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INTRODUCTION

In Australia, upon graduation from midwifery education programs, most new graduates find employment in hospitals and most undertake a new graduate program (Clements, Fenwick & Davis 2011). This usually requires the new graduate midwife to rotate through antenatal clinics, birth suite and postnatal wards over a 12 month period (Clements, Fenwick & Davis 2011). Another model is midwifery continuity of care, that is caseload midwifery in small group practices, however new graduate midwives are usually not offered the opportunity to work in midwifery continuity of care as they are seen as lacking the skills necessary to care for all women including those that may have medical complications (Panettiere & Cadman 2002). Rotating through wards has historically been seen as necessary to gain enough experience to work in midwifery continuity of care although it is not clear now whether a traditional transitional program is appropriate or necessary for new graduates who desire to work in these models (Clements, Davis & Fenwick 2013). New graduate midwives feel they are prepared to work in continuity of care due to the “follow through” experiences they undertake as students as part of the Australian registration requirements for midwifery (Cummins, Denney-Wilson & Homer 2015; Australian Nursing and Midwifery Council 2010; Gray et al. 2012). In addition, new graduate midwives in Australia have expressed a desire to work in midwifery continuity of care models soon after graduation and there is high level evidence of the benefits of these models for women (Sandall et al. 2013) and for midwives (Cummins, Denney-Wilson & Homer 2015; Dawson et al. 2015). Perhaps what is required is a mentor to support the new graduate midwife to transition from student to autonomous practice within a midwifery continuity of care model.

Midwifery continuity of care (also known as caseload midwifery or one-to-one midwifery) is defined as “care provided to women throughout pregnancy, birth and the early parenting period from one midwife or a small group of midwives” (Sandall et al. 2013). Limited numbers of new graduate midwives have the opportunity to work in midwifery continuity of care in Australia although the numbers are slowly increasing due to demand from graduates and to address workforce needs. Public maternity services have been directed by both the federal and state government to increase the numbers of continuity of care models available to women (Australian Government Department of Health and Ageing 2009; New South Wales Department of Health 2010) consequently there is a demand for midwives to staff

these models. New graduates who enter these models of care are often formally or informally mentored while their confidence grows although the precise nature of their mentoring is not known. Mentoring new graduate midwives into a midwifery continuity of care model may be an answer to increasing confidence and consolidating skills. The aim of this paper was to explore the mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia as part of a wider study exploring the experiences of new graduates.

Mentoring

Mentorship is defined as a relationship between a more senior staff member with a more junior member focusing on the development of job related skills and career advancement within a hierarchical organisation (Eby 1997). Mentoring is about the development of an interpersonal relationship between a less experienced individual a more experienced individual (Eby 2011). Mentoring has been described as a one-to-one activity that can happen in many different contexts or environments with various definitions of coach, mentor or tutor, often used interchangeably (Parsloe 2000). Mentoring has been used in many disciplines including business and nursing (Beecroft et al. 2006; Fajana & Gbajumo-Sheriff 2011). Throughout the literature the concept of mentoring involves support from a more senior or experienced person to someone new to the organisation. In the business model the overall aim of mentoring is to meet the strategic directions of the company while advancing the career path of the mentee (Fajana & Gbajumo-Sheriff 2011). Mentoring has become such common practice in business that some resistance has evolved, a suggested solution to this problem is to make mentoring as informal as possible along with the promotion of a mentoring culture (Fajana & Gbajumo-Sheriff 2011). In nursing, the goals of mentoring are to provide a smooth transition from student to the profession of nursing through socialisation into the culture and environment (Beecroft et al. 2006). It has been found that registered nurses will resign if they have not assimilated into the culture within twelve months, making mentoring an important strategy for staff retention (Beecroft et al. 2006) Similar to the business model it is recommended that mentors have training in mentoring, adequate time for meeting between the mentor and mentees is also recommended to make the mentoring program a success (Beecroft et al. 2006; Fajana & Gbajumo-Sheriff 2011).

