

**Enabling new graduate midwives to work in
midwifery continuity of care models
in Australia**

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the Degree of Doctor of Philosophy

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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

Allison Cummins

Date: 14 December 2016

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Abstract

Enabling New Graduate Midwives to work in Midwifery Continuity of Care Models in Australia

Background

Midwifery continuity of care is care provided to a woman throughout pregnancy, birth and the early parenting period, from one midwife or a small group of midwives. Midwifery continuity of care is considered the gold standard of care for women - they will experience less obstetric intervention and higher levels of satisfaction with their birth experience. Newly graduated midwives are ideally placed to work in these models, especially as in Australia they have had continuity of care opportunities through their education. However, there are limited opportunities in Australia for new graduate midwives to work in midwifery continuity of care and the literature focuses on new graduate midwives working in standard hospital transition to professional practice programs without midwifery continuity of care. This study was interested in exploring where midwifery continuity of care was available for new graduates, their experiences and how this might be expanded across the country.

Aims

The aim of the research was to:

1. Explore the experiences of new graduate midwives who work in midwifery continuity of care models in Australia.
2. Explore the facilitators and barriers to employing and supporting new graduate midwives working in midwifery continuity of care models.

Methods

This research was conducted in two phases. Phase one explored the experiences of new graduate midwives working in midwifery continuity of care models. Phase two explored the facilitators and barriers to employing new graduate midwives in midwifery continuity of care models. A qualitative study was undertaken. Data were collected through face-to-face, phone and Skype interviews. A thematic analysis was undertaken and the theories of continuity of care and the diffusion of innovation were used to further analyse the data. The study was set in Australia.

Results

The new graduate midwives built trusting relationships with the women, consolidating skills through knowing the women. They built trusting relationships with the small group of midwives they worked alongside and this provided the new graduates with a high level of support. The barriers to employing new graduate midwives in midwifery continuity of care models were overcome by visionary leaders.

Conclusions

The findings provide unique insights into the experiences of new graduate midwives who work in midwifery continuity of care models and the challenges of employing them into the models. New graduate midwives are prepared and feel supported to work in midwifery continuity of care models. Managers and other key stakeholders provide high levels of support to new graduate midwives working in the models. This research provides a conceptual model that identifies the essential elements to enabling new graduate midwives to work in midwifery continuity of care models.

Chapter One: Background

1.1 Introduction

Midwifery continuity of care 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. 2016). Midwifery continuity of care has been discussed in the literature as beneficial to women and babies and providing high levels of job satisfaction for midwives. Midwifery continuity of care models may be expanded in Australia, based on the benefits demonstrated in the research (Australian Government Department of Health and Ageing 2009; Sandall et al. 2016). With the expansion of midwifery continuity of care models, new graduate midwives will have the opportunity to work in these models. Historically, in Australia, new graduate midwives have not been able to work in midwifery continuity of care models. Instead, they have to complete a transition to professional practice program that consists of rotating through different maternity wards providing care to women that they have not met previously. Midwifery students are prepared to work to the full scope of practice as a midwife by the nature of their degree and so their frustration of not being able to provide continuity of care is often felt. My background as a midwifery educator supporting new graduate midwives to work in midwifery continuity of care models was the inspiration for this research.

This research explores the experiences of new graduate midwives who work in midwifery continuity of care models, in Australia. In particular, the research focuses on the support that new graduate midwives need to consolidate skills and practice to the full definition of a midwife. The International Confederation of Midwives (ICM) definition of a midwife is:

A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and

the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of 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 2011).

The graduates from midwifery education programs in Australia and in many countries around the world are required to practise to the ICM's definition of a midwife. In addition, in Australia, the competencies for midwifery practice include a specific competency in relation to midwives providing or supporting midwifery continuity of care (Nursing and Midwifery Board of Australia 2006b).

This chapter will explain the concept of midwifery continuity of care. New graduate midwives will be defined. The transition to professional practice program will be described as the usual transition from student to midwife. Other forms of support will be defined to provide context for the study.

1.1.1 Midwifery continuity of care

As stated earlier, midwifery continuity of care has been 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. 2016). The definition that has been adopted for the purpose of this research is the concept of continuity of *carer* where a woman receives care from one midwife sometimes referred to as the primary midwife (Homer, Brodie & Leap 2008). This term is often synonymous with independent, one-to-one or caseload midwifery practice (Homer, Brodie & Leap 2008). These midwives may choose to work in groups of up to four or six with one midwife acting as the lead carer for a woman, building a professional relationship (Homer, Brodie & Leap 2008). The different organisations of midwifery continuity of care will be discussed in detail later in this section.

Continuity of *carer* needs to be defined as separate from continuity of *care*. Continuity of *carer* refers to a known midwife providing care throughout the childbearing experience. In contrast, one midwife can provide continuity of care in a specific setting such as the antenatal clinic or birth setting but not consistently as the lead care giver throughout the childbearing experience (Homer, Brodie & Leap 2008). Continuity of care is defined as care provided by several, or even many, midwives throughout the woman's pregnancy, birth and postnatal period as long as there is good communication and consistent philosophy or policies for care (Green, Renfrew & Curtis 2000). Continuity of *care* lacks the relationship aspect of continuity of *carer*. Continuity of *carer* means the development of a relationship over time between the woman and the lead care midwife who is available throughout the woman's pregnancy, birth and transition to parenthood, ending at a mutually agreed time, usually four to six weeks after the woman has given birth (Page 2003). This professional relationship is a partnership between the woman and the midwife (McAra-Couper et al. 2014). Both international and Australian definitions of the midwife discuss midwives as working in partnership with the woman (International Confederation of Midwives 2011; Nursing and Midwifery Board of Australia 2015).

The organisation of midwifery continuity of care varies to suit the needs of women and of the midwives. Midwifery continuity of carer refers to a midwife providing care for up to 40 women a year (Homer, Brodie & Leap 2008; Page 2003). One-to-one care encompasses a professional relationship between the woman and the midwife throughout the woman's pregnancy until six weeks after the birth (Kirkham 2000; Page 2003). Often these midwives work together with a second midwife to ensure they have some time off with a second midwife being available if the primary midwifery carer is unavailable (Page 2003). One-to-one care is often termed caseload midwifery and is publicly funded in a number of countries including the United Kingdom, Canada (Page 2003) and New Zealand (New Zealand College of Midwives 2016). In Australia, most private midwifery services are organised as a caseload practice, otherwise referred to as independent midwifery practice or privately practising midwives (Davison et al. 2015). This model is sometimes difficult to sustain as it involves a lot of on-call work for the midwife. Therefore midwives work together in small groups providing midwifery continuity of care from a group practice.

Midwifery group practice (MGP) usually refers to groups of two to six midwives who have a caseload of women with the flexibility to have rostered time off including sick and annual leave with backup from one or more midwives in the group (Homer, Brodie & Leap 2008). This model is becoming more available in the publicly funded maternity services in Australia (Australian Government Department of Health and Ageing 2009; New South Wales Department of Health 2010) and offers midwifery continuity of care positions to new graduate midwives. Each midwife is primarily responsible for up to four women a month, when unavailable due to rostered days off or leave, the group work together to negotiate that there is another midwife available to the woman (Homer, Brodie & Leap 2008). The models vary in their organisation and processes across Australia (Hartz, Foureur & Tracy 2011). Midwifery group practice allows the woman to get to know a small group of midwives with one midwife acting as a primary caregiver.

Another model offering continuity of midwifery care is team midwifery. Team midwifery comprises six to eight midwives providing care in a midwifery-led unit such as a birth centre or an alongside midwifery-led unit (AMU) (Homer, Brodie & Leap 2008; Rayment et al. 2015). Women accessing this model of care usually do not have a named midwife. Birth centres are homelike settings, often located outside of the hospital. The model of care provided in a birth centre is designed for women without any known complications of pregnancy, often referred to as women of low 'risk' suitable for midwifery-led care (Biro et al. 2003). Team midwifery has been evaluated for women with both low and high risk pregnancy as satisfying to women (Biro et al. 2003). This indicates that women with a complication of their pregnancy may desire to have care provided by a known midwife or a small team of midwives.

Midwives working within midwifery continuity of care models usually care for women who are predominantly healthy. In recent years there has been some exceptions to this rule (Griffiths, McAra-Couper & Nayar 2013; Menke et al. 2014; Tracy et al. 2013), however, midwives are required to both promote preventative measures and also detect complications (Nursing and Midwifery Board of Australia 2015). In Australia, in the event of a complication, in a normal pregnancy, labour, birth or events in the postpartum period, guidelines have been developed for consultation and referral to medical colleagues (Australian College of Midwives 2008). These guidelines are particularly relevant to midwives working in midwifery continuity of care models.

The Australian Nursing and Midwifery Board (2006) provides an overarching competency framework that states women are self-determining and have a right to choice, control and continuity of care. The competency standard 'Midwifery Knowledge and Practice' states that midwives will provide or support continuity of care for women, as women are central to a midwives practice (Nursing and Midwifery Board of Australia 2006a). The cues that fall under this competency standard include demonstrating an understanding of continuity of care and carer, and supporting models that provide continuity of carer (Nursing and Midwifery Board of Australia 2006a). The Australian Nursing and Midwifery Accreditation

Council accredits the process of curriculum development and the curriculum requirements that are similar for both the Bachelor of Midwifery and the postgraduate nursing program that leads to registration as a midwife (Australian Nursing and Midwifery Accreditation Council 2014). The pathway to becoming a midwife and the inclusion of continuity of carer in the curriculum are discussed next.

1.1.2 Pathways to becoming a midwife

The pathway to qualify as a midwife in Australia is either via an undergraduate Bachelor of Midwifery course, a postgraduate degree in midwifery or a double degree in nursing and midwifery (Australian Nursing and Midwifery Accreditation Council 2010). Studies have distinguished between the experiences of new graduate midwives reaching the point of registration from different award programs (Davis et al. 2011; Hammond et al. 2011). All are eligible for registration as a midwife although these groups have expressed low levels of confidence at the beginning of their first year of practice as a midwife (Davis et al. 2011; Hammond et al. 2011).

The Bachelor of Midwifery course is offered by a limited number of universities and has only been available since 2002 in Australia, although this direct entry course has been available in other countries such as the United Kingdom for a much longer period (Brodie & Barclay 2001; McKenna & Rolls 2007). Previously in order to undertake a midwifery course the student needed to complete a nursing program. In the year 2004 after many years of political negotiation by leaders in the midwifery profession of New South Wales, the *Nurses Act 1991* was changed to reflect midwifery as a separate profession from nursing and became the *Nurses and Midwives Act (Nurses and Midwives Act 1991; Brodie & Barclay 2001)*. This change reflected the situations in other countries such as the United Kingdom and New Zealand. The change in education moved midwifery away from the historical nature of being a specialised area of nursing and enabled direct entry programs to be established in New South Wales.

1.1.3 Midwifery students experience of continuity of care

In Australia, midwifery students are currently exposed to midwifery continuity of care models through curriculum requirements and clinical experience working with midwifery group practices. These opportunities may increase their confidence to work at the full scope of a midwife as defined by the International Confederation of Midwives (International Confederation of Midwives 2011). The current midwifery curriculum standards require midwifery students to complete a minimum of 10 continuity of care experiences (Australian Nursing and Midwifery Accreditation Council 2014) during their degree that leads to registration as a midwife, therefore exposing and preparing new graduate midwives to work in midwifery continuity of care models. A continuity of care experience means the student will engage with a minimum of 10 women; engagement involves attending four antenatal visits, two postnatal visits and, for the majority of women, the labour and birth (Australian Nursing and Midwifery Accreditation Council 2010). Both women and midwifery students report the continuity of care experiences to be highly valuable (Aune, Dahlberg & Ingebrigtsen 2012; Browne & Taylor 2014; Hilder et al. 2014; Tickle et al. 2015) with many students wanting to work in this way on graduation (Dawson, Newton, et al. 2015; Gray, Taylor & Newton 2016). The next section will discuss the usual working patterns of new graduate midwives in Australia.

1.1.4 New graduate midwives

The term 'newly graduated' is specific to midwives who are working in the first 12 to 24 months following eligibility for registration. For the purpose of this research, a new graduate midwife is defined as having completed an award program that makes them eligible for registration as a midwife in Australia with the national registration board and in their first one to two years of practice. As explained earlier, at the time of graduation, midwifery students will have met all the curriculum requirements including providing continuity of care to at least 10 women during their clinical experience (Australian Nursing and Midwifery Accreditation Council 2014); therefore, new graduate midwives are prepared to work in midwifery continuity of care models after completing the curriculum requirements. This pre-registration

exposure to midwifery continuity of care, together with newfound knowledge and enthusiasm, make new graduate midwives perfect candidates for working in midwifery continuity of care models (Fenwick et al. 2012; Hammond et al. 2011).

Historically in Australia, as in some other countries, new graduate midwives have not had the opportunity to work in midwifery continuity of care as they have been required to complete a transition to professional practice program for their first year of practice (Clements, Davis & Fenwick 2013; Davies & Mason 2009; Davis et al. 2011; Hollands et al. 2001; Levett-Jones 2005). This model evolved from the discipline of nursing and is based on the premise that new graduates gain experience from rotating through different hospital wards.

1.1.5 Transition to professional practice programs

New graduate transition to professional practice programs for graduate nurses have existed since nurse education was transferred from being hospital-based to the university setting (Levett-Jones 2005). These have included midwives in the past decade as well. The transition to professional practice program offers graduate nurses and midwives consolidated clinical support (including preceptorship) and education study days, which goes beyond standard orientation and induction of new employees (Nursing and Midwifery Office 2015) and lasts for approximately 12 months. These programs usually rotate new graduate nurses and midwives from one area or ward for a specified period of time, around three months, before moving the graduate to another area. The programs vary from organisation to organisation and there is debate in the literature on the best model of support for new graduates (Evans, Boxer & Sanber 2008; Johnstone, Kanitsaki & Currie 2008; Levett-Jones 2005). Studies report that new graduate nurses were looking to more experienced nurses to guide their clinical practice and decision-making, hence transition to professional practice programs were introduced to facilitate this and help reduce the stress levels of new graduates (Missen, McKenna & Beauchamp 2014). This may be the same for midwives.

New graduate transition to professional practice programs have been positively reviewed in relation to support for new nurses, however, the programs vary enormously in structure and can be somewhat ineffectual (Laschinger 2012; Levett-Jones 2005; Missen, McKenna & Beauchamp 2014). A Canadian exploratory study used focus groups of new graduate nurses to discover their experience (Wolff, Pesut & Regan 2010). The findings revealed new graduates being 'grouped' on the basis of their training into either diploma or degree courses, technical or professional nurses - diverging from the intention to give support to the new graduates (Wolff, Pesut & Regan 2010). The authors argued that this initiation to practice was not a supportive process and only serves to perpetuate a cycle of nurses feeling underprepared for practice (Davis et al. 2011; Wolff, Pesut & Regan 2010).

Wolff's (2010) findings are similar to those of other disciplines, who have coined the term 'they eat their young', meaning the more experienced nurses, midwives or teachers do not support the graduates in their transition from student to professional (Halford 1998; Hastie 1985; Wolff, Pesut & Regan 2010). New graduates are actively recruited by hospitals to assist with staffing for the organisation (Evans, Boxer & Sanber 2008) and are then marginalised and unsupported at the time that support is paramount (Evans, Boxer & Sanber 2008; Johnstone, Kanitsaki & Currie 2008; Levett-Jones 2005; Wolff, Pesut & Regan 2010). It is questionable whether transition to professional practice programs are appropriate for supporting new graduate midwives who desire to work in midwifery continuity of care models, as their role differs greatly from a nurse working within a rostered structure (Clements, Fenwick & Davis 2012; Davis et al. 2011). The scope of practice of a midwife is to work across the continuum of pregnancy, birth and the postnatal period with a woman at the centre of the care provision, not the needs of the hospital organisation.

In a midwifery continuity of care model, women become the centre of the relationship as less organisational issues exist and the relationship is solely between the woman and the midwife (Kirkham 2000). A recent Australian study measured the confidence of new graduate midwives from both the Bachelor of Midwifery program

and postgraduate nursing programs (Davis et al. 2011). All the graduates reported low levels of confidence at the beginning of practice when self-assessed against the competency standards of a midwife (Nursing and Midwifery Board of Australia 2006b). The importance of this measurement is that new graduate midwives may not have the confidence to work in midwifery continuity of care models. At the completion of the first year of practice, confidence did improve marginally (Davis et al. 2011). The authors note this low level of confidence may have stemmed from the lack of student experience of working in midwifery continuity of care models and it is recommended that students' exposure to midwifery continuity of care models may prepare them better to work against the Australian competency standards for the midwife (Davis et al. 2011).

The transition from student midwife to practising as a confident registered midwife may be challenging, as the transition to professional practice programs in existence often vary to suit organisational needs rather than developing the confidence of the clinician (Davis et al. 2011). In New Zealand, approximately half the midwifery workforce provide continuity of midwifery care as lead maternity carers (Dixon et al. 2015; Gilkison et al. 2016). New graduate midwives working in these caseload and small group practices are offered mentoring, described below, instead of a transition to professional practice programs.

1.1.6 Mentoring in midwifery practice

Mentoring has been one strategy used to support new graduates. Mentoring in midwifery is support from a more experienced midwife to a less experienced midwife. Guidance provided through goodwill and kindness is one kind of mentoring while classical mentoring is career support for a less experienced colleague within corporations (Lennox, Skinner & Foureur 2008). The business model of mentoring emerged in the 1970s and is so widespread that some resistance has developed from the industry who are now calling for formalised mentoring to develop a positive mentoring culture (Fajana & Gbajumo-Sheriff 2011). Formalised mentoring is a structured process where mentors opt into the program, attend training sessions

and keep a record of contact hours they spend with the mentee (Lennox, Skinner & Foureur 2008). The New Zealand Midwifery First Year of Practice Program is an example of a formalised mentoring program for new graduates who begin to work in midwifery continuity of care practices (New Zealand College of Midwives 2015).

In Australia, there are no formalised opportunities for new graduate midwives to experience mentoring but there are lots of less formal options. The transition to professional practice program purports to offer preceptorship (Nursing and Midwifery Office 2015), as will be described in the next section.

1.1.7 Preceptorship

Preceptorship is generally defined as clinical teaching and socialisation into the organisation within a specified time frame (Davies & Mason 2009; Lennox, Skinner & Foureur 2008). The manager appoints preceptors and their main role is to teach the new graduate the conventions and processes of that particular hospital (Lennox, Skinner & Foureur 2008). Unlike mentoring, preceptors specifically teach clinical requirements for a particular clinical context within a specified time frame. In contrast mentoring supports the needs of the new graduate and the mentoring relationship may exist long after the initial orientation to the new clinical area (McKenna 2003). Mentoring appears to be an appropriate form of support for new graduate midwives who are transitioning from student to registered midwife working within a midwifery continuity of care model as the new graduate can develop a relationship with the mentor who usually works within the small group of midwives (Kensington 2006).

1.1.8 Context for the introduction of midwifery continuity of care models in Australia

The following discussion provides an overview of the context of maternity care in Australia and the introduction and expansion of midwifery continuity of care models.

Government directives for publicly funded maternity services to provide midwifery models of care instigated the expansion of caseload midwifery, usually known as midwifery group practice (Australian Government Department of Health and Ageing 2009; New South Wales Health 2010). Despite these initiatives, uptake has been slow with less than 10 per cent of women having access to midwifery-led care (Dove & Muir-Cochrane 2014). Following consumer action and lobbying, midwives in Australia were granted the ability to provide services through the universal health insurance scheme called Medicare and a mechanism known as an 'eligible midwife' (Teakle 2013).

One strategy to increase women's access to midwifery-led continuity of care was for eligible midwives to provide private midwifery care and claim health insurance benefits. Eligible midwives have standards to adhere to and are able to move into private practice and offer midwifery services to women (Nursing and Midwifery Board of Australia 2013). The privately practising midwives mostly provide care in the woman's home including homebirth. According to Teakle (2013), the government underestimated the resistance from the medical profession in response to this change in maternity services. Only one state in Australia, Queensland, has progressed in providing collaborative arrangements between hospitals and eligible midwives in private practice, although, the states of Victoria, New South Wales and South Australia now have homebirth policies. Many public hospitals are providing midwifery continuity of care models, such as midwifery group practice, for women to access.

One of those hospitals is the Royal Hospital for Women in New South Wales, Australia, where a clinical redesign (Hartz et al. 2012) saw the introduction of 32 full time equivalent midwives working in midwifery continuity of care models known as midwifery group practice (MGP). At the time of the maternity reform at this hospital, I was employed as a midwifery educator in birthing services and had a unique role in supporting midwives as they moved from working rostered on shift in wards to working in continuity of care, working hours around the needs of the women. The

next section will explain further my interest in exploring the area of new graduate midwives working in midwifery continuity of care models.

1.2 My personal experience

As a researcher, it is important to explain my interest in, and reasons for, undertaking this topic in my doctoral research study in order to provide an audit trail of my reflexivity. As explained above, my previous position and experience was a midwifery educator in the clinical setting. At the time there was a need to recruit new graduate midwives into midwifery continuity of care models in order for the models to be adequately staffed. As an educator, I found that newly graduated midwives do require extra clinical support when working in midwifery continuity of care models as they consolidate skills and practice across the full scope of practice of a midwife. My experience of working with and supporting new graduate midwives who work in midwifery continuity of care models required me to take a reflexive approach throughout this thesis.

During the transition process, new graduate midwives requested my presence at antenatal visits, births or postnatal checks. My role was to provide clinical support for example, the first waterbirth the new graduate attended/and supervise skills such as perineal repairs, venepuncture and cannulation. The new graduate midwives would also come and meet with me, phone me or sometimes send a text message in order to run a question or clinical decision by me. They also accessed the other three midwives in the group for these kinds of questions. Midwifery group practice demands the new graduate provide care to women throughout pregnancy, being on call for her labour, birth and continuing to provide care in the postnatal period. This care is provided both within and outside the hospital and the midwives are provided with mobile phones so the woman can contact the midwife at any time. Having a mobile phone assists with the provision of support when working in midwifery continuity of care practice as the new graduates could call me or the other midwives in their group at different times when we were not necessarily close by. The new graduate midwives had to adjust to a change in their working pattern. This change in work patterns can be daunting for experienced midwives (Collins et al. 2010) and

prove an extra challenge for those midwives in the transition from student to midwife.

The new graduate midwives had been rostered on shifts as students to gain clinical experience, so transitioning to working their own hours was a new experience, consolidating skills in midwifery practice, and being on call was a big transition period. Providing a high level of support initially to the new graduate midwives demonstrated how well they could transition from student to newly qualified midwife providing continuity of care. After a short period of orientation and support, the new graduates' confidence increased and they no longer needed support. They would just meet with their small group once a week where collegiality developed.

The government recommendation for public maternity services in New South Wales and Australia to provide midwifery continuity of care models means all midwives including new graduate midwives will have the opportunity to work in these models (Australian Government Department of Health and Ageing 2009; New South Wales Department of Health 2010). My experience of supporting new graduate midwives working in continuity of care models instigated the need to study the area as most new graduates do not have access to continuity of care models and are required to work in a transition to professional practice model despite having a desire to work in continuity of care models (Fenwick et al. 2012; Hammond et al. 2011) at the time of registration. The next section describes the research process as I summarise the structure of this thesis.

1.3 Thesis structure

The following provides an overview of the contents of each chapter of the thesis. Chapters, Four, Five and Six provide the findings of the research. Each of these chapters presents a published paper in its original form. Each paper has a reference list at the end of the chapter. These reference lists are in addition to the final reference list at the end of the thesis. The articles are provided, with permission, from the publisher, in their published form as Appendices.

1.3.1 Chapter One: Background

Chapter One of this thesis has explored the background to the research. Midwifery continuity of care was defined and the various models in existence have been clarified. The definition of a new graduate midwife was provided along with a description of the various support programs in existence to provide a smooth transition from student to midwife. The pathways to becoming a midwife provide further context for the research. My personal journey of how I became interested in the topic area has also been provided.

1.3.2 Chapter Two: Literature review

Chapter Two of the thesis presents a review of the literature in relation to the outcomes for women, midwives and midwifery students who engage in midwifery continuity of care. A review of the literature on new graduate midwives' experiences are provided, however, there is limited literature on the experiences of new graduate midwives working in midwifery continuity of care models in Australia. Most new graduate midwives have to complete a transition to professional practice program and the literature that has evaluated these programs in Australia has been reviewed. The New Zealand experience is quite different and the literature on new graduate experiences particularly in relation to mentoring is discussed.

1.3.3 Chapter Three: Research design and methods

This research used a qualitative descriptive methodology and this is described and discussed in this chapter. Data were collected through interviews and thematic analysis was undertaken. A qualitative methodology was determined to be the most suitable for this research due to the nature of the research questions. Studying the experiences and perspectives of the participants was vital in this research and the use of qualitative methods, such as interviews, enabled this. After the initial analysis, a theoretical framework, that was a good fit for the data, provided a scaffold for further analysis. Two theoretical frameworks were utilised that were considered to be the most relevant: continuity of care and the diffusion of innovation theory. The

ethical considerations inherent in this research are described in this chapter. This includes identifying the issues concerning my integral role as both researcher and knowing some of the participants through my previous work as a clinical educator and my current role as midwifery lecturer.

1.3.4 Chapter Four: Phase one findings: The experiences of new graduate midwives working in midwifery continuity of care models.

This chapter presents the findings from the analysis of the data collected from participants who were new graduate midwives working in midwifery continuity of care models. This chapter provides the first phase of the research findings and, as such, gives a foundation to the remaining chapters. In this chapter the experiences of the new graduate midwives are explored within the Continuity of Care framework to arrive at the final findings. The relationship with the woman and the relationship with the small group of midwives made the new graduate midwives feel like a real midwife. This chapter was published in the journal *Midwifery* in 2015.

1.3.5 Chapter Five: The mentoring experiences of new graduate midwives working in midwifery continuity of care models.

Further analysis of data collected from the new graduate midwives is presented in this chapter. These participants described their mentoring experiences from within the small group of midwives they worked alongside or from other midwives who worked in the maternity service but not in continuity of care models. The value of mentoring and associated challenges of mentoring becomes apparent in this chapter. This chapter was published in the journal *Nurse Education in Practice* in 2016.

1.3.6 Chapter Six: Phase two: The challenges of employing and supporting new graduate midwives working in midwifery group practice in hospitals.

Chapter Six provides the results of the interviews with the managers and other key stakeholders who employ and support new graduate midwives to work in midwifery continuity of care models. The other key stakeholders include clinical educators, clinical support midwives and clinical midwifery consultants who provide orientation and support to new graduate midwives. The data was analysed using the Diffusion of Innovation theory because employing new graduate midwives into midwifery continuity of care models requires innovation within the organisation. There were drivers, enablers and facilitators to employing new graduate midwives into the midwifery continuity of care models. It was found that visionary leadership was able to overcome barriers to employing new graduate midwives to work in midwifery continuity of care models. This chapter was published in the *Journal of Nursing Management* in 2016.

1.3.7 Chapter Seven: Enabling continuity of care for new graduate midwives

Chapter Seven brings together the findings from an analysis of all the data collected in this research along with the relevant literature. Further synthesis of the findings, the literature and the theoretical frameworks led to the development of a new conceptual model. This conceptual model provides the essential elements to enable new graduate midwives to work in midwifery continuity of care models.

1.3.8 Chapter Eight: Implications and conclusions

The research has led to implications for new graduate midwives, organisations that provide midwifery continuity of care models and women who access the models. The limitations of the study are provided in this chapter and the conclusions including implications for future research in the area.

1.4 Conclusion

The background information of this chapter is to provide some definitions and context relevant to the current study. The following chapter will review the literature relevant to the study. Firstly, the next chapter will look at the evidence supporting midwifery continuity of care in order to establish the benefits for women, midwives and the health services that provide maternity service. Further evidence will be reviewed to discover the existing evidence about new graduate midwives working in midwifery continuity of care models and identify any gaps in the literature related to my study.

Chapter Two: Literature review

2.1 Introduction

This chapter reviews the literature on new graduate midwives working in midwifery continuity of care models. Analysis and critique of the literature will provide an understanding of the continuity of care models and the experiences of new graduate midwives. The evidence for midwifery continuity of care models, both in Australia and internationally, will be explored. The aim of the literature review will be to describe the outcomes for women, babies, midwives and the maternity services who provide midwifery continuity of care models. As midwifery students are required to complete a number of continuity of care experiences in order to complete their degree, the literature in relation to their experiences will also be analysed. Finally, the existing support programs for new graduate midwives working in midwifery continuity of care both in Australia and overseas will be critiqued.

Method

In order to undertake the review the following databases were searched: MEDLINE, CINAHL, OVID, Maternity and Infant Care (MIDIRS) and the Science databases. The timeframe for inclusion was from 1989 when the ground-breaking work 'Know Your Midwife Scheme' was first published (Flint, Poulengeris & Grant 1989) and the search includes all published studies until September 2015. The following search terms were used: *new graduate midwives, midwifery continuity of care, new graduate support programs, mentoring, precepting and transitional support programs*. Several search terms were combined and shortened versions of these phrases with different spelling options were used. The review includes literature from the United Kingdom, Canada, New Zealand and also from Australia but is limited to high income countries as the setting for the research was Australia. The literature includes published peer-reviewed research, conference presentations and midwifery commentaries from experts in the field. The development of textbooks and any government recommendations that have been informed by the literature will also be included in the review although it is acknowledged that these are not

primary research sources. The review begins with an exploration of the literature on midwifery continuity of care.

2.2 Midwifery continuity of care

Midwifery continuity of care has been evaluated through a systematic review and randomised controlled trials that provide numerous positive outcomes for women and babies. The experiences of women, midwives and midwifery students have been provided through qualitative studies.

2.2.1 Outcomes for women and babies

A systematic review that included 15 trials involving 17,674 women has found midwifery continuity of care when compared with standard care is beneficial to women (Sandall et al. 2016). Midwifery continuity of care was care provided to women through pregnancy, birth and the early parenting period by one midwife or a small group of midwives. Standard care was cited as care from an obstetrician or a family physician such as a general practitioner (GP) as well as midwives working in a fragmented or non-lead ways. The review included women who had both no risk of complications and those who had some increased risks of complications. The studies were from Australia, Canada, Ireland, New Zealand and the United Kingdom (Sandall et al. 2016). Benefits to women and babies included a reduction in epidural anaesthetic, decreased rates of instrumental births and episiotomies. There was an increase in spontaneous births with women having a known midwife present at the birth. Women had less chance of having a preterm birth, and the overall perinatal death rate was lower (Sandall et al. 2016). This systematic review is limited to high-income countries and did not find a difference in the rates of caesarean section births. The authors concluded that midwifery continuity of care was an important intervention for all women although more research in women with risks is needed.

An Australian randomised controlled trial, included in the above review, compared caseload midwifery (primary midwife or backup midwife) with standard care from a

variety of midwives, trainee obstetricians or GPs (McLachlan et al. 2012). They found women who had caseload midwifery were less likely to have caesarean sections than women in the standard care group (McLachlan et al. 2012). The findings from this trial are limited to women with a low risk pregnancy and in a setting with a relatively high baseline caesarean section rates. In contrast, a second Australian trial comparing caseload with standard care primarily measuring caesarean section outcomes found no difference in the rates of caesarean section. This trial included women of all-risk, only excluding women who planned a caesarean section at the booking visit and women with a multiple pregnancy (Tracy et al. 2013). Significant differences were found in the secondary outcomes including less inductions of labour and less birth-related blood loss greater than 500mLs (Tracy et al. 2013). Women were more likely to be discharged home within two days. The costs were calculated as \$A566.74 less for a woman allocated to caseload midwifery than those allocated to standard care (Tracy et al. 2013). These two Australian trials have provided recent evidence to support the benefits to women and their families when they have caseload midwifery care in Australia.

An increase of women's satisfaction when receiving midwifery-led continuity of care was demonstrated in the systematic review, however, the authors did not draw any conclusions to maternal satisfaction as all the trials included in the review measured satisfaction differently (Sandall et al. 2016). Women's satisfaction was measured in one of the Australian trials (McLachlan et al. 2013; Tracy et al. 2013). McLachlan et al. (2016) sent out a postal survey two months after the women gave birth; they found the women randomised to caseload midwifery were more able to express their feelings, felt more in control, more proud of themselves, and coped better physically and emotionally with the birth. However, there was no difference in women's perception of pain (McLachlan et al. 2016). These findings have built on the findings from other studies looking at women's experiences of midwifery continuity of care. Other levels of evidence that are not randomised controlled trials have looked at women's experience of midwifery-led continuity of care. These will be discussed in the next section.

An Australian evaluation of an earlier midwifery group practice found that women were most satisfied with the relationship aspect of the model when they knew their midwife (Fereday et al. 2009). Women's satisfaction and adjustment to motherhood was measured in one pilot midwifery project in New South Wales, Australia, that provided a high level of continuity; that is, the primary midwife provided most of the woman's antenatal and intrapartum care (Williams et al. 2010). Women responded positively to the self-reported questionnaire, stating they felt in control and built trusting relationships with their midwives (Williams et al. 2010). The women also reported feeling special. The authors state this phenomena is associated with new models of care and not necessarily caseload, and they conclude that continuity of care should not be the only focus of improving services for women (Williams et al. 2010). The findings should be interpreted with caution as they came from a small regional hospital in New South Wales, Australia, making generalisability limited. Continuity of care and familiarity of the caregiver has been described as more important to women than the facility in a descriptive analysis from the state of New South Wales, Australia (Jenkins et al. 2014). The analysis was conducted in a variety of settings that included urban and rural, large and small, tertiary and non-tertiary hospitals, and community clinics throughout the state (Jenkins et al. 2014). Continuity of care could be interpreted as a general practitioner (GP) or an obstetrician and not necessarily midwifery-led care. However, applying the findings to midwifery continuity of care means there will be a familiar caregiver throughout the woman's pregnancy, on call for her birth and who will see her in the postnatal period.

Midwifery continuity of care has been proposed as highly satisfactory to both women and midwives as will be described in the next section (Collins et al. 2010; Hartz, Foureur & Tracy 2011; McCourt, Beake & Page 2001; Page 2003; Stevens & McCourt 2002).

2.2.2 Outcomes for midwives

More than a decade ago, Stevens and McCourt (2002) found that midwives joined caseload practice as they felt disillusioned working in the fragmented hospital

system. These midwives reported feeling more in control in managing their time autonomously, working with the needs of women rather than organisational structures and the midwives received more interest and respect from their medical colleagues when working in the continuity of care models. 'Practising as a real midwife' was the final theme from focus groups (n= 20) working in the continuity of care practice for three years. The models were part of a larger quasi-experimental study evaluating one-to-one midwifery care when compared with standard care in the hospital setting (McCourt, Beake & Page 2001; Stevens & McCourt 2002). Although an early study, there were a large number of midwives who took part in the focus groups after working in the model for three years. Their views are valuable in understanding that midwives can develop skills to look after all women in a continuity of care model. The study was limited to including midwives who had experience working within the local service, 17 in the hospitals and three in the community, but there were no new graduate midwives in the sample (McCourt, Beake & Page 2001). A key element of the evaluation was the support the midwives experienced from working within the practice, stating it took, on average, 10 months to consolidate skills in autonomous practice (McCourt, Beake & Page 2001).

The widespread introduction of midwifery continuity of care (caseload) under the national health scheme in the United Kingdom, known as one-to-one midwifery, was evaluated and found midwives were highly satisfied when working in this model (Page 2003). Although the evaluation is over 10 years ago, it is important to discuss the findings as one-to-one midwifery care forms the basis of many midwifery continuity of care models. The outcomes for midwives were found to be highly satisfying when they carry a caseload. The caseload in one-to-one midwifery is described as providing care to a specific number of women a year (40 women a year, working on average 37.5 hours per week) (Page 2003). The evaluation of this model demonstrated midwives felt more confident when they work in midwifery continuity of care (Page 2003). There was some controversy amongst the midwives as they adapted to working in the continuity of care models when they were used to working shifts (Page 2003).

Similarly, in Australia the provision of continuity of care can be difficult to implement as most midwives have become accustomed to working shifts and may not understand the highly satisfying nature of working in a continuity of care model (Hartz et al. 2012). It is therefore important to understand what aspects of continuity of care midwives value, especially when discussing new graduate midwives moving straight into midwifery continuity of care models at the time of graduation.

In continuity of care, midwives value being able to organise their work/life balance. The idea of being on call for a woman's birth has often been reported as a threat to the midwives' work/life balance causing professional burnout (Hartz et al. 2012). Burnout refers to emotional exhaustion leading to loss of workplace engagement and low professional self-esteem (Jordan et al. 2013; Sandall 1997). Some midwives report working in midwifery continuity of care models as a challenge with the amount of 'on call' and associated adjustments to their life (Collins et al. 2010).

An early, well known and regularly cited study reports case studies of midwives providing continuity of care, where the midwife was the main, but not the only, carer for the woman (Sandall 1997). Sandall (1997) found nine out of the 48 midwives experienced burnout (Sandall 1997). A lack of collegial support, a high workload with fragmented client care, idealistic expectations and lack of support at home were all the factors reported as leading to 'burnout' (Sandall 1997). Strategies suggested to increase the sustainability of caseload midwifery included occupational autonomy, social support and the opportunity to develop meaningful relationships with women.

In another study, midwives were reported to be dissatisfied with midwifery because they were unable to provide the relationship aspect of midwifery care due to organisational restraints and this led to an attrition of midwives from the National Health Service (Curtis, Ball & Kirkham 2006). The findings from this study need to be considered carefully as most attrition was attributed to midwives who were aged between 36 and 49 years and there could have been other life factors that influenced their career change. This study from the United Kingdom may be

considered less relevant as more continuity of care models are introduced and the issues/concerns from earlier research are being addressed.

Autonomous practice and teamwork have been associated with low levels of burnout for midwives providing continuity of care in community midwifery programs in the United Kingdom (Yoshida & Sandall 2013). The aim of this study was to measure occupational burnout for community and hospital-based midwives, from just one health trust located in the United Kingdom as part of a larger evaluation of caseload midwifery (Yoshida & Sandall 2013). Higher levels of satisfaction, job control, team-work, and perception of management support were reported by the community midwives while the hospital-based midwives were more likely to experience bullying and harassment leading to feelings of burnout (Yoshida & Sandall 2013). Community midwives had higher levels of professional autonomy and that led to feelings of satisfaction. However, the authors recommend the conclusions are applied with caution as the community midwives also had high levels of stress associated with their workload (Yoshida & Sandall 2013).

Several Australian studies have found that professional burnout may be more prevalent among midwives working rostered shifts rather than in continuity of care models (Jordan et al. 2013; Mollart et al. 2013; Newton et al. 2014). In one study burnout was found to be related to shifts worked, years in the midwifery profession and caring for women with high psychosocial needs (Mollart et al. 2013). This latter study was limited to one area health service in Australia and assessed the level of burnout in midwives working in a hospital on a roster system (Mollart et al. 2013) and therefore may not be applicable to midwives working in midwifery continuity of care models.

Similar findings were reported in a study from South East Queensland, another state of Australia, where only five out of the 58 midwives surveyed worked in continuity of care, the rest worked rostered shifts in the hospital with over 60 per cent of the respondents working in only one area of the maternity service (Jordan et al. 2013). Work area was a factor associated with emotional exhaustion (burnout) but not

providing continuity of care (Jordan et al. 2013). Other factors including the age of the midwife, years of experience and employment position were all rated as low (Jordan et al. 2013). The authors recommended employing midwives in models of care that provided higher levels of job satisfaction, such as a continuity of care model (Jordan et al. 2013).

One study, that was part of a larger randomised controlled trial, discussed earlier, compared caseload midwives with midwives working rostered shifts in a hospital setting (standard care) (Newton et al. 2014). The midwives in caseload practice scored higher on professional satisfaction, professional support and client interactions and had lower rates of burnout (Newton et al. 2014). The study is limited as the participants self-selected, with less than a 50 per cent response rate from the midwives in the standard model. It is possible those midwives who experienced burnout did not respond (Newton et al. 2014). The findings from this study, however, help to identify the reasons that midwives may want to work in caseload midwifery and raises the question of what parts of continuity of midwifery care are professionally satisfying (Newton et al. 2014). New graduate midwives may be attracted to work in midwifery continuity of care due to the higher levels of professional support available and the potential level of autonomy.

A phenomenological study, from New Zealand, looked at the lived experience of burnout for caseload midwives (Young, Smythe & McAra-Couper 2015). The authors found that midwives in New Zealand, have a passion for building relationships and being on call for women. In some instances this means the midwife is 'everything' to the woman and does not take care of herself, resulting in burnout (Young, Smythe & McAra-Couper 2015). Often the midwives did not recognise the symptoms of burnout, it was hidden from others and the midwives lacked support. The authors call for educative measures to raise awareness of burnout in midwifery practice and support through mentoring (Young, Smythe & McAra-Couper 2015). The study is limited to the New Zealand setting where many midwives work autonomously in caseload practice. Some of their recommendations are applicable to the Australian

setting and to this research, particularly the Midwifery First Year of Practice Program that will be discussed in detail later in this chapter.

Collins et al. (2010), in South Australia, found midwives moving into caseload practice from standard care were excited about the more autonomous nature of the role, providing continuity of care, building collegiality with their group practice and new beginnings. The midwives were concerned about conflict and acceptance, both within the group and the hospital, work arrangements such as being on call and the work environment; that is, not having a designated space for the midwifery group practice (MGP) midwives (Collins et al. 2010). The evaluation was carried out over an 18 month period and, after five rounds of assessment, the authors concluded the midwives were highly satisfied with the change in working from standard care to midwifery group practice (Collins et al. 2010). After several years, midwives working in continuity of care models such as caseload were becoming accepted in the hospital system as another model of care available to women.

Looking at general reasons why midwives continue to stay in midwifery may also shed some light on the concept of professional satisfaction. In New South Wales, Australia, the highest-ranking reason midwives stay in the profession has been reported as building relationships with women and midwifery colleagues (Sullivan, Lock & Homer 2011). The authors recommended that area health services in New South Wales, Australia, should consider introducing more continuity of care models in order to attract and retain midwives in the profession (Sullivan, Lock & Homer 2011). This evidence suggests that midwives want to work in midwifery continuity of care models due to the relationships with the women and the small group of midwives they work alongside.

There are some perceptions or reports that midwives in Australia do not want to provide continuity of care. Such perceptions that midwives would not want to work in continuity of care models were dismissed as one large hospital underwent clinical redesign with the introduction of 32 full-time equivalent midwives working in the midwifery group practices, discussed earlier (Hartz et al. 2012). The maternity

service enjoys a full complement of staff attracting midwives from England, who want to work in caseload practice in Australia (Hartz et al. 2012).

Midwives also value autonomous practice as found in a recent Australian study (Edmondson & Walker 2014). The midwives from a regional birth centre providing caseload midwifery care reported more autonomy in their practice with a good work/life balance (Edmondson & Walker 2014). These midwives built effective and supportive work relationships and an ability to practice within the hospital guidelines, while developing a relationship of trust with the woman (Edmondson & Walker 2014). The study was limited to a birth centre in North Queensland, Australia, that employs nine full-time caseload midwives, however, the findings add to the growing evidence that midwives seek relationships with women and autonomous practice.

The midwife-mother relationship is a professional relationship developed from the first point of contact and is dependent upon trust and respect (Kirkham 2000). Having access to a continuity of care model does not always equate to the development of meaningful relationships between midwives and mothers (Freeman 2006). Midwives working in larger team models may not provide the same level of continuity or relationship building and therefore the outcomes for both mothers and midwives cannot be generalised (Freeman 2006; Homer 2006). Some of the reasons that midwives choose to work in larger teams is to avoid the on-call component. Working in a continuity of care model will never be suitable for all midwives, especially due to family commitments (Hartz et al. 2012). Maternity services still need core staff working on a roster system as not all women will have access to continuity of care models (Hartz et al. 2012).

Other than the relationship with women, midwives are attracted to working in a small team of two to four midwives as collegiality develops between midwives in group practice (Collins et al. 2010).

There is a risk that the midwives may not work cohesively in the small group, however, this was not identified in the literature search. The reported reasons for midwives leaving caseload in one hospital in New South Wales, Australia, was to take up positions in other continuity of care models around Australia and maternity leave (Hartz et al. 2012). The benefits to women and midwives from midwifery continuity of care extend beyond their relationship with the women and the group of midwives to the overall provision of maternity services.

2.2.3 Benefits for the organisation

The benefits of lower obstetrical interventions and care provided by midwifery group practice in a birth centre setting have led to cost-effectiveness in service provision in one Australian hospital (Toohill 2012). Although this study is not a randomised controlled study, it adds to other evidence that obstetric intervention is costly for maternity services. A randomised controlled trial aimed to assess both the clinical and cost effectiveness of caseload compared with standard midwifery care for women irrespective of risk factors (Tracy et al. 2013). The clinical outcomes have been discussed previously and the cost benefit was reported as a saving of \$A566.74 for every woman who had an unassisted vaginal birth (Tracy et al. 2013).

The cost benefits are explained in a text that provides a practical approach to introducing midwifery continuity of care model - midwives working around the needs of women are more cost effective than working on shifts where activity may be minimal (Sandall et al. 2008). The cost savings from lower obstetric intervention rates are important when providing publicly funded midwifery-led models of care (Homer, Brodie & Leap 2008; Sandall et al. 2008; Tracy et al. 2013) and these findings should influence the allocation of Australian health funding.

The benefits of midwifery-led continuity of care have instigated reviews and recommendations for the expansion and provision of these models, for women to access (Australian Government Department of Health and Ageing 2009; Australian Health Minister's Advisory Council 2016; Commonwealth of Australia 2009; NSW Kids and Families 2010). Midwifery curriculum design has also been influenced by

the growing evidence about the benefits of midwifery-led continuity and the government reports. Continuity of midwifery care has been incorporated into the midwifery curriculum standards since 2002, when the first Bachelor of Midwifery course was introduced in Australia (Gray et al. 2012). The experience of midwifery students providing continuity of care is important information to inform this study, as students have experienced providing continuity of care, through their degrees.

2.2.4 Midwifery students' experience of providing continuity of care

The current Australian midwifery education standards require midwifery students to have experience in providing continuity of care for 10 women within their degree (Australian Nursing and Midwifery Accreditation Council 2014). Previous standards required initially 30 and then 20 continuity of care experiences. Midwifery students are therefore exposed to midwifery continuity of care as they 'follow through' a number of women during their program (Gray et al. 2012). A qualitative descriptive study aimed to explore the follow-through experience and associated learning outcomes from all the Bachelor of Midwifery programs in Australia at the time (Gray et al. 2012). The research found students learn from and with the woman, although providing continuity of care to 30 women was reported as a challenge (Gray et al. 2012). Later research aimed to discover both undergraduate and postgraduate midwifery students' experiences of providing continuity of care in one state in Australia (Dawson, Newton, et al. 2015). The study used a purposely-developed survey tool (Dawson, Newton, et al. 2015). The students rated the relationship positively but voiced concerns about being on call for women when the students had competing family, work, and university commitments (Dawson, Newton, et al. 2015; Gray et al. 2012). Both studies reported the students having positive experiences of learning through providing continuity of care and student concerns about the commitment of being on call for women (Dawson, Newton, et al. 2015; Gray et al. 2012). The challenges of continuity of care include students' need to balance the experience with paid employment, carer responsibilities and university responsibilities (Gray, Taylor & Newton 2016). The number of continuity of care experiences need to be manageable and embedded into the curriculum with collaboration between the universities and the clinical experience providers to

enable students' learning through continuity of care experiences (Gray, Taylor & Newton 2016).

