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THE LIVED EXPERIENCES OF NEWLY QUALIFIED MIDWIVES' TRANSITION DURING THE FIRST YEAR OF MIDWIFERY PRACTICE IN JAMAICA

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**THE LIVED EXPERIENCES OF NEWLY QUALIFIED MIDWIVES TRANSITION  
DURING THE FIRST YEAR OF MIDWIFERY PRACTICE IN JAMAICA**

**Title: THE LIVED EXPERIENCES OF NEWLY QUALIFIED MIDWIVES'  
TRANSITION DURING THE FIRST YEAR OF MIDWIFERY PRACTICE IN JAMAICA**

By:

Evrette Samuels-Bailey

A thesis submitted to the University of Huddersfield in  
partial fulfilment of the requirements for the degree of  
Master of Philosophy

July 08, 2021

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**Abstract**

**Title:** The lived experiences of newly qualified midwives' transition during the first year of midwifery practice in Jamaica.

**Background:** The transition from a student to a newly qualified midwife is usually loaded with various expectations and responsibilities. In Jamaica, these experiences are further challenged by the migration of senior midwives searching for better opportunities. The result of this is the increased workload and great autonomy with very little support system in place for them. This study sought to explore in-depth, the challenges or opportunities of newly qualified midwives 'successful transition into their midwifery practice.

**Aim:** To provide more in-depth insight and understanding of transitional experiences of newly qualified midwives into midwifery practice in Jamaica throughout their 12 months post-registration period.

**Methodology:** A phenomenological approach, which utilised a purposive sampling design, guided this study's data collection process. The study was conducted using semi-structured interviews at set time intervals: the initial three months, four to six months, and twelve months of practice with eight newly qualified midwives from three hospitals in Jamaica. Data was analysed using the interpretative phenomenology analysis informed by Smith, Flowers and Larkin (2009).

**Findings and discussion:** Five superordinate themes emerged: 'Being a midwife and expectations'; 'Transition shock'; 'Confidence and competence to develop autonomous midwifery practice'; 'Support and a sense of belonging' and 'Theory Practice Gap'. The findings revealed that newly qualified midwives entered the midwifery practice with high expectations and were expected to function autonomously in their employment. However, these were short-lived as transition shock sets in. Throughout the newly qualified midwives' transition into practice, they



experience a period of fear with various challenges. However, over time, their self-confidence and competence improved during their progression. This compelled them to adapt and gradually increased their confidence, becoming more assertive, advocating, and managing high-risk cases autonomously. The findings also revealed that some newly qualified midwives lacked support from the senior midwives. In some instances, this meant they had to rely on their peers; alternatively, they had to learn through socialised practise during their transition period.

The study highlighted how newly qualified midwives successfully consolidated their learning throughout their one-year transition into midwifery practice. The orientation period was also found to be untailored, unstructured, and did not fulfil most participants' needs.

**Conclusion:** There is a need for newly qualified midwives in Jamaica to be supported during their orientation period. Also, a structured orientation and preceptorship programme is needed during their first year of midwifery practice to facilitate their smooth transition into midwifery practice. Future research must determine suitable strategies to enhance the newly qualified midwives' transition into the hospital and community settings.

**Summary of the Project**

**Topic: The lived experiences of newly qualified midwives' transition during the first year of midwifery practice in Jamaica.**

This qualitative interpretative phenomenological study explored the lived experiences of newly qualified midwives' transition to independent midwifery practice in Jamaica. This study addressed the gaps identified in existing literature with the aim to generate a deeper understanding of the meanings and lived experiences of midwifery transition from newly qualified midwives' perspectives during the first year of their midwifery practice post-registration in Jamaica.