Mentors may be either allocated or selected by the mentee ([Lennox Sue, Skinner et al. 2008](#), [Eby 2011](#)) . The mentoring relationship may have no defined end date; the period of mentorship may be over when either the mentor or mentee decide they no longer require the support ([Lennox Sue, Skinner et al. 2008](#)). Preceptorship is different to mentoring in that it

tends to be of a shorter duration and focused on the development of clinical skills not on confidence building (Lennox Sue, Skinner et al. 2008).

Mentoring in midwifery has been described as being primarily concerned with confidence building based on a more personal relationship and not just an assessment of competence (Lennox, Skinner & Foureur 2008). Mentoring in this context includes teaching, role modeling and socialising for the mentee however the benefits are reciprocal as new graduates bring enthusiasm to the mentor (McKenna 2003). Constraints of mentoring include time and financial barriers including the necessity of the health system to provide resources to support the ongoing development of midwives into mentors (Lennox, Skinner & Foureur 2008).

There are few studies that specifically explore the mentoring needs and experiences of new graduate midwives as they transition into midwifery continuity of care. One particularly relevant study is from New Zealand; which examined the experiences of new graduate midwives who were mentored into caseload practice (Kensington 2006). Mentoring occurred 'within' the midwifery practice from a midwife working alongside the new graduate in the same group practice or from 'outside' the practice where midwives working in other caseload practice provided mentoring without working alongside the new graduate (Kensington 2006). 'Inside practice' was seen as mentoring through providing support, advice, a second opinion and education, the mentor and new graduate met casually, at caseload practice meetings or on scheduled occasions to meet with women (Kensington). 'Outside practice' included support without meeting in the practice although the mentor did provide assistance with setting up the contractual business provided by the midwives (New Zealand College of Midwives (inc) 2012). On occasion, they did attend births, mostly when there was some difficulty or the midwife was distressed by the clinical events (Kensington 2006). These experiences were described as supportive and empowering (Kensington 2006) rather than the condescending nature of other transition support programs within the hospital setting and demonstrated the ability of mentoring to build confidence.

An earlier ethnographic study from the United Kingdom used focus groups and observations of new graduate midwives to report reflections from the midwives on feedback received from women (Stevens 2002). This reflective practice provided the new graduates with the realization of "what they did" and "did not know", proving to be an excellent model for consolidation of midwifery skills and knowledge (Stevens 2002) towards professional development. These two qualitative studies discussed show that new graduate midwives working in caseload practice have a positive experience and are well supported. This part of

our wider study aimed to explore similar issues in a different context, in particular, to discover the mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia.

METHOD

The experiences of mentoring are part of a larger study looking at the overall experiences of new graduate midwives working in midwifery continuity of care. A qualitative descriptive study was undertaken (Sandelowski 2000) and framed by the concept of continuity of care (Saultz 2003). Qualitative descriptive designs are a rigorous and credible form of inquiry (Avis 2003; Hughes & Fraser 2011; Sandelowski 2000) and particularly useful to describe how people feel about an event. In this case, the event was the experiences of the newly graduated midwives working in midwifery continuity of care models, in particular their experience of mentorship. Mentoring for novice midwives has been found to be about the relationship with each other (Lennox, 2012). The benefit of continuity of care as a relationship was articulated by Saulz (2003) and applied to midwifery (Page & McCandlish 2006) and provides a framework to the proposed research design.

Participants

Midwives who were either in their first or second year of practice and working in midwifery continuity of care were recruited to the study. The new graduate midwives worked as caseload midwives, in small group practices in public hospitals throughout Australia, only one participant had worked in private practice providing caseload care from a small group of privately practicing midwives. Sampling began after researching which hospitals/area health services within Australia offered midwifery continuity of care and employed new graduate midwives into midwifery group practices. In addition, the first author attended the Australian College of Midwives (South Australian branch) state conference titled “Models of Midwifery Care” held in Adelaide (Australian College of Midwifery 2012), and met a number of hospital and health service managers and midwives working in midwifery continuity of care. This opportunity allowed the researcher to network and recruit participants using purposive sampling. Once a potential participant was identified they were sent an information sheet describing the study. As few participants were gathered in this way, snowball sampling was also used. Once a participant consented and the interview was conducted the new graduate midwives’ offered the names of other potential participants. Using both these processes, 13 newly graduated midwives working in either their first or second year of practice around Australia in midwifery continuity of care models participated in the study. They were employed in a variety of models in the public sector ranging from caseload midwifery or small group practice where they worked an on-call roster providing care to approximately

forty women a year.