Mentorship seems to be another way of learning. Learning opportunities provided by the students' mentors were reported in a qualitative study from the United Kingdom (Rawnsdon 2011). The study explored students' experiences of carrying a caseload, although the number of women who were in the caseload was not provided. The authors felt that students prefer small numbers due to the demands of the midwifery course and family commitments (Rawnsdon 2011). The support from the mentors varied, due to the availability of the mentor. Recommendations from this study were to prepare mentors to support students in the realities of providing continuity of care and have a systematic approach to providing mentors (Rawnsdon 2011). This is a small qualitative study from the United Kingdom where mentorship of students is part of the clinical experience. Although we do not have such a formalised system in Australia, the findings from this study may be useful in the Australian setting.

Mentoring and support to the student could be achieved by placing the midwifery student with a small group of midwives practising continuity to help manage the challenges of being on call (Gray et al. 2012). Unfortunately, there is a lack of widespread continuity of care models in Australia and that could be perceived as an obstacle to placing students within the models to gain experience in continuity of care.

One study examined the experiences of seven students placed with a private midwifery group practice, two students with a sole practising private midwife and seven in a rural hospital with a midwifery group practice (Carter et al. 2015). This was part of an initiative to grow the midwifery workforce and introduce continuity of midwifery care programs to rural Australia in Queensland (Carter et al. 2015). The students demonstrated a high level of satisfaction as the students gained experiential learning opportunities, partnerships with women and felt prepared to practice in a continuity of care model as a new graduate (Carter et al. 2015). It would

be difficult to replicate the findings from this study to any other setting in Australia as Queensland's privately practising midwives are the only group in Australia with widespread collaborative arrangements to practise in public maternity settings (Australian College of Midwives 2015).

Working in midwifery continuity of care has been reported as being attractive to the students from their student experience (Dawson et al. 2015). Combining all this recent relevant Australian research suggests that midwifery students' experience of providing continuity of care prepares them to work in midwifery continuity of care models and therefore is important to contextualise the experiences of new graduate midwives.

2.3 New graduate midwives' experiences of transition from student to midwife

New graduate midwives may be interested in working in midwifery-led continuity of care models due to the experiences of providing continuity as part of their degree. Only a small number of studies look at the experiences of newly graduated midwives working in midwifery continuity of care models.

An early study was identified from Australia where new graduate midwives were employed in a continuity of care model (Passant, Homer & Wills 2003). The study was small and described the experiences of four new graduates working in midwifery group practice providing care for women with no complications in a birth centre setting within a major city hospital over a decade ago (Passant, Homer & Wills 2003). The features of this model are unusual as the new graduates were provided with one-to-one orientation into the model for a month and a clinical support midwife to provide mentoring. The clinical support midwife did not have a caseload of women within the group and therefore had more time to provide mentoring (Passant, Homer & Wills 2003). The support led to the new graduates reporting professional growth, development and high levels of self-esteem (Passant, Homer & Wills 2003).

A more recent Australian study compared new graduate midwives who had experience of working in a 'birth suite' with new graduate midwives who had a 'rotation' period working in a midwifery continuity of care model (Clements, Davis & Fenwick 2013). The findings were taken from a larger study recently undertaken in Australia, aiming to explore the experiences of newly qualified midwives during their transition from student to registered midwife (Clements, Davis & Fenwick 2013). The midwives working in the birth suite reported feelings of stress when making clinical decisions, contrasting with the new graduate midwives working in the continuity of care model, who reported a sense of social and professional belonging while consolidating skills to work across the full scope of midwifery practice (Clements, Davis & Fenwick 2013). The findings come from a larger study, and the experiences of new graduate midwives working in continuity of care, although positive, are small (n=16) (Clements, Davis & Fenwick 2013). As only one hospital provided this opportunity and the numbers are small, the results need to be interpreted with caution.

Newly graduated midwives, in Australia, have rarely had the opportunity to work in midwifery continuity of care models. Instead the new graduate midwives have undertaken a transition to professional practice program. The programs will be discussed and the literature on the evaluation of these programs will be analysed in the next section.

2.3.1 Transition to professional practice programs

Similar to nursing graduates in many states in Australia, upon graduation, new midwives are usually employed in some form of transition to professional practice from student to registered practitioner (Nursing and Midwifery Office 2015). Transition to professional practice is the current name for a graduate year where new graduate nurses and midwives consolidate clinical practice; they are often supported through preceptorship and education study days, and the program goes beyond the usual standard orientation and induction of new employees (Nursing and Midwifery Office 2015). Other names for the transition support program include the graduate year, a rotation year or the new graduate program. Usually, the length of

the transition to professional practice program is approximately one year with new graduate midwives rotating through different areas of the maternity service such as birthing, antenatal ward, antenatal clinic and postnatal wards.

Transition to practice programs began when nursing transferred from the apprenticeship style of 'training' in the hospital system to being provided by tertiary education institutions (Evans, Boxer & Sanber 2008). Support for the new graduate nurse is provided through a range of sources including study days, preceptors, clinical nurse educators, and peer support groups (Evans, Boxer & Sanber 2008). Strengths of the program are the availability of all these resources; however, it has been found that out of business hours, such as on weekends and night duty, the support from preceptors or clinical educators has not been available resulting in the new graduates feeling isolated (Evans, Boxer & Sanber 2008). Other weaknesses identified in the transition to practice programs include staff shortages leading to new graduate nurses being in charge of wards before they felt comfortable, along with the ingrained culture of harassment and bullying of new graduates and casual nurses in the hospital system (Evans, Boxer & Sanber 2008).

There is an abundance of literature on the transition to professional support programs for nurses; many report that the programs evolved in response to the level of reality shock that new practitioners experience (Rush et al. 2013). However, there is little consensus on the length of the program, the number of study days or the availability of preceptors (Levett-Jones 2005; Rush et al. 2015). Recommendations for these programs include the increased availability of trained preceptors, and allocated time for study days with adequate staffing levels to enable a harmonious clinical environment (Levett-Jones 2005). Midwifery transitions to practice programs evolved from those available to nurses and may experience similar strengths and weaknesses.

Despite the probable similarities, few studies have focused on new graduate midwives. One from New South Wales, Australia, provided an overview of the core components of the transition to practice programs for new graduate midwives (Clements, Fenwick & Davis 2012). These components included having eight to 16

weeks placement in the one area, working in a supernumerary capacity, study days and access to a clinical educator (Clements, Fenwick & Davis 2012). These midwives positively identified being able to build professional networks while developing skills during their different rotations during the 12 months transition to practice program (Clements, Fenwick & Davis 2012). However, the new graduates felt anxiety and stress when their rotation was cut short or when they were asked to go and work in another area, leading to feelings of not being part of the team (Clements et al 2012). These findings are limited to the small number (n=7) of new graduates who participated in the focus group from one area health service in Australia (Clements, Fenwick & Davis 2012). Other studies have attempted to evaluate the experiences of new graduate midwives working in transition to practice programs, mostly in the United Kingdom, Australia and New Zealand.

In the United Kingdom, a larger study looked at the experiences of new graduate midwives (n=35) who worked in transition to practice programs, rotating through the following areas, antenatal, birth and postnatal ward, in a variety of hospital settings (Avis, Mallik & Fraser 2013). This study also found new graduate midwives did not appreciate shorter ward rotations or being moved around on a daily basis to staff wards (Avis, Mallik & Fraser 2013). The study found that graduates are competent to provide safe care at the time of registration while they lacked confidence in relation to their new responsibilities as a midwife (Avis, Mallik & Fraser 2013). The authors made recommendations for informal support from peers or senior midwives in addition to preceptors providing structured support and formalised feedback (Avis, Mallik & Fraser 2013).

Similarly in Australia, another study described the experiences of newly qualified midwives working in their first year of practice using the metaphor of a pond (Fenwick et al. 2012). The pond illustrated the new graduate midwives feeling like they were 'sinking' in busy, understaffed wards with little support from the educators, however, positive relationships developed with midwifery colleagues who acted as a 'life raft' for the new graduate midwives (Fenwick et al. 2012). 'Swimming' represented building confidence and 'sinking' described poor relationships with

midwifery colleagues and the hectic environment making the new graduates feel humiliated and intimidated (Fenwick et al. 2012). Both these qualitative studies are useful in providing insight into the experiences of new graduate midwives who are working in their first year of practice in the hospital system, where the majority of new graduates work on graduation. Growing or becoming confident was discussed in these two studies but not measured quantitatively.

The confidence of new graduate midwives was measured by Davis et al. (2011) against the Australian National Competency Standards for the Midwife and against the International Confederation of Midwives, definition of a Midwife (Australian Nursing and Midwifery Council 2006; Davis et al. 2011; International Confederation of Midwives 2011). The authors found that new graduate midwives had low levels of confidence to work in line with the international definition of a midwife both at the beginning of their transition to professional practice program and after 12 months. There was some growth in confidence for the midwives who participated in this study but not across all domains, such as those required to provide continuity of care for women (Davis et al. 2011). This raises the question of how to improve the support of new graduate midwives to work in midwifery continuity of care models. The authors propose placing new graduates within continuity of care models during their new graduate year to increase their confidence to work across the full scope of midwifery practice (Davis et al. 2011). The study has surveyed midwives working in just one area health service in New South Wales and, therefore, the findings are limited, however, the recommendations of placing new graduates in midwifery continuity of care models may be beneficial (Davis et al. 2011; Dawson, Newton, et al. 2015).

Despite these studies, it is unfortunate more widespread adoption of new graduates into midwifery continuity of care has not occurred in Australia. In New Zealand, there is widespread employment of new graduates into midwifery continuity of care models.

2.3.2 The New Zealand experience

New Zealand provides a maternity service which has midwives as lead maternity carers working in continuity of care models, providing care to a caseload of women (New Zealand College of Midwives 2016). It is usual practice for new graduate midwives to move straight into lead maternity carer positions, supported by the Midwifery First Year of Practice Program, although they can work in tertiary referral hospitals, secondary hospitals or primary care units (Dixon et al. 2015; New Zealand College of Midwives 2015). The program is funded by Health Workforce New Zealand, and provides a mentoring program to support newly qualified midwives into practice (New Zealand College of Midwives 2015). The program has been evaluated in regards to midwifery retention in the New Zealand workforce and found to have a high retention rate of 86 per cent of newly graduated midwives staying in the profession (Dixon et al. 2015).

A qualitative descriptive study set out to understand what sustains all midwives, not just new graduate midwives who work as lead maternity providers in the New Zealand model (McAra-Couper et al. 2014). The joy of having a reciprocal relationship with women was found to sustain midwives working in this model (McAra-Couper et al. 2014). The study authors suggest that midwives and women need to ensure the unique model of midwifery continuity of care based on a reciprocal relationship continues in New Zealand (McAra-Couper et al. 2014).

Placing midwifery graduates directly in midwifery continuity of care practice has been criticised as not providing enough consolidation of the skills required to care for women with complexities of their pregnancy, birth or postnatal period, in New Zealand (Panettiere & Cadman 2002). The criticism comes from an editorial piece written prior to the introduction of the Midwifery First Year of Practice Program by the clinical maternity leader and educator from one hospital in the North Island of New Zealand, and calls for the widespread introduction of a new graduate support program. The program recommended is similar to the Australian transition to professional practice program that has been discussed as probably not being useful

in supporting students to transition to provide continuity and work as per the international definition of a midwife (Davis et al. 2011; Dixon et al. 2015). Popularity of the lead maternity care providers model is evident from the numbers increasing from 47.8 per cent to 53.9 per cent following the Midwifery First Year of Practice Program and may be due to the support new graduate midwives have received in the program (Dixon et al. 2015).

In New Zealand it has been reported that professional support is provided through text message, via the phone, in person and regular team meetings for new graduate midwives, with many being allocated a mentor to support the transition from student to midwife (Kensington 2006; Lennox 2011; Lennox, Skinner & Foureur 2008). Supportive mentoring was important to the new graduates as they transitioned from student to lead maternity carer (Kensington 2006); however, this study did not mention the challenges of providing mentors for all new graduate midwives. Mentoring can be difficult to provide and some continuity of care models have adopted a group mentoring approach for new graduates recognising they are competent novices that need to develop confidence (Lennox 2011). Other supportive measures have been discussed, such as preceptorship and clinical supervision as well as mentoring, in the New Zealand context, with the overall findings that the three concepts are practised differently, in the amount of time dedicated to support, however, there are many overlaps with these three processes of support (Lennox, Skinner & Foureur 2008). Unfortunately, no formal support systems other than the transition to professional practice program exist in Australia for new graduate midwives, therefore it is worthwhile discussing the research on mentoring or precepting new graduate midwives to work in midwifery continuity of care models when it does exist.

2.3.3 Mentoring new graduate midwives into confident practitioners

Mentoring is primarily concerned with confidence building based on a more personal relationship and not the assessment of competence (Lennox, Skinner & Foureur 2008). The main aim of mentoring is the development of an interpersonal relationship between a less experienced individual and 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 & Wray 2000). New graduate midwives can be nurtured as they develop their practice and knowledge through mentoring and that was first noted as beneficial to the Australian profession of midwifery over 10 years ago (McKenna 2003). In particular, it is proposed that similar to the New Zealand model, new graduates could be mentored into midwifery continuity of care programs in Australia (Davis et al. 2011).

Nearly a decade ago, a feminist phenomenological study examined the experiences of new graduate midwives who were mentored into caseload practice in New Zealand (Kensington 2006). Mentoring occurred 'within' the midwifery practice from a midwife working alongside the new graduate in the same group practice or 'outside' the practice, meaning 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 2006). 'Outside' the practice included the mentor providing assistance with setting up the contractual business these midwives provide to women and, on occasion, the mentor would attend births, mostly when there was some difficulty or the midwife was distressed by the case (Kensington 2006; New Zealand College of Midwives 2016). This qualitative study allowed the investigator to listen to the participants' lived experiences of mentoring and working in group practice. These experiences were described as supportive and empowering rather than the more condescending nature of other transition to professional practice programs within the hospital setting (Kensington 2006). The study demonstrated that newly qualified midwives look to more experienced midwives to support them as they transition to practice in a midwifery continuity of care model. It also provided a useful guide on how mentoring can work for new graduate midwives working in continuity of care models, although it is useful to look at some of the difficulties of providing mentoring in this setting.

Constraints of mentoring include consuming time, taking a midwife away from her own caseload. Mentoring can be a financial burden to the health system if midwives have formal training to become mentors (Lennox, Skinner & Foureur 2008; McKenna 2003). The availability of mentors particularly in continuity of care models has been reported as being limited with the time available to provide mentorship (Lennox, Skinner & Foureur 2008). An alternative method of providing mentoring to new graduate midwives in continuity of care is group mentoring, in order to address some of the constraints on the mentoring process (Lennox, Jutel & Foureur 2012). Group mentoring enables the mentors to share responsibility for the needs of new graduates, and these needs are based on the knowledge that new graduates are competent at the point of registration and can identify what they needed to develop confidence to practice (Lennox 2011). Both these models of mentoring have been positively reported as beneficial to increasing the new graduate midwives, confidence in transitioning to practice in a midwifery continuity of care model.

A widespread form of support for midwives in the United Kingdom is precepting so it is useful to look at the literature in regard to precepting.

2.3.4 Precepting

Definitions of preceptorship vary although the general view is that precepting is conducted over a specified timeframe based around clinical teaching and socialisation into an organisation (Davies & Mason 2009; Lennox, Skinner & Foureur 2008). In midwifery, preceptorship proposes to support midwives to work in organisations based on ensuring the midwife develops an understanding of the organisational requirements (Lennox, Skinner & Foureur 2008). Precepting may be easier to deliver than mentoring as preceptors (more experienced midwives) are selected by the midwifery manager and the period of preceptorship is over a specified time frame (Lennox, Skinner & Foureur 2008).

In the United Kingdom, a number of health services have developed a preceptor model of support for new graduate midwives to consolidate skills and increase their confidence in either the community (caseload) or hospital setting. Allocation of a

named preceptor and rotation throughout different hospital areas is the most common model (Curtis, Ball & Kirkham 2006; Hobbs 2003; Hughes & Fraser 2011). The ad hoc nature of allocating a preceptor to a new graduate midwife by the local midwifery manager may be constrained by local budgets, availability of experienced staff and no clear guidelines of what needs to be taught (Avis, Mallik & Fraser 2013).

The problems cited with this model include the relative unavailability of preceptors due to roster restraints and the level of activity (busyness of the ward) preventing effective relationships developing between preceptors and new graduates. Concerns were expressed, by both managers and preceptors, in one qualitative study that the new graduates did not have the ability to care for women with complex needs (Mason & Davies 2013). The new graduates also identified they felt competent to practise midwifery, however struggled with certain medically oriented tasks such as siting cannulas and epidurals, although by the second interview the new graduates reported having mastered these skills (Mason & Davies 2013). The interviews were held half way through the preceptor program, however, it is not stated if this is a six-month period. It can be assumed that with support from a preceptor, the new graduate midwives have consolidated the skills necessary to care for women without complications in pregnancy. At the beginning of their practice they need support to build on their skills, particularly when providing care to women with complications.

Individualised or personalised preceptor programs were recommended from this qualitative evaluation rather than a standardised preceptor program (Mason & Davies 2013). Having a practice development midwife working on the wards providing support through the induction period and a structured preceptor program were seen as a strength to the preceptorship program (Davies & Mason 2009; Hughes & Fraser 2011). This recommendation may not be feasible in Australia, as many maternity units do not provide practice development midwives. Another problem with rotations through different wards is the period of time between rotations.

New graduate midwives reported low levels of confidence when there was a long period of time between graduation and returning to work, particularly in the labour and birth setting, further reducing their confidence in caring for women (Hughes & Fraser 2011). As a response to the low levels of support a national development scheme in Scotland called the 'flying start' works alongside the national health service providing online support to new graduate nurses and midwives aiming to increase the new graduates' competence and confidence (Roxburgh et al. 2010). Despite these attempts at increasing support for new graduate nurses and midwives, precepting is the main support provided in the United Kingdom, and, similar to transition to professional practice programs, the precepting period and structure of the program differ from organisation to organisation (Avis, Mallik & Fraser 2013; Davies & Mason 2009; Hobbs 2003).

2.4 Conclusion

This review provided an analysis of the literature about midwifery continuity of care in Australia and internationally. Midwifery continuity of care has been described as having positive outcomes for women through decreasing obstetric interventions. The implications of the research reviewed found midwifery continuity of care is safe for women and babies with cost savings for governments leading to recommendations for their implementation. Further analysis of descriptive and qualitative studies provided insight into the experiences of women and the midwives in caseload practice. Both women and midwives find midwifery continuity of care highly satisfying and there is limited evidence that midwives do not want to work in these models, rather, they are popular models to work in. As midwifery continuity of care models become more prevalent, new graduate midwives will have the opportunity to work in these models, hence the incorporation of continuity of care experiences to be included in the midwifery curriculum.

Midwifery students enjoy the continuity of care experiences although they express some concerns with juggling competing interests of family life, university commitments and being available to the women in the continuity of care experience.

However, the experiences do prepare the students to work in the models upon graduation. The analysis of the literature into the experiences of new graduated midwives working in continuity of care models identified a need for support especially in building the confidence of new graduates to work across the full scope of midwifery practice as per the international definition of the midwife.

A discussion of the various support programs available to new graduate midwives was provided. The most common in Australia is the transition to professional practice program. The literature evaluating transition to professional practice programs often concludes that precepting and mentoring should be considered for new graduates as they transition from student to midwife. Only one early study was identified that provided a very successful model of support for new graduate midwives working in midwifery continuity of care and this relied on the employment of a clinical support midwife just for the new graduate working in the model. Such an intervention would be an expensive support measure and is not realistic for the widespread employment of new graduate midwives working in midwifery continuity of care models. However, the literature from New Zealand demonstrates the value of putting a government supported mentoring program in place for new graduate midwives to work in autonomous practice again, this is unlikely to occur in the Australian context as we have not undergone such huge maternity reform to enable midwives to be the lead care providers as occurred in countries such as New Zealand. The United Kingdom provides insight into some benefits of precepting although all models of support examined in this review recommend individualised support programs for new graduates.

Due to the lack of research into the experiences of new graduate midwives working in midwifery continuity of care models, in the Australian context the importance of this research - to discover the experiences of the new graduate midwives working in midwifery continuity of care models in Australia - is highlighted.

In the next chapter, I will provide a discussion on the methods, design and theoretical frameworks that support the research.

Chapter Three: Research design and methods

3.1 Introduction

A qualitative descriptive methodology was undertaken to conduct this research. The study was divided into two phases. The first phase aimed to understand the experiences of new graduate midwives working in midwifery continuity of care models. The second phase aimed to understand the experiences of managers and other key stakeholders who employ or support new graduate midwives working in midwifery continuity of care models.

3.2 Research questions

Research aims

The research aimed to:

- Describe the experiences of new graduate midwives working in midwifery continuity of care models
- Describe the mentoring systems available to new graduate midwives working in this manner
- Discover what helps new graduate midwives transition from a student to practising at the full scope of a midwife.

Research questions

In order to meet these aims the following questions were asked:

Phase one:

- What are the experiences of newly graduated midwives working in midwifery continuity of care models?

Phase two:

- What are the experiences of managers and other key stakeholders when they employ and/or support new graduate midwives in midwifery continuity of care models?

3.3 Phase one - Experiences of new graduate midwives working in midwifery continuity of care models

3.3.1 Qualitative descriptive designs

A qualitative descriptive approach was used to understand the experiences of new graduate midwives working in midwifery continuity of care (Sandelowski 2000). Qualitative research is about understanding the participants' experiences. The method utilised in qualitative research is collecting data either through interviews, surveys or focus groups and then analysing the data (Braun & Clarke 2013). The methodology is a theory of how the research is to proceed; that is, what process will be used to analyse the data (Braun & Clarke 2013). Many of the theories that have become the foundation of qualitative research, for example, ethnography, phenomenology and grounded theory, have developed from the social sciences and been adopted by nursing and midwifery researchers (Braun & Clarke 2013; Lavender, Edwards & Alfirevic 2004; Thorne 2013). The problem is that the social scientist theory does not always fit with nursing and in this case midwifery research, as the nursing and midwifery professions often conduct research to influence practice rather than to create a theory (Thorne 2013).

Qualitative descriptive or interpretative descriptive research is a particularly relevant research design when trying to make sense of patterns and variations across the beliefs, attitudes and opinions of persons within the health sector (Thorne 2013). Descriptive interpretive research does exactly as it states describes and interprets and is useful when the researcher wants to hear the voices of people, analyse the themes and present the results (Smythe 2012). It is also a helpful approach to expand professional imagination about ways of being, thinking, feeling and acting in challenging health care settings (Thorne 2013). It has been proposed that qualitative descriptive research allows the findings to be reported without using a theoretical framework of interpretation (Sandelowski 2000), thus allowing the researcher to stay close to the collected data of new graduate experiences. Qualitative descriptive research is a useful form of rigorous and credible inquiry (Avis 2003; Hughes & Fraser 2011; Sandelowski 2000), however, further analysis can be applied through the use

of a theoretical framework.

Sandelowski (2010) states that a qualitative descriptive approach is particularly useful to describe how people feel about an event, however, the researcher still needs to conduct more interpretative work and this is where a theoretical framework will be utilised. Phase one of this study uses the concept of relational continuity of care to further interpret the findings (Saultz 2003). Phase two applies the diffusion of innovation theory to further analyse the data (Greenhalgh et al. 2004). Continuity of care and the diffusion of innovation theory as interpretative theories will be discussed later in this chapter. Initially, a discussion of other studies that have used a qualitative descriptive approach to understand the experiences of midwives is provided.

One example of qualitative descriptive design in midwifery is the study by Clements, Davis and Fenwick (2013) who used a qualitative descriptive approach to understand the experiences of 38 newly graduated midwives in Australia. They justified the use of this approach as there was very little information on the experiences of newly graduated midwives in Australia (Clements, Davis & Fenwick 2013). Similarly, the experiences of new graduate midwives in the United Kingdom were analysed using a qualitative descriptive approach, drawing themes from graduates' diary entries and interviews (Avis, Mallik & Fraser 2013). The authors chose this approach to describe the transition experiences of newly qualified midwives and to identify the impact of the various preceptorship schemes in the United Kingdom (Avis, Mallik & Fraser 2013). Another qualitative exploratory study used data collected from focus groups to demonstrate how new graduate midwives' experiences can be reported without a theoretical framework (Hughes & Fraser 2011). The authors used a qualitative descriptive approach in this study as there was very little research about how new graduate midwives *felt* about their transition from student to midwife (Hughes & Fraser 2011) These studies, and the fact that there is limited research on the experiences of new graduate midwives working in midwifery continuity of care models, influenced the decision for a qualitative descriptive approach to understand the feelings of new graduate midwives working in midwifery continuity of care

models in Australia. It is their experience of working in this manner and the support available to the new graduate that is of interest to me. This exploration is based on the interest in and understanding of the 'who, what and where' (Sandelowski 2000) of the new graduates' experiences. A qualitative descriptive method does not remove the need for the researcher to do any further analysis or interpretation of the data (Sandelowski 2010).

Further analysis of the findings is utilised through the application of the continuity of care theoretical framework as described in the next section.

3.3.2 Continuity of care as a theoretical framework

Theoretical frameworks can be thought of as the way of seeing the world (Lavender, Edwards & Alfirevic 2004), and a paradigm with a connotation of some theoretical philosophy (Sandelowski 2012; Braun & Clarke 2013). Phase one of this study used continuity of care as a theoretical framework. Midwives working in a continuity of care model develop a relationship over time with the pregnant women and they provide care during the woman's pregnancy, birth and in the early parenting period. The relationship is interpersonal in nature, with the woman and the midwife developing a relationship of trust over time. The woman knows how to contact her midwife and there is a backup midwife if the primary midwife is not available. The professional relationship ends at a mutually agreed time after the birth, usually at around six weeks. The interpersonal relationship that exists in continuity of care can be used as a theoretical underpinning, a way of understanding the experiences of new graduate midwives working in midwifery continuity of care models.

Continuity of care has been defined as care provided over time to a person, in a hierarchical formation (Haggerty et al. 2003; Saultz 2003). The base of this hierarchy is informational continuity where medical and social information about the person is available to a number of care providers ensuring safe communication about a person's particular situation (Haggerty et al. 2003; Saultz 2003). The next level of continuity is defined as longitudinal where information is shared in a familiar place by an organised team of care providers (Saultz 2003). The highest level of continuity

is interpersonal or relational continuity where the person’s care is assumed by one caregiver with the development of an ongoing relationship (Haggerty et al. 2003; Sandall et al. 2008; Saultz 2003). Table 1 represents the levels of continuity of care as defined by Saultz (2003).

Table 1: Levels of continuity of care

Level	Description
Informational	The person’s medical and social information is available to any health care professional caring for the person. A systematic process allows accessing and communicating this information to all those involved in the care.
Longitudinal	The person has a ‘medical home’ where they receive most of their care. The care is provided in an accessible and familiar environment from an organised team of providers.
Interpersonal or Relational	A relationship of trust develops over time between the person and the health professional. They know each other by name and the health care provider assumes sole responsibility for the person’s care. When unavailable, coverage is arranged by a backup provider. The relationship ends at a mutually agreed time

Adapted from: Saultz (2003)

The interpersonal or relational continuity level is applicable to this research as a theoretical framework. Midwives working in continuity of care models develop a relationship of trust with the women as they provide care through pregnancy, birth and the early parenting period. In particular, this is the framework that new graduates are entering when they commence providing continuity of care.

The concept of interpersonal or relational continuity of care is used as a theoretical framework to provide a further analysis of the data (Braun & Clarke 2013; Sandelowski 2010). The benefit of continuity of care is based on the woman having a relationship with one midwife or a small group of midwives (Sandall et al. 2016). Relational continuity is therefore a useful basis for exploring the experiences of new graduate midwives working in midwifery continuity of care models. Relational continuity of care drives the recruitment of new graduates; that is, the participants must be working in a continuity of care model where they provide one-to-one care to women throughout the woman’s pregnancy, birth and the early postnatal period.

Continuity of care as a theoretical framework fits with this study as the new graduate midwives have a relationship with the women they are providing care for throughout pregnancy, birth and the early parenting period. The continuity of care framework was used to analyse the data in a study exploring parents' experience of support in the postnatal period (Barimani & Vikström 2015). In their study, content analysis was conducted with further meaning extracted from the data categorised into Haggerty et al's (2003) levels of continuity, either informational or relational continuity. The findings revealed that parents discussed early parenting support from health professionals as reflecting the different levels of the continuity of care framework (Barimani & Vikström 2015). Although Haggerty's levels of continuity have different names from those as defined by Saultz (2003), the concepts are the same with the highest level referring to a relationship of trust over time between the health care professional and the person. A similar approach has been taken in my study, using continuity of care as a framework. The interpersonal/relational (Haggerty et al. 2003; Saultz 2003) level has been used to interpret and analyse the data to discover the experiences of new graduate midwives working in midwifery continuity of care. To further explore this it is necessary to look at the definition and measurement of the concept of continuity of care (Haggerty et al. 2003; Rogers & Curtis 1980; Saultz 2003).

Rogers and Curtis (1980) have provided a philosophical underpinning for the concept of continuity of care, as encompassing care and responsibility to the person and the family that grows over time. They decided to define and measure the components of continuity of care, as there are so many reported benefits, especially as medicine became more fragmented in the primary health care sector. Benefits of continuity of care in the primary health setting include improved doctor-patient relationships, increased patient satisfaction, increased compliance with medical instruction, reduced hospitalisation, increased rapport with the doctor and facilitation of the disclosure of personal information (Rogers & Curtis 1980). The elements of continuity of care include the physician having a feeling of personal responsibility, including after hours, and this responsibility grows with the increased continuity (Rogers & Curtis 1980). Continuity of care is discussed as an 'attitude' rather than a

health care task, with the essence of continuity of care concerning the 'relationship between the provider and the consumer' (Rogers & Curtis 1980). Further, the patient or, in the case of midwifery, the childbearing woman, has a responsibility to the relationship in order to maintain the continuity contract, that will expire only upon mutual agreement or a decision by one of the parties (Rogers & Curtis 1980). Rogers and Curtis (1980) concluded that continuity of care is multidimensional and it is difficult to measure and operationalise, recommending further defining and measuring.

Both Saultz (2003) and Haggerty et al. (2003) attempted to further define and measure continuity of care and both have developed hierarchical definitions of continuity of care. As explained earlier, the base of this hierarchy is informational continuity where medical and social information about the person is available to a number of care providers ensuring safe communication about a person's particular situation (Haggerty et al. 2003; Saultz 2003). The next level of continuity is defined as longitudinal where information is shared in a familiar place by an organized team of care providers (Saultz 2003). The highest level of continuity proposed is interpersonal or relational continuity where the person's care is assumed by one care provider with the development of an ongoing relationship of trust (Haggerty et al. 2003; Sandall et al. 2008; Saultz 2003). Haggerty et al. (2003) summarise continuity of care as care over time with the focus on the individual patient, with the three levels of continuity differing depending on the type and setting of the care.

When these levels of care are applied to midwifery there is one midwife providing care to one woman over the period of time of the woman's pregnancy and a relationship develops. In the industrialised world, midwifery has undergone similar fragmentation of care as has been seen in the primary health setting (Page 2003; Rogers & Curtis 1980). With the introduction of widespread obstetrics came an increase in the fragmentation of care, women began to give birth in hospitals outside of their community and the woman no longer experienced a relationship with her midwife (Page 2003). The reintroduction of midwifery continuity of care and carer practice is restoring the relationship aspect of midwifery that is built over time

between the woman and the midwife (Page 2003). When the primary midwife is not available a second or backup midwife takes over care based the concept of longitudinal continuity (Homer, Brodie & Leap 2008)

This hierarchical definition is useful in determining how the theoretical framework for my study took shape. It is the relational definition that is most appropriate based on the philosophical underpinning that continuity of care is about the relationship between the woman and the midwife over time. Information was gathered and then analysed within the theoretical framework of continuity of care.

3.3.3 Setting

The study is set in Australia with data collection occurring in three states and territories, that is, Northern Territory, Australian Capital Territory and New South Wales.

3.3.4 Recruitment

Purposive sampling was used to recruit the newly graduate midwives. The numbers of participants are small, as most newly graduated midwives do not have the opportunity to work in midwifery continuity of care models. Consequently, purposive sampling was utilised as it was known the number in the population of interest is small (Minichiello et al. 2004). Purposive sampling began at a midwifery conference held in South Australia in 2011. The theme for the conference was midwifery models of care and it was anticipated through networking and meeting midwives from all over Australia there would be some newly graduated midwives working in the models or they would be introduced/referred to voluntarily participate in the research. An information sheet (Appendix A) was developed and handed out to midwives working in midwifery continuity of care who worked alongside new graduates and managers of midwifery continuity of care models that had employed new graduate midwives.

Several newly graduated midwives identified at this conference were willing to participate in the research and in addition they were able to refer me to other new

graduate midwives they knew were working in continuity of care models. Snowball sampling became a second sampling technique (Minichiello et al. 2004). In addition, the difficulties with recruiting newly graduated midwives working in their first year of practice meant a revision of the criteria was required. It was decided that newly graduated midwives could be extended into their second year of practice in order to discover their experiences of working in midwifery continuity of care as a new graduate midwife in their first or second year of practice.

3.3.5 Ethical considerations

The use of 'human subjects' for data collection in this research requires ethical consideration. The participants must provide consent and the researcher aims to ensure confidentiality and anonymity. The concept of reflexivity will also be discussed ethically as the researcher knew some of the participants. Costs of collecting and transcribing data are also discussed as an ethical consideration as these exercises are costly.

Ethical approval was sought and granted by the university ethics committee (HREC Approval Number: 2012000328) (Appendix B).

Consent

Voluntary informed consent was obtained from the participant using a written information sheet (Appendix A). The information sheet outlined the aims of the research, the research question and how the information would be collected. The consent form (Appendix C) explained how privacy would be maintained and acknowledged that the participant may know the researcher. The names and contact details of my supervisors were provided to ensure the participants could discuss any concerns they may encounter from participating in the research. Voluntary consent means there must be no coercion of the participant and the participant can withdraw from the research at any time (Austin 2013). Participants were informed that their participation was voluntary and all the information regarding the study was provided in the information sheet and consent form. All participants were provided with the questions that guided the interview. At the beginning of each

interview, a discussion was held reminding participants that they could stop the interview at any time, withdraw from the research at any time and that their privacy and anonymity would be maintained.

Confidentiality, privacy and anonymity

Confidentiality of the participants was maintained through the use of pseudonyms. Pseudonyms are recommended as the best practice for protecting participants' anonymity (Braun & Clarke 2013). There was no need to name the hospitals or health services that the participants worked in, as this may reveal the identity of the participant. Demographics of the participants were restricted to gender, age, working full or part time, the year, program of study and the state or territory in Australia where they graduated. Demographics are important to collect as they tell the researcher about the sample.

The most appropriate time and place for the interview was negotiated with the participant. When telephone and Skype interviews were conducted the participants were informed that my office door was closed and no one could hear our conversation. The participants provided the phone number for me to contact them on and I told them at the time of interview it was being audio recorded with a hand-held device as they were unable to see the audio recording device. Audio recordings have the potential of breaking anonymity as the participant can be recognised by the sound of their voice, therefore all audio recordings must be kept in password protected files (Braun & Clarke 2013). The participants were informed that all the demographic information, consent forms and data collected would be stored in a locked drawer in my office and/or in a password protected file on my computer and that I would not supply anyone with their contact details.

Reflexivity

Qualitative research not just about the participants' view as the researcher brings their own values, knowledge, histories, assumptions and perspectives to the research (Braun & Clarke 2013). Reflexivity is about critically reflecting on the

knowledge we produce and positioning ourselves in the research (Braun & Clarke 2013). This research is using continuity of care as the theoretical framework which means questions were asked about the relationship the new graduate midwife had with the woman. The relationship aspect is the researcher's assumption based on the literature that reported midwives' satisfaction with working in continuity of care. However, the participant may describe the work/life balance of working in midwifery continuity of care as the best part of their experience and nothing about the relationships with women. Reflexivity is an essential requirement for qualitative research (Braun & Clarke 2013) and the researcher must be mindful of their position in the research design, methods and methodology.

I had been a lecturer in midwifery for some of the participants and this meant I had to manage our relationships in an ethical manner. Managing dual relationships is complex due to the extent of contact, and the personal and/or sensitive nature of the stories participants tell (Braun & Clarke 2013). Conducting face-to-face interviews in my office and two interviews in the participant's home made the interview process a physically engaging one. Building rapport and making the participants feel safe to tell their story is the aim of qualitative research and poses ethical considerations (Austin 2013). Power imbalances must be also acknowledged as the participants may answer questions with what they believe the researcher wants to hear (Austin 2013).

At the outset of the interview it was explained to the participant that I wanted to hear their experiences of working in midwifery continuity of care models (Braun & Clarke 2013). I explicitly discussed the safe nature of the interview space, encouraging the participants to take some time to gather their thoughts if they sounded or looked a little distressed. I reminded the participants they could stop at any time. I did not discuss my beliefs and philosophical stance on new graduate midwives working in midwifery continuity of care models with any of the participants, to avoid influencing the participants' thinking about the topic. I was situated in the data collection as a midwifery lecturer that taught continuity of care to students as a model to aspire to be employed in and had previously supported

new graduate midwives working in continuity of care models in a previous clinical position. Through the application of the continuity of care framework in the analysis of the data, I became away of my own views and attempted to keep them separate by focusing on the theory when reading the transcripts. Analysing the data through the lens of relational continuity was helpful in discovering the views of the participants. The participants' stories are analysed through the use of the continuity of care framework and the story becomes far removed from the raw data, making their story become my story, meeting the aims of the research question (Braun & Clarke 2013).

Costs

Most of the telephone calls were made from the privacy of my university office and therefore the university incurred the costs. I paid for any other calls. I paid all of the travel costs as I ensured the face-to-face interviews were conducted at a location convenient to the participant. There was no financial incentive for me to conduct this research. All except three of the interviews were transcribed by a professional transcription service. This expense was partly funded by the Australian College of Midwives scholarship fund and partly by myself. The transcriber completed and signed a confidentiality agreement ensuring the privacy of the participants.

3.3.6 Participants

The inclusion criteria was that the participants must have been working in a model of continuity of care, where they provide continuity of care to the woman and they are working in their first or second year of practice after graduation. Some of the participants worked in models where they have a buddy or backup when they take days off or leave.

The participants were aged between 21-46 years, with 12 of them graduating from a Bachelor of Midwifery program and only one from a post-registration nursing course that leads to registration as a midwife. Demographics of the participants are presented in the table: 2.

Table 2: Participants' demographics

No.	State	Year graduated	Program	Working full-time or part-time	Previous qualifications	Age range*
1	South Australia	2012	B Mid	FT	No	35-40
2	New South Wales	2011	B Mid	FT	Yes	25-30
3	New South Wales	2011	B Mid	FT	No	20-25
4	New South Wales	2010	B Mid	FT	No	20-25
5	South Australia	2011	B Mid	FT	Yes	35-40
6	South Australia	2011	B Mid	FT	Yes	30-35
7	Australian Capital Territory	2012	B Mid	FT	No	25-30
8	New South Wales	2011	B Mid		Yes	35-40
9	Australian Capital Territory	2011	B Mid	FT	Yes	20-25
10	New South Wales	2011	B Mid	FT	Yes	45-50
11	New South Wales	2011	B Mid	PT	Yes	35-40
12	New South Wales	2011	B Mid	FT	No	25-30
13	New South Wales	2012	Grad Dip	FT	Yes	35-40

*Note: Age ranges only are provided to protect anonymity.

3.3.7 Data collection

Semi-structured interviews were conducted to elicit rich data from the participants. The interviewer used a list of questions, as a guide in semi-structured interviews, however, there was room for the participants to raise issues that the researcher had not anticipated and for the researcher to explore these issues further (Braun & Clarke 2013). The questions were open ended and the participants responded in their own words (Braun & Clarke 2013). The interview questions are presented in Chapter Four along with the published paper.

Open-ended questions encourage participants to provide detailed explanations of their experience (Braun & Clarke 2013). The questions were designed to elicit the new graduate midwives' experiences of why they chose to work in a midwifery continuity of care model. Avoiding the use of leading questions and questions that pose a yes/no answer helped to generate meaningful data (Braun & Clarke 2013).

Data were collected via face-to-face, telephone and Skype interviews, mostly due to the distance between the participants and myself. Face-to-face interviews are ideal to elicit sensitive issues and they produce rich and detailed data about individual experiences and perspectives (Braun & Clarke 2013). However, face-to-face interviews are more time consuming for both the participants and the researcher, limiting their usefulness (Braun & Clarke 2013). It was difficult to secure a convenient location to conduct the interviews as the midwives do not usually have a private space and as they work their own hours that are likely to change at any time depending on the needs of the women, so the participants were invited to attend the interview at the researcher's office. The office location was perfect to protect privacy, with little background noise, no distractions and comfortable seating (Braun & Clarke 2013). I was aware that it might be intimidating to the participants as it was my office and this introduces the concept of a power imbalance in the interview process. The relationship between the researcher and the participant can be conceived as a hierarchical one, with the researcher being the expert (Braun & Clarke 2013). The power imbalance could be enhanced by conducting the interviews in the researcher's office; therefore, I needed to be aware of this imbalance to lessen the threat to the participant and aim to gain as much information about the new graduate midwives' experience of working in midwifery continuity of care as possible. In addition, I knew eight out of the 13 participants, and this posed a higher chance of a power imbalance. It is often easier to interview strangers because the researcher does not have to manage a dual relationship, however, it can be more difficult to build rapport (Braun & Clarke 2013). Having a background working as a midwife, I did not find it difficult to build rapport during the interviews due to my experience and interpersonal skills in building rapport with people during times of vulnerability. This experience helped guide the interviews with sensitivity and empathy.

There is still the chance of the participant becoming distressed as they tell a story that may cause them emotional distress (Braun & Clarke 2013). As new graduate midwives recalled coming across a critical incident for the first time in their practice, there was a level of distress for some. My role was to provide a safe space,

acknowledge their distress, pause the interview and allow them to express it while maintaining the course of the interview and not becoming a counsellor to them (Braun & Clarke 2013). These issues can be present in either face-to-face or virtual interviews.

Telephone and Skype interviews are becoming recognised as a valid interview technique as they are more convenient for the participants who can engage in the interview in the privacy of their own home, they are not limited by geography and the participants may feel more control and have a greater ability to pause and reflect on their answers (Braun & Clarke 2013). For all these reasons, only five of the interviews were conducted face-to-face, seven were phone interviews and one was via Skype. Again I did not have any trouble building rapport via the telephone or Skype even though these methods can be thought of as more difficult to build rapport due to the lack of visual cues (Braun & Clarke 2013). Conducting telephone interviews was more convenient for the participants and myself as five participants lived interstate. I was grateful for the opportunity to have a private office with a phone that had a speaker in order to record the interview for later transcription.

The interviews were audio recorded using a hand-held device with a microphone. The quality was very good and the recordings were saved in a folder on the device. The audio recordings provided a precise record of the interview (Braun & Clarke 2013). The audio recorder was tested prior to each interview and, in the case of the first few interviews, a second device was used to ensure a backup (Braun & Clark 2013). However, as I became familiar with the device and checked it prior to each interview, I decided one device was sufficient. I also made hand-written notes that are de-identified and kept in a locked file in my office. The audio recordings were then downloaded, de-identified and saved as MP3 files in a password-protected file on my computer ready for transcription.

I began to transcribe the data verbatim and found the process took a long time as I listened to the recording and found myself making choices of what to preserve and how to represent what I heard (Braun & Clarke 2013). As I did not have experience with transcribing and it was taking me so long without gaining any further insight

into the participants' experience, I decided it would be worthwhile to have the interviews professionally transcribed word for word and I would then be able to read and reread the transcripts in the process of data analysis. I employed someone who could follow my transcribing instructions and who also completed a confidentiality agreement (Braun & Clarke 2013). A professional transcriber service was recommended by a colleague and, after they completed the confidentiality agreement, I applied for funding from the Australian College of Midwives to employ the transcriber. The MP3 files were shared through a password protected shared folder via the university secure cloud storage system. The transcription service is very reliable and efficient with less than a week or two turnaround so I could then commence data analysis.

3.3.8 Data analysis

Thematic analysis was used to analyse the data, using a process of six phases described by Braun and Clarke (2006). Initially, I became familiar with the data by transcribing three interviews myself. In order to familiarise myself with the data, I read and reread the typed transcripts while listening again to the audio recordings, allowing me to immerse myself in the data. Immersion requires repeated readings in an active way, searching for meanings and patterns (Braun & Clarke 2006).

The second phase is the generation of initial codes that served to organise the data. I used the NVIVO software program for the initial coding. The NVIVO platform was chosen as I had training in the use of the software platform and it was thought to be a good way to start with initial coding organising and describing the data (Minichiello et al. 2004). It was also a good way to store the data and the transcripts safely in the university NVIVO password, protected data receptacle.

Phase three of the data analysis occurred by sorting all the different codes into potential themes (Braun & Clarke 2006). A concept map was developed where themes emerged with some overlap and subthemes within themes. The themes were initially descriptive and data driven. From the data, it was evident that interpersonal relationships formed an overarching theme with subthemes. The subthemes included relationships with the women and relationships with the small

group of midwives the new graduates worked alongside. As interpersonal relationships formed the overarching theme of all the data sets, the concept of continuity of care was utilised for further analysis.

The fourth phase involved reviewing the two emergent themes from the data. The themes were named 'interpersonal relationships with the women' and 'interpersonal relationships with the small group of midwives' within the continuity of care framework. The next phase of the analysis led to the emergence of sub themes under these overarching headings.

The concept of continuity of care helped to shape phase five of the data analysis, the naming and defining of the themes under both the two themes, the relationship with the woman and the relationship with the group. During this phase, I needed to identify the essence of what each theme is about, what is important about them and why (Braun & Clarke 2006). At this point I wrote around the themes and subthemes, producing a story and not just paraphrasing the data. Further subthemes under each of the two main themes were discovered. Sub themes give structure to large and complex themes such as interpersonal relationships and produce a hierarchy of meaning within the data (Braun & Clarke 2006).

The sixth phase of data analysis is the final write up, embedding data extracts within the analysis (Braun & Clarke 2006). The write up provides evidence of the themes with extracts from the data. This phase provides the analytical narrative going beyond description of the data and makes an argument in relation to the research question (Braun & Clarke 2006; Braun & Clarke 2013).

3.4 Phase two - Experiences of managers and other key stakeholders when they employ and/or support new graduate midwives in midwifery continuity of care models

The next phase of the research was to understand the facilitators and barriers to employing new graduate midwives in midwifery group practice or caseload models.

Following on from phase one of this research, the above research question was raised.

3.4.1 Qualitative descriptive design

As described in phase one, a qualitative descriptive approach was used in phase two as well with an aim to understand the experiences of managers and other key stakeholders who employ and support new graduate midwives working in midwifery continuity of care models.

The data was analysed using thematic analysis, initial coding was conducted manually and with the emergent themes the diffusion of innovation theory (Greenhalgh et al. 2004) was utilised to further analyse the data.