The transition from student to a registered practitioner can be a stressful time for all newly qualified midwives, and the reality of applying knowledge to their clinical practice is often challenging, as they are required to work autonomously in their role as midwives (Kitson-Reynolds et al., 2012). Newly qualified midwives' transition into autonomous practice may be hindered by the midwifery education programme they pursue (Fleming et al., 2001). Fleming et al. (2001) found that those midwives qualifying from the shortened programmes showed such a significantly higher skill score than the direct entry midwives in an extended role that the more experienced midwives attributed this to them having worked as nurses before, thus acquiring management experiences on the wards. Additionally, other studies found a knowledge deficit in key competencies among the newly qualified midwives (Avis et al., 2012; Skirton et al., 2012; Davies et al., 2012). Furthermore, the practice environment and the type of available support may also impact their transition experiences (Hobbs, 2012; Kitson-Reynolds et al., 2014). Transition support programmes facilitate staff retention and promote confidence and competence in newly qualified midwives (Dixon et al., 2015; Pairman et al., 2016; Kensington et al., 2016).

The study participants were eight newly qualified direct entry and post-basic midwives who pursued either a certificate or undergraduate degree programme in midwifery education in

Jamaica and were in their first year of midwifery practice, post-registration. The study was conducted in Jamaica at three large hospitals offering care in an acute midwifery setting and the community. The study participants were chosen by purposive sampling (Creswell, 2012). In this phenomenological study, the data collection method involved primarily audio-recorded, in-depth, semi-structured interviews with each participant's consent. Data collection took place in three stages: within the first three months, between four and six months, and at 12 months of the participants' post midwifery practice, in line with Duchscher Transition theory (2008).

The School Research Ethics and Integrity Committee (SREIC) of the University of Huddersfield in England (SREP/2018/059) and the South East Regional Health Authority in Jamaica granted ethical approval for the study. The Chief Executive Officers of all the three hospitals included in the study gave written permission to conduct the research.

Smith et al.'s (2009) Interpretative Phenomenology Analysis guided the process of data analysis. Analysis of the data collection identified thematic content: 'Being a midwife and expectations'; 'Transition shock'; 'Confidence and competence develop autonomous midwifery practice'; 'Support and a sense of belonging' and 'Theory Practice Gap'. The thematic analysis revealed that newly qualified midwives reported encountering challenges in the initial three months of their midwifery practice and perceived an improvement in their self-confidence as they progressed in their first year of practice.

The study's findings revealed that the orientation programme was inadequate and unstructured, it was not tailor-made to suit the newly qualified midwives' individual learning needs, and this sometimes resulted in midwives resorting to socialised learning. The staff shortage impacted the orientation process, with few senior midwives available to provide practice support to the newly qualified midwives. The staff shortage also impacted the community rotation because

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the midwives were unable to do their mandatory community placement. Future research is necessary to examine strategies that could be adapted to enhance midwives' rotation in the community. Another area that would necessitate research, is to explore the practice competence of the degree trained midwives compared to the certificate trained midwives in Jamaica. This study's findings are useful to midwifery educators, training and healthcare institutions in Jamaica and, possibly other settings globally.

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## **CHAPTER 1: INTRODUCTION**

### **Introduction**

#### **Background**

This study is set in the context of newly qualified midwives' experiences of transition in Jamaica. Chick and Meleis define transition as the "passage from one life phase, condition or status to another, embracing the elements of process, time span and perception" (1986, p. 239). Transition usually occurs as a process with different stages and distinguishing characteristics for each stage (Al-Yateem & Docherty, 2015).

These are challenging times for newly qualified midwives. The transition from student to registered practitioner can be a stressful time for all newly qualified healthcare staff, and the reality of applying knowledge into their clinical practice is often challenging. Newly qualified midwives experience challenges, as, on qualifying, they are required to work autonomously in their roles as midwives (Kitson-Reynolds, Cluett & Le-May, 2014). Additionally, the newly qualified midwife offers support to the woman and her family during the antenatal and postnatal periods, up to 28 days (MIDIRS, 2018). However, given such responsibilities as an autonomous practitioner, the newly qualified midwife may experience difficulties during this transition period. As per anecdotal evidence, a further challenge in Jamaica is that, due to the staff shortages, newly qualified midwives have an increased workload and are responsible for managing wards and making independent decisions on qualifying. However, given such responsibilities as an autonomous practitioner, the newly qualified midwife may experience challenges during their transition, such as "reality shock" due to anxiety and their lack of self-confidence, as theorised by Marlene Kramer (1974). Marlene Kramer defined reality shock as the reaction newly qualified nurses have when they find themselves in work situations that they have spent several years preparing for and find that they are unprepared to deal with the