Data collection

As the participants were from all over Australia face to face interviews were difficult. Semi-structured interviews were mostly conducted by phone or skype with only two interviews conducted face to face. Open ended questions were used while still providing some structure to the interview process. The participants were asked about their experiences of working in midwifery continuity of care and what factors helped them or hindered them to achieve their goals during their transition year. The interviews were audio recorded, all except three (these were transcribed by the first author) were transcribed by a professional transcriber. The transcriptions were read while listening to the audio recordings and re-read for accuracy.

Data analysis

As the aim of this part of the study was to explore the mentoring experiences for the new graduates, the focus of the analysis was on mentoring. Data that related to the provision of mentoring or support were extracted from the data for this part of this study.

The data were entered into the software program, NVIVO themes were coded into nodes, (Minichiello et al. 2004). The data were read and reread and analysis ceased when theoretical saturation occurred, that is when the same themes were being heard over and over again. The initial themes that emerged from the data were about the relationship with the woman and the relationship with the group of midwives the new graduate worked alongside. An audit trail extracting the mentoring data from the raw data was developed and the second and third researchers read and agreed on the themes that emerged. As relationships were the main themes it seemed appropriate to frame the analysis within the concept of continuity of care. Mentoring is based on a relationship between the mentor and the protégé (Lennox 2012) consistent with the relationships that develop when midwives work in midwifery continuity of care.

Continuity of care has been defined by Saultz (2003) as a hierarchical framework. The lowest level of continuity is called, informational; the details of a woman are shared by many care providers through safe medical records. The next level is longitudinal and means the woman may have shared care with a number of known care providers in the one place. The highest level and most applicable framework is interpersonal or relational continuity where one care provider takes sole responsibility for a woman, a professional relationship of trust forms and the care provider is available to the woman, if unavailable a second care provider

is available (Saultz 2003, Page & McCandlish 2006). The framework was used to examine the levels of the relationship that the new graduate had, not only the woman, but the midwives they worked alongside, as formal or informal mentors. The relational continuity of care concept was used to explore the nature of the mentoring relationships and the interactions and levels with them.

Ethical approval was sought and granted by the university ethics committee. (HREC Approval Number: 2012000328) prior to commencement. Confidentiality and anonymity was assured and any identifying information about the midwives, their mentors or hospital have been removed.

FINDINGS

Thirteen participants were recruited to the study aged between 21-46 years and employed in a variety of settings in the public sector from tertiary referral hospitals to stand-alone birth centres. Eleven worked full time with one part-time (six shifts a fortnight partnering with another midwife to provide a caseload practice) and one was not working at the time of the interview. Twelve had completed a direct-entry Bachelor of Midwifery program, three from South Australia (SA), two from the Australian Capital Territory (ACT) and eight from New South Wales (NSW). One completed a Graduate Diploma in Midwifery in NSW, a postgraduate course for registered nurses that leads to registration as a midwife. Eleven had started in a standard rotational new graduate transition program with two commencing directly into midwifery continuity of care after graduation. Three had the continuity of care program incorporated as part of their new graduate program and were then employed in that model without returning to the rotation program through the various maternity wards. Four of the participants stated they were allocated a mentor with the others finding their own mentor.

There were two broad themes identified in the analysis from the larger study; these were the “relationship with the woman” and “the relationship with the group”. For the purposes of this paper, the relationship with the group was the focus as this is where the mentoring experiences were highlighted. The participants discussed building a mentoring relationship of trust, “she knew where I was at” and we “developed a mentoring relationship”. It didn’t seem to matter whether the new graduate midwives were allocated a mentor or they found their own mentor, they all experienced a mentoring relationship.