3.4.2 Diffusion of innovation theory

Innovation is the central core in the diffusion of innovation theory as it attempts to explain and predict how individuals adopt new ideas (Rogers 1995). Diffusion relates to the innovation being communicated over time to members of a social system with the rate of adoption of the new innovation depending on the perceived attributes by the potential adopters (Rogers 1995). Adopters are categorised as innovators, relative early or late adopters, and the dimensions of the innovation are, trialability, observability, relative advantage, complexity and compatibility (Rogers 1995). An Australian study, using Roger's theory to explore the diffusion process at a micro level in a health care setting, was conducted looking at nursing case management as a health care reform (Lau 1997). Lau's study (1997) was set in a time of uncertainty with the introduction of health reforms that aimed to increase productivity and efficiency in the health care sector. The innovation in this study, a nursing case management system, was reported to result in a shortened length of hospitalisation and a decrease in hospitalisation costs (Lau 1997). Lau (1997 p.2) stated the nursing

profession was challenged to develop new ideas and to provide creative solutions to many health care delivery problems. The innovation in the case of my research is employing new graduate midwives to work in midwifery continuity of care models. This is an innovative solution for managers to provide staff for the midwifery continuity of care models within organisations. The diffusion of the innovation is based on the communication of the facilitators and barriers to the employment of new graduate midwives to work in midwifery continuity of care models. This is why the diffusion of innovation theory is appropriate for further analysis of the data from phase two of the research.

The diffusion of innovation theory in service organisations has been widely adopted across many disciplines resulting in a systematic review and recommendations to spread and sustain innovations in health service organisations (Greenhalgh et al. 2004). The review developed a conceptual model for considering the determinants of diffusion, dissemination, and implementation of innovations in health service delivery and organisation (Greenhalgh et al. 2004). The model discusses system antecedents for adopting the innovation, the innovation as having relative advantages, and compatibility to the system that needs to be ready for the adoption of the innovation (Greenhalgh et al. 2004). A receptive concept for change is based on leadership and vision, with managers and leaders taking a hands-on approach to implementation (Greenhalgh et al. 2004). Once adopted, the innovation needs to be disseminated, implemented and consequences then feed-back into the system antecedents for change. Simultaneously, there needs to be resources and change agents ready for the diffusion of the innovation (Greenhalgh et al. 2004).

Maternity services providing midwifery continuity of care models need to be system-ready to accept the innovative idea of new graduate midwives working in the models. The services may need funding or rearrangement of current funding to provide support to the new graduates as they transition from working as a midwifery student to practising at the full scope of practice as defined by the international definition of the midwife. The diffusion of innovation theory helped to provide another layer of interpretative analysis to the data.

3.4.3 Setting

The second phase of this study was set in Australia with data collection occurring in five states and territories Australian Capital Territory, New South Wales, Queensland, Victoria and South Australia where new graduate midwives were mostly working in midwifery continuity of care models.

3.4.4 Recruitment

Maternity services that offer midwifery continuity of care to women were identified from phase one of the study and are mostly in metropolitan settings, and all are publicly funded. The managers, educators and other key stakeholders who supported new graduate midwives to work in the midwifery continuity of care models were purposively contacted via email for a phone interview.

Three additional stakeholders were contacted, as I knew the maternity services provided midwifery continuity of care models, however, they did not have new graduate midwives working in the models. Identifying participants that did not employ or support new graduate midwives working in midwifery continuity of care models provides important insight into the challenges faced by managers when they are staffing and rostering midwives to work in the models.

3.4.5 Ethical considerations

Similar to the first phase of the research, the use of human subjects for data collection requires ethical consideration. An amendment (Appendix D) to the original ethics application was lodged, as I had not anticipated interviewing managers and other key stakeholders, at the beginning of the research. University ethics approval (HREC Approval Number: 2012000328) was obtained and 15 participants in total were recruited. The overall ethical considerations of consent, confidentiality, anonymity and costs were applied as discussed in phase one of the research. I will cover those considerations that were specifically related:

Consent

Participants provided voluntary consent without coercion and all signed a consent

form (Appendix E) covering privacy, confidentiality and anonymity. The names and contact details of my supervisors were provided to ensure the participants could discuss any concerns they may encounter from participating in the research. The participants were informed at the beginning of the interview that they could stop the interview at any time and withdraw from the research project at any time.

Confidentiality, privacy and anonymity

Each participant was allocated a number to protect his or her identity. There were more participants in this phase of the research and pseudonyms became cumbersome, therefore each manager is referred to as a participant number. The area health services and hospitals where the managers worked have also been de-identified to protect the participant's anonymity.

After negotiation in regard to the most appropriate time and place to conduct the interview, all of the managers decided they wanted to undertake phone interviews. The participants were informed that all the information collected including consent forms and data would be stored in a locked drawer in my office and/or in a password protected file on my computer and that I would not supply anyone with their contact details. The participants were informed that I was in my office with the door closed during the interview process and no one could hear our conversation to provide privacy and anonymity.

Costs

All the data was collected over the phone so there were minimal costs incurred by myself. I did again pay a professional transcriber for all but one of the interviews and this was a costly exercise. I was successful in obtaining a higher research degree student scholarship through the Graduate Research School at the University of Technology Sydney and this helped to pay for the transcribing fees. Once again, I requested the transcriber sign a confidentiality agreement ensuring the privacy of the participants.

3.4.6 Participants

Fifteen managers, educators, clinical midwifery consultants and clinical support midwives were recruited by purposeful sampling. Managers are responsible for employing and rostering staff for the midwifery continuity of care models. Clinical midwifery consultants, educators and support midwives are responsible for the ongoing support of staff in these models.

The details of the participants including location, type of manager, clinical midwifery educators or clinical support midwife are provided in Table 3, Chapter Six, as part of the published paper.

3.4.7 Data collection

Telephone interviews were considered the most convenient to the managers and other key stakeholders. These participants regularly use the telephone, making it easily accessible and acceptable to this group (Braun & Clarke 2013). As in phase one, the interviews were conducted in the privacy of my office with the door closed and a hand-held device recorded the interviews.

In phase one, a list of questions guided the semi-structured interviews. The questions were open ended and allow the participant to discuss their views on the topic of the question while also allowing the researcher to explore unexpected issues (Braun & Clarke 2013). The interview questions are presented in Chapter Six along with the published paper.

In phase two of the research I was more comfortable with conducting interviews and had more confidence to allow the participants to share their story, enabling me to hone in on areas of interest. In particular, when a participant discussed a facilitator or barrier to employing and/or supporting new graduate midwives, I was able to interject with a small phrase such as 'tell me more about that' providing rich data on the topics of my research question (Braun & Clarke 2013).

I had become confident with the hand-held audio recorder and tested it prior to each interview to ensure it was working properly. I again made hand written notes that were valuable when I listened to the audio recordings and read the transcripts. I only had time to transcribe one interview; the same professional transcriber I had used for phase one transcribed the other 14 interviews. The audio recordings were shared in a password-protected file and the transcriber completed and signed the confidentiality agreement. The notes and transcripts are kept in a locked file and all electronic versions of the interviews and the data are in a password-protected file on my computer and backup disk.

3.4.8 Data analysis

Thematic analysis was completed using a six-phase approach to data analysis, as in phase one (Braun & Clarke 2013). Initially, I became familiar with the data by reading the transcripts, listening to the audio recordings and reviewing my notes. I would begin the analysis as soon as the transcripts were placed in the share folder. The data was read and re-read and initial coding was undertaken with the beginning of an audit trail (Braun & Clarke 2006; Braun & Clarke 2013; Lavender, Edwards & Alfirovic 2004). The coding was done manually this time without the help of the NVIVO software. As I had already undertaken phase one thematic analysis, I had a systematic approach to analysing the data for phase two.

Once the data was organised with initial coding, then the next phase was to look for themes within the data (Braun & Clarke 2006). The first theme that became evident was the managers' need to staff the continuity of care models. The other theme that emerged early in the data analyses was to provide support for the new graduate midwives working in the models. These two themes have captured important elements from the data in relation to the research question about facilitators to employing new graduate midwives working in midwifery continuity of care models. Supporting new graduate midwives through providing a longer orientation period and a reduced caseload means less women for the new graduate midwives to provide care for each month, compared with the more experienced midwives in the group providing continuity of care. Barriers to employing new graduate midwives

began to resemble a theme around the historical approach to employing new graduate midwives in a transition to practice or rotation year rather than in a continuity of care model. Sub-themes were organisational culture and a fear of 'something going wrong'. At this stage of the analysis, these themes and sub-themes were descriptive and data driven.

Further analysis occurred to discover the who, what and where of the data being described (Sandelowski 2000). Interpretative work was undertaken to move from the descriptive level of analysis to a deeper understanding (Sandelowski 2010) of the facilitators and barriers to employing new graduate midwives in midwifery continuity of care models. The application of the diffusion of innovation theory provided a framework for further interpretative analysis (Greenhalgh et al. 2004). Integrating the data in the concepts of the diffusion of innovation shaped this phase of the analysis (Greenhalgh et al. 2004). The innovation is employing newly graduated midwives into midwifery continuity of care models. The system readiness and willingness to adopt, assimilate and implement the innovation were closely connected to resources, knowledge purveyors and change agents (Greenhalgh et al 2004). The employing hospital is the system that needs to be ready and willing to adopt the new innovation of employing new graduate midwives into midwifery continuity of care models. Some of the resources required include supporting the new graduate midwives and the managers and key stakeholders can be interpreted as knowledge purveyors and change agents. The data analysed within this framework led to themes and sub-themes that produced a story about the facilitators and barriers to employing new graduate midwives into midwifery continuity of care models.

The final phases of the analysis were to rename the themes and subthemes, and create a concept map and diagram that provided the findings.

3.5 Conclusion

A qualitative research methodology was used in this research. Data were collected using qualitative methods of interviews. Semi-structured interviews were conducted

either face-to-face, by telephone or by Skype . It was found that the telephone data collection method was appropriate and useful in this study.

Phase one participants were scarce and a mix of purposive and snowball sampling was undertaken to recruit participants. Participants were new graduate midwives working in their first or second year of practice in a midwifery continuity of care model. Thematic analysis of the data was undertaken framed by the concept of continuity of care. The analysis was data-driven and the emergence of relational continuity meant that further interpretative analysis occurred through the application of continuity of care as a theoretical framework.

Phase Two participants were recruited by purposive sampling. Both managers and other key stakeholders who did or did not employ or support new graduate midwives were recruited to allow data with varying views on the facilitators and barriers to employing new graduate midwives. Data were thematically analysed to understand the who, what and where of the managers, and other key stakeholders, views. Further interpretative analysis occurred to arrive at the findings that will be discussed in the next chapters. Issues of reflexivity and ethical considerations have been discussed in this chapter.

3.6 The findings chapters

The next three chapters of this thesis present the findings of this research. The findings have been reported and published in peer-reviewed journals. I took a lead role in the research, designing each phase of the study, applying for ethics approval, recruiting participants, collecting the data, undertaking data analysis and writing the research articles. Each chapter gives a background and describing the research method used for that particular aspect of the data collection. The second and third authors assisted in the data analysis as described in each paper. After the three chapters of results, Chapter Seven synthesises and discusses these findings.

Chapter Four: The experiences of new graduate midwives working in midwifery continuity of care models in Australia

4.0 Phase one findings

This chapter is the first of three chapters that present the findings of this study. As outlined in Chapter Three, the study was undertaken in two phases; the first phase was to explore the experiences of new graduate midwives who work in midwifery continuity of care models. The data from this phase were further analysed to discover the mentoring experiences of new graduate midwives before the second phase of the research was undertaken. I will initially present the findings of phase one, the experiences of new graduate midwives working in midwifery continuity of care models in Australia.

4.1 Chapter Preface

Publication reference:

Cummins, A.M., Denney-Wilson, E. & Homer, C. 2015, 'The experiences of new graduate midwives working in midwifery continuity of care models in Australia', *Midwifery*, vol. 31, no. 4, pp. 438-44.

This chapter presents an article in its original form, published in *Midwifery* volume 31, no 4 pages 438-44. This article is provided, with permission, in its published form as Appendix F.

Abstract

Background

Midwifery continuity of care has been shown to be beneficial to women through reducing interventions and other maternal and neonatal morbidity. In Australia, numerous government reports recognise the importance of midwifery models of care that provide continuity. Given the benefits, midwives, including new graduate midwives, should have the opportunity to work in these models of care. Historically,

new graduates have been required to have a number of years experience before they are able to work in these models of care although a small number have been able to move into these models as new graduates.

Aim

To explore the experiences of the new graduate midwives who have worked in midwifery continuity of care, in particular the support they received and to establish the facilitators and barriers to the expansion of new graduate positions in midwifery continuity of care models.

Method

A qualitative descriptive study was undertaken framed by the concept of continuity of care.

Findings

The new graduate midwives valued the relationship with the women and with the group of midwives they worked alongside. The ability to develop trusting relationships, consolidate skills and knowledge, be supported by the group and finally feeling prepared to work in midwifery continuity of care from their degree were all sub-themes. All of these factors led to the participants feeling as though they were 'becoming a real midwife'.

Conclusions

This is the first study to demonstrate that new graduate midwives value working in midwifery continuity of care – they felt well prepared to work in this way from their degree and were supported by midwives they worked alongside. The participants reported having more confidence to practise when they have a relationship with the woman, as occurs in these models.

The chapter concludes with an identified need to conduct further analysis to explore the mentoring needs of new graduate midwives working in midwifery continuity of care models. Chapter Five will provide further findings from the analysis of the data from phase one.

4.2 Introduction

Midwifery continuity of care 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). This way of providing care has been shown to be beneficial to women and babies (Hartz, Foureur & Tracy 2011; Hodnett 2008; Homer 2001; McLachlan et al. 2013; Page 2003; Pairman 2010; Sandall et al. 2016). Midwives and women have also reported high rates of satisfaction with midwifery continuity of care models (Collins et al. 2010; Fereday et al. 2009). In Australia, numerous government reports have recognised the importance of midwifery continuity of care models and have recommended widespread implementation (Australian Government Department of Health and Ageing 2009; New South Wales Health 2010).

Midwifery continuity of care can be organised in a variety of ways. One-to-one midwifery care refers to having a primary midwife who cares for 35-40 women a year (Homer, Brodie & Leap 2008; Page 2003). Often midwives work together with a second midwife to ensure they have some time off, with the second midwife being available if the primary midwife is unavailable to ensure some adequate life/work balance (Page 2003). Midwifery group practice (MGP) generally refers to groups of three to four midwives who have a caseload of women with the flexibility to have rostered time off including sick and annual leave with backup from one or more midwives in the group (Homer, Brodie & Leap 2008). A third model providing a level of continuity is team midwifery. Team midwifery generally comprises six to eight midwives providing care often on a rostered system (Homer, Brodie & Leap 2008). When midwives begin to work in a midwifery continuity of care model they are provided with a period of orientation and sometimes initially a reduced caseload. Midwifery continuity of care models often cater for women who are predominantly healthy, however, increasingly, all-risk models are being implemented in collaboration with obstetricians (Australian Nursing & Midwifery Council 2008). Various models exist throughout Australia with limited opportunities for new graduate midwives to work in continuity of care. The participants in this study were

employed in models ranging from one-to-one midwifery to small teams of midwives working an on-call roster to provide care for approximately 40 women a year.

A new graduate midwife is one working in their first or second year of practice post initial registration. Historically, most new graduate midwives in Australia undertake a transition support program that requires the new graduate midwife to rotate through antenatal clinics, birth suite and postnatal wards over a 12 month period (Clements, Davis & Fenwick 2013). A qualitative study reporting on newly graduated midwives' experiences of a similar model in the United Kingdom (Foster & Ashwin 2014) found the participants did not have enough time in any one hospital area before rotating to another where they had to relearn skills. It is not clear whether this style of transitional support is appropriate or necessary for new graduates who desire to work in continuity of care models (Clements, Davis & Fenwick 2013).

In Australia, midwives are prepared to work in continuity of care models as students; an essential part of the midwifery curriculum is to 'follow through' a number of women during their program (Australian Nursing and Midwifery Council 2010; Gray et al. 2012). This requirement is based on the evidence that these models have improved outcomes for women and their families. Despite this, when positions are advertised for continuity of care models, the criteria often includes a minimum two years' experience, prohibiting new graduate midwives from applying.

Despite obstacles to new graduates entering midwifery continuity of care, there are small numbers working in this way around Australia. In order to support wider implementation of such opportunities, we were interested in their experiences. This is the first study in Australia to focus on new graduate midwives working in midwifery continuity of care. The aim of the study was to explore the experiences of these new graduate midwives - in particular, to examine the support they received and to establish the facilitators and barriers to the expansion of new graduate positions in midwifery continuity of care models.

Ethical approval was sought and granted by the university ethics committee (HREC Approval Number: 2012000328).

4.3 Methods

A qualitative descriptive approach was used to describe and explore the new graduates' experiences of working in midwifery continuity of care. The exploration was based on the interest in, and understanding of, the 'who, what and where' of their experiences (Sandelowski 2000, p.338). Qualitative descriptive research is a useful form of rigorous and credible inquiry in situations where there is little knowledge and is particularly useful to describe how people feel about an event (Avis 2003; Hughes 2011; Sandelowski 2000). This study addresses each area of the who, what and where (Sandelowski 2010) of new graduate experiences of working in midwifery continuity of care.

4.3.1. Sample

Purposive sampling recruited newly graduated midwives working within their first or second year of practice in a midwifery continuity of care model. Purposive sampling is used when the population of interest is small (Minichiello et al. 2004). The difficulties in recruitment meant the authors needed to find midwifery models of care that employed new graduates. The first author attended a midwifery 'models of care' conference in South Australia with the intention of recruiting new graduate midwives to participate in the study. The purposive sampling then became a process of snowball sampling where participants were asked if they knew any other new graduate midwives working in continuity of care models. Both these sampling methods were approved by the university Human Research Ethics Committee. Using this process, 13 newly graduated midwives were recruited. From our professional networks, we estimate this to be approximately 50 per cent of the new graduate midwives working in midwifery continuity of care models across Australia.

The 13 participants were newly graduated midwives in either their first or second year of practice after graduation. Pseudonyms have been used to protect the

identity of the participants and to highlight the repletion of responses and to show when different participants had similar experiences. Participants were aged 21-46 years and employed in a variety of settings 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 the direct-entry Bachelor of Midwifery program, three from South Australia, two from the Australian Capital Territory (Australian Health Practitioner Regulation Agency) 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 new graduate transition program with two commencing in midwifery continuity of care immediately 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.

4.3.2 Data collection

Data were collected via semi-structured interviews. Participants were offered a choice of the interview being conducted face-to-face, via telephone or Skype . One researcher (the first author, who is also a midwife) conducted all the interviews. A list of open-ended questions were chosen that guided the interview but provided flexibility to respond to the participant.

Figure 1 – Questions

Questions

Why did you choose to work in midwifery continuity of care?

What is your experience of working in continuity of care?

What did you aim to achieve in your transitional year/s?

How did you achieve what you planned?

What has been the best part of working in midwifery continuity of care?

The questions gave the interview some structure but were not always asked in this order to enable flexibility. Using preformed questions/prompts can give an interview some structure (Rees 2012). The questions were designed to explore the barriers and facilitators to working in midwifery continuity of care models. In addition, we were interested in the positive aspects and levels of continuity of care in line with the theory around continuity of care (Saultz 2003).

The participants were from different parts of the country making face-to-face interviews difficult; hence phone interviews were the main mode of data collection. Burns et al. (2012) described the insider/outsider dilemmas experienced by a researcher during observations undertaken on a maternity ward by a midwife researcher. A similar concept had the potential to occur in this study, as the interviewer was also a midwife with extensive clinical experience and a sound understanding of continuity of midwifery care. The interviewer was in a unique position to identify the issues raised by the participants, with the potential for the blurring of boundaries as described by Burns et al (2012). The interviewer needed to position herself as a researcher rather than a colleague. Having a team of three researchers assisted with defining boundaries as the other team members only read de-identified data and therefore were outsiders to provide balance.

The interviews were audio recorded and transcribed verbatim. The researcher transcribed three of the interviews and the remainder were transcribed by a professional transcriber. The transcripts were all read while listening to the audio recordings to ensure transcription accuracy.

4.3.3 Analysis

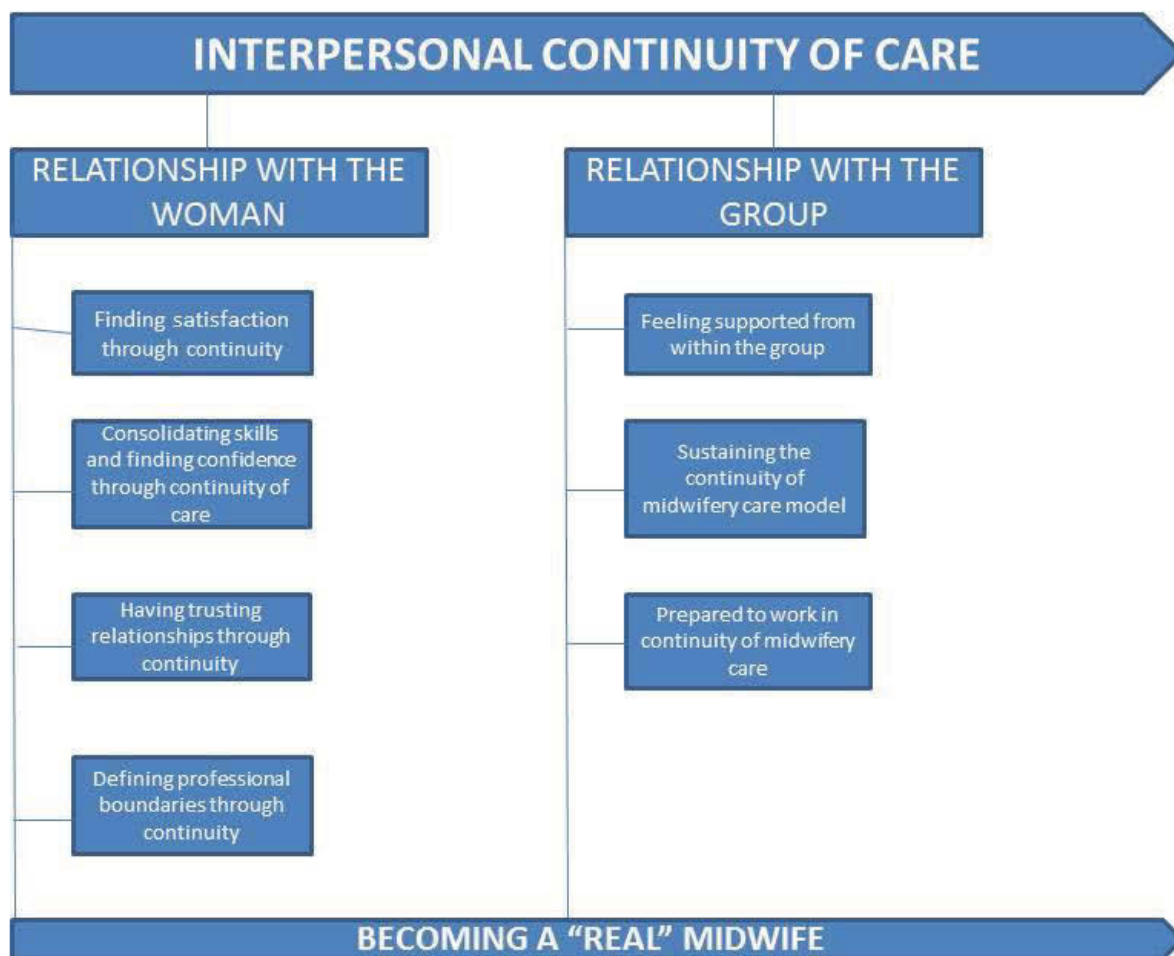
Thematic analysis was used to capture important concepts in relation to the research question (Braun & Clarke 2006). The data were read and entered into the software program NVIVO (Minichiello et al. 2004). A process of coding into groups known as nodes identified certain themes. The themes were initially descriptive and once the researcher began to write and reread the data, a deeper analysis occurred which was framed by the concept of continuity of care (Saultz 2003).

Saultz (2003) developed hierarchical definitions of continuity of care. The base of this hierarchy is informational continuity where medical and social information about the person is available to a number of care providers ensuring safe communication about a person's particular situation (Saultz 2003). The next level of continuity is defined as longitudinal where information is shared in a familiar place by an organised team of care providers (Saultz 2003). The highest level of continuity proposed is interpersonal based on the philosophical underpinning that continuity of care is about the relationship between the care provider and the person over time (Saultz 2003). The theory of continuity of care was developed by Saultz (2003) and applied to midwifery by Homer et al (2008). The interpersonal (Homer, Brodie & Leap 2008) definition is most appropriate based on the philosophical underpinning that continuity of care is about the relationship between the woman and the midwife over time. Themes and sub-themes were then identified and discussed with the two other co-authors, subsequent analysis, themes and subthemes were developed within the framework of continuity of care.

4.4 Findings

The overarching concept was interpersonal continuity of care (Saultz 2003) with two broad themes, that is, 'the relationship with the woman' and 'the relationship with the group'. There were further subthemes that led the participants to report they were 'becoming a real midwife' (Figure 2).

Figure 2 - Findings diagram for phase one



4.4.1 The relationship with the woman

The relationship with the woman was valued in so many aspects of the care provided by the participants. As Judy stated, ‘I really love the relationship’ and ‘it is food for my soul’.

The participants who had worked in a standard transition support program prior to working in continuity of care compared the two approaches. The relationship with the woman was highly valued and contributed to the provision of quality care. Samantha stated ‘now I can really spend time with women’. Samantha went on to say ‘as I get to know the woman, I think they get better care’ and ‘women get better

care' (Alice). Candice and other new graduates felt that 'the outcomes are better' compared with women they cared for when working in the standard transition support program. The participants did not explain which outcomes were better but went on to discuss issues like normal birth and increased rates of breastfeeding suggesting they were valued. The relationship with women enabled them to promote normal birth, provide more effective care and was highly satisfying. For example, Samantha described 'feeling happier' working in a continuity model.

Finding satisfaction with continuity

Working in continuity of care as a new graduate was highly satisfying. Bridget reported the satisfaction of 'seeing a woman being empowered' as 'so rewarding'. She went on to describe how she felt 'lucky to know the whole woman' and 'having a relationship with the woman is a position of privilege'. Christine described herself as 'one of those people that really enjoys having relationships' and therefore working in this way as a new graduate really suited her.

Being satisfied working in midwifery continuity of care was a two-way interaction. Lisbeth illustrates this point saying that the 'woman is so happy that you are there' and Ness, 'they [the women] were always happy to have me there'. Building a relationship between the woman and the midwife, for example, 'getting to know the woman I am caring for made me feel more effective as a midwife' was a crucial component of care. They felt that continuity of carer provided a satisfying experience for the woman, as she knew her midwife, as described here:

'I loved the satisfaction that women got from having that trust in the one carer; also the satisfaction I got and the midwives would get from seeing them from the beginning to end'. (Lisbeth)

The participants used positive emotional phrases to discuss the benefits of midwifery continuity of care. Hattie said she 'gets tingles every time she sees a woman starting her mothering journey' and Lisbeth stated she is 'happy all the time' when she knows the woman. These emotional accounts highlight the satisfaction of being in a

position to develop trusting relationship with women through continuity of carer and this was valuable for the new graduates.

Consolidating skills and finding confidence through continuity of care

The relationship with the woman helped the new graduates learn and consolidate skills. For example, Lisbeth said 'I found I learnt a lot more because I could see the story unfold and it made more sense to me' and Bridget also explained 'over time you get to see her pregnancy unfold together with her family'. When the midwife knows the woman then she can be quietly present at a birth without having to build rapport, as Christine said: 'seeing the whole process is easier than just snapshots of someone who has just walked in, in labour'. In addition, the relationship with the woman helped to increase their confidence. The 'unfolding' of the woman's pregnancy revealed new learning opportunities to consolidate skills and increase their confidence. For example, Alice described how knowing the woman, seeing her again rather than just a 'snapshot made me feel more effective as a midwife'. Similarly, Bridget stated as she got 'to know the woman and her family there is a lot of growth and learning' and Patrice noted that she was learning through 'experience'. The new graduate midwives were learning and consolidating skills alongside the woman as Samantha described: 'I liked the full range of my skills being used'. Bridget proposed that you 'learn so much from the woman herself' and Alice supported this saying 'I learn with the woman'.

Continuity supported learning; for example, Bridget stated 'continuity is amazing, so good for learning' and 'I get to know the woman and their families, there is a lot of growth and learning for me'. Lisbeth also talked about continuity providing learning opportunities across the full scope of practice for a midwife: 'I wanted the whole scope,' that is, providing care throughout pregnancy, birth and the postnatal period. These midwives felt that continuity of carer helped them learn and grow more quickly than the standard transitional support model.

Some midwives were challenged because they were learning; for example, Bridget said she felt it was 'annoying for some women because I am just learning'. She went

on to explain that it might take her longer to complete an antenatal visit because she was in her first year of practice and she was consolidating skills. Hattie felt this was not a problem when she knew the woman: 'they understand I am a graduate and in my first year of learning'. For Hattie, the trusting relationship with the woman meant that she understood if it took her longer to complete an antenatal visit, or if she had to look something up. Lisbeth thought this to be a positive of the relationship aspect: 'As a young practitioner, to be exposed to that emotional vulnerability [of the woman] is probably a really good thing [for learning]'. Lisbeth is referring to the interpersonal relationship that develops when the midwife knows the woman and 'something goes wrong'; for example, a fetal death in utero. The new graduates felt that their skills were consolidated through learning and growing in the relationship with the woman.

Having trusting relationships through continuity of care

The new graduates felt that the development of trusting relationships meant that they could work effectively with women. Hattie stated, 'I just give the information; in that model it is the woman making the decision', indicating that the participants trusted the woman's decisions and choices the woman made about her own care. None of the participants discussed caring for any woman who they felt made potentially unsafe decisions. Robyn talked about 'having more discussions antenatally' when you know the woman, as they have more time available to talk to women in person or on the telephone. Getting to know the woman and spending a lot of time with the woman antenatally enabled the development of a trusting relationship.

The participants also described having more trusting professional relationships with colleagues; for example, Christine said 'what I didn't realise was the relationship I would have with the obstetric staff'. They felt that the relationships with their medical colleagues were easier because when they needed to discuss a woman with the obstetrician, they were familiar with the woman's background. 'The ones [doctors] I go to know that I'm generally concerned, they trust my judgment because I know the woman' [Robyn].

The trusting relationship also assisted the woman to accept unexpected or unplanned outcomes. For example, Ness described, 'they [the women] are happy to transfer because of the relationship'. Transfer in this context refers to the woman needing to be referred to an obstetrician. The consultation may result in the woman having to birth in a hospital setting rather than the birth centre or homebirth setting. Some midwives would continue to provide continuity of midwifery care to the woman in collaboration with the obstetrician. Others needed to 'hand over' or transfer all care to the medical team and hospital midwifery staff. Overall, the new graduate midwives reported feeling 'confident' when consulting with their medical colleagues and the women were usually happy to transfer care, if necessary, due to the trusting relationship.

Defining professional boundaries through continuity of care

Some challenges arose from the relationship in relation to defining professional boundaries. Lisbeth stated you 'really relate to them' [the women] and 'understand them, like you are friends with some of these people'. Hattie reports they become 'part of your life' and 'it becomes like a friendship'. On the other hand, Hattie acknowledged that the 'relationship with the woman is wonderful yet sometimes challenging'. Candice stated 'it's gone beyond a professional relationship to a friendship' and she struggled with this, going on to say 'you are not their friend but their carer' and 'ending the relationship can be difficult'.

4.4.2 The relationship with the group

The new graduate midwives valued the relationship they had with the small team of midwives they worked alongside – their group. As Lisbeth said, 'we could call them any time day and night [for advice or assistance]'.

Finding support from within the group

The new graduate midwives valued the support provided by the group. They found support from *within* the group or pair of midwives, for example, Lisbeth said; 'I have been extremely supported by the midwives around me'. Siobhan also stated 'I feel incredibly well supported by all the midwives' and Christine said 'there is always

someone around I can ask'. Samantha also talked about 'always having someone around I can ask'. Even when the new graduate midwife was working alone in a stand-alone birth centre or in a woman's home, they had mobile phones to contact someone within the group if needed, for example, Hattie said; 'I would just call or text message them' and this was reassuring for the new graduates.

The use of technology, particularly text messaging, was a form of support as Lisbeth said: 'the day starts with a text message' and 'the group makes sure you are feeling ok'. Bridget said 'she can literally call them anytime' and Hattie also said she can 'run almost everything past them'. Siobhan was encouraged to 'call me [the more experienced midwife] in the middle of the night if you want to run something by me'. Gabi said 'I would call or text them anytime'. These new graduates reported feeling well supported and strong professional relationships formed.

Some participants were supported with a specific mentor within the group or found one themselves; for example, Gabi said 'I had a mentor for a month and now we still have a bit of a mentoring relationship going on'. Patrice mentioned how lucky she was to have such good support from one particular midwife in the group and 'if I had gone to another hospital I would not have had that luxury'. These midwives felt more supported in continuity compared with working in the standard transitional support program; for example, Ness said 'I actually found I got more support in a continuity of care model'.

Not all found support from within the group. Patrice mentioned, 'some people [other midwives in the group practice] never put up their hand to help yet expect a lot'. Alice stated that some midwives find providing 'support [to a new graduate] draining and that it will take them away from their own caseload'. Candice also stated 'people are reluctant to relieve' when she had been with a woman for a long time.

Those who had difficulty finding support from within the group found support from the midwifery core staff. A lack of staff was discussed as a problem in terms of

receiving enough support. Siobhan found support outside of the group, stating, 'with staffing the way it is we need to call in the core midwifery staff' as 'we can't get midwives to work in the model'. Samantha found the ward-based midwives helpful: 'there are some really good midwives, I specifically look for one, she works nights [night duty] and is a fountain of knowledge'. Samantha was not allocated a mentor or able to find someone in the team to mentor her so she looked elsewhere including her medical colleagues: 'the registrars and residents are really approachable'.

Support was also found in the group meetings that were highly valued by the participants. Hattie described 'weekly meetings' while Ness said they had 'monthly meetings'. Christine discussed regular meetings 'at least once a week we meet' and described having a 'big birth centre meeting once a fortnight' with a 'mini-audit' looking at practice. These meetings provided 'professional practice support' with the discussion of 'evidence' to support practice. In addition, the meetings provided emotional support, particularly after an event that the new graduate midwife had not experienced previously. Debriefing was a valuable experience for the new graduate midwife.

Most were appreciative of having a reduced caseload at the beginning of their practice. Christine said 'at the start they only give us two [women] a month' and Bridget noted 'it really helped having a reduced caseload'. This was not universally appreciated, with Samantha reporting frustration with her reduced caseload, saying, 'I wasn't given a full caseload at the start, I wanted to feel what it was really like, not be molly coddled'. She went on to say, 'I didn't enjoy my orientation, I wasn't allowed to do anything and I felt like a student again'. However, she did value the support offered to her: 'I have got people around me who are really happy to help'. The value of support had a dual role of assisting the new graduate midwife to begin autonomous practice and to sustain the continuity of care model.

Sustaining the continuity of midwifery care model

A couple of participants perceived the support they received from within the group as sustaining the model of care. Lisbeth stated 'they [other midwives] were very protective because they had never had new graduates working in it' and Siobhan said 'it's about protecting the model [of midwifery care]'. Siobhan referred to the model of care 'as such a precious thing'. The participants, along with the midwives that they worked alongside, wanted to ensure sustainability of the model of care by supporting new entrants. The participants were cautious to only call in another midwife when they really needed them, as Lisbeth stated: 'I try and call them [the other midwives] in daylight hours'. Once again, the participants valued the support that enabled them to sustain the midwifery continuity of care model.

Prepared to work in continuity of midwifery care

The participants felt they were prepared to work in continuity through their education. Alice stated 'we are introduced to it as students' and Lisbeth said 'we learnt about the benefits of it [continuity] and it all just makes sense'. Lisbeth goes on to say 'at uni I developed a passion for group practice' and 'we're taught from the beginning it's the gold standard of care; intuitively it makes sense'. The exposure and education about the benefits of continuity of midwifery care made some of the participants decide before they graduated that was where they wanted to work, 'in my final year I started following a homebirth midwife' (Hattie). Christine said that was 'what I really focused on at uni' and Robyn 'from uni I really wanted to work in those models'. Lisbeth also 'knew that is where I wanted to end up'. Bridget described herself as lucky because in my degree there would have been a dozen students out of 40 who would have jumped at the opportunity'. Siobhan said it was a 'real no-brainer, I had the skills to be able to do it'.

Working in continuity 'consolidated everything you learn at uni' (Lisbeth). When the participants developed a relationship with the woman they described feeling an authenticity in their practice for example, Lisbeth said, 'it makes me a good midwife' and Judy said 'I feel like a real midwife'. The new graduate midwives felt they had

grown into real midwives who practise across the full scope of midwifery practice. They acknowledged they have been learning through this first or second year of practice alongside the woman and were well supported by the group of midwives.

4.5 Discussion

In Australia, there are limited numbers of new graduate midwives working in midwifery continuity of care despite midwifery students being prepared to work in this way from their degree. This study explores the experiences of this small group. New graduates highly valued working in this way, especially the relationship with the woman and the relationship with the small group of midwives they worked alongside.

Midwifery continuity of care is highly satisfying for both midwives and women, and satisfaction contributes to the sustainability of midwifery continuity of care and the associated benefits for women and newborns (Collins et al. 2010; Curtis, Ball & Kirkham 2006; Freeman 2006; Sullivan, Lock & Homer 2011). The participants in our study described positive experiences working in these models of care with the development of a relationship with the woman being fundamental. The midwife-mother relationship is a professional relationship developed from the first point of contact and is dependent upon trust and respect and provides job satisfaction (Homer 2006; Kirkham 2000; Stevens & McCourt 2002). The new graduates in our study felt that working in continuity of care was more satisfying compared to working in a standard transition model where they rotated around different wards on a roster and did not develop a relationship with the woman. This has important implications for long-term retention of staff, especially in the early years after graduation. Providing opportunities for newly graduated midwives to work in continuity of midwifery care may contribute to the job satisfaction of midwives and address staff attrition rates from the profession (Curtis, Ball & Kirkham 2006).

Many of our participants described the women they provided care for as 'friends'. Other studies have found women have the same perception, with the midwife

described as their 'friend' (Freeman 2006; Walsh 1999). The challenge for these new graduate midwives was to maintain a professional relationship with the woman (Nursing and Midwifery Board of Australia 2010).

The transition from student midwife to practising as a confident registered midwife is challenging and many of the traditional support programs seem to suit organisational needs rather than developing the confidence of the midwife (Davis et al. 2011). The participants in our study believed they were able to consolidate skills through providing continuity of care. Consolidating skills meant that they could demonstrate their competence and increase their confidence as they got to know the woman. It has been reported that midwives working in one-to-one midwifery feel more confident in their practice when they know the woman (Page 2003). Confidence of new graduate midwives has been measured and found to improve at the completion of the first year of practice in accordance with the national competency standards for the midwife (Australian Nursing and Midwifery Council 2006; Davis et al. 2011). We found that a midwifery continuity of care model provides the opportunity for this group of new graduate midwives to consolidate skills and confidence and work to the full scope of their practice.

Having a trusting relationship with the small group of midwives was highly valued by the participants in our study. The new graduate midwives reported being well supported by the small group of midwives they worked alongside. Other studies have shown that new graduate midwives working in midwifery continuity of care need support from midwives within the midwifery group and, at times, from outside the group (Kensington 2006; Lennox, Skinner & Foureur 2008). Support has been described as mentoring, precepting or clinical supervision (Lennox, Skinner & Foureur 2008). Similarly, we found many different forms of support were useful including an orientation period with or without a mentor, support from within the group via text, phone or in person, a reduced caseload (although not for all) and support from outside the group.

Clinical decision making is a challenge for new graduates as they move out of a student role and into a fully qualified role. Newly graduated midwives have reported that any dialogue, either brief encounters such as a corridor conversation or a longer dialogue with their midwifery colleagues, assists clinical decision making (Young 2012). Our study has shown that these trusting relationships enabled the new graduate midwives to find support from outside of the group, such as corridor conversations with an experienced midwife or consultations with the medical staff.

The new graduates in our study reported that experienced midwives wanted to support the new graduate midwives to sustain midwifery continuity of care. The weekly, fortnightly or ad hoc meetings also provided support and should be considered an essential part of cohesive group practice (Homer, Brodie & Leap 2008). The reflections on practice discussed at the team meetings supported new graduate midwives to make clinical decisions.

In Australia, conscious efforts have been made in the midwifery curricula to prepare students to work in continuity of care models through the inclusion of continuity of care experiences (Australian Nursing and Midwifery Council 2010; Gray et al. 2012). This study has found that these experiences as students were highly beneficial in preparing midwives to work in continuity of care programs, therefore greater efforts need to be made to embed the continuity of care experience in all midwifery pre-registration programs.

4.6 Conclusion

Midwifery continuity of care is beneficial to women and newborns. The number of midwifery models providing continuity of care to women is increasing across Australia. Currently, there are very limited numbers of new graduate midwives working in midwifery continuity of care models throughout Australia. The new graduate midwives in this study wanted to work in midwifery continuity and felt prepared to work in this way from their degree. In addition, they were all well supported in one way or another to work autonomously. The findings from this

study suggest new graduate midwives learn and grow as midwives when working in continuity of care models and they are well supported in their practice. The findings from this study are limited to Australian midwifery continuity of care models with a small sample. As a qualitative descriptive study there is the potential for further interpretive work (Sandelowski 2010). Further research is needed to discover why new graduate midwives need to complete a transition support program or have a certain number of years' of experience before working in midwifery continuity.

References

- Australian Government Department of Health and Ageing 2009, Maternity Services Reform, Commonwealth of Australia, Canberra.
- Australian Nursing & Midwifery Council 2008, Code of Ethics for Midwives in Australia (viewed 15th May 2013).
- Australian Nursing and Midwifery Council 2006, National Competency Standards for the Midwife Nursing and Midwifery Board of Australia Canberra (viewed 15th May 2013).
- Australian Nursing and Midwifery Council 2010, Midwives - Standards and criteria for the accreditation of Nursing and midwifery courses leading to registration, enrolment, endorsement and authorisation in Australia, Australian Nursing and Midwifery Council, Dickson, Canberra.
- Avis, M. 2003, 'Do we need methodological theory to do qualitative research', *Qualitative Health Research*, vol. 13, no. 7, pp. 995-1004.
- Braun, V. & Clarke, V. 2006, 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, vol. 3, no. 2, pp. 77-101.
- Burns, E., Fenwick, J., Schmied, V. & Sheehan, A. 2012, 'Reflexivity in midwifery research: the insider/outsider debate', *Midwifery* vol. 28, pp. 52-60.
- Clements, V., Davis, D. & Fenwick, J. 2013, 'Continuity of care: Supporting new graduates to grow into confident practitioners', *International Journal of Childbirth* vol. 3, no. 1., pp 3-12.
- Collins, C.T., Fereday, J., Pincombe, J., Oster, C. & Turnbull, D. 2010, 'An evaluation of the satisfaction of midwives' working in midwifery group practice', *Midwifery*, vol. 26, no. 4, pp. 435-41.
- Curtis, P., Ball, L. & Kirkham, M. 2006, 'Why do midwives leave? (Not) being the kind of midwife you want to be', *British Journal of Midwifery*, vol. 14, no. 1, pp. 27-31.
- Davis, D., Foureur, M., Clements, V., Brodie, P. & Herbison, P. 2011, 'The self-reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia', *Women and Birth*, vol. 25, no. 3, pp. e1-e10.
- Fereday, J., Collins, C., Turnbull, D., Pincombe, J. & Oster, C. 2009, 'An evaluation of Midwifery Group Practice Part II: Women's Satisfaction', *Women and Birth*, vol. 22, pp. 11-6.
- Foster, J. & Ashwin, C. 2014, 'Newly qualified midwives' experiences of preceptorship: a qualitative study', *MIDIRS; Midwifery Digest* vol. 24 no. 2, pp. 151-6.
- Freeman, L. 2006, 'Continuity of carer and partnership: a review of the literature', *Women and Birth*, vol. 19, no. 2, pp. 39-44.
- Gray, J.E., Leap, N., Sheehy, A. & Homer, C.S.E. 2012, 'The 'follow-through' experience in three-year Bachelor of Midwifery programs in Australia: A survey of students', *Nurse Education in Practice*, vol. 12, no. 5, pp. 258-63.
- Hartz, D., Foureur, M. & Tracy, S. 2011, 'Australian caseload midwifery: the exception to the rule', *Women and Birth*, vol. 178, pp. 1-8.
- Hatem M, Sandall J, Devane D, Soltani H, Gates S. 2008, 'Midwife-led versus other models of care for childbearing women', *Cochrane Database of Systematic Reviews*, Issue 4. Art. No. CD004667. DOI: 10.1002/14651858.CD004667.pub2.
- Hodnett ED., 2008, 'Continuity of caregivers for care during pregnancy and childbirth' *Cochrane Database of Systematic Reviews*, Issue 4. Art. No. CD000062. DOI: 10.1002/14651858.CD000062.pub2.
- Hodnett ED, Gates S, Hofmeyr GJ, Sakala C., 2013, 'Continuous support for women during childbirth' *Cochrane Database of Systematic Reviews*, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub5.
- Homer, C., Brodie, P. & Leap, N. 2008, *Midwifery continuity of care; a practical guide*, Elsevier, Sydney.
- Homer, C., Davis, G., Brodie, P., Sheehan, A., Barclay, L., Wills, J. & Chapman, M. 2001, 'Collaboration in maternity care: a randomised controlled trial comparing continuity of care with standardised hospital care', *British Journal of Obstetrics and Gynaecology* vol. 108, pp. 16-22.
- Homer, C.S.E. 2006, 'Challenging midwifery care, challenging midwives and challenging the system', *Women and Birth*, vol. 19, no. 3, pp. 79-83.
- Hughes, A., Fraser, D., 2011, 'SINK or SWIM': The experience of newly qualified midwives in England', *Midwifery* vol. 27, pp. 382-6.
- Kensington, M. 2006, 'The faces of mentoring in New Zealand: Realities for the new graduate

- midwife', *New Zealand College of Midwives Journal* vol. 35, no. Oct., pp.22-27.
- Kirkham, M. 2000, *The midwife-mother relationship*, Palgrave Macmillan, Basingstoke, Hampshire.
- Lennox, S., Skinner, J. & Foureur, M. 2008, 'Mentorship preceptorship and clinical supervision: Three key processes for supporting midwives ', *New Zealand College of Midwives Journal* vol. 39, pp. 7-12.
- McLachlan, H., Forster, D., Davey, M.-A., Farrell, T., Gold, L., Biro, M., Albers, L., Flood, M., Oats, J. & Waldenström, U. 2012, 'Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial', *BJOG: An International Journal of Obstetrics & Gynaecology*, vol. 119, no. 12, pp. 1483-92.
- Minichiello, V., Sullivan, G., Greenwood, K. & Axford, R. 2004, *Research Methods for Nursing and Health Science* 2nd edn, Prentice Hall, Sydney.
- New South Wales Department of Health 2010, *Maternity - Towards Normal Birth in NSW*, NSW Department of Health, North Sydney viewed 13th May 2013, <http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_045pdf%3E>
- Nursing and Midwifery Board of Australia 2010, *A midwife's guide to professional boundaries for midwives*, Nursing and Midwifery Board, Melbourne, viewed 16th August 2014, <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx-boundaries>>.
- Page, L. 2003, 'One-to-One Midwifery: restoring the 'with Woman' Relationship in Midwifery ', *Journal of Midwifery & Women's Health*, vol. 48, no. 2, pp. 119-25.
- Pairman, S., Tracy, S., Thorogood, C., Pincombe, J., (eds) 2010 *Midwifery: Preparation for practice* 2nd edn, Elsevier, Chatswood.
- Rees, C., 2012, *Introduction to research for midwives*, 3rd edn, Churchill Livingstone, Edinburgh.
- Sandall J, Soltani H, Gates S, Shennan A, Devane D., 2013, 'Midwife-led continuity models versus other models of care for childbearing women', *Cochrane Database of Systematic Reviews*, Issue 8. Art. No. CD004667. DOI: 10.1002/14651858.CD004667.pub3.
- Sandelowski, M., 2000 'Whatever happened to qualitative description?', *Research in Nursing and Health*, vol. 23, pp. 334-40.
- Sandelowski, M. 2010 'What's in a name? Qualitative description revisited', *Research in Nursing and Health* vol 33 pp. 77-84.
- Saultz, J.W. 2003, 'Defining and Measuring Interpersonal Continuity of Care', *Annals of Family Medicine*, vol. 1, no. 3, pp. 134-42.
- Stevens, T. & Mc Court, C. 2002, 'One to one midwifery practice part 3: meaning for midwives', *British Journal of Midwifery*, vol. 10, no. 2, pp. 111-5.
- Sullivan, K., Lock, L. & Homer, C.S.E. 2011, 'Factors that contribute to midwives staying in midwifery: A study in one area health service in New South Wales, Australia', *Midwifery*, vol. 27, pp. 331-35.
- Walsh, D. 1999, 'An ethnographic study of women's experiences of partnership caseload midwifery practice: the professional as a friend', *Midwifery*, vol. 15, no. 3, pp. 165-76.
- Young, N. 2012, 'An exploration of clinical decision making among student and newly qualified midwives', *Midwifery*, vol. 28, pp. 824-30.