problem when it arises (1974). Boychuk Duchscher has recently expanded Kramer's conceptualization of reality shock (2007). According to Darvill et al. (2014), Duchscher (2007) described how a new graduate entering a professional practice role is presented with a wide range of emotional, physical, intellectual, developmental, and socio-cultural changes that are expressions of, and mitigating variables within, the transition experience. Whilst Kramer's (1974) and Duchscher's (2007) studies refer to nurses, there is evidence that newly qualified midwives also experience reality shock. Studies performed in the United Kingdom by Kitson-Reynolds et al. (2014) and Skirton et al. (2012) report that newly qualified midwives experienced reality shock. Kitson-Reynolds et al. (2014) revealed that newly qualified midwives' initial expectations and their ideals of a midwife's ideological role, their expected work, and their relationships with others did not equate to their initial expectations. Furthermore, Skirton et al. (2012) found that the newly qualified midwives' lack of self-confidence was due to their unrealistic expectations of how they would practice upon qualification. Newly qualified midwives' ability to successfully transition from student status to registered practitioner has implications for both the midwifery profession and the maternity health service in Jamaica. Clements, Davis and Fenwick's (2013) study suggests that supportive transition can positively help with the retention of staff, and the Royal College of Midwives (RCM) (2016) revealed that insufficient support was one of the main reasons newly qualified midwives decided to leave the profession in the UK. In Jamaica, there is a grave shortage of midwives due to migration, poor working conditions, and being 'burnt out' (Murphy et al., 2016). The shortage of midwives in Jamaica was identified in the United Population Fund's (UNFPA) 2017 report as one of the significant challenges impacting Jamaica's maternal health. Moreover, in some hospitals in Jamaica, the number of midwives on staff is under 50% of the Ministry of Health's recommended staffing requirement (Verbal Personal Communication with hospital Matron, 2017). Anecdotal evidence shows that, due to

the staff shortages, newly qualified midwives have an increased workload, are being assigned to in-charge positions, and are responsible for managing and coordinating ward activities and making independent decisions. It is supposed that staff shortages have caused burnout among some of the newly qualified midwives, which causes them to migrate to different countries in their quest to achieve a smooth transition into their midwifery practice. For newly qualified midwives in Jamaica, because they enter an environment where there is a staff shortage, essential support may not be available during their transition. Clements, Davis, and Fenwick (2013) suggest that supportive transition can positively help with staff retention. The ability of newly qualified midwives to efficaciously move from student status to enrolled practitioners can impact the midwifery professions and maternity health services.

### **Jamaican Context**

In Jamaica, maternity services are offered to pregnant women at 18 public and six private hospitals, in addition to 320 health centres; midwives are employed within these facilities (Graham, 2014). In Jamaica, women receive, on average, four to five antenatal visits during pregnancy as per the World Health Organisation recommendations (Graham, 2014). Most births are undertaken in the hospital rather than in the community and are attended by personnel trained to give appropriate care to women during the antenatal, intrapartum and postnatal period (World Bank, 2018) such as obstetricians and midwives. The annual birth rate in Jamaica in 2017 was 17.9 births per 1,000 people (IndexMundi, 2018), while in Australia, New Zealand, and the United Kingdom, it was 12.1, 13.2 and 12.1 births per 1,000, respectively. Additionally, the 2015 perinatal and maternal mortality rates in Jamaica were higher than in the UK: Jamaica's maternal mortality rate was 89 per 100,000 live births, while in the UK, it was 9 per 100,000 live births, 6 per 100,000 live births in Australia and 11 per 100,000 live births in New Zealand (IndexMundi, 2018). In Jamaica, newly qualified midwives engage in