Being allocated a mentor:

Four of the participants were allocated a mentor by the manager of the group practice as part of the new graduate’s support and orientation to the group, “we were allocated a

mentor” and “we were paired up with someone else”. Two of those explained that they “had a mentor for a month”. Having a mentor meant the new graduate midwife was working with some supervision as this participant recalls, “I had a mentor in the first month and I did everything with her”. Being allocated a mentor meant that a relationship developed between the new graduate and the more experienced midwife, described here “I was allocated a mentor for a month and we still have a bit of a mentoring relationship going on”. The mentoring relationship was discussed as helpful, “it really helped having that one person to go to”. One new graduate who did not have a mentor expressed her desire to have been allocated one saying “it would have been great to have a mentor, someone who puts themselves out [for me]”. Being allocated a mentor would have provided some continuity of mentoring for this new graduate midwife.

If the allocated mentor was not available the mentor attempted to find a backup. One of the participants stated “if she couldn’t come she would try and get somebody else”. The mentoring relationship is similar to the concept of interpersonal or relational continuity when the primary midwife is not available then the second or backup midwife is called for the woman. The similarity between interpersonal continuity of care and the mentoring relationship was expressed succinctly by this new graduate “I needed midwifing into being a midwife”. The continuity of mentorship was important whether the new graduate had been allocated a mentor or found their own mentor.

Finding my own mentor:

If the new graduate midwife was not allocated a mentor, most attempted to find their own mentor, as indicated here, “I do get on particularly well with one of the senior group members so I have gone to her with questions or problems”. As the participant described getting on well with this experienced midwife, she felt confident to approach her as a mentor. In contrast, one participant who was still looking for a mentor had to think about whom to approach “I’m slowly working out who I want to go to with different questions”. This participant hoped not to become a burden so was cautious in her approach but recognised that she would find a mentor. Choosing their own mentor meant the new graduate could develop a trusting one to one relationship with a more experienced midwife.

Some new graduate midwives described finding their mentors as students, “we followed them for two weeks and their caseload” and “the one that mentored me in the last year of uni”. A couple of participants described their recruitment into the new graduate position from their mentoring experiences as a student, “as students we teamed up with a mentor” and “before I even graduated they asked me if I wanted to join the group” and “I was with the one

[mentor] who mentored me in the last year of university". The new graduates remembered spending time with the mentors as students, "I remember having some amazing mentors" and "I was following them around". Similarly new graduate's followed a more experienced midwife around "I worked with one midwife in particular for quite a few weeks" and "we teamed up with a mentor". These midwives found their own mentor by working alongside more experienced midwives in the group.

Other participants reported going to the maternity ward staff outside of the group for support and mentoring. The maternity ward staff are more experienced midwives who do not work in caseload or a continuity of midwifery group practice. The participants found their own mentors outside of the group practice "everybody sort of mentored me on the ward" and another said "I have got some beautiful mentors on the ward". Another reported finding certain midwives on the ward for support "there are some really good midwives, I specifically look for one". Again, the concept of continuity of mentorship becomes evident through reports of finding a mentor.

One participant was unsure if she had been allocated a mentor or not, saying "I work with two midwives that maybe intentional". Another reported her mentoring relationship as "I think it [mentoring] is quite informal" and another "she is my main mentor just because I spend more time with her". It didn't seem to matter to these graduates whether the mentor was allocated or not; what was important was finding a mentor and having someone to go to, for example, "for the most part there is at least one experienced midwife we can go to" and "one of the senior staff on the team". It was important to these new midwives to have more experienced midwives to go to and this is how they articulated their experience of mentoring.

Valuing knowledge and wisdom:

The new graduate midwives valued the knowledge and wisdom of their mentors regardless of whether they were allocated or they found their own. As this participant recalls "she has got seven years of experience in midwifery" and another, "the two I work with are very experienced midwives". Further reports of experience, "it's really important to have more experienced midwives as a mentor" and my mentors are "two very experienced midwives". When participants called their mentor with a query the mentor was able to answer from their knowledge base as expressed by these new graduates, "she is a fountain of knowledge" and a "wealth of knowledge".