Chapter Five: Mentoring experiences

5.0 Phase one – further findings

This is the second chapter that reports on the findings from phase one of the research. Chapter Four provided the experience of new graduate midwives working in midwifery continuity of care. There were two broad themes that emerged from the data: the relationship with the woman, and the relationship with the group of midwives the new graduates worked alongside. Finding support from within the group of midwives was a sub-theme of the relationship aspect and many of the new graduate midwives reported developing a mentoring relationship. Further analysis of the data will be provided in this chapter.

5.1 Chapter preface

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Abstract

Background

Most new graduates find employment in hospitals and undertake a new graduate program rotating through different wards. Mentoring in midwifery has been described as being concerned with confidence building through a personal relationship. A limited number of new graduate midwives were found to be working in midwifery continuity of care.

Aim

The aim of this paper was to explore the mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia.

Method

A qualitative descriptive study was undertaken and the data were analysed using continuity of care as a framework.

Findings

We found having a mentor was important, and knowing the mentor made it easier for the new graduate to call their mentor at any time. The new graduate midwives had respect for their mentors and the support helped build their confidence in transitioning from student to midwife.

Conclusions

The new graduate midwives in this study were mentored by more experienced midwives. With the expansion of midwifery continuity of care models in Australia, mentoring should be provided for transition midwives working in this way.

5.2 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 12 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, and 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 (Eby 2011; Lennox, Skinner & Foureur 2008). 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, Skinner & Foureur 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, Skinner & Foureur 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 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 realisation 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.

5.3 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 are 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 Saultz (2003) and applied to midwifery (Page & McCandlish 2006) and provides a framework to the proposed research design.

5.3.1 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 40 women a year.

5.3.2 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, and 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.

5.3.3 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, and themes were coded into nodes, (Minichiello et al. 2004). The data were read and re-read 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 with 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.

5.4 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 (Australian Health Practitioner Regulation Agency) 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: 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 graduates 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 may be 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 noted, ‘the two I work with are very experienced midwives’. Further reports of experience were ‘it’s really important to have more experienced midwives as a mentor’ and one participant’s mentors were ‘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 graduates value 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* any time 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 'if 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 stated '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.

5.5 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; Saultz 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, Skinner & Foureur 2008; Beecroft 2006; Fajana & Gbajumo-Sheriff, 2011). Our study demonstrates the benefit 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 Midwifery First Year of 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, 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 utilised in business settings (Lennox, Skinner & Foureur 2008) to provide individual support in career transitions. The participants in this study had different ways of finding a mentor, and they reported having a mentor as valuable because 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.

5.6 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.

References

- Australian College of Midwives 2012, 'Midwifery Models of Care Conference', *Midwifery Models of Care*, Australian College of Midwives South Australian Branch, Adelaide.
- Australian Government Department of Health and Ageing 2009, *Maternity Services Reform*, Commonwealth of Australia, Canberra.
- Avis, M. 2003, 'Do we need methodological theory to do qualitative research', *Qualitative Health Research* vol. 13, no. 7, pp. 995-1004.
- Beecroft, P.C., Santner, S., Lacy, M.L., Kunzman, L. & Dorey, F. 2006, 'New graduate nurses' perceptions of mentoring: six-year programme evaluation', *Journal of Advanced Nursing*, vol. 55, no. 6, pp. 736-47.
- Clements, V., Fenwick, J. & Davis, D. 2011, 'Nurturing our future: The importance of midwifery transition support programs', *Women and Birth*, vol. 24, Supplement 1, p. S31.
- Cummins, A.M., Denney-Wilson, E. & Homer, C.S.E. 2015, 'The experiences of new graduate midwives working in midwifery continuity of care models in Australia', *Midwifery*, vol. 31, no. 4, pp. 438-44.
- Davis, D., Foureur, M., Clements, V., Brodie, P. & Herbison, P., 2012, 'The self reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia', *Women and Birth*, vol. 25, no. 3, pp. e1-e10.
- Davies, S. & Mason, J. 2009, 'Preceptorship for newly-qualified midwives: time for a change', *British Journal of Midwifery* vol. 17, no. 12, pp. 804-5.
- Dawson, K., Newton, M., Forster, D. & McLachlan, H. 2015, 'Exploring midwifery students' views and experiences of caseload midwifery: A cross-sectional survey conducted in Victoria, Australia', *Midwifery*, vol. 31, no. 2, pp. e7-e15.
- Eby, L.T., 1997, 'Alternative forms of mentoring in changing organizational environments: A conceptual extension of the mentoring literature', *Journal of Vocational Behavior*, vol. 51, no. 1, pp. 125-44.
- Eby, L.T., 2011, 'Mentoring', *APA handbook of industrial and organizational psychology, Vol 2: Selecting and developing members for the organization*, American Psychological Association, Washington, DC, US, pp. 505-25.
- Fajana, S. & Gbajumo-Sheriff, M. 2011, 'Mentoring: a human resource tool for achieving organisational effectiveness', *IFE Psychologia*, vol. Supplement, pp. 420-32.
- Gray, J.E., Leap, N., Sheehy, A. & Homer, C.S.E. 2012, 'The 'follow-through' experience in three-year Bachelor of Midwifery programs in Australia: A survey of students', *Nurse Education in Practice*, vol. 12, no. 5, pp. 258-63.
- Homer, C.S.E., Brodie, P., & Leap, N., 2008 *Midwifery continuity of care: a practical guide*, Churchill Livingstone, Sydney
- Hughes, A., Fraser, D., 2011, 'SINK or SWIM': The experience of newly qualified midwives in England', *Midwifery* vol. 27, pp. 382-6.
- Kensington, M. 2006, 'The faces of mentoring in New Zealand: Realities for the new graduate midwife', *New Zealand College of Midwives Journal* vol. 35, no. oct. 2006 pp 22-27.
- Lennox, S., Skinner, J. & Foureur, M. 2008, 'Mentorship, preceptorship and clinical supervision: Three key processes for supporting midwives', *New Zealand College of Midwives Journal* vol. 39, pp. 7-12.
- Lennox S., Jutel A, Foureur M., 2012 'The concerns of competent novices during a mentoring year', *Nursing Research and Practice*, Vol. 2012.
- McKenna, L. 2003, 'Nurturing the future of midwifery through mentoring', *Australian Midwifery*, vol. 16, no. 2, pp. 7-10.
- Minichiello, V., Sullivan, G., Greenwood, K. & Axford, R. 2004, *Research Methods for Nursing and Health Science* 2nd edn, Prentice Hall, Frenchs Forest
- New South Wales Department of Health 2010, *Maternity - Towards Normal Birth in NSW*, NSW Department of Health, North Sydney, viewed 13th May 2013 2013, <http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_45.pdf%3E>
- New Zealand College of Midwives, 2014, *Midwifery first year of practice*, New Zealand College of Midwives, New Zealand viewed 6/01/2015, <<http://www.midwife.org.nz/quality-practice/midwifery-first-year-of-practice>>.

- New Zealand College of Midwives, 2012, *New Zealand college of Midwives*, Auckland, viewed 20th april 2012 2012, <<http://www.midwife.org.nz/>>.
- Nursing and Midwifery Board of Australia 2006, *Midwifery competency standards*, viewed 8th Dec 2014, <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards>>.
- Page, L. & McCandlish, R. 2006, *The new midwifery: science and sensitivity in practice*, Elsevier Health Sciences.
- Panettiere, M. & Cadman, T. 2002, 'Do new graduate midwives need extra support? Are direct-entry midwifery graduates adequately prepared to practise in the hospital environment? A clinical midwifery leader and a nurse educator put the case for an entry-to-practice programme for midwives (viewpoint)', *Kai Tiaki: Nursing New Zealand*, vol. 8, no. 3, p. 18-22.
- Parsloe, E., Wray, M. 2000, *Coaching and Mentoring*, Kogan Page, London.
- Sandall, J., Soltani, H., Gates, S., Shennan, A. & Devane, D. 2013, 'Midwife-led continuity models versus other models of care for childbearing women', *Cochrane Database Syst Rev*, vol. 8, no. 8.
- Sandelowski, M. 2000 'Whatever happened to qualitative description?', *Research in Nursing and Health* vol. 23, pp. 334-40.
- Saultz, J.W. 2003, 'Defining and Measuring Interpersonal Continuity of Care', *Annals of Family Medicine* vol. 1, no. 3, pp. 134-42.

Chapter Six: Employing new graduate midwives to work in midwifery group practice.

6.0 Phase two findings

This chapter presents the findings from phase two of the research project - what are the experiences of managers and other key stakeholders who employ and support new graduate midwives to work in midwifery group practice? Chapters Three and Four presented the findings on the first phase of the study. Those findings led to the second research question to be developed. The data from this phase were analysed within the diffusion of innovation theory to discover the facilitators and barriers to employing new graduate midwives to work in midwifery continuity of care models.

6.1 Chapter preface

Publication reference:

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This chapter presents an article in its original form, published in *Journal of Nursing Management*. This article is provided in its published form, with permission, as Appendix H.

Abstract

Background

Maternity services in Australia are shifting towards providing more midwifery-led continuity of care models. With the increase in the number of models, there is a requirement by management to recruit midwifery staff to work in the models. Midwifery continuity of care models reduce obstetric interventions at no extra cost to the organisation. Publicly funded maternity services need to provide midwifery models of care in Australia. Managers have sought experienced midwives to work in

these models; as demand grows they have to employ new graduates to staff the models, proving challenging for some managers.

Aim

The aim of this study is to explore the views of midwifery managers, with regard to the facilitators and barriers to employing new graduate midwives in midwifery continuity of care models.

Method

A qualitative descriptive approach was used to explore the managers' experience of employing new graduates in the models. Managers (n=15) were recruited by purposeful sampling.

Results

Drivers, enablers, facilitators and barriers to employing new graduates in the models were identified. Visionary leadership enabled the midwifery managers to employ new graduates in the models.

Conclusion

Managers provide support both in orientation and ongoing, through offering the new graduate midwives a reduced workload initially. Despite these interventions, managers are challenged by organisational culture.

Implications for Nursing Management

Visionary leadership can be seen as critical to breaking down the barriers to employing new graduates into midwifery continuity of care models.

6.2 Introduction

Maternity services in Australia are gradually shifting towards midwifery-led continuity of care models and this requires significant changes to the organisation and management of staff. Midwifery continuity of care, also called caseload or midwifery group practice (MGP), is defined as care provided to women throughout pregnancy, birth and the early postnatal period from a single midwife or a small group of midwives (Sandall et al. 2013). Midwifery continuity of care models reduce obstetric interventions such as epidural anaesthesia, episiotomy and caesarean section operations, with fewer babies being admitted to the neonatal intensive care, at no extra cost to the organisation (Tracy et al. 2013; McLachlan et al. 2012; Sandall et al. 2013). Consequently, the Australian Government has recommended that publicly funded maternity services provide midwifery models of care (Australian Government Department of Health and Ageing 2009; New South Wales Health 2010) although uptake has been slow.

The managers and other key stakeholders in this study employed or supported midwives who provide care to the woman throughout her pregnancy at a time and place that suits the woman and is on call for the birth, with most postnatal care provided in the woman's home. Because workload varies according to the needs of the women in their care, traditional models of management are not always suitable for managing midwives working in flexible ways in continuity of care models, and managers need to adapt to managing this different workforce. In Australia, a clinical redesign saw the introduction of 32 full-time equivalent midwives in one hospital working in a flexible way around the needs of the women, again being on-call and focused on women's rather than institutional needs (Hartz et al. 2012). Again, this was a challenge for the structure of the health system and the way these midwives were managed. Midwives in midwifery continuity of care models are employed on an annualised salary, with a certain number of women to care for each year (Hartz et al. 2012).

Midwifery continuity of care has been found to be a highly satisfying way for midwives to work and is a popular way of working due to the professional relationships that midwives can develop with women and the flexible working arrangements the role enables (Collins et al. 2010; Hartz et al. 2012; Newton et al. 2014). In the past, experienced midwives have been recruited to work in these models; however, as demand grows, new graduate midwives are employed to sustain the models of care (Hartz et al. 2012) and this can be challenging for some health services to implement.

Midwifery continuity of care: a manager's challenge?

Similar to nursing, new graduate midwives have been traditionally employed in some form of 'transitional' support from student to registered practitioner for approximately one year. The new graduate year for nurses, known as transitional programs, have become commonplace in many countries (Rush et al. 2015). New graduate midwives, those in their first year post-graduation, have not historically worked in continuity of care models despite being prepared to work across the scope of midwifery practice from their degrees (Gray et al. 2012; Cummins et al. 2015). A modification of the transitional program has been adapted for midwives (called a 'rotation' year) and sees new graduates working in a number of different settings and rotating every few months through areas such as labour and birth, antenatal ward, antenatal clinic and postnatal wards. Several studies (Panettiere & Cadman 2002; Passant et al. 2003; Kensington 2006; Lennox et al. 2008; Davies 2009; Davis et al. 2011; Hughes and Fraser 2011; Barry 2011) have examined the experience of newly graduated midwives during the transition year; however, there is limited evidence about new graduate midwives who are initially placed within midwifery continuity of care models rather than in this rotational model.

When new graduate midwives work in midwifery continuity of care models, they are orientated into a small group of midwives and provide care to a caseload of women. Their practice is flexible in nature; that is, they work their own hours to suit the women's needs providing antenatal care at a time suitable to the woman and the

midwife, they are on-call for the birth and then provide postnatal care, often visiting the woman at home. New graduate midwives, working in this flexible way, are supported by more experienced midwives and mentors via text message, the phone, in person and through regular team meetings (Kensington, 2006; Lennox, 2012; Lennox 2008; Cummins et al 2015).

Our previous work has found that new graduate midwives who work in continuity of care are well supported to develop relationships with the women and the small group of midwives they work alongside (Cummins et al. 2015). The new graduates consolidated their skills when working with the woman and were supported from within the small group of midwives. Working in a continuity of care model was found to be satisfying while sustaining the model of care for women (Cummins et al. 2015). Although the study was conducted with a small number (n=13) of new graduate midwives, it led to the question of why new graduates are not being employed in midwifery continuity of care models.

Following on from our previous work, the following research question was raised as phase two of the study:

What are the experiences of managers and other key stakeholders when they employ new graduate midwives in midwifery continuity of care models?

Phase two of the research aimed to explore the views of midwifery managers, educators and other key stakeholders. The questions asked focused on the facilitators and barriers to employing new graduate midwives in midwifery continuity of care models. This paper reports on the second phase of the research project.

6.3 Method

A qualitative descriptive approach was used to describe and explore the managers' experience and perspective of employing new graduate midwives in midwifery continuity of care models. The exploration was based on the interest in, and

understanding of, the 'who, what and where' of their experiences (Sandelowski, 2000 p.338). There is little known on the facilitators and barriers to employing new graduate midwives in continuity of care models therefore a qualitative descriptive approach is a useful form of inquiry to describe how the managers feel (Sandelowski 2000).

Ethical approval was sought and granted by the University of Technology Sydney ethics committee (HREC Approval Number: 2012000328).

6.3.1 Participants

Fifteen managers, educators, clinical midwifery consultants and clinical support midwives were recruited by purposeful sampling. As our question was to enquire why new graduates were employed or not, we needed to recruit managers to the study; however, managers are not solely responsible for supporting staff in continuity of care models. The other staff responsible for the support of new graduate midwives working in midwifery continuity of care models are midwifery clinical educators and consultants; they were recruited as key stakeholders in supporting new graduates as they transition from student to an autonomous practicing midwife (Hartz et.al. 2012). The managers, educators and clinical midwifery consultants who supported the midwifery models of care were contacted via email for a phone interview. Maternity services that offer midwifery continuity of care to women were identified from phase one of the study and are mostly in metropolitan settings, and all are publicly funded (see Table 3). Privately practising midwives providing caseload midwifery were not included in the sample and were less likely to recruit new graduate midwives.

Table 3: Demographic details of the participants

No	State	Manager of group practice	Employ/support new graduate midwives	Rural/ Metropolitan
1	A	Manager of group practice	Yes	Metropolitan
2	B	Manager of Health service	Yes	Metropolitan
3	B	Manager of Maternity service	No	Metropolitan
4	B	Midwifery researcher	Yes	Metropolitan
5	B	Clinical support midwife	Yes	Metropolitan
6	B	Clinical midwifery consultant	No	Metropolitan
7	C	Manager of group practice	Yes	Metropolitan
8	B	Manager of group practice	No	Metropolitan
9	D	Manager of Health service	Yes	Metropolitan
10	E	Manager of Health service	Yes	Rural
11	B	Midwifery educator	Yes	Metropolitan
12	B	Clinical Midwifery consultant	Yes	Metropolitan
13	B	Manager of group practice	Yes	Metropolitan
14	B	Manager of group practice	Yes	Metropolitan
15	B	Educator of group practice	Yes	Metropolitan

6.3.2 Data collection

Phone interviews were the most convenient to both the managers and the researcher as the participants were from all over Australia. Face-to-face interviews are usually conducted in qualitative research; however, participants' views of telephone interviews have been positively reported in other qualitative studies (Holt 2010; Ward, Gott & Hoare 2015). The telephone is commonly used and participants report the value of anonymity when undertaking telephone interviews as part of qualitative research; telephone interviews should be considered depending on the nature of the participant group and data analysis (Holt 2010; Ward, Gott & Hoare 2015). Midwifery key stakeholders regularly use telephones for meetings and as the interviews are easily recorded with a hand-held device with the participants consent, telephone interviews were the first choice of method for data collection. Semi-structured interviews were conducted and the interviews were recorded with permission and transcribed verbatim. The researcher transcribed only one interview and due to time constraints had a professional transcriber for the remainder of the interviews the transcriber completed a confidentiality statement. The participants

were asked a series of questions about their decision to employ new graduate midwives to work in midwifery continuity of care, and the questions are included in figure 3. The researcher knew some of the participants and there was the potential for the blurring of boundaries (Burns et al 2012). The researcher positioning herself as a researcher rather than a colleague or acquaintance addressed the issue of reflexivity. The other two authors on the research team read de-identified data and therefore were outsiders (Burns et al 2012) to the data collection providing rigour.

Figure 3 - Questions, phase two

Have you employed and/or supported any new graduate midwives to work in midwifery continuity of care models?
Can you tell me about your decision process as to why you did/or didn't employ new graduate midwives to work in midwifery continuity of care models?
Are there any system or personal barriers to employing new graduate midwives in midwifery continuity of care models?
Can you tell me about your experience of working with new graduate midwives - either in midwifery continuity of care models or in other models?
Can you tell me about your views on the benefit of employing a new graduate midwife to work in a midwifery continuity of care model?
What are the challenges and barriers to employing a new graduate midwife to work in a midwifery continuity of care model?
What support systems would you like to see in place to encourage more managers to employ new graduates into continuity of care models?
If you are not a manager, what do you think of employing new graduate midwives in midwifery continuity of care programs?

6.3.3 Analysis

Thematic analysis was undertaken using several phases: the first phase involved the researcher becoming familiar with the data with initial coding of the data, then searching for themes, sub-themes, reviewing the themes and finally the themes were named and defined before writing the report of the findings, as described by Braun and Clarke (2006).

By reading the transcripts, the first author (AC) familiarised herself with the data. The data was read and then re-read systematically, generating initial codes across the entire data set (Braun & Clarke 2006). The first stage coding was conducted manually, organising the data into meaningful groups in a table (Braun & Clarke 2006). This was the beginning of an audit trail that allowed the other authors to understand how the themes emerged and conclusions were reached (Lavender et al 2004)

The next phase of analysis was to look for themes within the organised data (Braun & Clarke 2006). The initial themes that emerged from the data were: a) facilitating new graduate midwives in the continuity of care models in order to meet staffing needs; and b) providing support to the new graduates. These key themes have captured important elements from the data in relation to the research question (Braun & Clarke 2013). Sub themes included support, such as providing a longer orientation period and a reduced caseload for new graduate midwives. Key themes that emerged as barriers to employing new graduate midwives were based on the historical nature of traditional rotation programs and the organisational expectations of new graduate midwives. Under the key themes were sub-themes such as organisational culture and fear of something going wrong. This description of the data was further analysed to discover the who, what and where (Sandelowski 2000) of the managers' and other key stakeholders' experience. The analysis was driven by the data and not by a theoretical framework (Braun & Clarke 2006) in order to understand the experiences of the managers and other key stakeholders employing and supporting new graduate midwives working in midwifery continuity of care

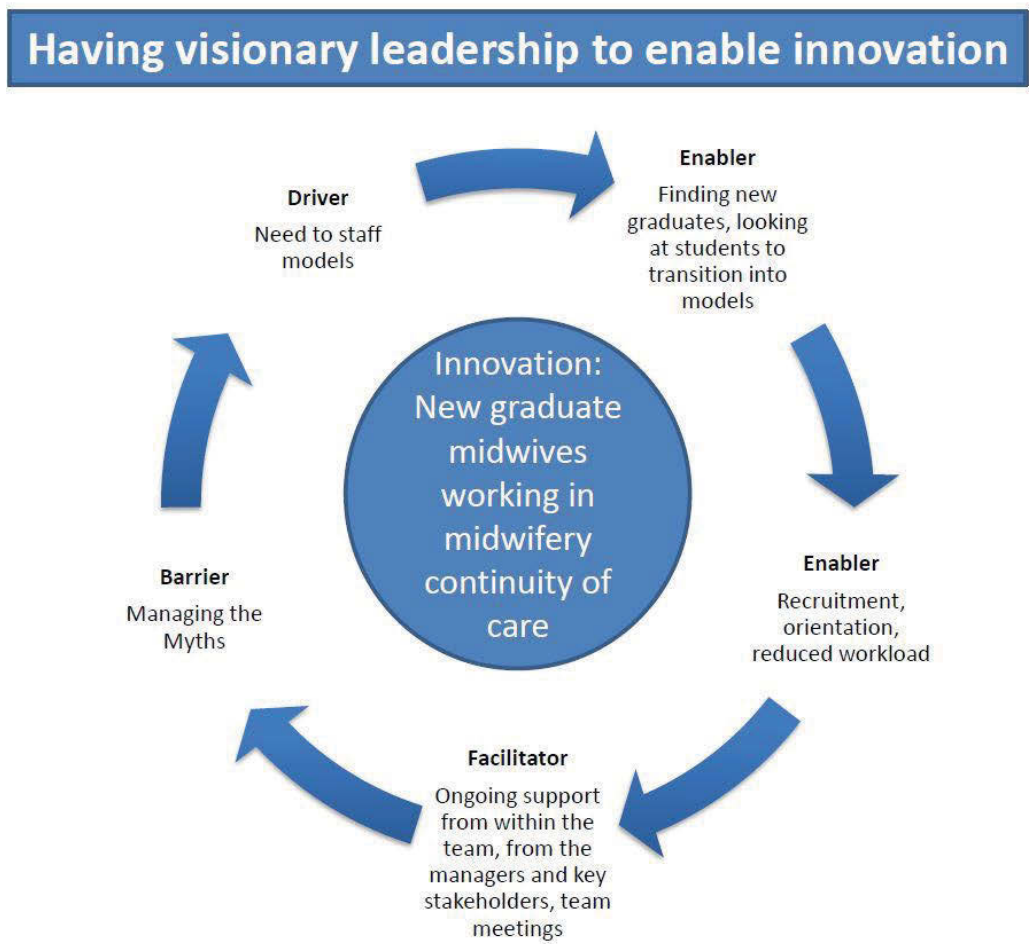
models. By reflecting and comparing the emergent themes with the other two authors (CH & EDW), further analysis occurred. We drew a concept map that showed where themes overlapped and were able to write a narrative around each theme; this exercise enabled the final naming of the themes.

The first author took responsibility for the phases of the analysis, looking for the points of interest in relation to the topic extracted from the themes and sub-themes to arrive at a final interpretation of the data (Braun & Clarke 2006). The constant checking and rechecking of emerging themes between the authors and the use of verbatim quotes from the participants were all steps to ensure rigour in the analysis (Lavender, Edwards & Alfirevic 2004)

6.4 Findings

Drivers, enablers, facilitators and barriers to employing new graduate midwives in midwifery continuity of care models were identified. Importantly, having visionary leadership enabled the midwifery managers to employ new graduate midwives in midwifery continuity of care models. Figure 4 describes the process that was taking place for the managers and in the health system around new graduates.

Figure 4 - Findings diagram for phase two



Drivers – A need to staff the continuity of care models

‘We are recruiting for the future’

Recruitment of midwives to staff the continuity of care models for the future was the main driver for employing new graduate midwives to work in midwifery continuity of care models, with an overarching theme that if they do not recruit new graduates they miss out in two ways: they won’t get the best graduates and they will not be able to staff their services. Two managers said *‘you have to think about your future’*; *‘you build succession planning’* (no. 2) and *‘so it is our ultimate plan that we have a first year of practice with each one of the group practices then every 12 months we’re growing another group practice’* (no. 10).

Midwives are predominantly female, and managing a feminised workforce meant the managers had to think about recruiting for the future as midwives working with continuity of care models may take maternity leave. These managers illustrated this by saying, *‘we do have a dominance of women [midwives] having babies’* (no. 4) and *‘we’ve needed them [new graduates] this year because we have had a lot of people [midwives] having pregnancies’* (no. 7). Recruiting for the future includes replacing retiring midwives in the continuity of care models as noted here: *‘we had a lot of staff who were planning retirement and a few staff who were planning babies’* and then goes onto say *‘new graduates are a really important part of our recruitment strategy’* (no. 1).

On the other hand, one key stakeholder who did not employ new graduates indicated that she had heard *‘we’re not coming to you because you don’t offer us a caseload as part of our graduate year’* (no. 9). This key stakeholder was worried that she would not be able to recruit the future midwifery workforce and recognised that change was needed. A clinical midwifery consultant supports this stance by saying *‘the [new graduate] midwives end up being dissatisfied and they probably leave because they’re in that fragmented model of care’* (no. 5). Recruiting for the future was a clear driver for staffing the continuity of care models.

Having employed new graduates into the continuity of care models has built the workforce capacity; for example, *'more than 50 per cent of our staff now working there started as new graduates'* and *'75 per cent have stayed'* (no. 1). Employing new graduate midwives to the model is important; this manager said *'find ways of getting new graduates in'* [into the model] and *'working with new graduates is imperative if we are going to grow the profession'* (no. 2). Hence the need to staff and maintain the midwifery continuity of care models was based on employing new graduate midwives into the model.

Another educator discussed removing barriers in order to staff and sustain the continuity of care models: *'if we are going to sustain the model, we need to be more accepting to putting up less barriers about how much experience [new graduate experience]'* (no. 11). Another manager took advice from the midwives working within the caseload practice: *'the girls [midwives] saw the sustainability of the model was to actually encourage the recruitment of new graduates'* (no. 13) and again here *'they (caseload midwives) look around and think who will fit into our service and be good with the women'* (no. 11). There was a reported fear of losing the models: *'we are going to be left with no continuity model if we don't do something'* (no. 1) - that is, employ new graduates.

Enablers – Preparing students, recruiting new graduates and providing orientation

'We have been preparing students to work in the continuity of care models'

An enabler for employing new graduate midwives was the process they had undertaken to prepare midwifery students to work in the models. One manager said, *'we are training students to work against the scope of practice; why would we not encourage them to work in a continuity model?'* (no. 2). Another discussed the point of competence at the time of registration, saying *'they come out competent, they come out knowing, many of them have been exposed to continuity of care models'* (no. 4) and again, *'new grads come straight from their training, they want to see a woman through a journey, they've already done that with their follow-throughs, I think a lot of them want to continue working in that way'* (no. 12). On the other hand, one manager discussed the new graduates varying degrees of ability as noted

here: *'some universities do prepare students more effectively than others, the product I get at the end as an employer is actually quite different even though they've had to reach a certain standard'* (no. 9). It is the continuity of care experiences in the midwifery student education that this educator saw as most important: *'the continuity is what has prepared the students to work in the continuity models'* (no. 15).

Managers discussed aligning certain students to work in continuity models: *'we ask them what their future plans are and what they want to do with their career and we will sort of like pick some people to go to various areas, we will change their rotation program'* as students (no. 11). Again, these managers discuss preparing the students to work in continuity: *'they have had 6-8 weeks in their training with a continuity of care group, then obviously you're hoping that could be part of the succession planning'* (no. 6) and *'we have really good relationships with the midwifery students so we tend to know a lot of them by the time they actually come and do the transition year'* (no. 7).

The managers discussed having well-prepared midwifery students to transition straight into the model: *'here we have always had problems getting staff so about 10-12 years ago we purposely set about growing our own workforce; there's a number of students with the plan that we may retain at least 50-60 per cent of those students'* (no. 10) and *'we needed staff so I kind of sought her out because I knew her – she'd spent a bit of time in the birth centre as student'* (no. 8).

There were repeated reports that the new graduates' need support: *'you don't just throw them in, you put support systems there to support them in order to make it successful'* (no. 11).

'We provide a good orientation'

The managers who do employ new graduates indicated that the orientation period was key to transitioning the new graduate into the continuity of care model: *'they are really well supported in that first four to six weeks and the workload is gradually*

increased, they start with a reduced caseload' (no. 1). A reduced caseload means the new graduate does not provide care for the same number of women as other midwives who are more experienced. A longer orientation period is described by this manager: *'give them high level support for the first two or three months, they find their feet and they fly'* (no. 2). Having to reduce the caseload was not always seen as helpful: *'the downside of a reduced caseload is the impact on the workload for the other midwives in the group'* (no. 6). It is important that the small group of midwives are cohesive as the other midwives in the group support the new graduate to transition from student to autonomous practitioner.

Facilitator – The new graduates need support

'Getting support from within the group'

The managers reported different models of support, although new graduate midwives were often supported through a buddy or mentoring system within the small group of midwives they worked alongside. For example, *'they have a direct buddy they are in a group of four'* (no. 14). Again reported here, *'there are four of them, they have a buddy and then they've all got [mobile] phones, so they can talk to each other'* (no. 8) and *'they get a week's orientation, then they work in partnership with the mentor for a while, so for the first few months they work the same clinic (off campus, various points around council but not in people's homes) as their mentors'* (no. 10). Mentoring was, at times, arranged; however, other managers let the new graduate find their own support: *'I haven't assigned them to a mentor; it has been a natural sort of attraction'* (no. 13) and *'they do buddy up, find a particular person they get on well with and maybe that's not their work partner'* (no. 12). Other support was discussed from within the group of midwives *'they don't have a buddy, they work with a team'* (no. 15) and *'midwives in the team support them'* (no. 2). Letting the new graduates find their own support aimed to reduce personality differences, reported by one midwifery consultant as a problem, saying *'we should not be relying on the group to mentor a new grad in'* (no. 6). This led to discussion of other support mechanisms including a support plan for the new graduates to consolidate their skill base.

Having support to consolidate the new graduate's skill base

Many of the managers reported putting a plan in place to assist the new graduates to consolidate their skill base; for example, *'we have a plan and I sit down with them; I would like you to achieve this in one month'* (no. 14) and *'setting up almost like a plan of you know what do I need to achieve, what are my goals, how I am going to get there'* (no. 13). Some reported formalised processes, with another saying, *'we did a skills inventory before and after three months and then at six months'* (no. 5).

There were different perspectives as to the readiness of new graduates for an independent role. One manager was completely confident the new graduates were ready for providing continuity of midwifery care for women through pregnancy, birth and the postnatal period: *'they are registered to practice midwifery to the full scope of practice'* and *'they have the skills and attributes to in fact do that'* (no. 2). Another said, *'you have got to have confidence that they've got a certain level of skill'* (no. 6). This educator expressed another example of confidence in the new graduates: *'new grads come in knowing what they don't know, they know how to ask for help'* (no. 11). Conversely, another manager was more skeptical *'when you're newly graduated, you actually don't even know what you don't know'* (no. 8).

Finding support through team meetings

Almost all the managers discussed team meetings as a form of support for new graduate midwives, illustrated by, *'we have a meeting every Wednesday, we say you need to be part of that so they come to the meeting'* (no. 7) and the *'teams meet each week with any concerns or questions'* (no. 1). Another said, *'[we have] weekly meetings where they would all bring food and have case reviews and talk about what they did, what helped and what didn't help'* (no. 5). The managers discussed their role in supporting the new graduate through regular meetings, explaining, *'they officially/unofficially meet up with me on a weekly basis and then on a monthly basis'* (no. 14) and *'they do feel supported; we meet with them quite regularly in their first, you know, couple of months to see how they're tracking and how it's working for them'* (no. 1).

Being supported by the senior management

The managers looked for support to employ new graduate midwives from the higher-level management. Two managers discussed the support they received from senior management, saying *'the overarching manager was very flexible'* (no. 5) and *'the directors of midwifery we had were very committed to supporting midwives to work in this model'* (no. 1). Another said, *'even our senior nurse manager, our senior operations manager, they know that if they [new graduates working in continuity models] have issues that can't be resolved by any of us, they can go to them'* (no. 12). When the senior management was supportive of new graduates working in midwifery continuity of care models, they were viewed as visionary; for example, *'it is visionary leadership who understand maternity services'* and *'it was the leadership we had supporting university teaching, being a practitioner in your own right'* (no. 5).

Some managers discussed needing to convince their senior management that new graduates working in continuity of care models was safe; for example, *'I suppose we have to get midwifery leadership group to recognise that the students who become registered are registered'* (no. 2). The manager was referring to the new graduates meeting the competency standards of the midwife and being a safe practitioner. There was some discussion from managers when new graduates worked in a standard transitional program they lost their ability to provide care across the scope of practice: as described here *'the new leader has talked about new grads going into caseload because she doesn't want them tainted'* (no. 5). This manager discussed convincing senior management of the maternity service, saying *'you need to sell your successes'* (no 2).

In some places, that senior management was not supportive as stated here: *'I wonder if management just thinks it's all too hard'* (no. 11). There was an optimistic outlook from this manager: *'we have got some better team leaders in our newer staff than in our older staff by years of experience'* and *'the way of changing forwards, through midwifery leadership [visionary leadership], is with our new graduates'* (no. 14).

Barriers – Managing the myths

‘We need to manage the fear around employing new graduates into continuity of care models’

There were concerns about an increase in adverse events if new graduates were working in midwifery continuity of care models, with one manager saying *‘managers and executives fear that something bad is going to happen to a woman or a baby’* (no. 1) and another *‘it is mostly managers who are the most nervous’* (no. 4). There was a thread of fear coming from senior management; for example, *‘they are nervous, they are frightened they don’t have enough skilled leaders who are confident in supporting midwives to be self-determining in the workforce’* (no. 4). Maternity services and obstetrics is a highly litigious environment as reported by this manager: *‘the heads of department are all looking at medico legal issues’* (no. 15). It was difficult for this group of managers to advocate for new graduates when the management were medico-legally defensive about previous adverse events; for example, *‘the midwifery managers as a group decide who works where and what skills people have and I guess for them they are looking at what IIMS [incident reporting system for adverse outcomes] are going to be in and what they felt are going to be the complaints’* (no. 15).

Fear also came from the new graduates’ colleagues, the core staff, with one saying *‘the older midwives would say they felt nervous for them’* (no. 5). Some reported the new graduates being fearful, illustrated by this quote: *‘one new graduate only lasted six weeks, I think it was her personal fear of working autonomously’* (no. 15) and *‘you really have to want to do it and not be frightened of it’* (no. 7). On the other hand, one manager stated, *‘because they have an expectation of learning, they don’t have a fear of it’* (no. 14).

Changing organisational culture

‘Culture is a challenge, not a barrier’

Managers discussed the need for new graduates to gain experience before working in continuity of care models based on history, with one saying, *‘I think we still have a culture where if you don’t do your penance in the birth suite, then you’re not*

experienced enough to care for women independently' (no. 10), also illustrated by this quote: *'sort of a backlash from senior people [midwives], we still have a lot of people [core midwifery staff] who think you have to be in a place for a long time before you should be a caseload midwife'* (no. 11) and *'it's the nature of working in a hospital, you know, it's based on history' and 'this is how we have always done things'* (no. 2). Finally, this manager challenged the historical nature of organisational culture,; saying *'once you start having these rules around who can come to you, you do look a bit exclusive it's a bit crazy because it's a midwifery model'* (no. 7).

There were reports of attempting to change the culture: *'to change the culture, the perception of staff on what a midwife is and what a midwife can do'* (no. 10). One manager reported attempting to change the organisational culture, trying to *'use the workforce in a different way'* and *'use your staff in a slightly better or different way'* (no. 2). However, many of the managers were complacent about the culture, saying *'it is the whole service and the culture around it is very medicalised'* (no. 4). Put simply by this manager, *'significant culture issues are in our maternity unit anyway'* meaning the culture is medicalised and not very midwifery-focused and it is *'the general culture of the organisation'* (no. 1).

6.5 Discussion

This study provides important insights into the role of managers in new models of midwifery care, and provides key learnings for all managers in a changing health care environment. This study found that staffing the midwifery models was the main driver for employing newly graduated midwives into the continuity of care models. Managing a feminised workforce that has high levels of maternity leave with limited capacity for part-time work (Forster et al. 2011; Hartz et al. 2012) has meant that managers need new graduate midwives to staff their continuity of care models. Building workforce capacity was seen as enabling the employment of new graduate midwives into the midwifery continuity of care models. Some units in Australia have undertaken workforce capacity building through clinical redesign. For example, one

large tertiary referral hospital in metropolitan Sydney undertook a well-planned clinical redesign when introducing large numbers of midwives to work in continuity of care models such as midwifery group practice (MGP), and one of the strategies for sustaining the models included the recruitment of new graduate midwives to work in the MGP (Hartz et al. 2012).

Exposing students to midwifery continuity of care was found to be important in our study, to enable the employment of new graduate midwives into continuity of care models upon graduation. This important finding from the managers and other key stakeholders: supports our previous findings and that of others, new graduate midwives felt prepared to work in midwifery continuity by completing their degree (Gray et al. 2012; Cummins et al. 2015). Without this early experience, retention of midwives may be at risk due to dissatisfaction with working in a standard rotation model when new graduate midwives have had experience in midwifery continuity of care models.

The initial support from the managers and senior management was found to be an enabler to employing new graduate midwives in midwifery continuity of care models. The initial support included a prolonged orientation period with a reduced caseload. Similarly, a Canadian study found one of the most positive experiences for new graduate nurses was a long (> 4 weeks) orientation period (Rush, et al. 2015). The other initial support finding, in our study, was a reduced workload with new graduate midwives having a lesser caseload initially. High workload, described as nurse-patient ratio, has been discussed as detrimental to the new graduate nurses' experience of their first year of practice (Feng and Tsai 2012). Other studies of new graduate nurses have found that job satisfaction, professional competence and turnover rates are related to adequate staffing (Numminen et al. 2015; Pineau et al. 2015). Therefore, the findings in our study of offering new graduate midwives a long orientation period and initially a reduced caseload/workload may enable the employment and retention of new graduate midwives.

In our study, support from the hospital senior management was integral in employing new graduate midwives into midwifery continuity of care models. It has been reported that the sustainability of midwifery continuity of care models depends on senior management to meet regularly and complete continuous assessment of the model (Hartz et al. 2012) and further that caseload midwifery would only be normalised as part of the maternity services with support from management (Forster et al. 2011). Hence visionary leadership is a critical driver and enabler to employing new graduate midwives to work in midwifery continuity of care models.

We found there were only a few barriers to employing new graduate midwives into midwifery continuity of care models. The barriers focused on safety and fears that something was going to happen to women and babies. The managers were able to manage the fears expressed from higher management despite a thread of nervousness from the core midwifery staff. It has been found that stand-alone midwifery-led units in England are more successful when there is collegiality between all the midwifery and medical team and supportive management (Rayment et al. 2015). Despite the fears, the managers were focused on ensuring the new graduate midwives built their skills within the continuity of care models and over time they were confident to provide care to women across the full scope of midwifery practice.

Limitations

This study is limited to the views of Australian midwifery continuity of care managers and stakeholders.

6.6 Conclusions and implications for management

We found a key driver for the employment of new graduate midwives to work in midwifery continuity of care models was the need to staff the models of care. The recruitment and retention of new graduate nurses has been examined in the literature as dependent upon work environment, collegial relationships and job satisfaction (Feng & Tsai 2012; Laschinger 2012). We have found in this study that

managers providing a longer orientation period are attracting new graduates to work in the continuity of care models. Collegiality is evident through the team meetings that the managers and other key stakeholders often attend and acts as a facilitator to retaining new graduate midwives working in the continuity of care model. Ongoing support is also important and new graduate midwives in New Zealand are mentored into midwifery continuity of care models (Lennox & Foureur 2012). Consequently, managers who provide a supportive orientation period with an initial reduced workload and ongoing support will attract and retain midwives to work in the midwifery continuity of care models. Despite these interventions and confidence that new graduates are competent to work across the scope of practice, the managers are challenged by organisational culture. Visionary leadership and managing myths that mothers and babies may be at risk can be seen as critical to breaking down the barriers to employing new graduates into midwifery continuity of care models.

Further research is needed to discover why there are larger organisational challenges to employing new graduate midwives to work in midwifery continuity of care models.

References

- Australian Government Department of Health and Ageing, 2009, Maternity Services Reform, Department of Health and Aging, Canberra, Commonwealth of Australia.
- Barry, M., 2011, Newly-graduated midwives applying the philosophy of midwifery: A theory of transcending barriers, 2011, A Midwifery Odyssey, Australian College of Midwives, Conference, Sydney.
- Burns, E., Fenwick, J., Schmied, V. & Sheehan, A., 2012, 'Reflexivity in midwifery research: the insider/outsider debate', *Midwifery*, vol. 28, pp. 52-60.
- Collins, C.T., Fereday, J., Pincombe, J., Oster, C. & Turnbull, D. 2010, 'An evaluation of the satisfaction of midwives' working in midwifery group practice', *Midwifery*, vol. 26, no. 4, pp. 435-41.
- Cummins, A., M., Denney-Wilson, E. and Homer, C. S. E., 2015, 'The experiences of new graduate midwives working in midwifery continuity of care models in Australia' *Midwifery*, vol.31, no.4, pp. 438-44.
- Davies, S., Mason J., 2009, 'Preceptorship for newly-qualified midwives: time for a change?' *British Journal of Midwifery*, vol.17, no.12, pp. 804-805.
- Davis, D., Foureur, M., Clements, V., Brodie, P. & Herbison, P., 2011, 'The self-reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia', *Women and Birth*, vol. 25, no. 3, pp. e1-e10.
- Feng, R. F., Tsai, Y.F., 2012, 'Socialisation of new graduate nurses to practising nurses.' *Journal of Clinical Nursing*, vol. 21, no.13-14, pp. 2064-2071.
- Forster, D. A., M. Newton, McLachlan, H. L., & Willis, K., 2011, 'Exploring implementation and sustainability of models of care: can theory help?', *BMC Public Health*, 11, (Suppl 5): S8
- Gray, J. E., Leap, N., Sheehy A. & Homer, C. S. E., 2012, 'The 'follow-through' experience in three-year Bachelor of Midwifery programs in Australia: A survey of students.' *Nurse Education in Practice* vol.12, no.5, pp.258-263.
- Hartz, D.L., White, J., Lainchbury, K.A., Gunn, H., Jarman, H., Welsh, A.W., Challis, D. & Tracy, S.K. 2012, 'Australian maternity reform through clinical redesign', *Australian Health Review*, vol. 36, no. 2, pp. 169-75.
- Holt, A., 2010, 'Using the telephone for narrative interviewing: a research note', *Qualitative Research*, vol. 10, no. 1, pp. 113-21.
- Hughes, A. & Fraser, D., 2011, 'SINK or SWIM: The experience of newly qualified midwives in England', *Midwifery*, vol.27, no.3, pp.382-386.
- Kensington, M., 2006, 'The faces of mentoring in New Zealand: Realities for the new graduate midwife' *New Zealand College of Midwives Journal*, 35, oct, pp 22-7.
- Laschinger, H.K.S., 2012, 'Job and career satisfaction and turnover intentions of newly graduated nurses', *Journal of nursing management*, vol. 20, no. 4, pp. 472-84.
- Lavender, T., Edwards, G. & Alfirevic, Z., 2004, *Demystifying Qualitative Research in Pregnancy and Childbirth*, Quay books, MA Healthcare Ltd, Wiltshire.
- Lennox, S. & Foureur, M., 2012, 'Developmental mentoring: New graduates' confidence grows when their needs shape the relationship', *New Zealand Com Journal* vol. 46, pp. 26-31.
- Lennox, S., Jutel, A. & Foureur, M., 2012, 'The concerns of competent novices during a mentoring year', *Nursing research and practice*, vol. 2012, article ID 812542, pp. 1-9.
- Lennox, S., Skinner, J., & Foureur, M., (2008). 'Mentorship preceptorship and clinical supervision: Three key processes for supporting midwives', *New Zealand College of Midwives Journal*, 39: 7-12.
- McLachlan, H., Forster, D., Davey, M.-A., Farrell, T., Gold, L., Biro, M., Albers, L., Flood, M., Oats, J. & Waldenström, U., 2012, 'Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial', *BJOG: An International Journal of Obstetrics & Gynaecology*, vol. 119, no. 12, pp. 1483-92.
- New South Wales Department of Health, 2010, *Maternity - Towards Normal Birth in NSW*, NSW Department of Health, North Sydney viewed 13th May 2013
<http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_45.pdf%3E>
- Newton, M.S., McLachlan, H.L., Willis, K.F., & Forster, D.A., 2014, 'Are caseload midwives more satisfied and less burnt out than standard care midwives? Findings from two cross-sectional surveys conducted in Victoria, Australia', *BMC Pregnancy and Childbirth*, vol. 14, p. 426.