formal transition support referred to as orientation. Orientation includes a support programme at the start of their employment in the healthcare setting. The orientation period varies and is dependent upon the hospital and the midwife's level of training. For example, newly qualified midwives who have completed the direct entry midwifery education programme (trained solely as a midwife) are required to be placed in a mandatory 'internship programme' which requires newly qualified midwives to have nine initial months of hospital orientation followed by three months of mandatory community orientation as per the Ministry of Health (MOH) (2005) directives. Conversely, for first-level nurses who have previously practised as registered nurses and completed the post-basic midwifery education programme, having acquired more clinical experiences, the orientation period could be one to three months, as determined by their employing institution (Verbal Personal Communication with hospital matron, 2017). However, staff shortages in Jamaica have reduced this level of support and reduced the transition period for newly qualified midwives. Some midwives are not being allowed the stipulated transition period of three months for their community orientation as specified by the Ministry of Health (MOH) (2005).

Seminal work by Kramer (1974) recommended transition to practice programmes for newly qualified staff globally. More recently, countries such as Australia, New Zealand and the United Kingdom have been adapting transition support programmes to ease their newly qualified staff into practice. Given the issues identified in this chapter in the variation in the duration of orientation in hospitals amongst newly qualified midwives in Jamaica, newly qualified midwives assuming the responsibility of maternity wards at times by themselves, and no orientation in the community setting, it is necessary to explore these issues further. However, what is unknown in Jamaica is the effectiveness and impact of the orientation programmes on newly qualified midwives' transition into midwifery practice which my study aims to address. Transition support programmes are structured programmes designed to

support newly registered midwives and nurses' transition from students to registered professionals (Clements et al., 2013). The duration of the transition support programme can vary from three months to one year. Most include various learning strategies, such as educational sessions, clinical rotations, and the provision of mentoring or debriefing opportunities (Clements et al., 2013).

### **Midwifery Training International Overview**

According to the International Confederation of Midwives (ICM) (2018), a well-trained and supported midwife can make the difference between life and death. Given this, the training of midwives internationally is essential to reduce maternal and foetal mortality and morbidity rates among pregnant women. Midwives must be registered with a Nursing and Midwifery Council before they can practice autonomously (Skirton et al., 2012). However, midwifery education varies in many countries, with the programmes being taught mainly by trained midwife lecturers and other staff from other disciplines, such as nursing, pharmacology, sociology and psychology (Skirton et al., 2012). In the United Kingdom, midwifery pre-registration education consists of two routes: the shortened programme (18 months) and a three-year course. The midwifery education programme is offered at the undergraduate and postgraduate level. The shortened or post basic programme is offered to individuals who were trained as registered nurses before undertaking their midwifery training.

The three-year or direct entry programme is provided to individuals not trained previously as nurses who want to be trained as midwives only (NMC, 2015). However, only a few of the shortened midwifery education programme courses exist. Furthermore, it is considered expensive and unnecessary to have a nursing qualification to be a midwife. In the UK, the Nursing and Midwifery Council requires newly qualified midwives to meet pre-registration education competency standards (NMC, 2015). Similarly, in Australia, becoming

a midwife requires an individual to undertake and complete a Bachelor of Midwifery or individuals with a Bachelor of Nursing degree may complete a Graduate Diploma or Master of Midwifery. The duration of these programmes is 12-24 months (ACM, 2021). In the United States of America, to become a certified nurse-midwife prospective applicants need to enrol on a two-year associate degree or four-year bachelor's programme in nursing. Following the nursing education programme's completion, the prospective applicant would need to acquire one year of nursing practice before pursuing the midwifery course in the USA (Nurse Practitioners School, 2014-2018).

### **Midwifery Training Jamaica Context**

In Jamaica, midwifery training is currently available at Bachelor of Science and Certificate levels. Both programmes accept entrants as direct entry or post-basic. The direct-entry midwifery programme accepts entrants who are not trained Registered Nurses and who possess the standard entry requirements. In contrast, the post-basic midwifery programme is only available to Registered Nurses. The study duration for a Bachelor of Science in Midwifery (BSc Midwifery) is four years for the direct entrants and two years for post-basic students and has been offered at only one university in Jamaica since 2014. The first cohort graduated in November 2018. Conversely, the Certificate in Midwifery programme is delivered through the Government's Ministry of Health; it offers midwifery training to post-basic entrants for one year, and two years for direct-entry entrants. Student midwives are assessed in practice, and assessment is ongoing. Upon completing the BSc Midwifery and Certificate in Midwifery programmes, students must pass a final practical examination and sit the national midwifery written exam. On passing the practical and written exams, it is a requirement that the successful students register with the Nursing and Midwifery Council in Jamaica.