The new graduates who had to find a mentor chose carefully, "I know there are people I can turn to and people I wouldn't necessarily turn to". When finding their own mentor one new

graduate midwife looked for a particular midwife, even after hours, “she works night duty and is a fountain of knowledge”. The mentors’ knowledge has grown from the experience of working with women providing continuity of care through pregnancy, birth and the early parenting period. The new graduate’s value for the knowledge and wisdom the mentor had gained during those years of midwifery practice and it was now shared in a supportive mentoring relationship. In particular, the new graduate midwives felt confident and safe to call their mentor at any time of day or night.

Valuing being able to call a mentor

Being able to call a mentor, day and night, for support or problem solving whether it was on the phone, in person or by text message was highly valued by participants. Being able to call a mentor varied from having just the one person to call to the whole group being available. As these two participants reported “I know I can go to *her* at any time for questions or support” and “we could call *them* anytime day and night”. The participants reported the call as well received by the mentor “I know she doesn’t mind me asking, wouldn’t mind me texting” and “if anything came up I could call her for extra support”. It didn’t matter if it was mentoring from an individual or the group as a whole “we could run it past them again” and “I can ring up whoever is on”. Mentoring in the context of midwifery group practice seems to vary to suit the particular group and individuals at different times. It is important the new graduates felt they were able to call their mentor at any time of day or night as they were working all hours of day and night.

Many of the participants reported calling in a midwife for support at a birth, particularly if they worked in a stand-alone birth centre. This form of mentoring is about supporting practice and assisted the new graduate to increase her confidence around attending births. One reported calling in her mentor “if I wasn’t confident” or “I thought I needed another set of hands at a birth”. If the new graduate felt overwhelmed it was obvious that any of the midwives from the group would support the new graduate, “they would come and help us” and “we can call them in anytime for labour support”. Another stated “so we can ring up whoever is on” and “I can literally call them in anytime for support” however one did qualify this statement with “I try and call them in daylight hours” demonstrating the reciprocal supportive nature of the mentoring relationship.

Through the development of the mentoring relationship it was easier for the participant to call for support as reported here, “I know her quite well and she wouldn’t mind me texting or asking” and another states “she was there for that sort of support”. The new graduate midwives felt comfortable with calling their mentor, “she wouldn’t mind me texting or asking”

and “be that extra support if I needed her. The mentoring relationship enabled the new graduate midwife to call either on the phone, in text message or in person for assistance in the consolidation of their skills and knowledge in their first months working in a midwifery continuity of care model.

DISCUSSION

The new graduate midwives in this study valued being allocated a mentor as they transitioned from student to an independent practitioner in midwifery continuity of care models. Being allocated a mentor is similar to the concept of preceptorship as precepting is conducted over a specified timeframe based around clinical teaching and socialisation into the organisation (Davies & Mason 2009; Lennox, Skinner & Foureur 2008; Saulz 2003). Having a mentor within a midwifery continuity of care practice differs in our study as the mentor was almost always available to the new graduate and a relationship developed over time consistent with relational mentoring (Eby 2011), there was no specified time frame that the mentoring would end as there is in a preceptor model.

Finding their own mentor either as students and/or new graduates made a difference to their experiences. According to Lennox et al (2008) formal mentoring is when a new graduate chooses their own mentor and the mentors are offered specific training about being a mentor. Given the positive experiences in our Australian study, formal mentoring could be beneficial to all new graduate midwives, especially those transitioning into midwifery continuity of care. Obstacles to providing formal mentoring are costs, time barriers and as in business and nursing it may become so routine that the relationship aspect is lost (Lennox Sue, Skinner & Foureur 2008; Beecroft, 2006; Fajana & Gbajumo-Sheriff, 2011). Our study demonstrates a benefits of mentoring final year students will attract them to work in a group practice and mentoring in their first year of practice has an impact on staff retention as in other disciplines (Beecroft, 2006; Fajana & Gbajumo-Sheriff , 2011; Lennox, 2012)