- Numminen, O., Ruoppa, E., Leino - Kilpi, H., Isoaho, H., Hupli, M. & Meretoja, R., 2015, 'Practice environment and its association with professional competence and work-related factors: perception of newly graduated nurses', *Journal of Nursing Management*, vol. 23, no. 8, pp. 963-1146.
- Panettiere, M. & Cadman T., 2002, 'Do new graduate midwives need extra support? Are direct-entry midwifery graduates adequately prepared to practise in the hospital environment? A clinical midwifery leader and a nurse educator put the case for an entry-to-practice programme for midwives (viewpoint)' *Kai Tiaki: Nursing New Zealand*, vol. 8, no. 3, pp.18-22.
- Passant, L., Homer, C. S. E., & Wills J., 2003, 'From student to midwife: the experiences of newly graduated midwives working in an innovative model of midwifery care.' *Australian Midwifery* vol.16, no. 2, pp. 18-21.
- Pineau S., Spence L.M., Laschinger, H.K.S., Regan, S. & Wong, C.A., 2015, 'The influence of personal and workplace resources on new graduate nurses' job satisfaction', *Journal of Nursing Management*, vol. 23, no. 2, pp. 190-9.
- Rayment, J., McCourt, C., and Sandall, J., 2015, 'What makes alongside midwifery-led units work? Lessons from a national research project.' *The Practising Midwife* vol.18, no.6, pp. 31-33.
- Rush, K.L., Adamack, M., Gordon, J., Janke, R. & Ghement, I.R., 2015, 'Orientation and transition programme component predictors of new graduate workplace integration', *Journal of Nursing Management*, vol. 23, no. 2, pp. 143-55.
- Sandall, J., Soltani, H., Gates, S., Shennan, A., Devane, D., 2013, 'Midwife-led continuity models versus other models of care for childbearing women' *Cochrane Database of Systematic Reviews*, Issue 8. Art. No. CD004667. DOI: 10.1002/14651858.CD004667.pub3.
- Sandelowski, M., 2000, 'Whatever happened to qualitative description?' *Research in Nursing and Health* vol. 23, pp. 334-40.
- Tracy, S. K., Hartz, D. L., Allen, J., Forti, A., Hall, B., White, J., Lainchbury, A., Stapleton, H., Beckmann M., Bisits, A., Homer, C., Foureur, M., Welsh A., & Kildea, S., 2013, 'Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial', *The Lancet*, 382(9906): 1723-1732.
- Ward, K., Gott, M. & Hoare, K., 2015, 'Participants' views of telephone interviews within a grounded theory study', *Journal of Advanced Nursing*, pp. 2775–2785.

Chapter Seven: Enabling continuity of care for new graduate midwives

7.1 Introduction

This chapter summarises the purpose of this research, presents a synthesis of the findings and discusses their implications in relation to being an innovation that will enable access to continuity of care models for new graduate midwives. The findings of this study have enabled the development of a description of the essential components for midwifery students, new graduate midwives, midwives working in continuity of care models, managers and other key stakeholders who employ and support the new graduates to implement and sustain the innovation. Both new graduates and managers/key stakeholders have a responsibility to ensure the success of implementing an innovative way to staff midwifery continuity of care models through the utilisation of new graduate midwives. It is hoped this model will assist the expansion of midwifery models of care for women to access.

7.2 The research

7.2.1 Purpose

This research sought to answer two specific questions in relation to the experiences of new graduate midwives working in midwifery continuity of care models. These were:

1. What are the experiences of new graduate midwives working in midwifery continuity of care models?
2. What are the experiences of managers and other key stakeholders when they employ and/or support new graduate midwives in midwifery continuity of care models?

7.2.2 Method

The data in relation to the phase one research question were analysed within the concept of interpersonal continuity of care (Saultz 2003) to arrive at two key themes with associated subthemes as described in Chapter Four and summarised below. The study was set in Australia and the participants for both phases were recruited using purposive sampling, as described in Chapter Three. In phase one, snowball sampling

was employed as a second method of recruitment due to the low numbers of participants. Data were collected via semi-structured interviews either in person, over the telephone or by Skype. Interpersonal continuity of care (Saultz 2003) was used to provide further analysis of the data. The two main themes included a relationship with the woman and a relationship with the small group of midwives, with further subthemes. The new graduate experiences led them to feel like a 'real midwife'.

Further analysis of phase one led to findings in relation to the mentoring experiences and these are extensively reported in Chapter Five. Despite these findings, the number of new graduate midwives working in midwifery continuity of care models is scarce. It was important to find out why midwives are not transitioning straight into continuity of care models at the time of graduation and this raised the second research question, addressed in phase two.

In phase two purposive sampling was used to recruit midwifery managers, clinical midwifery consultants, clinical educators and other key stakeholders who employ or support midwives in midwifery continuity of care models. All except three of the respondents supported new graduate midwives to work in midwifery continuity of care models. Data were collected via semi-structured phone interviews as this was the most suitable option for this group of participants. During analysis of phase Two, it became clear that new graduate midwives transitioning straight into a continuity of care model was an innovation. Therefore, the diffusion of innovation theory (Greenhalgh et al. 2004) was applied to further analyse the findings and these are reported in Chapter Six. Drivers, enablers, facilitators and barriers were the themes that emerged from the data.

7.2.3 The findings

Phase one of the research arrived at the following findings divided into main themes and sub themes:

1. Relationship with the woman

- I. Finding satisfaction through continuity of care
- II. Consolidating skills and finding confidence through continuity of care
- III. Having trusting relationships through continuity of care
- IV. Defining professional boundaries through continuity of care.

2. Relationship with the group

- V. Feeling supported from within the group
- VI. Sustaining the continuity of care model
- VII. Prepared to work in continuity of care.

The experiences led the new graduate midwives to feel like they were practising as a real midwife as defined by the International Confederation of Midwives (International Confederation of Midwives 2011). Further analysis of the data indicated the new graduate midwives had experienced mentoring, either having an allocated mentor or finding their own mentor. The mentoring relationship provided ongoing support to the new graduate midwives as they transitioned from student to practising to their full scope of midwifery practice in their first or second year after graduation. As the new graduates developed trusting relationships with women, consolidated skills and built confidence, they also found support and collegiality from within the small group of midwives they worked alongside.

Phase two of the research arrived at the following findings, divided into main themes and sub themes:

1. Drivers

- I. Need to staff the model.

2. Enablers

- I. Preparing students
- II. Recruiting new graduates
- III. Providing orientation.

3. Facilitators

- I. Providing support from within the group
- II. Having support to consolidate the new graduate's skill base
- III. Finding support through team meetings
- IV. Being supported by the senior management.

4. Barriers

- I. Managing the myths
- II. Changing organisational culture.

The findings from both questions were compared and contrasted together with the relevant literature and again with the appropriate theoretical framework and that led to a synthesis that instigated the development of a model. Figure 5 demonstrates the synthesis:

Figure 5 -The process of developing the conceptual model

INTERPERSONAL CONTINUITY OF CARE THEORY			
My Findings		Conceptual model	
Phase one	Findings synthesised with existing literature	Essential elements	Responsibilities
<p>The importance of the relationship with the woman</p> <ul style="list-style-type: none"> • Having trusting relationships • Consolidating skills through continuity • Finding satisfaction through continuity • Defining professional boundaries through continuity 	<p>The evidence states there are better outcomes for mothers and babies with midwifery continuity of care. The higher the level of midwifery continuity the higher levels of satisfaction</p> <p>My study found new graduates confidence grows when they know the woman. The midwives experience increased satisfaction.</p> <p>Professional boundaries are an integral part of continuity of care . New graduates working in this way are challenged.</p>	<p>Provide new graduates with opportunities to work in midwifery continuity of care models</p>	<p>Students to seek out and be offered clinical experience in continuity of care models to obtain the continuity of care experiences</p>
<p>The importance of the relationship with the small group of midwives</p> <ul style="list-style-type: none"> • Feeling supported from the group • Sustaining continuity model • Prepared to work in continuity 	<p>The evidence state: Students experience continuity of care as part of their degree. New graduate midwives need support. Mentoring from either inside the group or outside the group of midwives is positively evaluated</p> <p>My study found new graduate midwives were dependant on collaborative and reflective meeting and developed professional relationships with the midwives and medical colleagues</p>	<p>Provide support from the small group including mentors</p> <p>Leads to well prepared graduate midwives</p> <p>Ensure collaborative & reflective team meetings</p>	<p>New graduate midwives need to develop professional boundaries</p> <p>New graduate midwives need to find and access a mentor</p> <p>New graduate midwives need to engage in reflective team meetings and collaborate with medical colleagues</p>

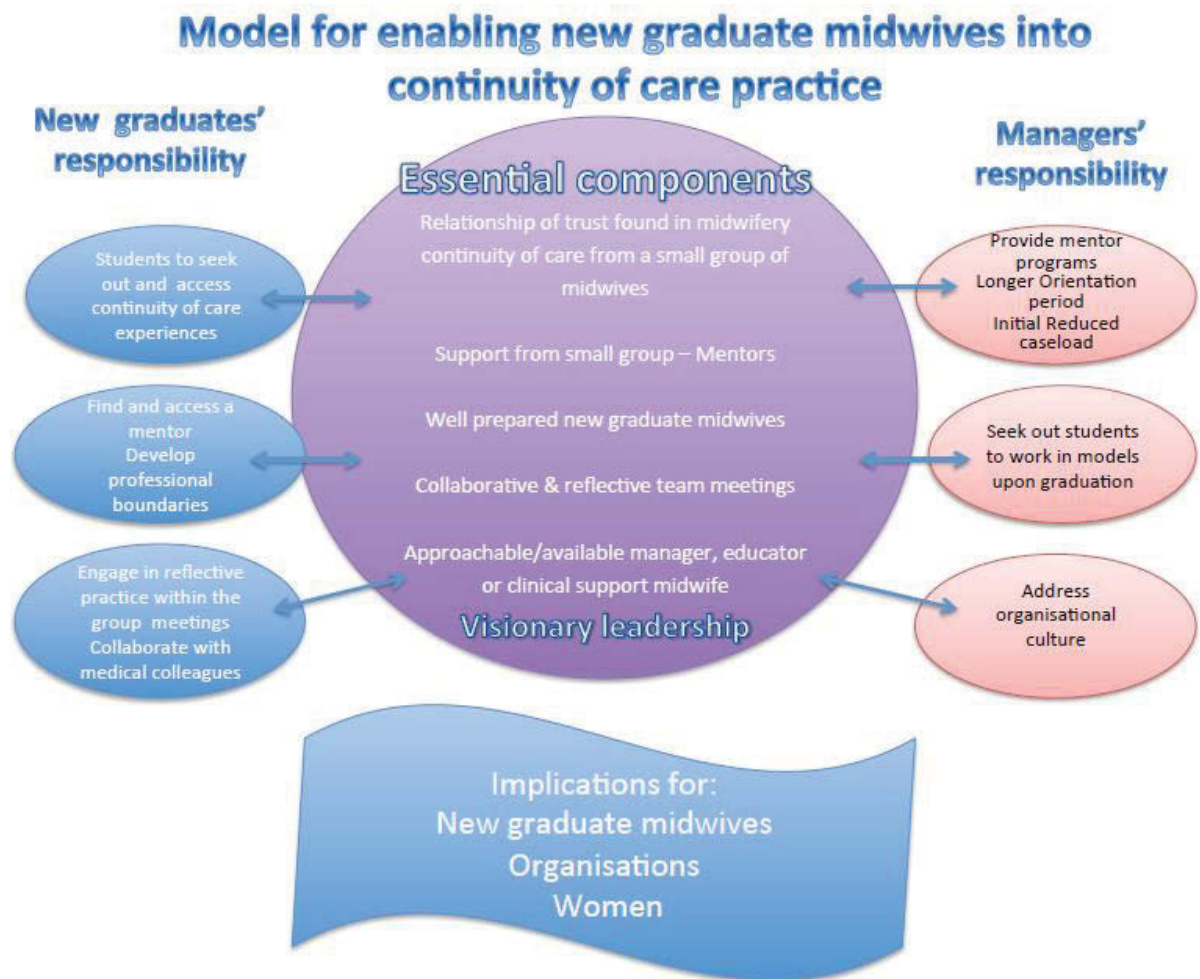
DIFFUSION OF INNOVATION THEORY

My Findings		Conceptual model	
Phase Two	Findings synthesised with existing literature	Essential elements	Responsibilities
<p>Innovation is the employment of new graduate midwives working in midwifery continuity of care models.</p> <ul style="list-style-type: none"> • Drivers - Recruiting for the future • Enablers- Finding new graduates, looking at students to transition to the models. • Facilitators - orientation, reduced workload • Barriers -Managing the myths, changing organisational culture 	<p>The evidence states: Exposing students to midwifery continuity of care models prepares them to work in the models. New graduates need support such as a longer orientation period.</p> <p>My study found managers need new graduate midwives to staff the continuity of care models. They provided a longer orientation period and a reduced caseload initially to support their transition</p> <p>These findings indicate visionary leadership is required to instigate change-related behaviour. The vision is shared between the leader and the constituents of the organisation so all engage in adopting the innovation. Some adopters are slower than others.</p>	<p>Prepare new graduate midwives through providing continuity of care experiences to students</p> <p>Having an approachable/available manager</p> <p>Aim for visionary leadership</p>	<p>Managers should seek out students to work in models upon graduation</p> <p>Managers will schedule and attend the meetings, and provide learning plans to support new graduates as they transition into the models.</p> <p>Mangers will provide a longer orientation period and initially a reduced caseload</p> <p>Managers need to address organisational culture</p>

7.2.4 Conceptual model for enabling new graduate midwives to work in midwifery continuity of care practice

The synthesis of the data within the theoretical frameworks (Figure 5 above) led to the development of a conceptual model (Figure 6). The centre of the conceptual model contains the essential elements. The essential elements have a reciprocal relationship with the responsibilities of both the new graduate midwives and the managers. Their responsibilities are outlined on either side of the essential elements. Visionary leadership forms the base of the conceptual model. Enabling new graduate midwives to work in midwifery continuity of care models has implications for new graduate midwives of the future, the organisations that provide midwifery continuity of care and for the women who access midwifery continuity of care.

Figure 6 - Conceptual model for enabling new graduate midwives to work in midwifery continuity of care practice



The essential components of this model will now be explained, drawing on evidence from my research findings and the evidence from other authors in the relevant literature.

7.3 Essential components

The essential components of the model will be discussed individually. Both new graduate midwives and managers/key stakeholders need to apply their individual responsibilities to ensure success of the model.

7.3.1 Midwifery continuity of care: building relationships of trust

Having a trusting relationship between the midwife and the mother is the essential component of midwifery continuity of care that occurs in midwifery continuity of care practices. With the increasing medicalisation of childbirth, women are forced to see many different care providers throughout their pregnancy, birth and the early parenting period (Page 2003). This is known as fragmented care, and has led to the erosion of the relationship that is the essence of the midwife-mother relationship (Page 2003). The new graduate midwives in my study built trusting relationships with the women they provided with continuity of care. Other studies have found both midwives and women build trusting relationships through continuity of midwifery care models (Edmondson & Walker 2014; Williams et al. 2010).

The relationship of trust that is found in midwifery continuity of care between the woman and the midwife provides high levels of satisfaction for both the woman and the midwife. Satisfaction was found to be a two-way interaction between the women and the midwives, described here by one of the new graduate midwives in my study: 'I loved the satisfaction that women got from having that trust in the one carer'. Women desire to experience a relationship with one person or even a team, as previously shown in another study in New South Wales, Australia (Jenkins et al. 2014). The size of the team of midwives does matter to women; the smaller the size of midwifery teams the better, and they provide higher satisfaction for women (Farquhar, Camilleri-Ferrante & Todd 2000; Homer 2006). Midwifery continuity of care, both in Australia and in the United Kingdom, has been reported as providing a relationship of trust, with women stating they have a higher sense of comfort and

safety and experience higher levels of satisfaction (Fereday et al. 2009; Page 2003). Women's experiences of labour and birth were reported more positively when they had caseload midwifery as compared to standard maternity care that did not include a known midwife (McLachlan et al. 2013). Although birth outcomes were not measured in my study, the new graduates felt women had more positive birth outcomes as noted by one new graduate, 'the outcomes are better' compared with women they cared for, when working in the transition to professional practice programme. New graduate midwives believed that the women were more satisfied with their care when they knew their midwife. While women's satisfaction was not measured directly, it is likely that there are higher levels of job satisfaction and satisfaction for the woman when they have a relationship of trust with a known midwife as shown in other studies (Fereday et al. 2009; Lewis et al. 2016; McLachlan et al. 2016; Page 2003; Williams et al. 2010).

When compared with working in a transition support program, the new graduates discussed higher levels of satisfaction when they knew the woman as noted here: 'also the satisfaction I got and the midwives would get from seeing them from the beginning to end'. Satisfaction has been shown to be higher in other studies. Midwives working on shifts were compared with midwives working in a caseload model and satisfaction was higher for the caseload midwives (Newton et al. 2014). My study found the new graduate midwives felt they were most satisfied when working in midwifery continuity of care models rather than in transitional support programs.

Another study showed that the relationship with the woman through continuity of care provided by a small group of community midwives in England proved to be the most satisfying aspect of their work (Common 2015). In Australia, midwives gained satisfaction through the relationship with the woman when providing continuity of care (Collins et al. 2010). Satisfaction is experienced through the relationship with the woman and is clearly an important component in employing and retaining midwives in continuity of care models. My study demonstrates that the development of a relationship with the woman provides new graduate midwives

with high levels of satisfaction. Other studies have found job satisfaction is an important consideration to attract and retain midwives to work in continuity of care models (Hughes & Fraser 2011; Stevens & McCourt 2002; Van der Putten 2008).

The highest ranking reason midwives stay in the profession has been reported as the relationships with the women (Sullivan, Lock & Homer 2011; Van der Putten 2008). In the Australian study in this area, the authors recommended health services consider the way care is organised, particularly in times of acute staff shortages, considering relationships with women was ranked so highly in providing job satisfaction (Sullivan, Lock & Homer 2011).

Sustaining midwifery practice has been researched in New Zealand where lead maternity carers provide one-to-one midwifery care in a continuity of care model (McAra-Couper et al. 2014). As explained earlier, the aim of this research was to discover what sustains the midwives to work in one-to-one care rather than focusing on what instigates feelings of burnout. The authors found that the reciprocal relationship between the woman and the midwife was the primary reason that sustained midwives to work in midwifery continuity of care (McAra-Couper et al. 2014). The midwives in this study described the reciprocal partnership as reinforcing their passion for midwifery (McAra-Couper et al. 2014). Similarly, the new graduate midwives in my study described similar feelings of joy when they knew the woman, as described here: 'having a relationship with the woman is a position of privilege' and 'I really love the relationship'.

Midwives also need to consider a balance between life and work commitments that require the development of professional boundaries. Professional boundaries are required when working in a model based on interpersonal relationships, as there was some evidence in my study that the new graduate midwives struggle with the relationship concept, as noted by these new graduates: 'they [the women] become part of your life, it becomes like a friendship' and 'it's gone beyond a professional relationship to a friendship'.

An early English evaluation of one-to-one midwifery in the United Kingdom reported very similar comments from the women who had their own midwife in a caseload practice: 'well, you just feel that they're your best friend' and 'I came to look upon my midwife as a friend rather than a professional' (Walsh 1999). These women experienced problems ending the relationship. At the end the relationship was just like a friendship, and they missed their midwives: 'suddenly your best friends aren't going to talk to you anymore' and sadly this woman felt the 'experience was so good up until the end of the 10 days when I really felt abandoned' it was termed by one woman as 'midwife grief' (Walsh 1999). The new graduate midwives in my study had to manage these professional boundaries: building trusting relationships are important, however, defining boundaries is a requirement for all midwives, not just new graduate midwives in order to avoid emotional exhaustion known as burnout.

The concept of burnout is complex and although some studies have looked at the prevalence of burnout in caseload midwives compared with midwives working shifts (Jordan et al. 2013), there are many factors that may contribute. As explained in Chapter Two, caseload midwifery has been shown to provide higher satisfaction with less rates of professional burnout when compared with standard midwifery care (Newton et al. 2014).

Maintaining a balance between work and life commitments contributes to avoiding professional burnout (Fereday & Oster 2010). Working in a caseload or midwifery group practice model in Australia provides flexibility through the industrial agreement, working within a small team and individuals managing their own hours (Fereday & Oster 2010) and hopefully leads to avoiding burnout. Anecdotally, some of the new graduate midwives in my study were mothers or had other life commitments; however, none of them described feelings of burnout. They were all highly satisfied and described the relationship with the woman as the best part of working in midwifery continuity of care models, leading to sustaining them to work in the model and providing job satisfaction. There was also evidence that the new graduate midwives consolidate skills and build confidence better when they know the woman.

The new graduate midwives in my study felt they did work to the full scope of practice as a midwife as one graduate said: 'I liked the full range of my skills being used' and working in continuity 'consolidated everything you learn at uni'. There was also discussion about increasing confidence through the relationship aspect with the woman: 'there is a lot of growth and learning'. As discussed earlier, in another study, the confidence of newly graduated midwives in Australia was measured against the competency standards from the International Confederation of Midwives (ICM) and found to be low on graduation (Davis et al. 2011). There was some increase in confidence at the end of a twelve-month period but not across all skill sets needed for the full scope of practice of a midwife as per the ICM definition (Davis et al. 2011). It was recommended that new graduate midwives may benefit from having a rotation in a midwifery continuity of care model (Davis et al. 2011). Having the opportunity to consolidate skills within a continuity of care model is vital to the new graduates developing their confidence and feeling like a real midwife, who is practising across the full scope to the international definition of a midwife.

The leading essential component for the employment of new graduate midwives into midwifery continuity of care models is to provide the opportunity for a high level of midwifery continuity of care, where the midwife can develop a relationship with the woman. This is best achieved when the continuity model is based on small group practices, likely to be around three to four midwives, rather than large teams. High levels of continuity of care enable a trusting relationship that leads to increased levels of satisfaction for both the woman and the midwife. However, it should be noted that new graduate midwives need support as they transition from student to midwife. My findings provide evidence that new graduate midwives are well supported when they work in a small group of midwives.

7.3.2 Support from the small group including mentors

There was evidence from my study that new graduate midwives were provided with support from the small group of midwives they worked alongside. The new graduate midwives felt supported day and night, particularly when on call. As reported earlier,

they said: 'I have been extremely supported by the midwives around me' and 'I feel incredibly well supported by all the midwives'.

The use of text message and telephone calls was also evident as a form of support as noted here by one midwife: 'the day starts with a text message' and 'I would call or text them anytime'. Support is an essential component to ensuring a successful transition from student to new graduate midwife and the managers enabled this to occur by providing a longer orientation period with a reduced caseload. As discussed in Chapter Six, managers made statements like: 'they are really well supported in that first four to six weeks and the workload is gradually increased, they start with a reduced caseload'.

A facilitator to enabling new graduate midwives to work in midwifery continuity of care was the managers providing a buddy, also known as a mentor: 'I decide who buddies with who'. The new graduate midwives discussed having one person to go to as being really useful: 'it really helped having that one person to go to'. Alternatively, some managers' thought it was important to let the new graduate midwives find their own buddy: 'they do buddy up, find a particular person they get on well with and maybe that's not their work partner'. These are examples of buddying/mentoring that occurs to support the new graduate midwives as they transition from student to midwife practising across the full spectrum of midwifery practice.

Mentoring has been found to be valuable to new graduate midwives in building their confidence, skills and knowledge. As described in Chapter Two, the challenges of mentoring include training for the mentor and providing extra time to facilitate a mentoring relationship with the new graduate (Lennox, Skinner & Foureur 2008; McKenna 2003). The new graduate midwives, in my study, valued having a mentoring relationship: 'I was allocated a mentor for a month and we still have a bit of a mentoring relationship going on' and 'I do get on particularly well with one of the senior group members so I have gone to her with questions or problems'. Despite the challenges, some managers seem to have adopted the innovation of

employing new graduate midwives in continuity of care models with some formalised mentoring while others have allowed the new graduates to find their own mentors. Concerns during the early adoption phase of this new innovation would be whether the midwives who are acting as mentors have sufficient training and support on the mentoring role so they can adapt it to their daily work (Greenhalgh et al. 2004). The mentoring model that was described in my study was based on the midwives' goodwill and kindness. This type of mentoring is of a voluntary nature and they offer their time and share their knowledge and experience without training or acknowledgment (Lennox, Skinner & Foureur 2008; McKenna 2003).

As discussed earlier in Chapter Two, formal mentoring has been implemented in midwifery practice in New Zealand. In this model the new graduate midwives choose their own mentor; the mentor has to volunteer to be part of the nationwide project, known as the Midwifery First Year of Practice Program (New Zealand College of Midwives 2015). New graduate midwives experience a structured yet individualised programme of support which includes formal mentoring, funding for ongoing engagement in education and professional activities and at the completion of the first year provides a reflective, quality assurance process (Dixon et al. 2015). During times of staff shortages there may be a challenge in providing one-to-one mentoring, and innovative adoptions of the mentoring process have been implemented such as group mentoring (Lennox 2011).

The New Zealand Midwifery First Year of Practice Program is very structured and contrasts with the model of midwifery mentoring in Australia. The new graduate midwives in my study received mentorship from more experienced midwives within the small group they worked alongside. These midwives provide mentorship for new midwives without formal training and it is undertaken as part of the Australian midwifery competency standards and requires a commitment of time and energy in addition to the midwives' normal workload with little recognition (Australian Nursing and Midwifery Council 2006; McKenna 2003). If the new graduate midwife did not have one mentor, then the whole group of two to four experienced midwives often mentored them.

The new graduate midwives reported group mentoring as supportive, stating they could call one of the more experienced midwives from the group: 'we could run it past *them*' and 'we could call *them* anytime day and night'. At least initially, this support also extended to one of the more experienced midwives coming in to support the new graduate with births: 'I can call *them* in anytime for labour support'. Group mentoring took the extra responsibility off only one member of the group and has been positively evaluated from one new graduate group practice in New Zealand (Lennox 2011). In New Zealand, when at one time midwifery mentors were difficult to find due to staff shortages, a group of four new graduate midwives were mentored by a group of four experienced midwives with the main purpose to increase the new graduate's confidence (Lennox, Jutel & Foureur 2012). The evaluation of the New Zealand model highlighted the concerns of the new graduates', referred to as 'competent novices'. Their concerns were about the relationships they had both in themselves, and with others. The new graduates' confidence to practice as a lead maternity carer was the competent novices' main concern, however, confidence was found to increase through group mentoring (Lennox, Jutel & Foureur 2012). Mentoring either on a one-to-one basis or from a group is likely to increase new graduate midwives' confidence to practise in a midwifery continuity of care model.

Managers have a responsibility to provide support to new graduate midwives as they transition from student to practising in a midwifery continuity of care model. Providing a longer orientation period and a reduced caseload has been found in my study to provide a smooth transition for the new graduate midwives. My study also found the new graduates valued having a mentor: if they were not allocated a mentor they found one, and sometimes the whole group would mentor the new graduate midwife. It would be ideal for all new graduate midwives to be mentored into midwifery continuity of care models similar to the New Zealand formalised mentoring program.

A barrier to providing a mentor is the associated costs of providing formal training and the hidden costs of the increased workload for the mentor. Funding is a barrier

to implementing caseload models in Australia and when they have been implemented it was often the result of seed funding or redirected funds from other areas within the organisation (Dawson, McLachlan, et al. 2015). In New South Wales, Local Health Districts are provided with funding for the transition to professional practice program dependent on the number of new graduate midwives they employ (White 2016). The redirection of these funds to supporting new graduate midwives through the introduction of a formalised mentoring program would be an enabler for new graduate midwives to work in midwifery continuity of care models. Managers and other key stakeholders should seek out funding and programs for mentoring - they should recognise the importance of the role the midwives play in providing mentoring to the new graduate midwives in continuity of care. New graduate midwives should actively seek out mentors to assist in their transition.

7.3.3 Well prepared graduates

The graduates in my study all felt prepared to work in midwifery continuity of care models because they had to complete continuity of care experiences as part of their degree. As explained in Chapter Four: 'we are introduced to it as students' and 'at uni I developed a passion for group practice'.

The requirement of continuity of care experiences for students, prepares new graduate midwives to work in midwifery continuity of care models. At times, the continuity of care experience can be challenging for the midwifery students, however, they are able to manage all aspects of these experiences, including being on call, due to the relationship they build with the woman (Gray et al. 2012; Hilder et al. 2014). The student experience will influence where students work in the future, whether they will consider working in a midwifery continuity of care model upon graduation (Dawson, Newton, et al. 2015; Hilder et al. 2014).

There was evidence in my study that new graduate midwives had decided they wanted to work in midwifery continuity of care from the experiences they had

during their degree. As shown by the following statements: 'from uni I really wanted to work in those models' and 'I knew that is where I wanted to end up'.

As explained previously, the Australian Accreditation Standards for the Midwife (Australian Nursing and Midwifery Accreditation Council 2014) have included a number of continuity of care experiences as part of the midwifery curriculum. Studies have highlighted the benefits of learning with, and from, the woman (Dawson, Newton, et al. 2015; Gray et al. 2012). Over the last decade, the inclusion of continuity of care experiences as part of the curriculum requirements have been reduced from 'following through' thirty women, to twenty women, and in 2014 was reduced to ten continuity of care experiences (Australian Nursing and Midwifery Accreditation Council 2014). It is difficult to know what the right number of continuity of care experiences are as the benefits of experiential learning opportunities need to be balanced with the students' other competing responsibilities such as carer responsibilities and paid employment. The continuity of care experiences as midwifery students have been found to prepare new graduates to work in midwifery continuity of care both in my study and other studies (Clements, Davis & Fenwick 2013; Dawson, Newton, et al. 2015; Gray et al. 2012) The inclusion of continuity of care experiences in the midwifery curriculum is an important strategy to enable new graduates to be prepared to work in the models. Where possible, students should seek out opportunities to gain experience within a midwifery continuity of care model when undertaking their continuity of care experiences as new graduates with experience of working in continuity of care models are sought by managers to staff the models.

7.3.3.1 Managers seek out well-prepared graduates

Well-prepared graduates were found to be the main driver for the managers to employ new graduate midwives to work in the continuity of care models, as they needed to staff the models. As noted by this manager: 'new graduates are a really important part of our recruitment strategy'.

The need stems from a feminised workforce with many midwives taking maternity leave and also the ageing midwifery population summed up by this manager: 'we've needed them [new graduates] this year because we have had a lot of people [midwives] having pregnancies' and 'we had a lot of staff who were planning retirement and a few staff who were planning babies'. The main barrier to implementing new caseload models has been reported as a lack of midwifery staff willing to work in this way (Dawson, McLachlan, et al. 2015). Employing new graduate midwives to work in the models may overcome this obstacle, providing more women with access to midwifery continuity of care. The managers who did not employ new graduate midwives understood the implications of losing their future workforce, saying, 'if we can't offer models that the midwives want to work in, we're at the risk of really losing a lot of valuable people to our profession'.

Students were actively sought out by some managers as a way of preparing them to work in midwifery continuity of care models when they graduated. As reported by these managers, 'we try to attract student midwives to apply for positions'. The midwives who work in the model are also looking for students to recruit to work in the model: 'all the time the midwives who work here are looking out for student midwives who they think will be good to work in the model'. This was reiterated by this midwifery consultant who said, 'it is ideal where they have had 6-8 weeks in their training with a group, then obviously you're hoping that could be part of the succession planning'. There was plenty of evidence in this study that the midwives who work in the model and wish to sustain the model of care are actively seeking new graduates to work with them, the managers are recruiting for the future and the clinical educators who support new graduates want them prepared to work in continuity of care, by way of their degree. A key strategy would be to place students

in continuity of care models and prepare them to work in the model at the time of graduation.

7.3.3.2 Student experiences prepare new graduates

Embedding midwifery continuity of care experiences into student experiences is likely to prepare new graduate midwives to work in continuity of care models upon graduation and may contribute to adequate staffing for the future in these models (Carter et al. 2015). Providing students with experience in continuity of care models influences their career choice, with students stating they would consider working in continuity of care models after a period of skill consolidation (Dawson, Newton, et al. 2015). Conversely, the new graduate midwives in my study wanted to work in midwifery continuity of care models as soon as they graduated. These findings were based on their student experiences and they consolidated skills better when they had the trusting relationship with the woman, consistent with the findings of Carter (2015). Rawson (2011) had similar findings in her qualitative study into student experiences of providing caseload: they developed trusting relationships with the women and the group of midwives who facilitated experiential learning, making them feel like a real midwife. The evidence from my study and that of others is graduates are well prepared when they have experience in continuity of care models as students (Carter et al. 2015; Dawson, Newton, et al. 2015; Rawson 2011). These experiences positively influence their decision to want to work in midwifery continuity of care models (Dawson, Newton, et al. 2015; Gray et al. 2012; Hilder et al. 2014; Rawson et al. 2009). Some doubt exists whether new graduate midwives are competent to work in the models, as historically they are asked to complete a transition to professional practice program.

This was not the finding in my study, where graduates were reported as competent as per the Australian midwifery competency standards (Nursing and Midwifery Board of Australia 2006b). As expressed by this manager: 'I don't see any evidence that they're lacking in competence' and 'if the state deems them competent and capable to be registered then why shouldn't we?'

Competence is measured against the Australian National Competency Standards for the Midwife (Nursing and Midwifery Board of Australia 2006b). Students are assessed against these standards in order to register as a midwife with the registering authority, Australian Health Practitioners Regulation Agency (Nursing and Midwifery Board of Australia 2006b). New graduate midwives are deemed competent at the time of registration; what needs to be recognised is that unless the new graduate continues to use all the midwifery skills across the continuum, as per the definition of a midwife, some skills may be lost. Transition to professional practice programs may not offer the full range of midwifery skills to be practised and have been criticised as not aiding in the development of confidence and competence when the rotation is short or not well planned (Clements, Fenwick & Davis 2012).

Competence is based on contemporary knowledge and practice but is not a once only achievement (Steele 2009). Competence can be related to the work or practice environment (Numminen et al. 2015), indicating a nurturing environment will enhance competence. Midwifery continuity of care models are proposed as a nurturing environment for new graduates as they are supported by the small group of midwives to consolidate their skills and grow in confidence, both in my study and that of Clements (2013). Newly graduated midwives are competent but may lack confidence and they may also experience low levels of confidence and stress, often due to increased levels of responsibility and accountability (Davis et al. 2011; Dixon et al. 2015; Van der Putten 2008). Support from the midwives the new graduate works alongside, either in person, by phone or text message, is an essential element to enable new graduate midwives to move straight into working in midwifery continuity of care models.

An essential component to enabling new graduate midwives to work in midwifery continuity of care models is to continue to embed continuity of care experiences as a compulsory requirement in midwifery students' curriculum. Students need to seek out these opportunities and managers need to support students to complete the continuity of care experiences so that they can fulfill future workforce requirements.

7.3.4 Collaborative and reflective team meetings

My findings showed one benefit of working in a small team is the collaborative and reflective team meetings. There was evidence from both the new graduate midwives and the managers of regular collaborative team meetings providing further support for the new graduate midwives to transition from student to midwife in continuity of care models. All the new graduates interviewed discussed regular meetings. The meetings provided emotional support particularly after an unanticipated event, with one midwife stating she was asked 'Are you ok?' while an educator discussed the collegiality of the team meetings 'weekly meetings where they would all bring food and have case reviews and talk about what they did and what helped, what didn't help'. The managers also stated that the 'teams meet each week with any concerns or questions'. The meeting provided a learning opportunity with the more experienced midwives and often the small team had an allocated obstetrician.

Having an obstetrician and sometimes the manager, clinical support midwife or educator attend the meetings made them more collaborative. A relationship of trust between the obstetrician and the new graduate midwives developed and the managers saw this relationship as a supportive measure. Other research discusses the benefit of having an obstetrician at the regular team meetings as providing an opportunity for the midwives to discuss any women they had concerns about and made the midwife feel respected by other members of the health care team (Edmondson & Walker 2014). An early Australian introduction of an innovative model of midwifery continuity of care proposed weekly meetings as an education opportunity and provided a time for the new graduates to debrief (Passant, Homer & Wills 2003). Any new innovation requires structure such as regular team meetings to enhance the success of implementing the new innovation (Greenhalgh et al. 2004).

As discussed in Chapter Three, once a new innovation is adopted it needs to be disseminated and consequences are then fed back into the system for change to occur (Greenhalgh et al. 2004). The collaborative team meetings offer an opportunity for dissemination of the innovation of new graduates working in midwifery continuity of care models. The reflective nature of the meetings allows for

feedback to the system for continued change and adoption of the innovation. Other literature that describes midwifery continuity of care models discusses regular team meetings as inherent requirements for success (Hartz et al. 2012; Kensington 2006; Lennox, Jutel & Foureur 2012).

Collaboration with an obstetrician at the team meetings helps to facilitate consultation and referral process for the new graduate midwives working in midwifery continuity of care. The fear that harm may come to a mother or baby was discussed by managers in my study as a barrier to employing new graduate midwives. Some models have designated obstetricians working with them to ease the consultation and referral process, enabling new graduate midwives to work within their scope of practice as outlined by the Australian College of Midwives Guidelines for Consultation and Referral (Australian College of Midwives 2013; Hartz et al. 2012). As all of the new graduate midwives in my study were employed in public hospitals, they found obstetricians they were able to negotiate with and who were keen to see the development of primary models of midwifery care. Examples of collaborating with the public hospital employed doctors were evident in my study, beautifully described by this new graduate: 'The ones [doctors] I go to, know that I'm generally concerned, they trust my judgment because I know the woman'.

The evidence that continuity of midwifery care is not harmful to women (McLachlan et al. 2012; Sandall et al. 2016; Tracy et al. 2013) is so compelling that a barrier to employing new graduate midwives is to use the rhetoric of harm to mothers and babies. Unfortunately, collaborative medical relationships between midwives working in midwifery group practice and organisation doctors can be a barrier to implementing innovative models (Menke et al. 2014), including employing new graduates to work in the models. Techniques and tools for building collaboration between traditionally philosophically opposed obstetricians and midwives was recommended in a literature review that focused on collaboration in maternity care (Downe, Finlayson & Fleming 2010). As discussed earlier, there are excellent models of collaboration in Australia and lessons can be learnt from New Zealand (Hartz et al. 2012; Skinner & Foureur 2010). Having an individual obstetrician working with one

group practice was an innovative success for this organisation (Beasley et al. 2012; Hartz et al. 2012) and could be the key to enhancing collaborative team meetings.

The team meetings offered an opportunity for ongoing reflective practice. Reflective practice is discussed in a group mentoring approach from New Zealand as one essential element in responding to new graduate midwives' concerns when working in a continuity of care model (Lennox, Jutel & Foureur 2012). New graduates rarely missed a group meeting during this mentoring experience and the meetings offered a safe forum for new graduates to raise concerns (Lennox, Jutel & Foureur 2012). These concerns were analysed to reveal that new graduates were confident to reflect on their own performance and their interactions with others within the group meetings with their mentors (Lennox, Jutel & Foureur 2012). Collaborative team meetings provide new graduates with the opportunity to reflect and learn from and with each other. Trusting relationships with the small group of midwives enables the new graduates to feel safe in reflective practice.

The managers were content in the knowledge that the team met regularly and provided support for the new graduates working in an innovative position. Regular team meetings provide a safe supportive arena for new graduates to discuss their practice. The managers and other key stakeholders provided further support to the new graduate midwives on a one-to-one basis. It is the responsibility of all midwives, not just new graduate midwives, to attend the team meetings and it is also the responsibility of the manager and other key stakeholders to be available to the new graduates either at the team meetings or on other occasions, as discussed by this hospital educator: 'We have team meetings so the manager, myself, the clinical consultants for the group and whoever is available; it is expected all the caseload midwives come unless they are sleeping'.

7.3.5 Approachable/available manager, educator or clinical support midwife

Managers and educators who are approachable and available to the new graduate midwives to provide support are important in supporting the new graduate, as noted here by a manager: 'they [new graduates] do feel supported; we meet with them

quite regularly in their first, you know, couple of months to see how they're tracking and how it's working for them'.

Despite this, the new graduate midwives barely mentioned the managers or clinical educators as being supportive in the first phase of this study. Although they were not asked directly, the new graduate midwives were asked 'What did you aim to achieve in your transitional year and how did you achieve what you planned?'. The new graduates discuss the small group of midwives as being supportive and helping them transition to practice, rather than the managers. These findings are consistent with the literature that discusses the experiences of new graduates undertaking the transition to professional practice program. Clements, Fenwick and Davis (2012) found only some new graduates reported receiving the bulk of the support from the manager. The overall findings of the support managers provided were mixed, with reports that managers were distant, disinterested and busy juggling high workloads with limited staff or poor skill mix of staff (Clements, Fenwick & Davis 2012). Their study was set in three area health services in Australia, transition to professional practice programs and not in a midwifery continuity of care model (Clements, Fenwick & Davis 2012). When specifically asked, the new graduates stated that they would like managers to remember what it felt like to be a newly practising midwife with the allocation of appropriate workloads (Clements, Fenwick & Davis 2012). Both managers and new graduates in my study recognised the value of the initial reduced caseload as an appropriate workload in the transition period. Evidently, it is more about the perception that the managers are providing an appropriate workload and this perception makes the manager approachable. Managers also saw their role as assisting the new graduate midwives to consolidate their skills through implementing measures such as skill inventories and the development of learning support plans.

Individualised learning plans were devised for the new graduate midwives in a one-to-one meeting with the managers making the manager available. As this manager explains: 'we have a plan and I sit down with them - I would like you to achieve this in one month'.

Learning plans were devised by the clinical educators in another Australian study (Clements, Fenwick & Davis 2012). One-to-one meetings in transition to professional practice programs only occurred during the orientation period when the new graduate rotated to a new clinical area (Clements, Fenwick & Davis 2012). The new graduate midwives in my study were unlikely to have one-to-one time with a clinical educator or clinical support midwife, other than in the said meetings; they were more likely to have a mentor available not only in their orientation period but throughout their experience of working in midwifery continuity of care. The mentor relationship lasted longer than the orientation period, providing ongoing support to the new graduate midwife. The role of a clinical educator or clinical support midwife in my study was unclear; although the educators said they were available, there was evidence they were not, as noted by this manager: 'I would love to have a clinical support midwife whose role is just to support graduate midwives in the models but they [senior management] won't give me one of those'.

The role of the manager and clinical educators was to meet with the new graduate at specified times and track their progress rather than work alongside them. Although it was proposed that having a designated clinical educator for the midwifery groups would be highly valuable, there was only one group in my study who had their own clinical support midwife.

To provide a designated clinical support midwife for midwifery continuity of care models would depend on extra funding and it is unlikely that many organisations would allocate funds for this intervention due to competing funding needs. The success of implementing caseload models was reported as dependant on funding as well as midwifery and medical support (Dawson, McLachlan, et al. 2015). If funding has been identified as a barrier to implementing of caseload models (Dawson, McLachlan, et al. 2015) it seems unlikely that funding would be available for a designated clinical support midwife. It is evident from my study that new graduate midwives need to find an approachable and interested experienced midwife to provide support. This was an important element of the transition to professional practice programs as well (Clements, Fenwick & Davis 2012).

Managers and other key stakeholders wish to be available and approachable; however, the experiences of the new graduate midwives in this study and the findings of others is that new graduates find most of their support from more experienced midwives (Clements, Fenwick & Davis 2012; Hartz, Foureur & Tracy 2011; Kensington 2006; Lennox 2011). That reality does not detract from the new graduate midwives appreciating an approachable and available manager, as found by Clements, Fenwick and Davis (2012). A good leader was described in one study as approachable, empathetic, supportive and friendly (Byrom & Downe 2010). Communications skills focused not only on being available to talk but actively seeking out interactions (Byrom & Downe 2010). Managers and other key stakeholders, such as clinical educators and clinical support midwives, should aim to be available. Some practical ways to make this happen would be scheduling meetings and attending the group meetings. Formal or informal meetings convey to a new graduate the manager or educator is available and approachable, as evident here: 'they officially/unofficially meet up with me on a weekly basis and then on a monthly basis'.

Managers and other key stakeholders have a responsibility to be available to the new graduates by making space in their busy schedules. The reality is the new graduate needs to understand the competing workloads of managers and educators and continue to find support from more experienced midwives they either work alongside (within the group) or outside the group. Often managers of midwifery continuity of care models do not have any experience in providing caseload midwifery (Kay 2010; Menke et al. 2014) and this may be construed as a barrier to approachable and available managers. Visionary leadership that understands the needs of not only caseload midwifery but also transitioning new graduate midwives straight into caseload and not into transition to professional practice programs is a vital component to enabling new graduate midwives to work in midwifery continuity of care models.

7.4 Visionary leadership

An overarching facilitator to employing new graduate midwives in midwifery continuity of care is having visionary leadership. Managers and other key stakeholders discussed their leaders as visionary, as noted here: 'the Directors of Midwifery we had were very committed to supporting midwives to work in this model' and 'it is visionary leadership who understand maternity services'.

Visionary leaders share a vision with their constituents in the organisation and practice a transformational leadership style (Taylor, Corneilus & Colvin 2013). Transformational leadership is characterised by change-related behaviour in organisations (Taylor, Corneilus & Colvin 2013). Employing new graduate midwives into midwifery continuity of care requires change-related behaviour that is based on a vision from senior management. Leaders who have a vision and share their vision with their colleagues are known as visionary leaders (Taylor, Corneilus & Colvin 2013).

The managers' vision was to employ the new graduate midwives into the continuity of care models so that they had adequate staffing as staffing, the models was the main driver for this change from a manager's perspective. The new graduates' vision is to apply for positions in the midwifery continuity of care models, as they felt prepared to work across the full scope of practice. The managers, other key stakeholders and the new graduate midwives all shared a vision. It is argued that communication of the vision is what leads people to act (Taylor, Corneilus & Colvin 2013). Therefore, the managers, other key stakeholders and the new graduate midwives have a responsibility to communicate their visions to enable the employment of new graduate midwives into midwifery continuity of care models. Visionary leadership has been found to have a positive effect on organisational effectiveness in the nonprofit sector and engages participation, openness, innovation and adaption (Taylor, Corneilus & Colvin 2013).

As discussed in Chapter Three, leaders with a vision and managers who take a hands-on approach to implementing the innovation have a powerful influence on the introduction and assimilation of new innovations (Greenhalgh et al. 2004). I found in my study that the managers and other key stakeholders who readily adopted a new innovation of employing new graduate midwives in midwifery continuity of care models were leaders with a vision to grow midwifery continuity of care models. Evidence from other studies where new graduate midwives have been employed in midwifery continuity of care is dependent on the leadership that is often shown at different levels in the organisation (Hartz et al. 2012; Passant, Homer & Wills 2003). Midwifery continuity of care models will only be seen as mainstream maternity services and sustainable models with support from senior management (Forster et al. 2011; Hartz et al. 2012). Therefore, support from senior management is necessary for the introduction of new graduate midwives to work in the midwifery continuity of care models. Visionary leadership is thought to be the most critical aspect to this innovation. The vision of new graduate midwives working in midwifery continuity of care models is creative and requires change in the organisation. Developing a vision is categorised under 'leading for creativity and change' in a review of leadership theory (Dinh et al. 2014). Visionary leaders are not confined to following mandates but create change in organisations - they are innovative and leading in their area of expertise with a vision that is shared (Rainey 2013). Visionary leadership are those managers in senior positions who encompass the mandate to expand midwifery continuity of care models through changing the transition of new graduate midwives to work in the models. These managers support midwives working to their full capacity as defined by the ICM, that is, working alongside the woman and her needs rather than working on a rotating roster to meet the organisations' needs.