## **1.2 Rationale for the Study**

The reason for my interest in this area of study is related to my own experience of being a midwife, a preceptor, and of supporting newly qualified midwives as a link lecturer for student nurses undertaking their obstetric placement. I was also concerned that if there are staff shortage issues, newly qualified midwives may not receive the extra support they need, and therefore, they may feel unprepared for autonomous practice. The transition of newly qualified midwives is a topic that has not been studied in Jamaica. A research study that explores transition can uncover the related issues so that ways to improve it can be found, which may lead to a smoother transition for midwives into professional practice and enhanced retention.

## **Purpose of the Study**

The purpose of the study is to provide more in-depth insight and understanding of transitional experiences of newly qualified midwives into midwifery practice throughout their 12 months post-registration in Jamaica. This study's findings would be useful to midwifery educators, training, and healthcare institutions in Jamaica, and possibly other settings globally.

## **Theoretical Framework**

The study was guided by Judy Duchscher's (2007) *Transition Shock Model and Stages of Transition Theory*. Judy Duchscher's (2007) *Transition Shock Model and Stages of Transition Theory* provides descriptions and explanations of the transition process, including insights as to how individuals transition into their new roles and situations, and identify factors that inhibit or enhance their transition to provide strategies to facilitate an individual's smooth transition. Thus, providing the theoretical framework for this study.

stage

## **Introduction**

This chapter examines the existing literature regarding newly qualified midwives' transition to midwifery practice guided by transition theory. A systematic literature review was undertaken to identify, select, and critically evaluate the research studies related to the transition to practice (Rother, 2007). This type of review allowed me to undertake an exhaustive review of all the existing research; alleviated selection bias due to the rigour with which the literature was chosen (Temple University, 2018); helped to establish what is known already about the research topic, and informs the study's aims and objectives (CSU, 2018).

## **Search Strategy**

### ***The PEO Model for Developing the Search Question***

The PEO model, a question format tool for developing the search question during the research process (see Appendix 1) (University of Dundee, 2018) was utilised in this study. I used the PEO model to manage and break down the study's research questions, as it allows the identification of the key concepts in the research question pertinent to Population, Exposure and Outcomes (VCU, 2020). The PEO model also helps the researcher to develop appropriate search terms to describe these factors and determine the research's inclusion. The research question developed for this study was, 'What are the experiences of newly qualified midwives in their transition to midwifery practice in Jamaica in their first-year post registration?'

### ***Literature Search Strategies***

A thorough online search was undertaken, including: the Cochrane Library, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Applied Social Sciences Index and Abstracts (ASSIA), PUBMED, the National Library of Medicine (MEDLINE) via EBSCOhost, the Electronic Theses Online Service (EThOS), ProQuest, and the Education Resources Information Centre (ERIC). These databases were chosen as they are used by health professionals and cover relevant areas in the social sciences. Additionally, these databases have a peer review or scholarly filter, which is important because they offer advanced search features that helped focus the search and ensure reliable and authoritative information (The University of Queensland, 2018).

Keywords and their synonyms were created and used interchangeably to search these databases (see Appendix 2). A combination of the search terms was used, using Boolean operators such as “AND”, “OR”, and “NOT”. Boolean operators helped narrow or widened the search (Booth, Rees & Beecroft, 2015) to generate a wide range of studies relevant to the search question. Wildcards were used (e.g. newly qualified midwi\$e), as was truncation, that is, the shortening of words (e.g. newly qualified midwif\*). Using wildcards and truncation, which are advanced search techniques, maximises the researchers’ search results in library databases. The literature search was conducted from January to March 2018, updated between July and September 2018, and a further update was completed in December 2020.