In our study, the new graduate midwives valued the knowledge and experience of their mentors. The role of the mentor was to assist the less experienced member to develop job related skills and develop confidence as a new practitioner as shown in previous research (Eby 1997;Lennox, 2012). The participants in our study developed an interpersonal relationship with their mentor. Most participants who reported having the same mentor meant they had a professional relationship of trust (Saultz 2003) and assisted them to increase their confidence as they consolidated their skills and practice. Confidence is an essential part of the transition to graduate midwife as Davis et al (2011) found that new graduate midwives have low levels of confidence upon registration in relation to the

competency standards of a midwife (Nursing and Midwifery Board of Australia 2006). The participants in our study found their confidence increased with the support of a mentor and this was augmented when there was also continuity of mentoring. The mentoring relationship meant the new graduate midwife did not need to tell her mentor what skills or experiences she required as she knew where the mentee was up to and what they needed. This is similar to the midwifery continuity of care relationship, especially when relational continuity is able to develop (Homer et al. 2008).

The new graduate midwives valued being able to call the mentor with questions, seek advice and support, sometimes having them physically present at a birth. Similar to other work by Kensington (2006), our participants found support, advice, a second opinion and teaching from midwifery mentors. The mentors supported the new graduates to transition into midwifery continuity of care through providing a high level of relational support in person, by phone and by text messaging. The new graduate midwives in our study found mentors both inside the group practice and outside the group as did the participants in Kensington's (2006) study. In addition the new graduate midwives utilised the experience and knowledge of the ward maternity staff where no mentor was available.

The findings from our study showed that having a mentor is valuable. Unlike other disciplines such as business and nursing (Beecroft et al. 2006; Fajana & Gbajumo-Sheriff 2011) the experience of mentoring in our study was rather ad hoc, only four participants were allocated mentors and the remainder had to find their own. There was no mention of the mentors having any formal training. In New Zealand, the first year midwifery practice program is funded by the Health Workforce New Zealand to provide a mentoring program to support newly qualified midwives into practice (New Zealand College of Midwives 2014). There is no system to provide mentoring programs to new graduate midwives in Australia and many seek out an informal mentor. Informal mentoring is dependent upon the "goodwill" and "kindness" of the mentor (Lennox Sue, Skinner & Foureur 2008). In Australia, when new graduate midwives are offered a mentor from within their midwifery group practice the mentor is usually nominated and not chosen. This style of mentoring is defined as institutional and often utilized in business settings (Lennox Sue, Skinner & Foureur 2008) to provide individual support in career transitions. The participants in this study had different ways of finding a mentor, they reported having a mentor as valuable as they could call them any time of day or night. The essential element was the relationship of trust they developed with their mentor. The concept of mentoring is ideal for midwifery group practice and this

may be the best place to support new graduate midwives in their transition to the full scope of practice as a midwife (Davis et al. 2012).

This is the first study in Australia to explore the mentoring experiences of newly graduated midwives as they transition into continuity of care. However, the study is limited as there were only 13 participants interviewed as new graduate midwives working in midwifery continuity of care are scarce in Australia. It is estimated that this represents about half of the new graduates working in these models in Australia although the number is growing quickly. As the proportions of new graduates to experienced midwives working in continuity of care grows, further research to determine the appropriate balance to ensure adequate support can be provided and also the benefits of allocation versus finding their own mentor needs to be addressed. It should be noted that not all midwifery continuity of care models will be staffed or funded to be able to provide mentoring or a reduced caseload. Once clarity about the best model is achieved, recommendations to service providers who arrange transitional programs for new graduates can be made. Traditional transitional programs should also be examined to determine how best mentoring can facilitate growth and development of newly graduated midwives.

Conclusions

This study explored the experiences of newly graduated midwives working in midwifery continuity of care models, specifically, the mentoring experiences. The mentoring support helped build their confidence in transitioning from student to practising midwife. With the expansion of midwifery continuity of care models in Australia mentoring should be invested in as a valuable safety net for transition midwives.

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