The historical nature of midwifery being considered a specialty of nursing has created a culture of midwives working in institutional settings under medical instruction (Bogossian 1998; Brodie & Barclay 2001; Teakle 2013). The findings in my study reinforced the feelings that midwives have been expressing for many years; that is, autonomous midwifery practice and scope of practice is suppressed by the medically-dominated maternity services (Brodie 2002). Barriers to employing new

graduate midwives in midwifery continuity of care models included a traditionally medicalised hospital culture that insisted midwives work for a period of time in the birth suite, as described here: 'whole service and the culture around it is very medicalised' and 'I think we still have a culture where you must do your penance in the birth suite'.

Culture is about the social contexts that influence the way people behave and the social norms that are accepted and expected (Manley et al. 2011). An example of a social norm in the hospitals that provide midwifery is for the midwifery leaders to have a nursing title. As one manager in my study explained, 'I don't have nursing registration in this country, yet I am employed as a nurse manager'.

Historical regulation of midwifery as part of nursing in Australia was based on the lack of strong midwifery leadership as was present in the United Kingdom (Bogossian 1998). Unlike nurses, midwives are able to practice reasonably autonomously and only refer to medical colleagues when there is a medical need. Raising the profile of midwifery through research that led to changes in the regulation of midwifery in Australia, led to the acknowledgement of Patricia Brodie being awarded an Order of Australia medal in 2012 (Australian College of Midwives 2012); the work of this midwifery leader is exemplary and visionary. The results of this research and lobbying from both leaders in midwifery and consumers led to changes in legislation across Australia where midwives could register separate from nursing, acknowledging midwifery as a separate profession.

However, I found the pervading culture of midwifery as a specialty of nursing was a barrier to employing new graduate midwives to work in midwifery continuity of care. Workplace culture was ranked fourth as a key issue in why midwives are leaving the profession in one state of Australia (Pugh et al. 2013). The aim of the study was to inform the medium to long-term sustainability of the midwifery workforce and workplace culture was identified as a reason midwives are leaving the profession. The midwives in this study also desired supportive management (Pugh et al. 2013). Other studies have found midwives will leave the profession if they cannot practise

to the philosophy of woman-centred care and provide care across the continuum through a continuity of care model (Curtis, Ball & Kirkham 2006; Stevens & McCourt 2002; Sullivan, Lock & Homer 2011). The new graduate midwives in my study had concerns about the sustainability of the continuity of care model. The more experienced midwives in the small group supported the new graduate midwives to sustain the model and that was important to ensure women had access to continuity of care and all the associated benefits. This was discussed here by new graduates: 'it's about protecting the model' and 'It's such a precious thing'.

Visionary leadership includes the traits of a transformational leadership style effecting change in the workplace through a horizontal and transparent management while creating an effective workplace culture through shared vision (Manley et al. 2011; Taylor, Corneilus & Colvin 2013). Effective workplace culture enables human flourishing of person-centeredness, safety, and positive influences on other organisations (Manley et al. 2011). Wanting the new graduate midwives to flourish was the vision stated here by one of the clinical support midwives from the second phase of the research: 'I didn't want them to learn the bad habits, the incestuous kind of culture of obstetric handmaiden; I wanted them to be able to flourish, how they had been taught our definition of a midwife'.

Organisational culture became a barrier to employing new graduate midwives into continuity of care when management focused on the pathway to become a midwife. The distinction between Bachelor of Midwifery graduates and Midwifery graduates who have completed a postgraduate nursing course in order to become a midwife continues to perpetuate a myth that you need to be a nurse to be a midwife, and it is ingrained in hospital cultures. Several examples were identified in my research; for example: 'if you haven't been a nurse; then you are just a fledgling midwife, you don't really know what you are doing' and 'it's different I think between the B Mids [Bachelor of midwifery graduates) and the grad dips [post nursing registration] I think there's only a couple of exceptional students where you feel comfortable with them going in without getting a consolidated year of a transitional program'.

There is no difference between midwives who have qualified from an undergraduate midwifery degree or a postgraduate nursing qualification, both cohorts of new graduates are welcomed into the workforce, they both experience low levels of confidence at the time of registration and have the same experiences in the transitional support year (Clements 2012; Davis et al. 2011; McKenna & Rolls 2007). It is not helpful to distinguish between the degree that the new graduate has completed and is divisive in nature. Visionary leaders need to dispel the myth there is a difference between a new graduate midwife who has completed a Bachelor degree and a nurse who has completed a postgraduate or double degree program of study. Having confidence in a new graduate midwife regardless of their mode of education is a trait of a visionary leader; for example: 'They [other staff in the hospital] need to develop that confidence that these midwives are registered they are competent they are safe' and 'to change the culture the perception of staff on what a midwife is and what a midwife can do'.

Visionary leaders will share their vision with others and when faced with challenges adapt or reinvent the vision. An example is where managers rotated the new graduate midwives into continuity of care models as part of their transition to professional practice program. The diffusion of innovation theory states the modification or adaption of an innovation makes it more easily adopted to suit the managers' vision (Greenhalgh et al. 2004). In my study the managers' vision was to employ new graduate midwives into continuity of care models. They adopted this innovation by rotating the new graduate into the continuity of care model from the traditional transition support program. This is an excellent example of sharing a vision, modifying the innovation without disrupting workplace culture. Compatibility with the organisation's norms, values and perceived needs will make the innovation more readily adopted (Greenhalgh et al. 2004). The majority of managers in my study were able to implement, adapt or reinvent their shared vision of expanding midwifery continuity of care models through employing new graduate midwives. The essential characteristic of a visionary leader is to effect organisational change even in the face of obstacles such as hospital culture.

7.5 Conclusion

The findings from my study have been synthesised with the existing literature, leading to the development of a conceptual model to enable new graduate midwives to work in midwifery continuity of care models. There are essential components to the conceptual model that have been discussed in detail. New graduates, managers and other key stakeholders have responsibilities to ensure the essential components are met. Once met the innovation of employing new graduate midwives to work in midwifery continuity of care models can be successfully implemented.

The conceptual model has implications for new graduate midwives wanting to work in midwifery continuity of care and organisations wanting to implement or expand continuity of care models. With the expansion of the models, more women will be able to access midwifery-led continuity of care and all the known benefits of reduced obstetric interventions and higher satisfaction with their care. The contribution of this thesis, the implications for practice and future research will be discussed in the final chapter.

Chapter Eight: Implications and conclusions

8.1 Contribution of this thesis

My research offers insights into the experiences of new graduate midwives and the challenges of employing and supporting new graduate midwives who work in midwifery continuity of care models. It brings new evidence to the best way to enable new graduate midwives to work to the international definition of a midwife through employment in a midwifery continuity of care model. There is limited research in Australia about the experiences of new graduate midwives during their first year of practice and the available studies recommend midwifery continuity of care models may be the best place for new graduate midwives to transition from student to registered midwife working across the continuum of pregnancy, birth and early parenting while building relationships with women (Clements, Davis & Fenwick 2013; Clements, Fenwick & Davis 2011, 2012; Davis et al. 2011; Fenwick et al. 2012; Passant, Homer & Wills 2003). Through a qualitative methodology, my study brings rich insights to the new graduates' experiences and discovers the facilitators and barriers to implementing this innovative measure to the expansion of midwifery continuity of care models. In-depth interviews allowed for the participants' voices to be heard and their experiences to be shared. New graduate midwives articulated they felt like real midwives when working in midwifery continuity of care practice and visionary leadership created the change necessary in organisations to implement this innovative model. Visionary leadership has a role in changing not only their organisation's culture and norms but influencing other organisations to adopt the innovation of employing new graduate midwives to work in midwifery continuity of care models.

The expansion of midwifery continuity of care models is a complex intervention. Only one study in Australia has examined the facilitators and barriers to implementing midwifery continuity of care models (Dawson, McLachlan, et al. 2015). They found staffing the models to be a significant barrier to implementation. My study adds support to these findings and provides a solution to the staffing dilemma. Employing new graduate midwives into the models is the main driver for staffing and

sustaining existing models and the expansion of new ones. Funding to expand continuity of care models is described as another barrier by managers from all over Australia (Dawson, McLachlan, et al. 2015). I found that managers looked for funding to support new graduates as they transition into the role of a midwife working in midwifery continuity of care models; for example, they wished for a clinical support midwife whose sole responsibility would be to support the new graduate midwives. My inference from this wish is that there is no funding to introduce such an 'expensive' intervention.

New graduate midwives need to be prepared for the transition to working across the full scope of practice. The evidence from the new graduate midwives in my study was they felt prepared to work in midwifery continuity of care because of their studies on the benefits and their clinical experiences as a student. Inclusion of the midwifery continuity of care models in the Australian midwifery curriculum is proposed as essential to preparing graduates for the role. Students' experience of participating in continuity of care has been assessed as a valuable learning experience providing high levels of satisfaction (Carter et al. 2015; Gray et al. 2012; Rawnsion 2011; Rawnsion et al. 2009). All of this evidence, combined with the views and experiences of the new graduate midwives in my study, means the continuity of care experiences need to remain as part of the midwifery curriculum without a continuing dilution from 30 experiences to 10 we have witnessed over the past decade (Australian Nursing and Midwifery Accreditation Council 2014).

Support for new graduate midwives was expressed as having a mentor in my study. Mentoring came from one midwife or the entire group of midwives and they are instrumental in supporting new graduate midwives to work across the full scope of practice. The mentors were available in person, over the phone and via text message at any time of day or night. Mentoring new graduate midwives is recognised and valued in New Zealand where midwives are provided resources such as mentor training under the government funded Midwifery First Year of Practice Program (New Zealand College of Midwives 2015). The success of this program means that about half midwives are lead maternity carers with retention of over 80 per cent of

new graduate midwives who participated in the first year of practice program (Dixon et al. 2015). It is unlikely with the pressure on the Australian health dollar that a mentoring program would be introduced for midwives. The solution may be to redirect funds allocated by health services in some states for the transition to professional practice programs (White 2016) into mentoring programs to support new graduate midwives to work in continuity of care models. Other organisations have redirected funds in order to set up or introduce continuity of care models (Dawson, McLachlan, et al. 2015), and a similar approach could be taken to ensuring new graduate midwives are supported to work in the continuity of care models.

8.2 Limitations

The research findings are limited to the Australian context, one high-income country only. The sample size in both phases one and two are small and therefore not comparable to other settings. Midwifery continuity of care models are expanding; however, they are not mainstream maternity services in Australia and this further limits the research. In phase one of the study, the participants were limited to new graduate midwives working in midwifery continuity of care models. A weakness of the study was an inability to compare new graduate midwives working in midwifery continuity of care models and new graduate midwives working in the transition to professional practice program. Similarly, in phase two all but three managers and other key stakeholders employed or supported new graduate midwives to work in midwifery continuity of care models. Both phases of the study had participants who were interested in the study and supported the study and this is seen as a limitation to the study.

However, the insights gained have implications for further research and future midwifery practice.

8.3 Implications for practice

Implications for practice include the responsibilities of new graduates and midwifery students as they prepare for graduation, the responsibilities of managers and other

key stakeholders who employ new graduate midwives and what the expansion of midwifery continuity of care models will mean for women.

These implications will now be discussed under the following topics:

1. Implications for new graduate midwives
2. Implications for organisations that employ new graduate midwives
3. Implications for women who want to access midwifery continuity of care.

8.3.1 Implications for new graduate midwives

New graduate midwives need to be prepared for the transition to working across the full scope of practice. The evidence from the new graduate midwives in my study was they felt prepared to work in midwifery continuity of care because of their experiences as a student. Inclusion of the midwifery continuity of care models in the Australian midwifery curriculum prepares graduates for the role. Students' experience of participating in continuity of care has been assessed as a valuable learning experience providing high levels of satisfaction (Carter et al. 2015; Gray et al. 2012; Rawnsion 2011; Rawnsion et al. 2009). All of this evidence, combined with the views and experiences of the new graduate midwives in my study, means the continuity of care experiences need to remain a part of the midwifery curriculum (Australian Nursing and Midwifery Accreditation Council 2014). Midwifery students could also seek out additional experiences in midwifery continuity of care models in order to feel prepared at the time of graduation to apply for positions in midwifery continuity of care models.

Finding a mentor and having regular meetings with the mentor provides valuable support to new graduate midwives as they transition from student to working across the full scope of practice as defined by the international definition of a midwife (International Confederation of Midwives 2011). Training mentors, relying on their goodwill and factoring in extra time can all be challenges of one-to-one mentoring. It has been proposed by Lennox (2011) that mentoring can occur from a small group of midwives working in midwifery continuity of care models to relieve some of the

pressure from the mentor. As already explained, the New Zealand Midwifery First Year of Practice Program provides mentors with a one day workshop designed to provide midwives with the principles and practicalities of being a mentor and clarify the differences between mentoring, precepting and clinical supervision (New Zealand College of Midwives 2015). Currently in Australia, there is no such program available and part of my model on enabling midwives to work in midwifery continuity of care is to request managers provide mentoring programs. Programs should include an overview of individual learning theories and styles, the context where learning occurs in clinical practice, developing interpersonal relationships and some challenges in these relationships as well as self-care strategies (West 2007). The introduction of a program to prepare mentors is based on my findings that new graduate midwives will seek out a mentor either from within the small group of midwives they work alongside or outside the group from midwives working on the ward. The new graduate midwives are mindful of not overburdening their mentors and would only call, text or ask the mentor to attend in person when they really needed to run something by them. The new graduates built relationships of trust with their mentors and this increased their confidence.

Confidence was also increased through the new graduates' attendance at the group meetings. The reflective nature of the meetings enabled the new graduates to discuss their clinical decision-making and collaborate with their medical colleagues in a safe and supportive environment. At this time, any concerns about a woman's health can be discussed and an appropriate care plan implemented, making all midwives, not just new graduate midwives, feel respected in a collaborative relationship (Edmondson & Walker 2014; Hartz et al. 2012). The group meetings are also an opportunity for the new graduate midwives to build professional friendships and collegiality with their colleagues. The meetings provide a safe forum for new graduate midwives to debrief and find support from their small group. New graduate midwives have the responsibility to ensure they attend the meetings on a regular basis and these meetings have been found to be important to the success of working collaboratively in midwifery continuity of care models (Beasley et al. 2012; Edmondson & Walker 2014; Hartz et al. 2012).

The implications for new graduate midwives' practice is to engage in midwifery continuity of care experiences as students so they feel well-prepared to work in the models at the time of graduation, find and regularly meet with mentors, and attend team meetings to build collegial and collaborative professional relationships.

The next section will discuss the implications for organisations where new graduate midwives are employed.

8.3.2 Implications for organisations

Australian government recommendations are to implement and expand midwifery continuity of care models in maternity services (Department of Health and Ageing 2011). The expansion of midwifery continuity of care models is a complex intervention that requires a change to the way maternity services are organised including taking midwives off shifts or rotating rosters and allowing them the flexibility to work alongside the needs of the women, including being on call (Hartz et al. 2012). The evidence from my study is new graduate midwives are prepared to work in midwifery continuity of care models, they find support from the group they work alongside, they build trusting relationships with the woman and the small group of midwives, as they build confidence and consolidate skills. The new graduates are enthusiastic and desire to work in the models. There is no evidence that new graduate midwives do not have the skills or capacity to work in midwifery continuity of care models, although my study did not specifically examine this aspect. The implications from my research demonstrate that organisations wanting to implement, expand or sustain existing midwifery continuity of care models should employ new graduates to work in the models after preparing students and supporting their transition from student to registered midwife practising as per the International Definition of a Midwife.

One study in Australia has looked at the facilitators and barriers to implementing caseload models and cited staffing as an important element (Dawson, McLachlan, et al. 2015). My study adds support to these findings and provides a solution to the

staffing dilemma. The inability to staff maternity units in rural Australia has led to their closure, causing women having to travel long distances, often separated from their families (Brown & Dietsch 2013). The introduction of midwifery continuity of care models (caseload midwifery) has been argued as a solution to staffing these rural maternity units where midwives work to the needs of the woman through flexible work arrangements (Brown & Dietsch 2013). Flexible work arrangements mean that midwives can be responsive to the needs of the women and are available to work when the women need care (Hartz et al. 2012). This means the midwives are not at work unless the women they provide continuity of care for are requiring an antenatal visit, are in labour or they are providing postnatal care. Working in a flexible arrangement saw the reduction of sick leave in one hospital setting due to the increased satisfaction of the midwives working flexibly (Hartz et al. 2012). The implications for organisations from a reduction in sick leave, together with the known cost savings from providing continuity of care to women (Hartz et al. 2012; Tracy et al. 2013), means expanding midwifery continuity of care models should be cost effective.

Funding to expand continuity of care models is described as another barrier by managers from all over Australia (Dawson, McLachlan, et al. 2015). I found that managers looked for funding to support new graduates as they transition into the role of a midwife working in midwifery continuity of care models; for example, they wished for a clinical support midwife whose sole responsibility would be to support the new graduate midwives. Organisations in New South Wales, Australia, receive funding for employing new graduate nurses and midwives into the transition to professional practice program (White 2016). The transition to support program as explained in Chapter One is the standard program that involves the new graduate midwife rotating through different wards/units of the maternity service; it does not encompass new graduate midwives working in continuity of care models. One suggestion to enable new graduate midwives to transition directly from student to midwife in a midwifery continuity of care model is to redirect funds from the transition to professional practice program into mentoring programs for midwives and supporting new graduate midwives through providing a longer orientation

period and initial reduced caseload. The redirection of funds was found to be a facilitator in implementing new midwifery continuity of care models in the state of Victoria, in Australia (Dawson, McLachlan, et al. 2015). The implications for organisations would be to rethink how they use the funding they receive and also how they support students to become part of their future workforce.

The responsibility of the employer is to offer midwifery continuity of care models to midwifery students as part of their clinical experience in order to prepare them to work in the models at the time of graduation. Midwifery students learn from the relationship they form with the woman and this has been demonstrated in research from both Australia and overseas (Carter et al. 2015; Dawson, Newton, et al. 2015; Gray et al. 2012; Rawnsdon 2011; Rawnsdon et al. 2009). Women have positively evaluated having a midwifery student provide continuity of care and this is important particularly when women cannot access a midwifery continuity of care model, they are building a relationship with a midwifery student (Aune, Dahlberg & Ingebrigtsen 2012; Browne & Taylor 2014; Tickle et al. 2015). The learning midwifery students experience through midwifery continuity of care opportunities needs to be balanced with careful consideration to the number of experiences they undertake and ensuring the student has support (Carter et al. 2015; Dawson, Newton, et al. 2015; Gray et al. 2012; Rawnsdon 2011). Placing students within a small midwifery continuity of care model would address some of the issues that students experience in being on call. The lack of continuity of care models may pose a challenge to placing students in these models. Employing new graduate midwives directly into continuity of care models will help to expand the models and sustain existing models.

New graduate midwives in my study had an easier transition to working across the full scope of practice through carrying a caseload when they had a longer orientation period with an initially reduced caseload. The first few months are critical to the experience of transition for new graduate midwives, who should have supported rotations with a named preceptor and learning and debriefing opportunities (Clements, Fenwick & Davis 2012). My research found that new graduate midwives

working in midwifery continuity of care models had reduced caseloads, mentors for support and learning opportunities and debriefing through the regular team meetings. Organisations should consider changing the transition to professional practice programs to placing new graduate midwives in midwifery continuity of care models. The other option is to add a rotation into a small group practice as part of the standard rotation. Adapting the innovative transition of new graduate midwives into midwifery continuity of care models was found to be successful in my study. Further evidence from my research found that if you provide good support initially the new graduate midwife 'will fly' and be as competent and confident as more experienced midwives.

The success of the Midwifery First Year of Practice Program in New Zealand has seen high levels of retention of new graduate midwives who participated in the program (Dixon et al. 2015; New Zealand College of Midwives 2015). It is unlikely that a mentoring program would be easily introduced for midwives, as this would seem a low priority with other competing costs such as rising caesarean sections and increasing acuity, such as increased caesarean section rates, in hospitals (Stavrou et al. 2011). As suggested, redirecting funds from the transition to professional practice program towards a mentoring program may be unrealistic; however, if the cost savings of caseload midwifery (Tracy et al. 2013) were made explicit there may be more impetus to consider a mentoring program with the aim of enabling new graduate midwives to staff the midwifery continuity of care models.

8.3.3 Implications for women

Enabling new graduate midwives to work in midwifery continuity of care models will address the staffing barrier to implementing and sustaining midwifery continuity of care models through providing enthusiastic and well-prepared midwives. Having available staff will aid organisations to expand the models and sustain the existing models in Australia, thus providing more opportunities for women to access midwifery continuity of care models. Midwifery continuity of care has many benefits for women including reduced obstetric interventions, less chance of their babies

being admitted to the neonatal nursery and higher satisfaction with the birth experience.

The majority of women do not have access to midwifery continuity of care models, with only 31 per cent of health services who responded to a survey that asked if they offered midwifery continuity of care in Australia, offering access (Dawson, McLachlan, et al. 2015). In addition access was mostly to women who are deemed to have a low risk pregnancy and who live in metropolitan areas (Dawson, McLachlan, et al. 2015). Through preparing midwives and enabling new graduate midwives to work in midwifery continuity of care models, there is a chance that more women will have access to midwifery continuity of care models. The implications for women include experiencing less epidural anaesthetic, instrumental births, episiotomies, premature birth and less neonatal admissions to the nursery, and an increase in spontaneous births (Sandall et al. 2016).

There is also evidence that women experience higher satisfaction with the birth experience. Women's satisfaction with midwifery continuity of care has been measured and found to be positive (Fereday et al. 2009; McLachlan et al. 2013; Page 2003; Williams et al. 2010). In particular, the relationship aspect has been described as highly satisfying - knowing your midwife built women's confidence in their ability to give birth and become a mother (Sandall et al. 2016). The implications for women who have midwifery continuity of care means they are less likely to experience obstetric intervention that can lead to increased morbidity and they have feelings of satisfaction through building positive relationships with the midwife providing continuity of care.

Through consumer-led groups there could be pressure for governments to provide the publicly funded maternity services with midwifery continuity of care models. In Queensland, Australia, the collaboration between private midwifery services and the state-run hospitals has seen women being able to access a midwifery continuity of care model via the universal health insurance scheme, Medicare, through consumer and midwife led lobbying (Teakle 2013).

Enabling new graduate midwives to work in midwifery continuity of care models has implications for new graduates, organisations and women. New graduate midwives can work to the international definition of a midwife and find high levels of job satisfaction as they transition from student to midwife. Organisations will find it easier to expand and sustain the midwifery continuity of care models through access to well-prepared graduates to staff the models. The workforce will be more flexible and with a more satisfied workforce and cost savings for the organisation. Women will gain access to midwifery continuity of care models with all the known benefits of reducing obstetric interventions and higher satisfaction with the birth experience.

8.4 Conclusions and implications for future research

My research aimed to discover the experiences of new graduate midwives working in midwifery continuity of care models. The abundance of evidence that midwifery continuity of care provided by one midwife or a small team of midwives is beneficial for women, babies and provides satisfaction for both women and midwives has been discussed throughout this thesis. My personal experience of supporting new graduate midwives working in midwifery continuity of care models inspired my research when I commenced this journey in 2011. At the time there was little research on the topic here in Australia. Overseas research focused on the support new graduate midwives required to work in continuity of care models. Once I began to uncover the new graduate experiences it became clear to me that new graduate midwives consolidated skills and knowledge through the relationship with the woman and were well supported through the relationship with the small group of midwives they worked alongside. It was these initial findings that provided the impetus for the application of the continuity of care framework (Saultz 2003) to provide further analysis, as discussed in Chapter Three. The final findings illustrated well-prepared new graduate midwives who were well supported and highly satisfied working in midwifery continuity of care models.

The findings made it difficult to understand why new graduate midwives were not transitioning straight into midwifery continuity of care models; instead they were

expected to undertake the transition to professional practice program. This prompted phase two of the research. The aim was to discover the facilitators and barriers to employing new graduate midwives to work in midwifery continuity of care models. I sought out the experiences of managers and other key stakeholders of midwifery continuity of care models. The initial findings were about the difficulties of introducing a new concept into organisations that viewed midwifery as a part of nursing. This led to further analysis of the data through the application of the diffusion of innovation theory (Greenhalgh et al. 2004). The innovation is to employ new graduate midwives into midwifery continuity of care models. The final analysis provided the drivers, enablers, facilitators and barriers to employing new graduate midwives in these innovative models.

The findings from both phases of the research have been synthesised with what is already known about new graduate midwives' experiences and the experiences of managers implementing midwifery continuity of care models, to arrive at a conceptual model to enable new graduate midwives to work in a midwifery continuity of care model.

The conceptual model provides a new way of understanding how new graduate midwives can transition from student to a midwife consistent with the International Confederation of Midwives (2011) definition of a midwife. The conceptual model provides the essential components to enable this transition. The components encompass the provision of a high level of midwifery continuity of care models where a relationship of trust is built. The small group of midwives working in the continuity of care models provide support to the new graduate midwife, including the provision of mentoring. The graduates are well-prepared from their experience of providing continuity of care as students. It is important the graduates attend the collaborative and reflective team meetings. It is helpful if the manager is available and approachable. All these essential components fall within a maternity service with visionary leadership.

The new graduates and the managers both have responsibilities for the essential components to occur. New graduates have a responsibility to plan to work in the models at the time of graduation by seeking out experience in midwifery continuity of care models as students. The new graduate will seek out a mentor and attend the collaborative team meetings. The managers should seek out students they think would be good to work in the models. A supportive manager will offer a mentor, a longer orientation period and an initial reduced caseload to the new graduate. It is also the responsibility of the manager to address organisational culture that prohibits new graduates from working in midwifery continuity of care models.

The essential components of the conceptual model together with the new graduate and managers' responsibilities have implications for new graduates midwives, organisations and women. Women will benefit from the expansion and sustainability of midwifery continuity of care models.

There is scope for further research to test the recommendations from the conceptual model. If the essential components were implemented, would midwifery students' transition directly into midwifery continuity of care models be similar to the experience in New Zealand? Further research could potentially identify other barriers and facilitators to adapting the conceptual model and these would need to be explored in order for the normal transition of new graduate midwives directly into midwifery continuity of care models with an aim of providing access to more Australian women.

References

- Aune, I., Dahlberg, M.U. & Ingebrigtsen, O. 2012, 'Parents' experiences of midwifery students providing continuity of care', *Midwifery*, vol. 28, no. 4, pp. 432-8.
- Austin, W. 2013, 'Contemporary issues in qualitative nursing research methods', in C. Tatano Beck (ed.), *Routledge, International Handbook of Qualitative Research*, Routledge, London.
- Australian College of Midwives 2012, *Media Release*, viewed 21st May 2016, <https://www.midwives.org.au/sites/default/files/uploaded-content/field_f_content_file/11_june_2012__midwife_pat_brodie_awarded_member_of_the_order_of_australia_for_services_to_midwifery.pdf %3E>
- Australian College of Midwives 2013, *National Midwifery Guidelines for Consultation and Referral*, 3rd edn, Australian College of Midwives, Canberra.
- Australian College of Midwives, 2015, *Implementing Visiting Access for Medicare Eligible Midwives* Australian College of Midwives, Canberra, viewed 25th Sept 2015, <http://issuu.com/austcollegemidwives/docs/issuu_acm_eligible_midwives_implem %3E>
- Australian Government Department of Health and Ageing 2009, *Maternity Services Reform*, Commonwealth of Australia, Canberra.
- Australian Health Minister's Advisory Council 2016, *National Maternity Services Plan 2014-2015 Annual Report*, Commonwealth of Australia Canberra, viewed 24th June 2016, <[http://www.coaghealthcouncil.gov.au/Portals/0/National Maternity Services Plan 2014 - 2015 Annual Report.PDF](http://www.coaghealthcouncil.gov.au/Portals/0/National%20Maternity%20Services%20Plan%202014%20-%202015%20Annual%20Report.PDF) %3E.
- Australian Health Practitioner Regulation Agency 2015, *Approved Programs of Study*, Australian Health Practitioner Regulation Agency, viewed 14th August 2015, <<http://www.ahpra.gov.au/Education/Approved-Programs-of-Study.aspx?ref=Midwife&Type=General> %3E>
- Australian Nursing and Midwifery Accreditation Council 2014, *Midwives Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia*, Australian Nursing and Midwifery Council, viewed 18th July 2014, <<http://www.anmac.org.au/midwife-accreditation-standards-2014> %3E.
- Avis, M. 2003, 'Do we need methodological theory to do qualitative research? ', *Qualitative Health Research* vol. 13, no. 7, pp. 995-1004.
- Avis, M., Mallik, M. & Fraser, D.M. 2013, 'Practising under your own Pin'- a description of the transition experiences of newly qualified midwives', *Journal of Nursing Management*, vol. 21, no. 8, pp. 1061-71.
- Barimani, M. & Vikström, A. 2015, 'Successful early postpartum support linked to management, informational, and relational continuity', *Midwifery*, vol. 31, no. 8, pp. 811-7.
- Beasley, S., Naomi, F., Tracy, S.K. & Welsh, A. 2012, 'Collaboration in Maternity Care is achievable and practical ', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol. 52, no. 6, pp. 576-81.
- Beecroft, P.C., Santner, S., Lacy, M.L., Kunzman, L. & Dorey, F. 2006, 'New Graduate Nurses' Perceptions of Mentoring: six-year programme evaluation', *Journal of Advanced Nursing*, vol. 55, no. 6, pp. 736-47.

- Biro, M., Waldenstrom, U., Brown, S. & Pannifex, J. 2003, 'Satisfaction with Team Midwifery care for low and high risk women: a randomized controlled trial', *Birth*, vol. 30, no. 1. pp.1-10.
- Bogossian, F. 1998, 'A review of midwifery legislation in Australia — history, current state and future directions', *Australian College of Midwives Incorporated Journal*, vol. 11, no. 1, pp. 24-31.
- Braun, V. & Clarke, V. 2006, 'Using thematic analysis in psychology', *Qualitative research in Psychology*, vol. 3, no. 2, pp. 77-101.
- Braun, V. & Clarke, V. 2013, *Successful Qualitative Research*, Sage Publications Ltd, London.
- Brodie, P. 2002, 'Addressing the barriers to midwifery-Australian midwives speaking out', *The Australian Journal of Midwifery*, vol. 15, no. 3, pp. 5-14.
- Brodie, P. & Barclay, L. 2001, 'Contemporary issues in Australian midwifery regulation', *Australian Health review*, vol. 24, no. 4, pp. 103-18.
- Brown, M. & Dietsch, E. 2013, 'The feasibility of caseload midwifery in rural Australia: A literature Review', *Women and Birth*, vol. 26, no. 1, pp. e1-e4.
- Browne, J. & Taylor, J. 2014, "It's a good thing...": 'Women's views on their continuity experiences with midwifery students from one Australian region', *Midwifery*, vol. 30, no. 3, pp. e108-e14.
- Byrom, S. & Downe, S. 2010, "She sort of shines": 'midwives' accounts of 'good' midwifery and 'good' leadership', *Midwifery*, vol. 26, no. 1, pp. 126-37.
- Carter, A.G., Wilkes, E., Gamble, J., Sidebotham, M. & Creedy, D.K. 2015, 'Midwifery students' experiences of an innovative clinical placement model embedded within midwifery continuity of care in Australia', *Midwifery*, vol. 31, no. 8, pp. 765-71.
- Clements, V., Davis, D. & Fenwick, J. 2013, 'Continuity of Care: Supporting New Graduates to Grow Into Confident Practitioners', *International Journal of Childbirth*, vol. 3, no. 1, pp. 3-12.
- Clements, V., Fenwick, J. & Davis, D. 2011, 'Nurturing our future: The importance of midwifery transition support programs', *Women and Birth*, vol. 24, Supplement 1, p. S31.
- Clements, V., Fenwick, J. & Davis, D. 2012, 'Core elements of transition support programs: The experiences of newly qualified Australian midwives', *Sexual & Reproductive Healthcare*, vol. 3, no. 4, pp. 155-62.
- Collins, C.T., Fereday, J., Pincombe, J., Oster, C. & Turnbull, D. 2010, 'An evaluation of the satisfaction of midwives working in midwifery group practice', *Midwifery*, vol. 26, no. 4, pp. 435-41.
- Common, L. 2015, 'Homebirth in England: Factors that impact on job satisfaction for community midwives', *British Journal of Midwifery*, vol. 23, no. 10 pp. 716-22.
- Commonwealth of Australia 2009, *Improving Maternity Services in Australia - the report of the Maternity Services Review*, Commonwealth of Australia, Canberra, viewed 15th May 2013, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/\\$File/Improving Maternity Services in Australia - The Report of the Maternity Services Review.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf) %3E>

- Curtis, P., Ball, L. & Kirkham, M. 2006, 'Why do midwives leave? (Not) being the kind of midwife you want to be', *British Journal of Midwifery*, vol. 14, no. 1, pp. 27-31.
- Davies, S. & Mason, J. 2009, 'Preceptorship for newly-qualified midwives: time for a change', *British Journal of Midwifery*, vol. 17, no. 12, pp. 804-5.
- Davis, D., Foureur, M., Clements, V., Brodie, P. & Herbison, P. 2011, 'The self reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia', *Women and Birth*, vol. 25, no. 3, pp. e1-e10.
- Davison, C., Hauck, Y.L., Bayes, S.J., Kuliukas, L.J. & Wood, J. 2015, 'The relationship is everything: Women's reasons for choosing a privately practising midwife in Western Australia', *Midwifery*, vol. 31, no. 8, pp. 772-8.
- Dawson, K., McLachlan, H., Newton, M. & Forster, D. 2016, 'Implementing caseload midwifery: Exploring the views of maternity managers in Australia – A national cross-sectional survey', *Women and Birth*, vol. 29, no. 3, pp. 214-22.
- Dawson, K., Newton, M., Forster, D. & McLachlan, H. 2015, 'Exploring midwifery students' views and experiences of caseload midwifery: A cross-sectional survey conducted in Victoria, Australia', *Midwifery*, vol. 31, no. 2, pp. e7-e15.
- Department of Health and Ageing 2011, *National Maternity Services Plan*, Commonwealth of Australia, Canberra.
- Dinh, J.E., Lord, R.G., Gardner, W.L., Meuser, J.D., Liden, R.C. & Hu, J. 2014, 'Leadership theory and research in the new millennium: Current theoretical trends and changing perspectives', *The Leadership Quarterly*, vol. 25, no. 1, pp. 36-62.
- Dixon, L., Calvert, S., Tumilty, E., Kensington, M., Gray, E., Lennox, S., Campbell, N. & Pairman, S. 2015, 'Supporting New Zealand graduate midwives to stay in the profession: An evaluation of the Midwifery First Year of Practice programme', *Midwifery*, vol. 31, no. 6, pp. 633-9.
- Dove, S. & Muir-Cochrane, E. 2014, 'Being safe practitioners and safe mothers: A critical ethnography of continuity of care midwifery in Australia', *Midwifery*, vol. 30, no. 10, pp. 1063-72.
- Downe, S., Finlayson, K. & Fleming, A. 2010, 'Creating a Collaborative Culture in Maternity Care', *Journal of Midwifery & Women's Health*, vol. 55, no. 3, pp. 250-4.
- Eby, L.T. 2011, 'Mentoring', *APA handbook of industrial and organizational psychology, Vol 2: Selecting and developing members for the organization*, American Psychological Association, Washington, DC, pp. 505-25.
- Edmondson, M.C. & Walker, S.B. 2014, 'Working in caseload midwifery care: The experience of midwives working in a birth centre in North Queensland', *Women and Birth*, vol. 27, no. 1, pp. 31-6.
- Evans, J., Boxer, E. & Sanber, S. 2008, 'The strengths and weaknesses of transitional support programs for newly registered nurses', *Australian Journal of Advanced Nursing*, vol. 25, no. 4, pp. 16-22.
- Fajana, S. & Gbajumo-Sheriff, M. 2011, 'Mentoring: an organisational tool for achieving organisational effectiveness', *IFE Psychologia*, vol. Supplement, pp. 420-32.

- Farquhar, M., Camilleri-Ferrante, C. & Todd, C. 2000, 'Continuity of care in maternity services: women's views of one team midwifery scheme', *Midwifery*, vol. 16, no. 1, pp. 35-47.
- Fenwick, J., Hammond, A., Raymond, J., Smith, R., Gray, J., Foureur, M., Homer, C. & Symon, A. 2012, 'Surviving, not thriving: a qualitative study of newly qualified midwives' experience of their transition to practice', *Journal of Clinical Nursing*, vol. 21, no. 13-14, pp. 2054-63.
- Fereday, J., Collins, C., Turnbull, D., Pincombe, J. & Oster, C. 2009, 'An evaluation of Midwifery Group Practice: Part II: Women's satisfaction', *Women and Birth*, vol. 22, no. 1, pp. 11-6.
- Fereday, J. & Oster, C. 2010, 'Managing a work-life balance: the experiences of midwives working in a group practice setting', *Midwifery* vol. 26, pp. 311-8.
- Flint, C., Poulengeris, P. & Grant, A. 1989, 'The 'know your midwife' scheme — a randomised trial of continuity of care by a team of midwives', *Midwifery*, vol. 5, no. 1, pp. 11-6.
- Forster, D.A., Newton, M., McLachlan, H.L. & Willis, K. 2011, 'Exploring implementation and sustainability of models of care: can theory help?', *BMC Public Health*, vol. 11, no. Suppl 5, p. S8.
- Freeman, L. 2006, 'Continuity of carer and partnership: a review of the literature ', *Women and Birth*, vol. 19, no. 2, pp. 39-44.
- Gilkison, A., Pairman, S., McAra-Couper, J., Kensington, M. & James, L. 2016, 'Midwifery education in New Zealand: Education, practice and autonomy', *Midwifery*, vol. 33, pp. 31-3.
- Gray, J., Taylor, J. & Newton, M. 2016, 'Embedding continuity of care experiences: An innovation in midwifery education', *Midwifery*, vol. 33, pp. 40-2.
- Gray, J.E., Leap, N., Sheehy, A. & Homer, C.S. 2012, 'The "follow-through" experience in three-year Bachelor of Midwifery programs in Australia: A survey of students', *Nurse Education in Practice*, vol. 12, no. 5, pp. 258-63.
- Green, J., Renfrew, M. & Curtis, P. 2000, 'Continuity of care: What matters to women', *Midwifery* vol. 16, pp. 186-96.
- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P. & Kyriakidou, O. 2004, 'Diffusion of innovations in service organizations: systematic review and recommendations', *Milbank Quarterly*, vol. 82, no. 4, pp. 581-629.
- Griffiths, C., McAra-Couper, J. & Nayar, S. 2013, 'Staying Involved 'Because the Need Seems So Huge': Midwives Working With Women Living in Areas of High Deprivation', *International Journal of Childbirth*, vol. 3, no. 4, pp. 218-32.
- Haggerty, J.L., Reid, R.J., Freeman, G.K., Starfield, B.H., Adair, C.E. & McKendry, R. 2003, 'Continuity of care: a multidisciplinary review', *BMJ*, vol. 327, no. 7425, pp. 1219-21.
- Halford, J.M. 1998, 'Easing the way for new teachers', *Educational Leadership*, vol. 55, no. 5, p. 33.
- Hammond, A., Gray, J., Smith, R., Fenwick, J. & Homer, C.S.E. 2011, 'Same... same but different: expectations of graduates from two midwifery education courses in Australia', *Journal of Clinical Nursing*, vol. 20, no. 15/16, pp. 2315-24.
- Hartz, D., Foureur, M. & Tracy, S. 2011, 'Australian caseload midwifery: the exception to the rule', *Women and Birth*, vol. 178, pp. 1-8.

- Hartz, D.L., White, J., Lainchbury, K.A., Gunn, H., Jarman, H., Welsh, A.W., Challis, D. & Tracy, S.K. 2012, 'Australian maternity reform through clinical redesign', *Australian Health Review*, vol. 36, no. 2, pp. 169-75.
- Hastie, C. 1985, 'Midwives eat their young don't they? A story of horizontal violence in midwifery ', *Birth Issues*, vol. 4, no. 3, pp. 5-9.
- Hilder, L., Li, Z., Zeki, R. & Sullivan, E.A. 2014, *Stillbirths in Australia, 1991-2009* AIHW National Perinatal Epidemiology and Statistics Unit, Canberra.
- Hobbs, J., Green, S., 2003, 'Development of a Preceptor Programme ', *British Journal of Midwifery*, vol. 11, no. 6, pp. 372-5.
- Hodnett, ED., 2008, Continuity of caregivers for care during pregnancy and childbirth, *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD000062. DOI: 10.1002/14651858.CD000062.pub2.
- Hollands, K., McMahon, S., Copley, J., Jonston, K., Bunyan, C., Hoyes, N. & Hoey, N. 2001, 'The effectiveness of a mentoring program for new graduate allied health professionals', *Focus on Health Professional Education: a Multi-Disciplinary Journal* vol. 2, no. 2, pp. 42-58.
- Homer, C., Brodie, P. & Leap, N. 2008, *Midwifery continuity of care: a practical guide*, Elsevier Health Sciences, Sydney.
- Homer, C., Davis, G., Brodie, P., Sheehan, A., Barclay, L., Wills, J., Chapman, M. 2001, 'Collaboration in maternity care: a randomised controlled trial comparing continuity of care with standardised hospital care ', *British Journal of Obstetrics and Gynaecology* vol. 108, pp. 16-22.
- Homer, C.S. 2006, 'Challenging midwifery care, challenging midwives and challenging the system', *Women and Birth*, vol. 19, no. 3, pp. 79-83.
- Hughes, A. & Fraser, D. 2011, 'SINK or SWIM: The experience of newly qualified midwives in England', *Midwifery* vol. 27, no. 3, pp. 382-6.
- International Confederation of Midwives 2011, *ICM International definition of a midwife*, Netherlands, viewed 8 September 2015, <<http://www.internationalmidwives.org/assets/uploads/documents/Definition of the Midwife - 2011.pdf> %3E.
- Jenkins, M.G., Ford, J.B., Morris, J.M. & Roberts, C.L. 2014, 'Women's expectations and experiences of maternity care in NSW – What women highlight as most important', *Women and Birth*, vol. 27, no. 3, pp. 214-9.
- Johnstone, M., Kanitsaki, O. & Currie, T. 2008, 'The nature and implications of support in transition programs: an Australian study ', *Journal of Professional Nursing*, vol. 24, no. 1, pp. 46-53.
- Jordan, K., Fenwick, J., Slavin, V., Sidebotham, M. & Gamble, J. 2013, 'Level of burnout in a small population of Australian midwives', *Women and Birth*, vol. 26, no. 2, pp. 125-32.
- Kay, L. 2010 'Leading other midwives: experience of midwife team leaders ', *British Journal of Midwifery*, vol. 18, no. 12, pp. 764-9.
- Kensington, M. 2006, 'The faces of mentoring in New Zealand: Realities for the new graduate midwife', *New Zealand College of Midwives Journal*, vol. 35, October, pp 22-7.
- Kirkham, M. 2000, *The midwife-mother relationship*, Palgrave Macmillan, Basingstoke, Hampshire.

- Laschinger, H.K.S. 2012, 'Job and career satisfaction and turnover intentions of newly graduated nurses', *Journal of Nursing Management*, vol. 20, no. 4, pp. 472-84.
- Lau, C.S.H. 1997, 'An investigation of Rogers' theory on the diffusion of a clinical system innovation', PhD thesis, University of Technology Sydney, Sydney.
- Lavender, T., Edwards, G. & Alfirevic, Z. 2004, *Demystifying Qualitative Research in Pregnancy and Childbirth* Quay books MA Healthcare Ltd Wiltshire.
- Lennox, S. 2011, 'Group mentoring of new graduate midwives: emerging professional capacity: a naturalistic enquiry', PhD thesis, Victoria University of Wellington, Wellington.
- Lennox, S., Jutel, A. & Foureur, M. 2012, 'The concerns of competent novices during a mentoring year', *Nursing Research and Practice*, vol. 2012, pp. 1-9.
- Lennox, S., Skinner, J. & Foureur, M. 2008, 'Mentorship, preceptorship and clinical supervision: three key processes for supporting midwives', *New Zealand College of Midwives Journal*, vol. 39, p. 7.
- Levett-Jones, T., Fitzgerald, M., 2005, 'A review of Graduate Nurse Transition Programs in Australia', *Australian Journal of Advanced Nursing*, vol. 23, no. 2, pp. 40-5.
- Lewis, L., Hauck, Y.L., Crichton, C., Pemberton, A., Spence, M. & Kelly, G. 2016, 'An overview of the first "no exit" midwifery group practice in a tertiary maternity hospital in Western Australia: Outcomes, satisfaction and perceptions of care', *Women and Birth*. In Press, Corrected Proof, Available online 16 May 2016.
- Manley, K., Sanders, K., Cardiff, S. & Webster, J. 2011, 'Effective workplace culture: the attributes, enabling factors and consequences of a new concept', *International Practice Development Journal* vol. 1, no. 2, pp. 1-29.
- Mason, J. & Davies, S. 2013, 'A qualitative evaluation of a preceptorship programme to support newly qualified midwives', *Evidence Based Midwifery*, vol. 11, no. 3, pp. 94-8.
- McAra-Couper, J., Gilkison, A., Crowther, S., Hunter, M., Hotchin, C. & Gunn, J. 2014, 'Partnership and reciprocity with women sustain Lead Maternity Carer midwives in practice', *New Zealand College of Midwives Journal*, vol. 49, p. 29.
- McCourt, C., Beake, S. & Page, L. 2001, *Evaluation of One-to-One Midwifery: second cohort study*, Centre for Midwifery Practice, Thames Valley University, London.
- McKenna, L. 2003, 'Nurturing the future of midwifery through mentoring', *Australian Midwifery*, vol. 16, no. 2, pp. 7-10.
- McKenna, L. & Rolls, C. 2007, 'Bachelor of Midwifery: Reflections on the first 5 years from two Victorian universities', *Women and Birth*, vol. 20, no. 2, pp. 81-4.
- McLachlan, H., Forster, D., Davey, M.-A., Farrell, T., Gold, L., Biro, M., Albers, L., Flood, M., Oats, J. & Waldenström, U. 2012, 'Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial', *BJOG: An International Journal of Obstetrics & Gynaecology*, vol. 119, no. 12, pp. 1483-92.