I completed a manual search of the reference list of articles retrieved from the databases search. I read these articles' abstracts and selected only the articles relevant to the research topic, as Booth et al. (2015) recommended. Manual searching was useful as it allowed me to find poorly or incorrectly indexed or unindexed articles. It also allowed me to manually scan the reference list of journals for additional studies pertinent to the topic being investigated (Rutgers, 2018).

### **Screening and Study Selection**

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## *Eligibility Criteria*

Inclusion and exclusion criteria were applied in the selection and review of the studies (see Appendix 3) to keep the research question focussed and prevent bias in selecting the studies to be used in the proposed research; and the pre-defined criteria for choosing the studies prevented selection bias (Booth et al., 2015).

There was no date restriction applied. This was to ensure that seminal work done previously on the phenomenon being studied was not missed. The inclusion of both qualitative and quantitative studies was likely to yield an in-depth insight into the participants' experiences. The search was limited to research pertaining to new midwives in their first year of practice only to ensure focus and the exploration of the phenomenon being studied among the target population only. Only studies written in the English Language were used to prevent loss in translation. Research papers that did not meet the criteria were rejected.

## **Data Extraction**

For my data extraction and quality appraisal processes, a data extraction sheet was created for this study. This document consisted of the 21 included studies and presented information pertinent to the study's methodological approach, the population being investigated, and the study's findings as recommended by Lorenc et al. (2014) (see Appendix 4).

## **Overview of Results**

### *Study Characteristics*

The flow chart (see Appendix 5 for PRISMA Chart) provides an overview of the 21 articles that met the inclusion criteria and were selected for use in the literature review. After removing duplicates, a total of 1024 citations were screened. Following a review of the titles and abstracts, 996 were excluded as they did not meet the inclusion criteria. The full-text of the remaining 28 articles was examined in greater detail, and seven studies were excluded as they

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did not meet the study's inclusion criteria. In total, 21 studies met the inclusion criteria of this study. The studies included in the review were conducted in Australia, England, New Zealand, Ireland and Scotland: eight studies were conducted in Australia Cummins, Cummins et al. (2017); Denney-Wilson & Homer (2015); Barry et al. (2013); Clements, Davis & Fenwick (2013); Clements (2012); Clement, Fenwick & Davis (2012); (Davis, Foureur, Clements, Brodie & Herbison (2012); Fenwick et al. (2012); six in England Foster & Ashwin (2014); Wain (2017), Mason & Davies (2013); Hobbs (2012); Kitson, Reynolds, Cluett & Le-May (2012); (Hughes & Fraser (2011); two in the UK (UK: England, Scotland, Wales, and Ireland) Avis, Malik & Fraser (2013), (Skirton, Stephen, Doris, Cooper, Avis & Fraser, (2012); three in New Zealand Pairman et al. (2016), Kensington et al. (2016), Dixon et al., (2015); one in Ireland (van der Putten, 2008), and one in Scotland (Fleming, Poat, Curzio, Douglas & Cheyne, 2001).

### **Analysis**

#### ***Assessment of Methodological Quality***

Over 80% of the included studies were of qualitative design. The reviewed papers' methodological quality was assessed using a tool developed by Hawker et al. (2002) and a grading scale adapted by Lorenc et al. (2014). I used Hawker et al.'s (2002) quality assessment tool because it allowed me to assess the quality of studies with varied designs that met my study's inclusion criteria.

The appraisal tool used by Hawker et al. (2002) (see Appendix 6) consists of nine questions under the following headings: abstract and title, introduction and aims, methods and data, sampling, data analysis, ethics, bias, findings, generalisability /transferability, implications, and usefulness. This tool allowed for the nine areas of an article to be assessed out of four such as 'good' (four points), 'fair' (three points), 'poor' (two points) or 'very poor' (one point) as stated by Braithwaite et al. (2017, p.5).). However, because Hawker et al. (2002)



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did not provide a scale to classify the total quality rating of each article, like Braithwaite et al. (2017), I used the grading scale developed by Lorenc et al. (2014) using the following definitions: high quality (A), 30–36 points; medium quality (B), 24–29 points; low quality (C), 9–24 points to obtain an overall quality grade for each of my studies.

