONG/2 - AU RED
Project Title:	Evaluation of Transition Support Programs for Newly Graduated Midwives in Three Area Health Services in NSW.
Name of Researchers:	A/Professor Deborah Davis, Professor Maralyn Foureur, Professor Patricia Brodie, Ms Cathy Adams, Ms Vanessa Clements, Ms Margaret Martin, Mr Richard Gilfillan
Renewed From:	21 February 2010
Expiry Date:	20 February 2011

This certificate relates to the research protocol submitted in your original application and all approved amendments. As a condition of approval, the Human Research Ethics Committee requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforseen events that might affect continued ethical acceptability of the project.

You are also required to complete monitoring reports annually and at the end of your project. These reports are sent out approximately 6 weeks prior to the date your ethics approval expires. The reports must be completed, signed by the appropriate Head of Department, and returned to the Research Services Office prior to the expiry date.

Yours Sincerely,

Production Note:
Signature removed prior to publication.
Dr Nadia Cattenden
Chairperson
UOW&SESIAHS Health and Medical HREC

cc. Research Directorate, Wollongong Hospital

Research Services Office University of Wollongong NSW 2522 Australia
Telephone: +61 2 4221 3386 **Facsimile:** +61 2 4221 4338
research_services@uow.edu.au www.uow.edu.au/research
CRICOS Provider No: 00102E

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