- McLachlan, H., Forster, D., Davey, M.-A., Gold, L., Biro, M.-A., Flood, M., Albers, L. & Waldenström, U. 2013, 'The effect of caseload midwifery on women's experience of labour and birth: Results from the COSMOS randomised controlled trial', *Women and Birth*, vol. 26, Supplement 1, p. S13.
- McLachlan, H.L., Forster, D.A., Davey, M.A., Farrell, T., Flood, M., Shafiei, T. & Waldenström, U. 2016, 'The effect of primary midwife-led care on women's experience of childbirth: results from the COSMOS randomised controlled trial', *BJOG: An International Journal of Obstetrics & Gynaecology*, vol. 123, no. 3, pp. 465-74.
- Menke, J., Fenwick, J., Gamble J., Brittain, H. & Creedy D., 2014, 'Midwives' perceptions of organisational structures and processes influencing their ability to provide caseload care to socially disadvantaged and vulnerable women', *Midwifery* vol. 30, pp. 1096-103.
- Minichiello, V., Sullivan, G., Greenwood, K. & Axford, R. 2004, *Research Methods for Nursing and Health Science*, 2nd edn, Prentice Hall, Frenchs Forest.
- Missen, K., McKenna, L. & Beauchamp, A. 2014, 'Satisfaction of newly graduated nurses enrolled in transition-to-practice programmes in their first year of employment: a systematic review', *Journal of Advanced Nursing*, vol. 70, no. 11, pp. 2419-33.
- Mollart, L., Skinner, V.M., Newing, C. & Foureur, M. 2013, 'Factors that may influence midwives work-related stress and burnout', *Women and Birth*, vol. 26, no. 1, pp. 26-32.
- New Zealand College of Midwives 2015, *The Midwifery First Year of Practice Programme*, viewed 2 August 2015, <<http://www.midwife.org.nz/quality-practice/midwifery-first-year-of-practice/> %3E>
- New Zealand College of Midwives 2016, *New Zealand college of Midwives - Integrated Services* Auckland, viewed 24th June, 2016 <<https://http://www.midwife.org.nz/in-new-zealand/midwifery-in-new-zealand/integrated-services/> %3E>
- Newton, M.S., McLachlan, H.L., Willis, K.F. & Forster, D.A. 2014, 'Comparing satisfaction and burnout between caseload and standard care midwives: findings from two cross-sectional surveys conducted in Victoria, Australia', *BMC Pregnancy and Childbirth*, vol. 14, no. 1, p. 426.
- NSW Kids and Families 2010, *Maternity - Towards Normal Birth in NSW*, viewed 24th March 2014, <http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_045.pdf %3E
- Numminen, O., Ruoppa, E., Leino-Kilpi, H., Isoaho, H., Hupli, M. & Meretoja, R. 2015, 'Practice environment and its association with professional competence and work-related factors: perception of newly graduated nurses', *Journal of Nursing Management*, vol. 23, no. 8, pp. 963-1146.
- Nurses and Midwives Act 1991* (NSW).
- Nursing and Midwifery Board of Australia 2006a, *Midwifery competency standards*, viewed 8th Dec 2014 <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx> - competencystandards>.

- Nursing and Midwifery Board of Australia 2006b, *National competency standards for the midwife*, Nursing and Midwifery board of Australia, Melbourne, viewed 11th June 2015, <Midwifery-Competency-Standards-January-2006-3.PDF>.
- Nursing and Midwifery Board of Australia 2013, *Eligible midwife registration standard*, viewed 21st August 2015, <<http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx>>
- Nursing and Midwifery Board of Australia 2015, *Fact sheet: Context of practice for registered nurses and midwives*, Melbourne, Australia, viewed 17th June 2016, <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Context-of-practice-for-registered-nurses-and-midwives.aspx>>
- Nursing and Midwifery Office 2015, *2016 Graduate Nursing and Midwifery Transition to Professional Practice Handbook*, NSW Ministry of Health, New South Wales, viewed 23 August 2015, <<http://www.health.nsw.gov.au/nursing/employment/Publications/transition-to-professional-practice.pdf>>
- Page, L. 2003, 'One-to-one Midwifery: Restoring the 'with Woman' Relationship in Midwifery', *Journal of Midwifery & Women's Health*, vol. 48, no. 2, pp. 119-25.
- Pairman, S., Tracy S., Thorogood C., Pincombe J., 2010, *Midwifery: Preparation for Practice* 2nd edn, Elsevier, Chatswood, NSW.
- Panettiere, M. & Cadman, T. 2002, 'Do new graduate midwives need extra support? Are direct-entry midwifery graduates adequately prepared to practise in the hospital environment? A clinical midwifery leader and a nurse educator put the case for an entry-to-practice programme for midwives (viewpoint)', *Kai Tiaki: Nursing New Zealand*, vol. 8, no. 3, p18-22.
- Parsloe, E. & Wray, M. 2000, *Coaching and Mentoring*, Kogan Page, London.
- Passant, L., Homer, C.S.E. & Wills, J. 2003, 'From student to midwife: the experiences of newly graduated midwives working in an innovative model of midwifery care', *Australian Midwifery*, vol. 16, no. 4, pp. 18-21.
- Pugh, J.D., Twigg, D.E., Martin, T.L. & Rai, T. 2013, 'Western Australia facing critical losses in its midwifery workforce: A survey of midwives' intentions', *Midwifery*, vol. 29, no. 5, pp. 497-505.
- Rainey, D.L. 2013, *Visionary Strategic Leadership: Sustaining success through Strategic Direction, Corporate Management, and High-Level Programs*, Information Age Publishing, Inc., Charlotte, North Carolina.
- Rawson, S. 2011, 'A qualitative study exploring student midwives' experiences of carrying a caseload as part of their midwifery education in England', *Midwifery*, vol. 27, no. 6, pp. 786-92.
- Rawson, S., Brown, S., Wilkins, C. & Leamon, J. 2009, 'Student midwives' views of caseloading: The BUMP study', *British Journal of Midwifery*, vol. 17, no. 8, pp. 484-9.
- Rayment, J., McCourt, C., Rance, S. & Sandall, J. 2015, 'What makes alongside midwifery-led units work? Lessons from a national research project', *The Practising Midwife*, vol. 18, no. 6, pp. 31-3.
- Rogers, E.M. 1995, *Diffusion of innovations*, Free Press, New York.

- Rogers, J. & Curtis, P. 1980, 'The Concept and Measurement of Continuity in Primary Care', *American Journal of Public Health* vol. 70, no. 2, pp.122-127
- Roxburgh, M., Lauder, W., Topping, K., Holland, K., Johnson, M. & Watson, R. 2010, 'Early findings from an evaluation of a post-registration staff development programme: The Flying Start NHS initiative in Scotland, UK', *Nurse Education in Practice*, vol. 10, no. 2, pp. 76-81.
- Rush, K.L., Adamack, M., Gordon, J., Janke, R. & Ghement, I.R. 2015, 'Orientation and transition programme component predictors of new graduate workplace integration', *Journal of Nursing Management*, vol. 23, no. 2, pp. 143-55.
- Sandall, J. 1997, 'Midwives burnout and continuity of care ', *British Journal of Midwifery*, vol. 5, no. 2, pp. 97-9.
- Sandall, J., Page, L., Homer, C. & Leap, N. 2008, 'Midwifery continuity of care: what is the evidence?', in C. Homer, P. Brodie & N. Leap (eds), *Midwifery continuity of care; a practical guide*, Churchill Livingstone, Chatswood, NSW.
- Sandall J., Soltani H., Gates S., Shennan A., Devane D., 2016 Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5
- Sandelowski, M. 2000, 'Whatever happened to qualitative description? ', *Research in Nursing and Health* vol. 23, pp. 334-40.
- Sandelowski, M. 2010, 'What's in a Name? Qualitative Description Revisited ', *Research in Nursing and Health*, vol. 33, pp. 77-84.
- Saultz, J.W. 2003, 'Defining and measuring interpersonal continuity of care', *Annals of Family Medicine*, vol. 1, no. 3, pp. 134-42.
- Skinner, J.P. & Foureur, M. 2010, 'Consultation, Referral, and Collaboration between Midwives and Obstetricians: Lessons From New Zealand', *Journal of Midwifery & Women's Health*, vol. 55, no. 1, pp. 28-37.
- Smyth, S., Houghton, C., Cooney, A. & Casey, D. 2012, 'Students' experiences of blended learning across a range of postgraduate programmes', *Nurse Education Today*, vol. 32, no. 4, pp. 464-8.
- Smythe, L. 2012, 'Discerning which qualitative approach fits best', *New Zealand College of Midwives Journal*, no. 46, pp. 5-12.
- Stavrou, E.P., Ford, J.B., Shand, A.W., Morris, J.M. & Roberts, C.L. 2011, 'Epidemiology and trends for Caesarean section births in New South Wales, Australia: a population-based study', *BMC Pregnancy and Childbirth*, vol. 11, no. 1, p. 8.
- Steele, R. 2009, 'Gaining Competence and Confidence as a Midwife', *British Journal of Midwifery*, vol. 17, no. 7.
- Stevens, T. & McCourt, C. 2002, 'One to one midwifery practice part 3: meaning for midwives ', *British Journal of Midwifery* vol. 10, no. 2, pp. 111-5.
- Sullivan, K., Lock, L. & Homer, C.S.E. 2011, 'Factors that contribute to midwives staying in midwifery: A study in one area health service in New South Wales, Australia ', *Midwifery*, vol. 27, pp. 331-35.
- Taylor, C., Corneilus, C. & Colvin, K. 2013, 'Visionary leadership and its relationship to organisational effectiveness', *Leadership & Organizaton Journal* vol. 35, no. 6, pp. 566-83.

- Teakle, B. 2013, 'Have the 2010 national maternity reforms delivered choice, control and continuity to Australian women?', *Women and Birth*, vol. 26, no. 2, pp. 97-9.
- Thorne, S. 2013, 'Interpretive description ', in C. Tatano Beck (ed.), *Routledge International Handbook of Qualitative Nursing Research*, Routledge, New York.
- Tickle, N., Sidebotham, M., Fenwick, J. & Gamble, J. 2016, 'Women's experiences of having a Bachelor of Midwifery student provide continuity of care', *Women and Birth*, vol. 29, no. 3, pp. 245-51.
- Toohill, J., Turkstra, E., Gamble, J. & Scuffham, P.A. 2012, 'A non-randomised trial investigating the cost-effectiveness of Midwifery Group Practice compared with standard maternity care arrangements in one Australian hospital', *Midwifery*, vol. 28, no. 6, pp. e874-e9.
- Tracy, S.K., Hartz, D.L., Tracy, M.B., Allen, J., Forti, A., Hall, B., White, J., Lainchbury, A., Stapleton, H., Beckmann, M., Bisits, A., Homer, C., Foureur, M., Welsh, A. & Kildea, S. 2013, 'Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial', *The Lancet*, vol. 382, no. 9906, pp. 1723-32.
- Van der Putten, D. 2008, 'The lived experience of newly qualified midwives: a qualitative study', *British Journal of Midwifery*, vol. 16, no. 6, pp. 348-58.
- Walsh, D. 1999, 'An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend', *Midwifery*, vol. 15, no. 3, pp. 165-76.
- West, S., Jasper, M., Clark, T., 2007, *Enabling learning in nursing and midwifery practice: a guide for mentors*, John Wiley & Sons, Chichester.
- White, J. 2016, 'Principal Adviser Midwifery; Nursing & Midwifery Office; NSW Government: Health', personal communication.
- Williams, K., Lago, L., Lainchbury, A. & Eagar, K. 2010, 'Mothers' views of caseload midwifery and the value of continuity of care at an Australian regional hospital', *Midwifery*, vol. 26, no. 6, pp. 615-21.
- Wolff, A., Pesut, B. & Regan, S. 2010, 'New graduate nurse practice readiness: Perspectives on the context shaping our understanding and expectations', *Nurse Education Today*, vol. 30, pp. 187-91.
- Yoshida, Y. & Sandall, J. 2013, 'Occupational burnout and work factors in community and hospital midwives: A survey analysis', *Midwifery*, vol. 29, no. 8, pp. 921-6.
- Young, C.M., Smythe, L. & McAra-Couper, J. 2015, 'Burnout: Lessons from the lived experience of case loading midwives ', *International Journal of Childbirth*, vol. 5, no. 2, pp. 154-65.

Appendices



Are you a New Graduate Midwife working in a Midwifery Continuity of care model?



Here is an opportunity to tell us about your experience

I am conducting research into the experiences of newly graduated midwives
working in midwifery continuity of care models

My research aims to develop a program of support for new graduate midwives
working in these models.

If you are interested in participating please contact me

ALLISON CUMMINS

Allison.cummins@uts.edu.au

Ph: 02 9515 4913

The interview will take approximately one hour and can be conducted in
person, via phone or skype at a time convenient to you

This study has ethics approval from the University of Technology, Sydney

APPENDIX B

Allison Cummins

From: Research.Ethics@uts.edu.au
Sent: Wednesday, 3 October 2012 3:29 PM
To: Allison Cummins; Caroline Homer
Subject: HREC Approval Granted

Dear Applicant

The UTS Human Research Ethics Committee reviewed your application titled, "New Application The Experiences of New Graduate Midwives working in Midwifery Continuity of Care Models", and I am pleased to inform you that ethics approval is now granted. Any conditions of approval as stipulated in the Committee's comments will be noted on our files.

Your approval number is UTS HREC REF NO. 2012000328

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.

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:

* if accessing within the UTS network: <http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx>

* if accessing outside of UTS network: <https://remote.uts.edu.au>, and click on "RMENet - ResearchMaster Enterprise" after logging in.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9645
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: <http://www.research.uts.edu.au/policies/restricted/ethics.html>
P: PO Box 123, BROADWAY NSW 2007
[Level 14, Building 1, Broadway Campus]
CB01.14.08.04



CONSENT FORM

I _____ agree to participate in the research project:

What are the experiences of New Graduated Midwives working in Midwifery Continuity of Care Models.

UTS HREC REF NO. 2012000328

Conducted by:

Allison Cummins,

Faculty of Health,

Level 7

235 Jones St

Ultimo.

Phone 9514 4913

of the University of Technology, Sydney for her PhD

Funding for this research has been provided by Australian College of Midwives.

I understand that the purpose of this study is explore and report the experiences of New Graduate Midwives working in Midwifery Continuity of care models.

I understand that I have been asked to participate in this research because I am a New Graduate Midwife working in a midwifery continuity of care model and that my participation in this research will involve an interview with the researcher. I understand the duration of the interview will be approximately one hour. I understand the interview will be conducted in a private location at a time convenient to myself. I understand there is a potential risk of possibly becoming emotionally distressed during this interview if I am recalling a sensitive or sad clinical situation. I understand that the researcher will stop the interview at any time if I request. I understand that I may know Allison Cummins from professional encounters and that she will maintain my privacy and confidentiality.

I am aware that I can contact Allison Cummins or her supervisor(s) Professor Caroline Homer and Dr Elizabeth Denney-Wilson if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. I am aware that withdrawing from this research will not prejudice any relationship with the researcher. I agree that Allison Cummins has answered all my questions fully and clearly. I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

Signature (participant)

____/____/____

Signature (researcher or delegate)

____/____/____

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

APPENDIX D

Allison Cummins

From: Research Ethics
Sent: Monday, 10 February 2014 10:05 AM
To: Allison Cummins; Caroline Homer; Research Ethics
Subject: UTS HREC Approval

Dear Applicant

UTS HREC REF NO. 2014000009

The UTS Human Research Ethics Expedited Review Committee reviewed your amendment application for your project titled, "The Experiences of New Graduate Midwives working in Midwifery Continuity of Care Models (for UTS HREC 2012000328)", and agreed that the amendments, which requested to ask maternity services managers and other key stakeholders about their reasons for employing or not employing new graduate midwives to work in midwifery continuity of care models, meet the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007).

I am pleased to inform you that the Committee has approved your request to amend the protocol.

You should consider this your official letter of approval. If you require a hardcopy please contact the Research Ethics Officer (Research.Ethics@uts.edu.au).

To access this application, please follow the URLs below:

* if accessing within the UTS network: <http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx>

* if accessing outside of UTS network: <https://remote.uts.edu.au>, and click on "RMENet - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: <http://surveys.uts.edu.au/surveys/onlineethics/index.cfm>

If you wish to make any further changes to your research, please contact the Research Ethics Officer in the Research and Innovation Office, Ms Racheal Laugery on 02 9514 9772.

In the meantime I take this opportunity to wish you well with the remainder of your research.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9645
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: <http://www.research.uts.edu.au/policies/restricted/ethics.html>
P: PO Box 123, BROADWAY NSW 2007
[Level 14, Building 1, Broadway Campus]
CB01.14.08.04



CONSENT FORM

I _____ agree to participate in the research project:

What are the experiences of New Graduated Midwives working in Midwifery Continuity of Care Models – Phase two

UTS HREC REF NO. 2014000009

Conducted by:

Allison Cummins,
Faculty of Health,
Level 7
235 Jones St
Ultimo.

Phone 9514 4913

of the University of Technology, Sydney for her PhD

Funding for this research has been provided by Australian College of Midwives.

I understand that the first phase of this study was to explore and report the experiences of New Graduate Midwives working in Midwifery Continuity of care models. **The second phase is to explore and report the views of managers and other key stakeholders** that employ or do not employ new graduate midwives in midwifery continuity of care models.

I understand that I have been asked to participate in this research because I am a maternity service manager or clinical leader and that my participation in this research will involve an interview with the researcher. I understand the duration of the interview will be approximately one hour. I understand the interview will be conducted in a private location at a time convenient to myself. I understand that the researcher will stop the interview at any time if I request. I understand that I may know Allison Cummins from professional encounters and that she will maintain my privacy and confidentiality.

I am aware that I can contact Allison Cummins or her supervisor(s) Professor Caroline Homer and Dr Elizabeth Denney-Wilson if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. I am aware that withdrawing from this research will not prejudice any relationship with the researcher. I agree that Allison Cummins has answered all my questions fully and clearly. I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

Signature (participant)

____/____/____

____/____/____

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Signature (researcher or delegate)



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The experiences of new graduate midwives working in midwifery continuity of care models in Australia



Allison M. Cummins, RM MA(ed) PhD candidate (Lecturer in Midwifery)*,
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ABSTRACT

Background: midwifery continuity of care has been shown to be beneficial to women through reducing interventions and other maternal and neonatal morbidity. In Australia, numerous government reports recognise the importance of midwifery models of care that provide continuity. Given the benefits, midwives, including new graduate midwives, should have the opportunity to work in these models of care. Historically, new graduates have been required to have a number of years' experience before they are able to work in these models of care although a small number have been able to move into these models as new graduates.

Aim: to explore the experiences of the new graduate midwives who have worked in midwifery continuity of care, in particular, the support they received; and, to establish the facilitators and barriers to the expansion of new graduate positions in midwifery continuity of care models.

Method: a qualitative descriptive study was undertaken framed by the concept of continuity of care.

Findings: the new graduate midwives valued the relationship with the women and with the group of midwives they worked alongside. The ability to develop trusting relationships, consolidate skills and knowledge, be supported by the group and finally feeling prepared to work in midwifery continuity of care from their degree were all sub-themes. All of these factors led to the participants feeling as though they were 'becoming a real midwife'.

Conclusions: this is the first study to demonstrate that new graduate midwives value working in midwifery continuity of care – they felt well prepared to work in this way from their degree and were supported by midwives they worked alongside. The participants reported having more confidence to practice when they have a relationship with the woman, as occurs in these models.

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Introduction

Midwifery continuity of care 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). This way of providing care has been shown to be beneficial to women and babies (Homer et al., 2001; Page, 2003; Hodnett, 2008; Pairman et al., 2010; Hartz et al., 2011; Hodnett et al., 2011; McLachlan et al., 2012; Sandall et al., 2013). Midwives and women have also reported high rates of satisfaction with midwifery continuity of care models (Fereday et al., 2009; Collins et al., 2010). In Australia, numerous government reports have recognised the importance of midwifery continuity of care

models and have recommended widespread implementation (Australian Government Department of Health and Ageing, 2009; New South Wales Health, 2010).

Midwifery continuity of care can be organised in a variety of ways. One-to-one midwifery care refers to having a primary midwife who cares for 35–40 women a year (Page, 2003; Homer et al., 2008). Often midwives work together with a second midwife to ensure they have some time off with the second midwife being available if the primary midwife is unavailable to ensure some adequate life/work balance (Page, 2003). Midwifery group practice (MGP) generally refers to groups of three to four midwives who have a caseload of women with the flexibility to have rostered time off including sick and annual leave with backup from one or more midwives in the group (Homer et al., 2008). A third model providing a level of continuity is team midwifery. Team midwifery generally comprises six to eight midwives providing care often on

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a rostered system (Homer et al., 2008). When midwives begin to work in a midwifery continuity of care model they are provided with a period of orientation and sometimes, initially a reduced caseload. Midwifery continuity of care models often cater for women who are predominantly healthy however increasingly, all-risk models are being implemented in collaboration with obstetricians (Australian Nursing & Midwifery Council, 2008). Various models exist throughout Australia with limited opportunities for new graduate midwives to work in continuity of care. The participants in this study were employed in models ranging from one to one midwifery to small teams of midwives working an on-call roster to provide care for approximately 40 women a year.

A new graduate midwife is one working in their first or second year of practice post initial registration. Historically, most new graduate midwives in Australia undertake a transition support programme that require the new graduate midwife to rotate through antenatal clinics, birth suite and postnatal wards over a 12 month period (Clements et al., 2013). A qualitative study reporting on newly graduated midwives' experiences of a similar model in the United Kingdom (Foster and Ashwin, 2014) found the participants did not have enough time in any one hospital area before rotating to another where they had to relearn skills. It is not clear whether this style of transitional support is appropriate or necessary for new graduates who desire to work in continuity of care models (Clements et al., 2013).

In Australia, midwives are prepared to work in continuity of care models as students; an essential part of the midwifery curriculum is to 'follow through' a number of women during their programme (Gray et al., 2012; Australian Nursing and Midwifery Council, 2010). This requirement is based on the evidence that these models have improved outcomes for women and their families. Despite this, when positions are advertised for continuity of care models, the criteria often includes a minimum two years' experience, prohibiting new graduate midwives from applying.

Despite obstacles to new graduates entering midwifery continuity of care, there are small numbers working in this way around Australia. In order to support wider implementation of such opportunities, we were interested in their experiences. This is the first study in Australia, to focus on new graduate midwives working in midwifery continuity of care. The aim of the study was to explore the experiences of these new graduate midwives, in particular, to examine the support they received and to establish the facilitators and barriers to the expansion of new graduate positions in midwifery continuity of care models.

Ethical approval was sought and granted by the university ethics committee (HREC Approval Number: 2012000328).

Methods

A qualitative descriptive approach was used to describe and explore the new graduate's experiences of working in midwifery continuity of care. The exploration was based on the interest in, and understanding of, the 'who, what and where' of their experiences (Sandelowski, 2000, p. 338). Qualitative descriptive research is a useful form of rigorous and credible enquiry in situations where there is little knowledge and is particularly useful to describe how people feel about an event (Sandelowski, 2000; Avis, 2003; Hughes and Fraser, 2011). This study addresses each area of the who, what and where (Sandelowski, 2010) of new graduate experiences of working in midwifery continuity of care.

Sample

Purposive sampling recruited newly graduated midwives working within their first or second year of practice in a midwifery continuity of care model. Purposive sampling is used when the population of

interest is small (Minichiello et al., 2004). The difficulties in recruitment meant the authors needed to find midwifery models of care that employed new graduates. The first author attended a midwifery 'models of care' conference in South Australia with the intention of recruiting new graduate midwives to participate in the study. The purposive sampling then became a process of snowball sampling where participants were asked if they knew any other new graduate midwives working in continuity of care models. Both these sampling methods were approved by the university human research ethics committee. Using this process, 13 newly graduated midwives were recruited. From our professional networks, we estimate this to be approximately 50% of the new graduate midwives working in midwifery continuity of care models across Australia.

The 13 participants (Table 1) were newly graduated midwives in either their first or second year of practice after graduation. Pseudonyms have been used to protect the identity of the participants and to highlight the repletion of responses and to show when different participants had similar experiences. Participants were aged 21–46 years and employed in a variety of settings 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 the direct-entry Bachelor of Midwifery program, three from South Australia, 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 new graduate transition programme with two commencing in midwifery continuity of care immediately after graduation. Three had the continuity of care programme incorporated as part of their new graduate programme and were then employed in that model without returning to the rotation programme through the various maternity wards.

Data collection

Data were collected via semi-structured interviews. Participants were offered a choice of the interview being conducted face-to-face, via telephone or skype. One researcher (the first author, who is also a midwife) conducted all the interviews. A list of open-ended questions were chosen that guided the interview but provided flexibility to respond to the participant (Box 1).

Table 1

Demographic details of the participants – location, year of graduation, programme, working status and age.

No	State	Year graduated	Programme	Working fulltime	Age range*
1	South Australia	2012	BMid	Yes	36–40
2	New South Wales	2011	BMid	Yes	26–30
3	New South Wales	2011	BMid	Yes	20–25
4	New South Wales	2010	BMid	Yes	20–25
5	South Australia	2011	BMid	Yes	31–35
6	South Australia	2011	BMid	No	31–35
7	Australian Capital Territory	2012	BMid	Yes	25–30
8	New South Wales	2011	BMid	No	31–35
9	Australian Capital Territory	2011	BMid	Yes	20–25
10	New South Wales	2011	BMid	Yes	46–50
11	New South Wales	2011	BMid	No	36–40
12	New South Wales	2011	BMid	Yes	26–30
13	New South Wales	2012	GradDipM	Yes	36–40

BMid=Bachelor of Midwifery (direct entry); GradDipM=Graduate Diploma in Midwifery.

* Ranges have been given to protect anonymity.

Box 1**Questions**

Why did you choose to work in midwifery continuity of care?
 What is your experience of working in continuity of care?
 What did you aim to achieve in your transitional year/s?
 How did you achieve what you planned?
 What has been the best part of working in midwifery continuity of care?

The questions gave the interview some structure but were not always asked in this order to enable flexibility. Using preformed questions/prompts can give an interview some structure (Rees, 2012). The questions were designed to explore the barriers and facilitators to working in midwifery continuity of care models. In addition, we were interested in the positive aspects and levels of continuity of care in line with the theory around continuity of care (Saultz, 2003).

The participants were from different parts of the country making face-to-face interviews difficult; hence phone interviews were the main mode of data collection. Burns et al. (2012) described the insider/outsider dilemmas experienced by a researcher during observations undertaken on a maternity ward by a midwife researcher. A similar concept had the potential to occur in this study, as the interviewer was also a midwife with extensive clinical experience and a sound understanding of continuity of midwifery care. The interviewer was in a unique position to identify the issues raised by the participants with the potential for the blurring of boundaries as described by Burns et al. (2012). The interviewer needed to position herself as a researcher rather than a colleague. Having a team of three researchers, assisted with defining boundaries as the other team members only read de-identified data and therefore were outsiders to provide balance.

The interviews were audio recorded and transcribed verbatim. The researcher transcribed three of the interviews and the remainder were transcribed by a professional transcriber. The transcripts were all read while listening to the audio recordings to ensure transcription accuracy.

Analysis

Thematic analysis was used to capture important concepts in relation to the research question (Braun and Clarke, 2006). The data were read and entered into the software program NVIVO (Minichiello et al., 2004). A process of coding into groups known as nodes identified certain themes. The themes were initially descriptive and once the researcher began to write and reread the data, a deeper analysis occurred which was framed by the concept of continuity of care (Saultz, 2003).

Saultz (2003) developed hierarchical definitions of continuity of care. The base of this hierarchy is informational continuity where medical and social information about the person is available to a number of care providers ensuring safe communication about a person's particular situation (Saultz, 2003). The next level of continuity is defined as longitudinal where information is shared in a familiar place by an organised team of care providers (Saultz, 2003). The highest level of continuity proposed is interpersonal based on the philosophical underpinning that continuity of care is about the relationship between the care provider and the person over time (Saultz, 2003). The theory of continuity of care was developed by Saultz (2003) and applied to midwifery by Homer et al. (2008). The interpersonal (Homer et al., 2008)

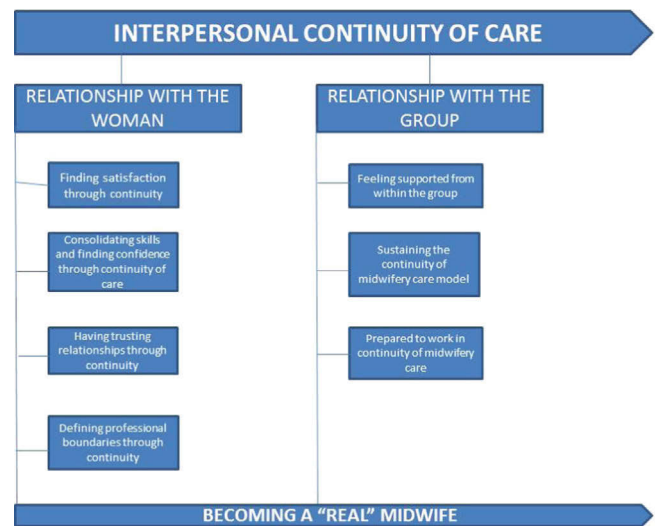


Fig. 1. Broad themes and sub-themes and the relationship with continuity of care.

definition is most appropriate based on the philosophical underpinning that continuity of care is about the relationship between the woman and the midwife over time. Themes and sub-themes were then identified and discussed with the two other co-authors, subsequent analysis, themes and subthemes were developed within the framework of continuity of care.

Findings

The overarching concept was interpersonal continuity of care (Saultz, 2003) with two broad themes, that is, 'the relationship with the woman' and 'the relationship with the group'. There were further subthemes that led the participants to report they were 'becoming a real midwife' (Fig. 1).

The relationship with the woman

The relationship with the woman was valued in so many aspects of the care provided by the participants. As Judy stated, 'I really love the relationship' and 'it is food for my soul'.

The participants who had worked in a standard transition support programme prior to working in continuity of care compared the two approaches. The relationship with the woman was highly valued and contributed to the provision of quality care. Samantha stated 'now I can really spend time with women'. Samantha went on to say 'as I get to know the woman, I think they get better care' and 'women get better care' (Alice). Candice and other new graduates felt that 'the outcomes are better' compared with women they cared for when working in the standard transition support programme. The participants did not explain which outcomes were better but went on to discuss issues like normal birth and increased rates of breast feeding suggesting they were valued. The relationship with women enabled them to promote normal birth, provide more effective care and was highly satisfying. For example, Samantha described 'feeling happier' working in a continuity model.

Finding satisfaction with continuity

Working in continuity of care as a new graduate was highly satisfying. Bridget reported the satisfaction of 'seeing a woman being empowered' as 'so rewarding'. She went onto describe how

she felt 'lucky to know the whole woman' and 'having a relationship with the woman is a position of privilege'. Christine described herself as 'one of those people that really enjoys having relationships' and therefore working in this way as a new graduate really suited her.

Being satisfied working in midwifery continuity of care was a two-way interaction. Lisbeth illustrates this point saying that the 'woman is so happy that you are there' and Ness, 'they [the women] were always happy to have me there'. Building a relationship between the woman and the midwife, for example, 'getting to know the woman I am caring for made me feel more effective as a midwife' was a crucial component of care. They felt that continuity of carer provided a satisfying experience for the woman, as she knew her midwife, described here:

I loved the satisfaction that women got from having that trust in the one carer also the satisfaction I got and the midwives would get from seeing them from the beginning to end (Lisbeth)

The participants used positive emotional phrases to discuss the benefits of midwifery continuity of care. Hattie said she 'gets tingles every time she sees a woman starting her mothering journey' and Lisbeth stated she is 'happy all the time' when she knows the woman. These emotional accounts highlight the satisfaction of being in a position to develop trusting relationship with women through continuity of carer and this was valuable for the new graduates.

Consolidating skills and finding confidence through continuity of care

The relationship with the woman helped the new graduates learn and consolidate skills. For example, Lisbeth said 'I found I learnt a lot more because I could see the story unfold and it made more sense to me' and Bridget also explained 'over time you get to see her pregnancy unfold together with her family'. When the midwife knows the woman then she can be quietly present at a birth without having to build rapport as Christine said 'seeing the whole process is easier than just snapshots of someone who has just walked in, in labour'. In addition, the relationship with the woman helped to increase their confidence. The 'unfolding' of the woman's pregnancy revealed new learning opportunities to consolidate skills and increase their confidence. For example, Alice described how knowing the woman, seeing her again rather than just a 'snapshot made me feel more effective as a midwife'. Similarly, Bridget stated as she got 'to know the woman and her family there is a lot of growth and learning' and Patrice noted that she was learning through 'experience'. The new graduate midwives were learning and consolidating skills alongside the woman as Samantha described, 'I liked the full range of my skills being used'. Bridget proposed that you 'learn so much from the woman herself' and Alice supported this saying 'I learn with the woman'.

Continuity supported learning, for example, Bridget stated 'continuity is amazing, so good for learning' and 'I get to know the woman and their families, there is a lot of growth and learning for me'. Lisbeth also talked about continuity providing learning opportunities across the full scope of practice for a midwife 'I wanted the whole scope' that is providing care throughout pregnancy, birth and the postnatal period. These midwives felt that continuity of carer helped them learn and grow more quickly than the standard transitional support model.

Some midwives were challenged because they were learning, for example, Bridget said she felt it was 'annoying for some women because I am just learning'. She went onto explain that it might take her longer to complete an antenatal visit because she was in her first year of practice and she was consolidating skills.

Hattie felt this was not a problem when she knew the woman – 'they understand I am a graduate and in my first year of learning'. For Hattie, the trusting relationship with the woman meant that she understood if it took her longer to complete an antenatal visit, or if she had to look something up. Lisbeth thought this to be a positive of the relationship aspect 'As a young practitioner to be exposed to that emotional vulnerability [of the woman] is probably a really good thing [for learning]'. Lisbeth is referring to the interpersonal relationship that develops when the midwife knows the woman and 'something goes wrong', for example, a fetal death in utero. The new graduates felt that their skills were consolidated through learning and growing in the relationship with the woman.

Having trusting relationships through continuity of care

The new graduates felt that the development of trusting relationships meant that they could work effectively with women. Hattie stated, 'I just give the information, in that model it is the woman making the decision' indicating that the participants trusted the woman's decisions and choices the woman made about her own care. None of the participants discussed caring for any woman who they felt made potentially unsafe decisions. Robyn talked about 'having more discussions antenatally' when you know the woman, as they have more time available to talk to women in person or on the telephone. Getting to know the woman and spending a lot of time with the woman antenatally enabled the development of a trusting relationship.

The participants also described having more trusting professional relationships with colleagues, for example Christine said 'what I didn't realise was the relationship I would have with the obstetric staff. They felt that the relationships with their medical colleagues were easier because when they needed to discuss a woman with the obstetrician, they were familiar with the woman's background. 'The ones [doctors] I go to, know that I'm generally concerned, they trust my judgment because I know the woman' [Robyn].

The trusting relationship also assisted the woman to accept unexpected or unplanned outcomes. For example, Ness described, 'they [the women] are happy to transfer because of the relationship'. Transfer in this context refers to the woman needing to be referred to an obstetrician. The consultation may result in the woman having to birth in a hospital setting rather than the birth centre or homebirth setting. Some midwives would continue to provide continuity of midwifery care to the woman in collaboration with the obstetrician. Others needed to 'hand over' or transfer all care to the medical team and hospital midwifery staff. Overall, the new graduate midwives reported feeling 'confident' when consulting with their medical colleagues and the women were usually happy to transfer care, if necessary, due to the trusting relationship.

Defining professional boundaries through continuity of care

Some challenges arose from the relationship in relation to defining professional boundaries. Lisbeth stated you 'really relate to them' [the women] and 'understand them, like you are friends with some of these people'. Hattie reports they become 'part of your life' and 'it becomes like a friendship'. On the other hand, Hattie acknowledged that the 'relationship with the woman is wonderful yet sometimes challenging'. Candice stated 'it's gone beyond a professional relationship to a friendship' and she struggled with this going on to say 'you are not their friend but their carer' and 'ending the relationship can be difficult'.

The relationship with the group

The new graduate midwives valued the relationship they had with the small team of midwives they worked alongside – their group. As Lisbeth said ‘we could call them anytime day and night [for advice or assistance]’.

Finding support from within the group

The new graduate midwives valued the support provided by the group. They found support from *within* the group or pair of midwives, for example, Lisbeth said ‘I have been extremely supported by the midwives around me’. Siobhan also stated ‘I feel incredibly well supported by all the midwives’ and Christine, ‘there is always someone around I can ask’. Samantha also talked about ‘always having someone around I can ask’. Even when the new graduate midwife was working alone in a stand-alone birth centre or in a woman's home, they had mobile phones to contact someone within the group if needed, for example, Hattie said, ‘I would just call or text message them’ and this was reassuring for the new graduates.

The use of technology, particularly text messaging, was a form of support as Lisbeth said, ‘the day starts with a text message’ ‘the group makes sure you are feeling ok’. Bridget said ‘she can literally call them anytime’ and Hattie also said she can ‘run almost everything past them’. Siobhan was encouraged to ‘call me [the more experienced midwife] in the middle of the night if you want to run something by me’. Gabi said ‘I would call or text them anytime’. These new graduates reported feeling well supported and strong professional relationships formed.

Some participants were supported with a specific mentor within the group or found one themselves, for example, Gabi said ‘I had a mentor for a month and now we still have a bit of a mentoring relationship going on’. Patrice mentioned how lucky she was to have such good support from one particular midwife in the group and ‘if I had gone to another hospital I would not have had that luxury’. These midwives felt more supported in continuity compared with working in the standard transitional support programme, for example Ness said ‘I actually found I got more support in a continuity of care model’.

Not all found support from within the group. Patrice mentioned, ‘some people [other midwives in the group practice] never put up their hand to help yet expect a lot’. Alice stated that some midwives find providing ‘support [to a new graduate] draining and that it will take them away from their own caseload’. Candice also stated ‘people are reluctant to relieve’ when she had been with a woman for a long time.

Those who had difficulty finding support from within the group found support from the midwifery core staff. A lack of staff was discussed as a problem in terms of receiving enough support. Siobhan found support outside of the group stating, ‘with staffing the way it is we need to call in the core midwifery staff’ as ‘we can't get midwives to work in the model’. Samantha found the ward-based midwives helpful ‘there are some really good midwives, I specifically look for one, she works nights [night duty] and is a fountain of knowledge’. Samantha was not allocated a mentor or able to find someone in the team to mentor her so she looked elsewhere including her medical colleagues, ‘the registrars and residents are really approachable’.

Support was also found in the group meetings that were highly valued by the participants. Hattie described ‘weekly meetings’ whereas Ness said they had ‘monthly meetings’. Christine discussed regular meetings ‘at least once a week we meet’ and described having a ‘big birth centre meeting once a fortnight’ with a ‘mini-audit’ looking at practice. These meetings provided ‘professional practice support’ with the discussion of ‘evidence’ to

support practice. In addition, the meetings provided emotional support, particularly after an event that the new graduate midwife had not experienced previously. Debriefing was a valuable experience for the new graduate midwife.

Most were appreciative of having a reduced caseload at the beginning of their practice. Christine said ‘at the start they only give us two [women] a month’ and Bridget ‘it really helped having a reduced caseload’. This was not universally appreciated with Samantha reporting frustration with her reduced caseload saying, ‘I wasn't given a full caseload at the start, I wanted to feel what it was really like, not be molly coddled’. She went on to say, ‘I didn't enjoy my orientation, I wasn't allowed to do anything and I felt like a student again’. However, she did value the support offered to her ‘I have got people around me who are really happy to help’. The value of support had a dual role of assisting the new graduate midwife to begin autonomous practice and to sustain the continuity of care model.

Sustaining the continuity of midwifery care model

A couple of participants perceived the support they received from within the group as sustaining the model of care. Lisbeth stated ‘they [other midwives] were very protective because they had never had new graduates working in it’ and Siobhan said ‘it's about protecting the model [of midwifery care]’. Siobhan referred to the model of care ‘as such a precious thing’. The participants, along with the midwives that they worked alongside, wanted to ensure sustainability of the model of care by supporting new entrants. The participants were cautious to only call in another midwife when they really needed them as Lisbeth stated ‘I try and call them [the other midwives] in daylight hours’ Once again, the participants valued the support that enabled them to sustain the midwifery continuity of care model.

Prepared to work in continuity of midwifery care

The participants felt they were prepared to work in continuity through their education. Alice stated ‘we are introduced to it as students’ and Lisbeth ‘we learnt about the benefits of it [continuity] and it all just makes sense’. Lisbeth goes on ‘at uni I developed a passion for group practice’ and ‘we're taught from the beginning it's the gold standard of care intuitively it makes sense’ (Siobhan). The exposure and education about the benefits of continuity of midwifery care made some of the participants decide before they graduated that was where they wanted to work, ‘in my final year I started following a homebirth midwife’ (Hattie). Christine said that was ‘what I really focused on at uni’ and Robyn ‘from uni I really wanted to work in those models’. Lisbeth also ‘knew that is where I wanted to end up’. Bridget described herself as lucky ‘cause in my degree there would have been a dozen students out of 40 who would have jumped at the opportunity’. Siobhan said it was a ‘real no-brainer, I had the skills to be able to do it’.

Working in continuity ‘consolidated everything you learn at uni’ (Lisbeth). When the participants developed a relationship with the woman they described feeling an authenticity in their practice for example, Lisbeth says, ‘it makes me a good midwife’ and Judy ‘I feel like a real midwife’. The new graduate midwives felt they had grown into real midwives who practice across the full scope of midwifery practice. They acknowledged they have been learning through this first or second year of practice alongside the woman and were well supported by the group of midwives.

Discussion

In Australia, there are limited numbers of new graduate midwives working in midwifery continuity of care despite midwifery students being prepared to work in this way from their degree. This study explores the experiences of this small group. New graduates highly valued working in this way, especially the relationship with the woman and the relationship with the small group of midwives they worked alongside.

Midwifery continuity of care is highly satisfying for both midwives and women, satisfaction contributes to the sustainability of midwifery continuity of care and the associated benefits for women and newborns (Curtis et al., 2006; Freeman, 2006; Collins et al., 2010; Sullivan et al., 2011). The participants in our study described positive experiences working in these models of care with the development of a relationship with the woman being fundamental. The midwife-mother relationship is a professional relationship developed from the first point of contact and is dependent upon trust and respect and provides job satisfaction (Kirkham, 2010; Stevens and Mc Court, 2002; Homer, 2006). The new graduates in our study felt that working in continuity of care was more satisfying compared to working in a standard transition model where they rotated around different wards on a roster and did not develop a relationship with the woman. This has important implications for long-term retention of staff, especially in the early years after graduation. Providing opportunities for newly graduated midwives to work in continuity of midwifery care may contribute to the job satisfaction of midwives and address staff attrition rates from the profession (Curtis et al., 2006).

Many of our participants described the women they provided care for as 'friends'. Other studies have found women have the same perception, with the midwife described as their 'friend' (Freeman, 2006; Walsh, 1999). The challenge for these new graduate midwives was to maintain a professional relationship with the woman (Nursing and Midwifery Board of Australia, 2010).

The transition from student midwife to practising as a confident registered midwife is challenging and many of the traditional support programmes seem to suit organisational needs rather than developing the confidence of the midwife (Davis et al., 2011). The participants in our study believed they were able to consolidate skills through providing continuity of care. Consolidating skills meant that they could demonstrate their competence and increase their confidence as they got to know the woman. It has been reported that midwives working in one to one midwifery feel more confident in their practice when they know the woman (Page, 2003). Confidence of new graduate midwives has been measured and found to improve at the completion of the first year of practice in accordance with the national competency standards for the midwife (Davis et al., 2011; Australian Nursing and Midwifery Council, 2006). We found that a midwifery continuity of care model provides the opportunity for this group of new graduate midwives to consolidate skills and confidence and work to the full scope of their practice.

Having a trusting relationship with the small group of midwives was highly valued by the participants in our study. The new graduate midwives reported being well supported by the small group of midwives they worked alongside. Other studies have shown that new graduate midwives working in midwifery continuity of care need support from midwives within the midwifery group and, at times, from outside the group (Kensington, 2006; Lennox et al., 2008). Support has been described as mentoring, precepting or clinical supervision (Lennox et al., 2008). Similarly, we found many different forms of support were useful including an orientation period with or without a mentor, support from within the group via text, phone or in person, a reduced caseload (although not for all) and support from outside the group.

Clinical decision making is a challenge for new graduates as they move out of a student role and into a fully qualified role. Newly graduated midwives have reported that any dialogue, either brief encounters such as a corridor conversations or a longer dialogue with their midwifery colleagues, assists clinical decision making (Young, 2012). Our study has shown that these trusting relationships enabled the new graduate midwives to find support from outside of the group, such as corridor conversations with an experienced midwife or consultations with the medical staff.

The new graduates in our study reported that experienced midwives wanted to support the new graduate midwives to sustain midwifery continuity of care. The weekly, fortnightly or ad hoc meetings also provided support and should be considered an essential part of cohesive group practice (Homer et al., 2008). The reflections on practice discussed at the team meetings supported new graduate midwives to make clinical decisions.

In Australia, conscious efforts have been made in the midwifery curricula to prepare students to work in continuity of care models through the inclusion of continuity of care experiences (Australian Nursing and Midwifery Council, 2010; Gray et al., 2012) This study has found that these experiences as students were highly beneficial in preparing midwives to work in continuity of care programmes therefore greater efforts need to be made to embed the continuity of care experience in all midwifery pre-registration programmes.

Conclusion

Midwifery continuity of care is beneficial to women and newborns. The number of midwifery models providing continuity of care to women is increasing across Australia. Currently, there are very limited numbers of new graduate midwives working in midwifery continuity of care models throughout Australia. The new graduate midwives in this study wanted to work in midwifery continuity and felt prepared to work in this way from their degree. In addition, they were all well supported in one way or another to work autonomously. The findings from this study suggest new graduate midwives learn and grow as midwives when working in continuity of care models and they are well supported in their practice. The findings from this study are limited to Australian midwifery continuity of care models with a small sample. As a qualitative descriptive study there is the potential for further interpretive work (Sandelowski, 2010). Further research is needed to discover why new graduate midwives need to complete a transition support programme or have a certain number of years' experience before working in midwifery continuity.

Conflict of interest

There are no conflicts of interest.

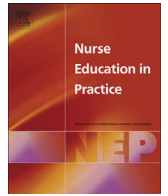
References

- Australian Government Department of Health and Ageing, 2009. *Maternity Services Reform*. Commonwealth of Australia, Canberra.
- Australian Nursing & Midwifery Council, 2008. Code of Ethics for midwives in Australia, Nursing and Midwifery Board of Australia (viewed 15th May 2013).
- Australian Nursing and Midwifery Council, 2006. National Competency Standards for the Midwife. Nursing and Midwifery Board of Australia, Melbourne (viewed 15 May 2013).
- Australian Nursing and Midwifery Council, 2010. *Midwives – Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia*. Australian Nursing and Midwifery Council, Dickson ACT.
- Avis, M., 2003. Do we need methodological theory to do qualitative research. *Qual. Health Res.* 13, 995–1004.

- Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. *Qual. Res. Psychol.* 3, 77–101.
- Burns, E., Fenwick, J., Schmied, V., Sheehan, A., 2012. Reflexivity in midwifery research: the insider/outsider debate. *Midwifery* 28, 52–60.
- Clements, V., Davis, D., Fenwick, J., 2013. Continuity of care: supporting new graduates to grow into confident practitioners. *Int. J. Childbirth* 3, page 3.
- Collins, C.T., Fereday, J., Pincombe, J., Oster, C., Turnbull, D., 2010. An evaluation of the satisfaction of midwives' working in midwifery group practice. *Midwifery* 26, 435–441.
- Curtis, P., Ball, L., Kirkham, M., 2006. Why do midwives leave? (not) being the kind of midwife you want to be. *Br. J. Midwifery* 14, 27–31.
- Davis, D., Foureur, M., Clements, V., Brodie, P., Herbison, P., 2011. The self reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia. *Women Birth* 25 (3), e1–10.
- Fereday, J., Collins, C., Turnbull, D., Pincombe, J., Oster, C., 2009. An evaluation of Midwifery Group Practice Part II: Women's satisfaction. *Women Birth* 22, 11–16.
- Foster, J., Ashwin, C., 2014. Newly qualified midwife's experiences of preceptorship: a qualitative study. *MIDIRS; Midwifery Dig.* 24, 151–156.
- Freeman, L., 2006. Continuity of carer and partnership: a review of the literature. *Women Birth* 19, 39–44.
- Gray, J.E., Leap, N., Sheehy, A., Homer, C.S.E., 2012. The 'follow-through' experience in three-year Bachelor of Midwifery programs in Australia: a survey of students. *Nurse Educ. Pract.* 12, 258–263.
- Hartz, D., Foureur, M., Tracy, S., 2011. Australian Caseload midwifery: the exception to the rule. *Women Birth* 178, 1–8.
- Hodnett, E.D., 2008. Continuity of caregivers for care during pregnancy and childbirth. *Cochrane Database Syst. Rev.*, issue 4 Art. No.: CD000062, <http://dx.doi.org/10.1002/14651858>.
- Hodnett, E.D., Gates, S., Hofmeyr, J.G., Sakala, C., Weston, J., 2011. Continuous support for women during childbirth. *Cochrane Database Syst. Rev.*
- Homer, C., Brodie, P., Leap, N., 2008. *Midwifery Continuity of Care*. Elsevier, Chatswood.
- Homer, C., Davis, G., Brodie, P., et al., 2001. Collaboration in maternity care: a randomised controlled trial comparing continuity of care with standardised hospital care. *Br. J. Obstet. Gynaecol.* 108, 16–22.
- Homer, C.S.E., 2006. Challenging midwifery care, challenging midwives and challenging the system. *Women Birth* 19, 79–83.
- Hughes, A., Fraser, D., 2011. 'SINK or SWIM': the experience of newly qualified midwives in England. *Midwifery* 27, 382–386.
- Kensington, M., 2006. The faces of mentoring in New Zealand: realities for the new graduate midwife. *N.Z. Coll. Midwives J.* 35, 7–12.
- Kirkham, M., 2010. *The Midwife–Mother Relationship*. 2nd eds., Palgrave Macmillan, Hampshire.
- Lennox, S., Skinner, J., Foureur, M., 2008. Mentorship preceptorship and clinical supervision: three key processes for supporting midwives. *N. Z. Coll. Midwives J.* 39, 7–12.
- McLachlan, H.L., Forster, D.A., Davey, et al., 2012. Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. *Br. J. Obstet. Gynaecol.* 119 (12), 1483–1492.
- Minichiello, V., Sullivan, G., Greenwood, K., Axford, R., 2004. *Research Methods for Nursing and Health Science*, 2nd edn. Prentice Hall, Frenchs Forest.
- New South Wales Health, 2010. *Maternity – Towards Normal Birth*. New South Wales Health, North Sydney.
- Nursing and Midwifery Board of Australia, 2010. *A midwife's guide to professional boundaries for midwives*. Nursing and Midwifery Board, Melbourne (viewed 16 August 2014). (<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx> - boundaries).
- Page, L., 2003. One-to-one midwifery: restoring the "with woman" relationship in midwifery. *J. Midwifery Women's Health* 48, 119–125.
- Pairman, S., Tracy, S., Thorogood, C., Pincombe, J., 2010. *Midwifery: Preparation for Practice*, 2nd edn. Elsevier, Chatswood.
- Rees, C., 2012. *Introduction to Research for Midwives*, 3rd edn. Churchill Livingstone, Edinburgh.
- Sandall, J., Soltani, H., Gates, S., Shennan, A. & Devane, D. 2013. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst. Rev.*, Issue 8, Art. No.: CD004667, <http://dx.doi.org/10.1002/14651858>.
- Sandelowski, M., 2000. Whatever happened to qualitative description? *Res. Nurs. Health* 23, 334–340.
- Sandelowski, M., 2010. What's in a name? Qualitative description revisited. *Res. Nurs. Health* 33, 77–84.
- Saultz, J.W., 2003. Defining and measuring interpersonal continuity of care. *Ann. Family Med.* 1, 134–142.
- Stevens, T., Mc Court, C., 2002. One to one midwifery practice part 3: meaning for midwives. *Br. J. Midwifery* 10, 111–115.
- Sullivan, K., Lock, L., Homer, C.S.E., 2011. Factors that contribute to midwives staying in midwifery: a study in one area health service in New South Wales, Australia. *Midwifery* 27, 331–335.
- Walsh, D., 1999. An ethnographic study of women's experiences of partnership caseload midwifery practice: the professional as a friend. *Midwifery* 15, 165–176.
- Young, N., 2012. An exploration of clinical decision making among student and newly qualified midwives. *Midwifery* 28, 824–830.

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The mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia

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ABSTRACT

The aim of this paper was to explore the mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia. Most new graduates find employment in hospitals and undertake a new graduate program rotating through different wards. A limited number of new graduate midwives were found to be working in midwifery continuity of care. The new graduate midwives in this study were mentored by more experienced midwives. Mentoring in midwifery has been described as being concerned with confidence building based through a personal relationship. A qualitative descriptive study was undertaken and the data were analysed using continuity of care as a framework. We found having a mentor was important, knowing the mentor made it easier for the new graduate to call their mentor at any time. The new graduate midwives had respect for their mentors and the support helped build their confidence in transitioning from student to midwife. With the expansion of midwifery continuity of care models in Australia mentoring should be provided for transition midwives working in this way.

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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 et al., 2011). This usually requires the new graduate midwife to rotate through antenatal clinics, birth suite and postnatal wards over a 12 month period (Clements et al., 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 and 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 et al., 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 et al., 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 et al., 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;

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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 focussing 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 and Wray, 2000). Mentoring has been used in many disciplines including business and nursing (Beecroft et al., 2006; Fajana and 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 and 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 and 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 and Gbajumo-Sheriff, 2011).

Mentors may be either allocated or selected by the mentee (Lennox et al., 2008b; 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 et al., 2008b). 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 et al., 2008b).

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 et al., 2008a). Mentoring in this context includes teaching, role modelling 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 et al., 2008a).

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 and 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 et al., 2012). The benefit of continuity of care as a relationship was articulated by Saultz (2003) and applied to midwifery (Page and 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 et al., 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 and McCandlish, 2006). The framework was used to examine the levels of the relationship that the new graduate had, not only with the woman, but also with 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 and 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 a 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 and Mason, 2009; Lennox et al., 2008a; 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. (2008a,b) 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 et al., 2008a; Beecroft et al., 2006; Fajana and 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 et al., 2006; Fajana and Gbajumo-Sheriff, 2011; Lennox et al., 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 et al., 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 and 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 et al., 2008a). 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 et al., 2008a) 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.

References

- Australian College of Midwifery, 2012. *Midwifery Models of Care*. Adelaide, South Australia.

- Australian Government Department of Health and Ageing, 2009. Maternity Services Reform. Commonwealth of Australia, Canberra.
- Avis, M., 2003. Do we need methodological theory to do qualitative research. *Qual. Health Res.* 13 (no. 7), 995–1004.
- Beecroft, P.C., Santner, S., Lacy, M.L., Kunzman, L., Dorey, F., 2006. New Graduate Nurses' perceptions of mentoring: six-year programme evaluation. *J. Adv. Nurs.* 55 (no. 6), 736–747.
- Clements, V., Fenwick, J., Davis, D., 2011. Nurturing our future: the importance of midwifery transition support programs. *Women Birth* 24 (Suppl. 1), S31 no. 0.
- Cummins, A.M., Denney-Wilson, E., Homer, C.S.E., 2015. The experiences of new graduate midwives working in midwifery continuity of care models in Australia. *Midwifery* 31 (4), 438–444.
- Davies, S., Mason, J., 2009. Preceptorship for newly-qualified midwives: time for a change. *Br. J. Midwifery* 17 (12), 804–805.
- Davis, D., Foureur, M., Clements, V., Brodie, P., Herbison, P., 2012. The self reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia. *Women Birth* 25 (3), e1–e10.
- Dawson, K., Newton, M., Forster, D., McLachlan, H., 2015. Exploring midwifery students' views and experiences of caseload midwifery: a cross-sectional survey conducted in Victoria, Australia. *Midwifery* 31 (2), e7–e15.
- Eby, L.T., 1997. Alternative forms of mentoring in changing organizational environments: a conceptual extension of the mentoring literature. *J. Vocat. Behav.* 51 (1), 125–144.
- Eby, L.T., 2011. 'Mentoring', *APA Handbook of Industrial and Organizational Psychology*. In: *Selecting and Developing Members for the Organization*, vol. 2. American Psychological Association, Washington, DC, US, pp. 505–525.
- Fajana, S., Gbajumo-Sheriff, M., 2011. Mentoring: an human resource tool for achieving organisational effectiveness. *IFE Psychol.* 420–432.
- Gray, J.E., Leap, N., Sheehy, A., Homer, C.S.E., 2012. The 'follow-through' experience in three-year Bachelor of Midwifery programs in Australia: a survey of students. *Nurse Educ. Pract.* 12 (5), 258–263.
- Homer, C.S.E., Brodie, P., Leap, N., 2008. *Midwifery Continuity of Care: a practical guide*. Churchill Livingstone, Sydney.
- Hughes, A., Fraser, D., 2011. SINK or SWIM: the experience of newly qualified midwives in England. *Midwifery* 27, 382–386.
- Kensington, M., 2006. The faces of mentoring in New Zealand: realities for the new graduate midwife. *N. Z. Coll. Midwives J.* 35, 22–27 oct. 2006.
- Lennox, S., Skinner, J., Foureur, M., 2008a. Mentorship preceptorship and clinical supervisory: three key processes for supporting midwives. *N. Z. Coll. Midwives J.* 39, 7–12.
- Lennox, S., Skinner, J., Foureur, M., 2008b. Mentorship, preceptorship and clinical supervision: three key processes for supporting midwives. *N. Z. Coll. Midwives J.* 39, 7.
- Lennox, S., Jutel, A., Foureur, M., 2012. The concerns of competent novices during a mentoring year. *Nurs. Res. Pract.* 2012.
- McKenna, L., 2003. Nurturing the future of midwifery through mentoring. *Aust. Midwifery* 16 (2), 7–10.
- Minichiello, V., Sullivan, G., Greenwood, K., Axford, R., 2004. *Research Methods for Nursing and Health Science*, second ed. Prentice Hall Frenchs Forest.
- New South Wales Department of Health, 2010. *Maternity - towards Normal Birth in NSW*.
- New Zealand College of Midwives, 2014. *Midwifery First Year of Practice New Zealand College of Midwives (inc)*, New Zealand viewed 6/01/2015 2014. <http://www.midwife.org.nz/quality-practice/midwifery-first-year-of-practice>.
- New Zealand College of Midwives (inc), 2012. *New Zealand college of Midwives (inc)*, Auckland viewed 20th april 2012 2012. <http://www.midwife.org.nz/>.
- Nursing and Midwifery Board of Australia, 2006. *Midwifery Competency Standards viewed 8th Dec 2014 2014*. <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards>.
- Page, L., McCandlish, R., 2006. *The New Midwifery: Science and Sensitivity in Practice*. Elsevier Health Sciences.
- Panettiere, M., Cadman, T., 2002. Do new graduate midwives need extra support? Are direct-entry midwifery graduates adequately prepared to practise in the hospital environment? A clinical midwifery leader and a nurse educator put the case for an entry-to-practice programme for midwives. (viewpoint). *Kai Tiaki Nurs.* N. Z. 8 (3), 18 (2).
- Parsloe, E., Wray, M., 2000. *Coaching and Mentoring*. Kogan Page, London.
- Sandall, J., Soltani, H., Gates, S., Shennan, A., Devane, D., 2013. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst. Rev.* 8 (no. 8).
- Sandelowski, M., 2000. Whatever happened to qualitative description? *Res. Nurs. Health* 23, 334–340.
- Saultz, J.W., 2003. Defining and measuring interpersonal continuity of care. *Ann. Fam. Med.* 1 (3), 134–142.
- Saultz, J.W., 2003. Defining and measuring interpersonal continuity of care. *Ann. Fam. Med.* 1 (3), 134–140.

APPENDIX H

The challenge of employing and managing new graduate midwives in midwifery group practices in hospitals

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The challenge of employing and managing new graduate midwives in midwifery group practices in hospitals

Aim(s) This study explores the views of midwifery managers and key stakeholders, regarding the facilitators and barriers to employing new graduate midwives in midwifery continuity of care models.

Background Maternity services in Australia are shifting towards midwifery continuity of care models, where midwives work in small group practices, requiring a change to the management of staff. Public policy in Australia supports maternity services to be reconfigured in this way. Historically, experienced midwives work in these models, as demand grows; new graduates are employed to staff the models.

Method(s) A qualitative descriptive approach exploring the manager's experience of employing new graduate's in the models. Managers, clinical educators and hospital midwifery consultants ($n = 15$) were recruited by purposeful sampling.

Results Drivers, enablers, facilitators and barriers to employing new graduates in the models were identified. Visionary leadership enabled the managers to employ new graduates in the models through initial and ongoing support. Managing the myths stemming from fear of employing new graduates to work in midwifery continuity of care models was challenging.

Conclusion Managers and other key stakeholders provide initial and ongoing support through orientation and providing a reduced workload.

Implications for nursing management Visionary leadership can be seen as critical to supporting new graduates into midwifery continuity of care models. The challenges for management to overcome include managing the myths stemming from fear of employing new graduates to work in a flexible way around the needs of the women within an organisation culture.

Keywords: new graduate midwives, support, facilitation

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Introduction

Maternity services in Australia are gradually shifting towards midwifery-led continuity of care models and this requires significant changes to the organisation and management of staff. Midwifery continuity of

care, also called caseload or midwifery group practice (MGP), is defined as care provided to women throughout pregnancy, birth and the early postnatal period from a single midwife or a small group of midwives (Sandall *et al.* 2013). Midwifery continuity of care models reduce obstetric interventions such as epidural

anaesthesia, episiotomy and Caesarean section operations and result in fewer babies being admitted to the neonatal intensive care unit, at no extra cost to the health service (McLachlan *et al.* 2012, Sandall *et al.* 2013, Tracy *et al.* 2013). Consequently, the Australian government has recommended that publicly funded maternity services provide midwifery models of care (Australian Government Department of Health and Ageing 2009, New South Wales Health 2010) although uptake has been slow.

The managers and other key stakeholders, in this study, employed or supported midwives who provide care to the woman throughout her pregnancy at a time and place that suits the woman and is on call for the birth with most postnatal care provided in the woman's home. Because the workload varies according to the needs of the women in their care, traditional models of management are not always suitable for managing midwives working in flexible ways in the continuity of care models, and managers need to adapt to managing this different workforce. In Australia, a clinical redesign saw the introduction of 32 full-time equivalent midwives in one hospital working in a flexible way around the needs of the women, being on-call and focused on women's rather than institutional needs (Hartz *et al.* 2012). Again, this was a challenge for the structure of the health system and the way these midwives were managed. Midwives in midwifery continuity of care models are employed on an annualised salary, with a certain number of women to care for each year (Hartz *et al.* 2012).

Midwifery continuity of care has been found to be a highly satisfying way for midwives to work and is a popular way of working as a result of the professional relationships that midwives can develop with women and the flexible working arrangements the role enables (Collins *et al.* 2010, Hartz *et al.* 2012, Newton *et al.* 2014). In the past, only experienced midwives have been recruited to work in these models however, as demand grows new graduate midwives are employed to sustain the models of care (Hartz *et al.* 2012) and this can be challenging for some health services to implement.

Midwifery continuity of care; a manager's challenge?

Similar to nurses, new graduate midwives have been traditionally employed in some form of 'transitional' support from student to registered practitioner for approximately 1 year. The new graduate year for nurses, known as transitional programmes, has

become commonplace in many countries (Rush *et al.* 2015). New graduate midwives, those in their first-year post-graduation, have not historically worked in continuity of care models despite being prepared to work across the scope of midwifery practice from their degrees (Gray *et al.* 2012, Cummins *et al.* 2015). A modification of the transitional programme has been adapted for midwives (called a 'rotation' year) and sees new graduates working in a number of different settings and rotating every few months through areas such as labour and birth, the antenatal ward, antenatal clinic and postnatal wards. Several previous studies (Panettiere & Cadman 2002, Passant *et al.* 2003, Kensington 2006, Lennox *et al.* 2008, Davies & Mason 2009, Barry 2011, Davis *et al.* 2011, Hughes & Fraser 2011) have examined the experience of newly graduated midwives during the transition year, however, there is limited evidence about new graduate midwives who are initially placed within midwifery continuity of care models rather than in this rotational model.

When new graduate midwives work in midwifery continuity of care models they are orientated into a small group of midwives and provide care to a case-load of women. Their practice is flexible in nature, that is, they work their own hours to suit the women's needs providing antenatal care at a time suitable to the woman and the midwife, they are on-call for the birth and then provide postnatal care often visiting the woman at home. New graduate midwives, working in this flexible way, are supported by more experienced midwives and mentors via text message, the phone, in person and through regular team meetings (Kensington 2006, Lennox *et al.* 2008, Lennox *et al.* 2012, Cummins *et al.* 2015).

Our previous work has found that new graduate midwives who work in the continuity of models are well supported to develop relationships with the women and the small group of midwives they work alongside (Cummins *et al.* 2015). The new graduates' consolidated their skills when working with the woman and were supported from within the small group of midwives. Working in a continuity of care model was found to be satisfying while sustaining the model of care for women (Cummins *et al.* 2015). Although the study was conducted with a small number ($n = 13$) of new graduate midwives, it led to the question of why new graduates are not being employed in midwifery continuity of care models.

Following on from our previous work, the following research question was raised as phase two of the study:

What are the experiences of managers and other key stakeholders when they employ new graduate midwives in midwifery continuity of care models?

Phase two of the research aimed to explore the views of midwifery managers, educators and other key stakeholders. The questions asked focused on the facilitators and barriers to employing new graduate midwives in midwifery continuity of care models. This paper reports on the second phase of the research project.

Method

A qualitative descriptive approach was used to describe and explore the manager's experience and perspective of employing new graduate midwives in midwifery continuity of care models. The exploration was based on the interest in, and understanding of, the 'who, what and where' of their experiences (Sandelowski 2000, P. 338). There is little known on the facilitators and barriers to employing new graduate midwives in the continuity of care models, therefore, a qualitative descriptive approach is a useful form of inquiry to describe how the managers feel (Sandelowski 2000).

Participants

Fifteen managers, educators, clinical midwifery consultants and clinical support midwives were recruited by purposeful sampling. As our question was to enquire why new graduates were employed or not, we needed to recruit managers to the study; however, managers are not solely responsible for supporting staff in the continuity of care models. The other staff responsible for the support of new graduate midwives are midwifery clinical educators and consultants, and they were recruited as key stakeholders in supporting new graduates as they transition from student to an autonomous practicing midwife (Hartz *et al.* 2012). The managers, educators and clinical midwifery consultants were contacted via email for a phone interview. Maternity services that offer midwifery continuity of care to women were identified from phase one of the study and are mostly in metropolitan settings and all are publicly funded. Participants were recruited from the following states in Australia: New South Wales, Australian Capital Territory, Victoria, Queensland and South Australia (Table 1). The states have been de-identified as there are only a small number of maternity services that provide continuity of care in each state and the managers could be identified. Privately practicing midwives providing caseload

Table 1

Demographic details of the participants: location, type of manager, educator or clinical midwifery educator

No	State	Manager of group practice	Employed/supported new graduate midwives	Rural/Metropolitan
1	A	Manager of group practice	Yes	Metropolitan
2	B	Manager of Health service	Yes	Metropolitan
3	B	Manager of Maternity service	No	Metropolitan
4	B	Midwifery researcher	Yes	Metropolitan
5	B	Clinical support midwife	Yes	Metropolitan
6	B	Clinical midwifery consultant	No	Metropolitan
7	C	Manager of group practice	Yes	Metropolitan
8	B	Manager of group practice	No	Metropolitan
9	D	Manager of Health service	Yes	Metropolitan
10	E	Manager of Health service	Yes	Rural
11	B	Midwifery educator	Yes	Metropolitan
12	B	Clinical Midwifery consultant	Yes	Metropolitan
13	B	Manager of group practice	Yes	Metropolitan
14	B	Manager of group practice	Yes	Metropolitan
15	B	Educator of group practice	Yes	Metropolitan

Participants were recruited from the following states in Australia: New South Wales, Australian Capital Territory, Victoria, Queensland and South Australia. The states have been de-identified to protect the anonymity of the participants.

midwifery were not included in the sample as they were less likely to recruit new graduate midwives.

Data collection

Phone interviews were the most convenient to both the managers and the researchers as the participants were from all over Australia. The first author was responsible for data collection. Face-to-face interviews are usually conducted in qualitative research, however, participants' views of telephone interviews have been positively reported in other qualitative studies (Holt 2010, Ward *et al.* 2015). The telephone is commonly used and participants report the value of anonymity when undertaking interviews as part of qualitative research. Telephone interviews should be considered depending on the nature of the participant group and the proposed methods of data analysis (Holt 2010,

Table 2
Questions

Have you employed and/or supported any new graduate midwives to work in midwifery continuity of care models?

Can you tell me about your decision process as to why you did/or didn't employ new graduate midwives to work in midwifery continuity of care models?

Are there any system or personal barriers to employing new graduate midwives in midwifery continuity of care models?

Can you tell me about your experience of working with new graduate midwives – either in midwifery continuity of care models or in other models?

Can you tell me about your views on the benefit of employing a new graduate midwife to work in a midwifery continuity of care model?

What are the challenges and barriers to employing a new graduate midwife to work in a midwifery continuity of care model?

What support systems would you like to see in place to encourage more managers to employ new graduates into continuity of care models?

If you are not a manager what do you think of employing new graduate midwives in midwifery continuity of care programs?

Ward *et al.* 2015). Midwifery key stakeholders regularly use telephones for meetings and as the interviews are easily recorded with a hand-held device with the participants consent, telephone interviews were the first choice of method for data collection. Semi-structured interviews were conducted and the interviews were recorded with permission and transcribed verbatim. The participants were asked a series of questions about their decision to employ new graduate midwives to work in midwifery continuity of care, and the questions are included in Table 2. The researcher knew some of the participants and there was the potential for the blurring of boundaries (Burns *et al.* 2012). The researcher positioning herself as a researcher rather than a colleague or acquaintance addressed the issue of reflexivity. The other two authors on the research team read de-identified data and, therefore, were outsiders (Burns *et al.* 2012) to the data collection, thus, enhancing rigour.

Analysis

Thematic analysis was undertaken using several phases, the first phase involved the researcher becoming familiar with the data with initial coding of the data, then searching for themes, sub-themes, reviewing the themes and finally, the themes were named and defined before writing the report of the findings, as described by Braun and Clarke (2006).

By reading the transcripts, the first author (A.C.) familiarised herself with the data. The data were read and then reread systematically generating initial codes across the entire data set (Braun & Clarke 2006). The first stage coding was conducted manually, organising

the data into meaningful groups in a table (Braun and Clarke 2006). This was the beginning of an audit trail that allowed the other authors to understand how the themes emerged and conclusions were reached (Lavender *et al.* 2004)

The next phase of analysis was to look for themes within the organised data (Braun and Clarke 2006). The initial themes that emerged from the data were: (i) facilitating new graduate midwives in the continuity of care models in order to meet staffing needs; and (ii) providing support to the new graduates. These key themes have captured important elements from the data in relation to the research question (Braun & Clarke 2013). Sub-themes included support, such as providing a longer orientation period and a reduced caseload for new graduate midwives. Key themes that emerged as barriers to employing new graduate midwives were based on the historical nature of traditional rotation programmes and the organisational expectations of new graduate midwives. Under the key themes were sub-themes such as organisational culture and fear of 'something going wrong'. This description of the data was further analysed to discover the 'who, what and where' (Sandelowski 2000) of the managers' and other key stakeholders' experience. The analysis was driven by the data and not by a theoretical framework (Braun and Clarke 2006) in order to understand the experiences of the managers and other key stakeholders. By reflecting and comparing the emergent themes with the other two authors (C.H. and E.D.W.) further analysis occurred. We drew a concept map that showed where themes overlapped and were able to write a narrative around each theme, this exercise enabled the final naming of the themes.

The first author took responsibility for the phases of the analysis, looking for the points of interest in relation to the topic extracted from the themes and subthemes to arrive at a final interpretation of the data (Braun & Clarke 2006). The constant checking and rechecking of emerging themes between the authors and the use of verbatim quotes from the participants were all steps to ensure rigour in the analysis (Lavender *et al.* 2004)

Results

Drivers, enablers, facilitators and barriers to employing new graduate midwives in midwifery continuity of care models were identified and a key theme was that having visionary leadership enabled the employment of new graduate midwives in these models. Figure 1 describes the process that was taking place for the

Having visionary leadership to enable innovation



Figure 1
Drivers, enablers, facilitators and barriers to employing new graduate midwives in midwifery continuity of care models.

managers and in the health system around new graduates.

Drivers: a need to staff the continuity of care models

'We are recruiting for the future'

Recruitment of midwives to staff the continuity of care models for the future was the main driver for employing new graduate midwives to work in midwifery continuity of care models, with an overarching theme that if they do not recruit new graduates they miss out in two ways: they will not get the best graduates and they will not be able to staff their services. Two managers said 'you have to think about your future'; 'you build succession planning' (no. 2) and 'so it is our ultimate plan that we have a first year of practice with each one of the group practices then every 12 months we're growing another group practice' (no. 10).

Midwives are predominantly female, and managing a feminised workforce meant the managers had to think about recruiting for the future as midwives working within continuity of care models may take maternity leave. These managers illustrated this by saying, 'we do have a dominance of women [midwives] having babies' (no. 4) and 'we've needed them [new graduates] this year because we have had a lot of people [midwives] having pregnancies' (no. 7). Recruiting for the future includes replacing retiring midwives in the continuity of care models as noted here, 'we had a lot of staff who were planning

retirement and a few staff who were planning babies' and then goes on to say 'new graduates are a really important part of our recruitment strategy' (no. 1).

In contrast, one key stakeholder who did not employ new graduates indicated that she had heard 'we're not coming to you because you don't offer us caseload as part of our graduate year' (no. 9). This key stakeholder was worried that she would not be able to recruit the future midwifery workforce and recognised that change was needed. A clinical midwifery consultant supports this stance by saying 'the [new graduate] midwives end up being dissatisfied and they probably leave because they're in that fragmented model of care' (no. 5). Recruiting for the future was a clear driver for staffing the continuity of care models.

Having employed new graduates into the continuity of care models has built the workforce capacity, for example, 'more than 50% of our staff now working there started as new graduates' and '75% have stayed' (no. 1). Employing new graduate midwives to the model is important that this manager said that 'find ways of getting new graduates' in' [into the model] and 'working with new graduates is imperative if we are going to grow the profession' (no. 2). Hence, the need to staff and maintain the midwifery continuity of care models was based on employing new graduate midwives into the model.

Another educator discussed removing barriers in order to staff and sustain the continuity of care models, 'if we are going to sustain the model we need to be more accepting to putting up less barriers about how much experience [new graduate experience]' (no. 11). Another manager took advice from the midwives working within the caseload practice, 'the girls [midwives] saw the sustainability of the model was to actually encourage the recruitment of new graduates' (no. 13) and evident here 'they (caseload midwives) look around and think who will fit into our service and be good with the women' (no. 11). There was a reported fear of losing the models 'we are going to be left with no continuity model if we don't do something' (no. 1), that is employ new graduates.

Enablers: preparing students, recruiting new graduates and providing orientation

'We have been preparing students to work in the continuity of care models'

An enabler for employing new graduate midwives was the process they had undertaken to prepare midwifery students to work in the models. One manager said, 'we

are training students to work against the scope of practice why would we not encourage them to work in a continuity model' (no. 2). Another discussed the point of competence at the time of registration, saying 'they come out competent, they come out knowing, many of them have been exposed to continuity of care models' (no. 4) and again, 'new grads come straight from their training, they want to see a woman through a journey, they've already done that with their follow-throughs, I think a lot of them want to continue working in that way' (no. 12). In contrast, one manager discussed the new graduates varying degrees of ability as noted here 'some universities do prepare students more effectively than others, the product I get at the end as an employer is actually quite different even though they've had to reach a certain standard' (no. 9). It is the continuity of care experiences in the midwifery student education that this educator saw as most important, 'the continuity is what has prepared the students to work in the continuity models' [students] (no. 15).

Managers discussed aligning certain students to work in continuity models, 'we ask them what their future plans are and what they want to do with their career and we will sort of like, pick some people to go to various areas we will change their rotation program' as students (no. 11). Again, these managers discuss preparing the students to work in continuity 'they have had 6–8 weeks in their training with a continuity of care group, then obviously you're hoping that could be part of the succession planning' (no. 6) and 'we have really good relationships with the midwifery students so we tend to know a lot of them by the time they actually come and do the transition year' (no. 7).

The managers discussed having well prepared midwifery students to transition straight into the model, 'here we have always had problems getting staff so about 10–12 years ago we purposely set about growing our own workforce there's a number of students with the plan that we may retain at least 50–60 percent of those students' (no. 10) and here 'we needed staff so I kind of sought her out because I knew her – she'd spent a bit of time in the birth centre as student' (no. 8).

There were repeated reports that the new graduates need support 'you don't just throw them in, you put support systems there to support them in order to make it successful' (no. 11).

'We provide a good orientation'

The managers who do employ new graduates indicated that the orientation period was the key to transitioning the new graduate into the continuity of care model, 'they are really well supported in that first 4–6 weeks

and the workload is gradually increased, they start with a reduced caseload' (no. 1). A reduced caseload means the new graduate does not provide care for the same number of women as other midwives who are more experienced. A longer orientation period is described by this manager "give them high level support for the first 2 or 3 months, they find their feet and they fly" (no. 2). Having to reduce the caseload was not always seen as helpful, "the downside of a reduced caseload is the impact on the workload for the other midwives in the group" (no. 6). It is important that the small group of midwives are cohesive as the other midwives in the group and support the new graduate to transition from student to autonomous practitioner.

Facilitator: the new graduates need support

'Getting support from within the group'

The managers reported different models of support although new graduate midwives were often supported through a buddy or mentoring system within the small group of midwives they worked alongside. For example, 'they have a direct buddy they are in a group of four' (no. 14). Again reported here 'there are four of them they have a buddy and then they've all got [mobile] phones, so they can talk to each other' (no. 8) and 'they get a week's orientation, then they work in partnership with the mentor for a while, so for the first few months they work the same clinic (off campus, various points around council but not in people's homes) as their mentors' (no. 10). Mentoring was, at times, arranged; however, other managers let the new graduate find their own support 'I haven't assigned them to a mentor it has been a natural sort of attraction' (no. 13) and here 'they do buddy up, find a particular person they get on well with and maybe that's not their work partner' (no. 12). Other support discussed from within the group of midwives, 'they don't have a buddy, they work with a team' (no. 15) and 'midwives in the team support them' (no. 2). Letting the new graduates find their own support aimed to reduce personality differences, reported by one midwifery consultant as a problem, saying 'we should not be relying on the group to mentor a new grad in' (no. 6). This led to a discussion of other support mechanisms including a support plan for the new graduate to consolidate their skill base.

Having support to consolidate the new graduate's skill base

Many of the managers reported putting a plan in place to assist the new graduates to consolidate their

skills base, for example, 'we have a plan and I sit down with them I would like you to achieve this in 1 month' (no. 14) and 'setting up almost like a plan of you know what do I need to achieve, what are my goals, how I am going to get there' (no. 13). Some reported formalised processes, with another saying, 'we did a skills inventory before and after 3 months and then at 6 months' (no. 5).

There were different perspectives as to the readiness of new graduates for an independent role. One manager was completely confident the new graduates were ready for providing continuity of midwifery care for women through pregnancy birth and the postnatal period, 'they are registered to practice midwifery to the full scope of practice' and 'they have the skills and attributes to in fact do that' (no. 2). Another said, 'you have got to have confidence that they've got a certain level of skill' (no. 6). This educator expressed another example of confidence in the new graduates 'new grads come in knowing what they don't know, they know how to ask for help' (no. 11). Conversely, another manager was more skeptical 'when you're newly graduated, you actually don't even know what you don't know' (no. 8).

Finding support through team meetings

Almost all the managers discussed team meetings as a form of support for new graduate midwives, illustrated by, 'we have a meeting every Wednesday, we say you need to be part of that so they come to the meeting' (no. 7) and the 'teams meet each week with any concerns or questions' (no. 1). Another said, '[we have] weekly meetings where they would all bring food and have case reviews and talk about what they did, what helped and what didn't help' (no. 5). The managers discussed their role in supporting the new graduate through regular meetings explaining, 'they officially/unofficially meet up with me on a weekly basis and then on a monthly basis' (no. 14) and 'they do feel supported we meet with them quite regularly in their first you know couple of months to see how they're tracking and how its working for them' (no. 1).

Being supported by the senior management

The managers looked for support to employ new graduate midwives from the higher-level management. Two managers discussed the support they received from senior management saying 'the overarching manager was very flexible' (no. 5) and 'the directors of midwifery we had were very committed to supporting midwives to work in this model' (no. 1). Another said, 'even our

senior nurse manager, our senior operations manager, they know that if they [new graduates working in continuity models] have issues that can't be resolved by any of us they can go to them' (no. 12). When the senior management was supportive of new graduates working in midwifery continuity of care models they were viewed as visionary, for example 'it is visionary leadership who understand maternity services' and 'it was the leadership we had supporting university teaching, being a practitioner in your own right' (no. 5).

Some managers discussed needing to convince their senior management that new graduates working in the continuity of care models were safe, for example, 'I suppose we have to get midwifery leadership group to recognise that the students who become registered are registered' (no. 2). The manager was referring to the new graduate meeting the competency standards of the midwife and being a safe practitioner. There was some discussion from managers when new graduates worked in a standard transitional programme they lost their ability to provide care across the scope of practice as described here, 'the new leader has talked about new grads going into caseload because she doesn't want them tainted' (no. 5). This manager discussed convincing senior management of the maternity service saying 'you need to sell your successes' (no. 2).

In some places, that senior management was not supportive as stated here, 'I wonder if management just thinks it's all too hard' (no. 11). There was an optimistic outlook from this manager, 'we have got some better team leaders in our newer staff than in our older staff by years of experience' and 'the way of changing forwards, through midwifery leadership [visionary leadership] is with our new graduates' (no. 14).

Barriers: managing the myths

'We need to manage the fear around employing new graduates into continuity of care models'

There were concerns about an increase in adverse events, if new graduates were working in midwifery continuity of care models, with one manager saying 'managers and executives fear that something bad is going to happen to a woman or a baby' (no. 1) and another 'it is mostly managers who are the most nervous' (no. 4). There was a thread of fear coming from senior management for example 'they are nervous, they are frightened they don't have enough skilled leaders who are confident in supporting midwives to be self-determining in the workforce' (no. 4). Maternity services and obstetrics is a highly litigious environment as reported by this manager, 'the heads of

department are all looking at medico legal issues' (no. 15). It was difficult for this group of managers to advocate for new graduates when the management was medico-legally defensive about previous adverse events, for example, 'the midwifery managers as a group decide who works where and what skills people have and I guess for them they are looking at what IIMS [incident reporting system for adverse outcomes] are going to be in and what they felt are going to be the complaints' (no. 15).

Fear also came from the new graduate's colleagues, the core staff with one saying 'the older midwives would say they felt nervous for them' (no. 5). Some reported the new graduate's being fearful, illustrated by this quote 'one new graduate only lasted 6 weeks, I think it was her personal fear of working autonomously' (no. 15) and discussed here, 'you really have to want to do it and not be frightened of it' (no. 7). In contrast, one manager stated, 'because they have an expectation of learning they don't have a fear of it' (no. 14).

Changing organisational culture

'Culture is a challenge, not a barrier'

Managers discussed the need for new graduates to gain experience before working in continuity of care models based on history with one saying, 'I think we still have a culture where if you don't do your penance in the birth suite, then you're not experienced enough to care for women independently' (no. 10). Illustrated by this quote, 'sort of a backlash from senior people [midwives], we still have a lot of people [core midwifery staff] who think you have to be in a place for a long time before you should be a caseload midwife' (no. 11) and here 'it's the nature of working in a hospital, you know it's based on history' and 'this is how we have always done things' (no. 2). Finally, this manager challenged the historical nature of organisational culture saying 'once you start having these rules around who can come to you, you do look a bit exclusive it's a bit crazy because it's a midwifery model' (no. 7).

There were reports of attempting to change the culture 'to change the culture, the perception of staff on what a midwife is and what a midwife can do' (no. 10). One manager reported attempting to change the organisational culture, trying to 'use the workforce in a different way' and 'use your staff in a slightly better or different way' (no. 2). However, many of the managers were complacent about the culture, saying 'it is the whole service and the culture around it is very medicalised' (no. 4). Put simply by this manager 'significant culture issues in our maternity unit anyway'

meaning, the culture is medicalised and not very midwifery focused and it is 'the general culture of the organisation' (no. 1).

Discussion

This study provides important insights into the role of managers in new models of midwifery care and provides key learnings for all managers in a changing health care environment. This study found that staffing the midwifery models was the main driver for employing newly graduated midwives into the continuity of care models. Managing a feminised workforce that has potential for frequent episodes of maternity leave with limited capacity for part-time work (Forster *et al.* 2011, Hartz *et al.* 2012) has meant that managers need new graduate midwives to staff their continuity of care models. Building workforce capacity was seen as enabling the employment of new graduate midwives into the midwifery continuity of care models. Some units in Australia have undertaken workforce capacity building through clinical redesign. For example, one large tertiary referral hospital in metropolitan Sydney undertook a well-planned clinical redesign when introducing large numbers of midwives to work in continuity of care models (MGP), one of the strategies for sustaining the models included the recruitment of new graduate midwives to work in the MGP (Hartz *et al.* 2012).

Exposing students to midwifery continuity of care during their undergraduate programmes was found to be important in our study, to enable the employment of new graduate midwives into the continuity of care models upon graduation. This important finding from the managers and other key stakeholders supports our previous findings and that of others, new graduate midwives felt prepared to work in midwifery continuity by completing their degree (Gray *et al.* 2012, Cummins *et al.* 2015). Without this early experience, retention of midwives may be at risk as a result of dissatisfaction with working in a standard rotation model when new graduate midwives have had experience in a midwifery continuity of care model.

The initial support from the managers and senior management was found to be an enabler to employing new graduate midwives in midwifery continuity of care models. The initial support included a prolonged orientation period with a reduced caseload. Similarly, a Canadian study found one of the most positive experiences for new graduate nurses was a long (>4 weeks) orientation period (Rush *et al.* 2015). The other initial support finding, in our study, was a reduced workload with new graduate midwives having

a lesser caseload initially. High workload, described as the nurse/patient ratio, has been discussed as detrimental to the new graduate nurses' experience of their first year of practice (Feng & Tsai 2012). Other studies of new graduate nurses have found that job satisfaction, professional competence and turnover rates are related to adequate staffing (Numminen *et al.* 2015, Pineau Stam *et al.* 2015). Therefore, the findings in our study of offering new graduate midwives a long orientation period and initially a reduced caseload/workload may enable the employment and retention of new graduate midwives.

In our study, support from the hospital senior management was integral in employing new graduate midwives into midwifery continuity of care models. It has been reported that the sustainability of midwifery continuity of care models depends on senior management to meet regularly and complete continuous assessment of the model (Hartz *et al.* 2012) and further that caseload midwifery would only be normalised as part of the maternity services with support from management (Forster *et al.* 2011). Hence visionary leadership is a critical driver and enabler to employing new graduate midwives to work in midwifery continuity of care models.

We found there were only a few barriers to employing new graduate midwives into midwifery continuity of care models. The barriers focused on safety and fears that something was going to happen to women and babies. The managers were able to manage the fears expressed from higher management despite a thread of nervousness from the core midwifery staff. It has been found that stand-alone midwifery led units in England are more successful when there is collegiality between all the midwifery and medical team and supportive management (Rayment *et al.* 2015). Despite the fears, the managers were focused on ensuring the new graduate midwives built their skills within the continuity of care models and over time they were confident to provide care to women across the full scope of midwifery practice.

Limitations

This study is limited to the views of Australian midwifery continuity of care managers and stakeholders.

Conclusions

We found a key driver for the employment of new graduate midwives to work in midwifery continuity of care models was the need to staff the models of care. The recruitment and retention of new graduate nurses

have been examined in the literature as dependent upon work environment, collegial relationships and job satisfaction (Feng & Tsai 2012, Laschinger 2012). We have found in this study that managers providing a longer orientation period are attracting new graduates to work in the continuity of care models. Collegiality is evident through the team meetings that the managers and other key stakeholders often attend and acts as a facilitator to retaining new graduate midwives working in the continuity of care model. Ongoing support is also important and new graduates midwives in New Zealand are mentored into midwifery continuity of care models (Lennox & Foureur 2012).

Implications for Nursing Management

Consequently, managers who provide a supportive orientation period with an initially reduced workload and ongoing support will attract and retain midwives to work in the midwifery continuity of care models. Despite these interventions and confidence that new graduates are competent to work across the scope of practice, the managers are challenged by organisational culture. Visionary leadership and managing myths that mothers and babies may be at risk can be seen as critical to breaking down the barriers to employing new graduates into midwifery continuity of care models.

Further research is needed to discover why there are larger organisational challenges to employing new graduate midwives to work in midwifery continuity of care models.

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References

- Australian Government Department of Health and Ageing (2009) *Maternity Services Reform*. Department of Health and Ageing, Canberra.
- Barry M. (2011) *Newly-graduated Midwives Applying the Philosophy of Midwifery: A Theory of Transcending Barriers*. 2011. University of Western Australia.
- Braun V. & Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3 (2), 77–101.

- Braun V. & Clarke V. (2013) *Successful Qualitative Research*. Sage Publications Ltd, London.
- Burns E., Fenwick J., Schmied V. & Sheehan A. (2012) Reflexivity in midwifery research: the insider/outsider debate. *Midwifery* 28, 52–60.
- Collins C.T., Fereday J., Pincombe J., Oster C. & Turnbull D. (2010) An evaluation of the satisfaction of midwives' working in midwifery group practice. *Midwifery* 26 (4), 435–441.
- Cummins A.M., Denney-Wilson E. & Homer C.S.E. (2015) The experiences of new graduate midwives working in midwifery continuity of care models in Australia. *Midwifery* 31 (4), 438–444.
- Davies S. & Mason J. (2009) Preceptorship for newly-qualified midwives: time for a change? *British Journal of Midwifery* 17 (12), 804–805.
- Davis D., Foureur M., Clements V., Brodie P. & Herbison P. (2011) The self reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia. *Women and Birth* 25 (3), e1–e10.
- Feng R.F. & Tsai Y.F. (2012) Socialisation of new graduate nurses to practising nurses. *Journal of Clinical Nursing* 21 (13–14), 2064–2071.
- Forster D.A., Newton M., McLachlan H.L. & Willis K. (2011) Exploring implementation and sustainability of models of care: can theory help? *BMC Public Health* 11 (Suppl 5), S8.
- Gray J.E., Leap N., Sheehy A. & Homer C.S.E. (2012) The 'follow-through' experience in three-year Bachelor of Midwifery programs in Australia: A survey of students. *Nurse Education in Practice* 12 (5), 258–263.
- Hartz D.L., White J., Lainchbury K.A. *et al.* (2012) Australian maternity reform through clinical redesign. *Australian Health Review* 36 (2), 6–6.
- Holt A. (2010) Using the telephone for narrative interviewing: a research note. *Qualitative Research* 10 (1), 113–121.
- Hughes A. & Fraser D. (2011) "SINK or SWIM": The experience of newly qualified midwives in England. *Midwifery* 27, 382–386.
- Kensington M. (2006) The faces of mentoring in New Zealand: Realities for the new graduate midwife. *New Zealand College of Midwives Journal* 35 (oct), 22–27.
- Laschinger H.K.S. (2012) 'Job and career satisfaction and turnover intentions of newly graduated nurses. *Journal of Nursing Management* 20 (4), 472–484.
- Lavender T., Edwards G. & Alfirevic Z. (2004) *Demystifying Qualitative Research in Pregnancy and Childbirth*. Quay books MA Healthcare Ltd, Wiltshire.
- Lennox S. & Foureur M. (2012) Developmental mentoring: New graduates' confidence grows when their needs shape the relationship. *New Zealand Communication Journal* 46, 26–31.
- Lennox S., Skinner J. & Foureur M. (2008) Mentorship preceptorship and clinical supervision: Three key processes for supporting midwives. *New Zealand College of Midwives Journal* 39, 7–12.
- Lennox S., Jutel A. & Foureur M. (2012) The concerns of competent novices during a mentoring year. *Nursing Research and Practice* 2012, (2012), Article ID 812542, 9 pages.
- McLachlan H.L., Forster D.A., Davey M.A. *et al.* (2012) Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. *British Journal of Obstetrics and Gynaecology* 119 (12), 1483–1492.
- New South Wales Health (2010) *Maternity - Towards Normal Birth*. N. S. W Ministry of Health, North Sydney.
- Newton M.S., McLachlan H.L., Willis K.F. & Forster D.A. (2014) Are caseload midwives more satisfied and less burnt out than standard care midwives? Findings from two cross-sectional surveys conducted in Victoria Australia. *BMC Pregnancy and Childbirth* 14, 426.
- Numminen O., Ruoppa E., Leino-Kilpi H. *et al.* (2015) Practice environment and its association with professional competence and work-related factors: perception of newly graduated nurses. *Journal of Nursing Management* 23 (8), 963–1146.
- Panettiere M. & Cadman T. (2002) 'Do new graduate midwives need extra support? Are direct-entry midwifery graduates adequately prepared to practise in the hospital environment? A clinical midwifery leader and a nurse educator put the case for an entry-to-practice programme for midwives. (viewpoint) *Kai Tiaki: Nursing New Zealand* 8 (3), 18(12).
- Passant L., Homer C.S.E. & Willis J. (2003) From student to midwife: the experiences of newly graduated midwives working in an innovative model of midwifery care. *Australian Midwifery* 16 (4), 18–21.
- Pineau Stam L.M., Spence Laschinger H.K., Regan S. & Wong C.A. (2015) The influence of personal and workplace resources on new graduate nurses' job satisfaction. *Journal of Nursing Management* 23 (2), 190–199.
- Rayment J., McCourt C., Rance S. & Sandall J. (2015) What makes alongside midwifery-led units work? Lessons from a national research project. *The Practising Midwife* 18 (6), 31–33.
- Rush K.L., Adamack M., Gordon J., Janke R. & Ghement I.R. (2015) Orientation and transition programme component predictors of new graduate workplace integration. *Journal of Nursing Management* 23 (2), 143–155.
- Sandall J., Soltani H., Gates S., Shennan A. & Devane D. (2013) Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* 8 (8), 1365–2834.
- Sandelowski M. (2000) Whatever happened to qualitative description? *Research in Nursing and Health* 23, 334–340.
- Tracy S.K., Hartz D.L., Tracy M.B. *et al.* (2013) Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet* 382 (9906), 1723–1732.
- Ward K., Gott M. & Hoare K. (2015) Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing*, 71 (12), 2775–2785.