Although only three studies were of high quality, thirteen were of medium quality, and five were of low quality. No study was excluded based on their quality score; instead, they were used in the review. See Appendix 7 for the studies with their score based on the quality assessment results for the quantitative and qualitative studies. There is no test available to exclude qualitative studies based on their quality (Thomas & Harden, 2008; Rolfe, 2006). Carroll, Booth and Lloyd-Jones' (2012) study proposes that there is a possibility of researchers excluding studies from qualitative evidence synthesis if the studies are inadequately reported. Consequently, I decided to include studies that were aligned with my study's aims and objectives.

### **Critical Appraisal**

Initially, I used the Critical Appraisal Skills Programme (CASP) (2018) tool, and the Joanna Briggs Institute (JBI) (2017) tool, to assess the methodological qualities of some of my studies. I used the CASP tool to evaluate some of my qualitative studies and I employed the JBI tool to evaluate one cohort study (Dixon et al., 2015). The CASP tool for evaluating qualitative studies consisted of 10 questions that focused on the methodological areas of qualitative studies, such as its validity, relevance, and results. Similarly, the JBI tool facilitated the evaluation of the methodological quality of a study while addressing the areas of bias in its design, conduct and analysis (JBI, 2017). However, the CASP and the JBI assessment tools did not provide a grading system to quantify and measure the quality of the reviewed papers. I subsequently performed a critical analysis and evaluation of all the papers selected using the Hawker et al. (2002) appraisal tool instead. I chose Hawker et al.'s (2002) appraisal tool in my

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study because it enabled me to quantify and measure the quality of the reviewed papers, which had varied study designs, both quantitative and qualitative (Alreshidi, Long & Darvill, 2017). Furthermore, Hawker et al.'s (2002) tool is simple; it provides me with an overall assessment of the quality of the studies irrespective of the study design as purported by (Green et al., 2014). Undertaking a Quality Appraisal (QA) of the included studies ensured transparency. Of the 21 studies, overall, the methodological quality of three studies scored as high quality (Wain (2017), Fenwick et al. (2012), and Fleming et al. (2001), while 13 scoring as medium quality (Davis et al. (2018), Pairman et al. (2016), Kensington et al. (2016), Cummins et al. (2015), Dixon et al. (2015), Kitson-Reynolds et al. (2014), Avis et al. (2013), Clements (2012), Clements et al. (2012), Skirton et al. (2012), Hugh & Fraser (2011), Hobbs (2008), and Van der Putten (2008). However, five studies scored at low quality (Cummins et al. (2017), Foster & Ashwin (2014), Barry et al. (2013), Clements et al. (2013), and Mason & Davies (2013). The 21 studies used in the review were categorised using the PRISMA data extraction form. The data extraction form (see page 181) was helpful as I used it to provide a summary table of study characteristics essential for inclusion in this study (Levett, 2021).

In an example of having completed a critical appraisal of Deidre Van der Putten's (2008) study, I found she used Coliazzi's (1978) data analysis method, which did not seem aligned with the study's interpretative phenomenology research methodology. According to Wirihanna et al. (2018), Coliazzi's analysis method is useful to researchers using a descriptive phenomenological approach because it helps them understand people's experiences reliably. However, Van der Putten (2008) justifies the use of Coliazzi's method of analysis in her interpretative phenomenological study as suitable, as it offers a seven-stage analysis process that is logical and credible. Yet, Morrow, Rodriguez and King (2015) argue that Coliazzi's (1978) method of data analysis is more suitable for studies undertaking a descriptive phenomenological methodology in which participants give a descriptive account of their

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experience of a phenomenon rather than an interpretation of their experience. Consequently, I appraised Van der Putten' research of moderate quality and chose to draw upon this study's findings because the study established rigor and trustworthiness.

### **Identification of Key Themes**

A thematic review of the papers was completed. The thematic analysis involves the researcher organising, labelling, and grouping related data into themes (Freshwater & Holloway, 2015). Hence, initially, each study's aims, and objectives were compared and their findings were categorised into themes; studies with similar themes were placed together under the same headings and their findings compared. A synthesis of the review study's findings was represented in tabular form.

### **Overarching Themes**

Three themes emerged from the review. Theme one I entitled 'preparedness for practice'. Theme two, 'confidence and competence', had four sub-themes: 'type of midwifery education undertaken before qualification', 'expectations of self and others' expectations', 'pressures of accountability/responsibility of being a registered health professional', and 'environment and confidence to practice'. Theme three, 'support during transition', had two subthemes: 'support programmes and retention' and 'cultural support and environment'.

#### ***Theme One: Preparedness for Practice***

Theme one, 'preparedness for practice', emerged from five studies in the review: Kitson-Reynolds et al. (2014) (England); Avis et al. (2013) (England/other countries in the UK); Davis et al. (2012) (Australia); Skirton et al. (2012) (UK: England, Scotland, Wales, and Ireland) and Van der Putten (2008) (Ireland).

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The lack of preparation to practice seems to originate from midwifery education where knowledge deficits in key competencies were identified. Newly qualified midwives reported perceived knowledge deficits in their ability to practice competently and confidently in certain aspects of their practice, which was associated with their preparation to practice. This includes assessing, planning, and implementing safe and effective care to high-risk mothers and their babies.

Newly qualified midwives in Skirton et al.'s (2012) study reported having a knowledge deficit in core competencies such as medication administration. The midwives were unable to interpret the prescription chart when administering medication to their clients, prioritise care, prepare women for caesarean sections, manage women having an induction of labour, perform vaginal examinations, and interpret cardiotocographic (CTG) recordings. Avis et al.'s (2013) study reported similar findings among the newly qualified midwives in their study. The newly qualified midwives reported that although they passed their course, they perceived their deficient knowledge in core competencies was due to their mentors' failure to provide exposure and learning opportunities in clinical practice during their undergraduate programmes. They reported that their mentors prevented them from assisting in planning care and managing high-risk cases while they were student midwives. Preventing student midwives from participating in high-risk cases under supervision is contrary to the NMC (2009). The Nursing and Midwifery Council's (NMC) standards for pre-registration midwifery education (2015) recommends that student midwives utilise critical thinking when caring for women and babies; If they recognise that the normal processes are, in any way compromised, they should refer the women or babies immediately to mitigate adverse effects.

Similarly, the newly qualified midwives in Kitson-Reynolds et al. (2014) reported that their midwifery training did not prepare them for the reality of clinical practice and that nothing could prepare them for the realities. The midwives who had been qualified for six months in

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Van der Putten's (2008) study thought that more clinical practice experience would have enhanced their confidence for practice as qualified midwives. The NMC (2009) expectation is that midwives can care for low-risk women alone and high-risk women with support at the point of registration. However, Kitson-Reynolds et al. (2014) reported that midwives beginning their transition from student to midwife did not get an opportunity to consolidate their skills in the community due to them being called into the hospital to cover staff shortages. Being removed from the community setting eroded the midwives' self-confidence "and diminished their ability to consolidate their knowledge and skills in one particular area before moving to another" (Kitson-Reynolds et al., 2014, p. 665).

The type of midwifery education training also impacted the newly qualified midwives' preparation to practice. Davis et al.'s (2012) Australian study compared the post-basic, one-year, postgraduate (PG) programs for registered nurses, such as a Graduate Diploma or Masters degree, and the direct entry programme, which is a three-year, Bachelor of Midwifery undergraduate (UG) degree programme for midwives who did not have an initial qualification as a nurse. Findings were similar to Avis et al.'s (2013) study, which was conducted in the UK. Avis et al. (2013) claimed that newly qualified midwives who had previously trained as nurses may have an advantage, as they may already have gained confidence in practice and acquired transferrable skills and experience, unlike those midwifery students who did not have experience as nurses. However, Davis et al. (2012) found newly qualified midwives did not feel confident in their practice due to being unable to care for high-risk women and their babies.

From the review, various factors that impacted the newly qualified midwives' preparedness for practice were identified, such as a lack of knowledge in key midwifery skills due to their mentors not allowing them to care for clients with complications under their supervision. In addition, the type of midwifery programme undertaken by the newly qualified midwives was another issue identified.

***Theme Two: Confidence and Competence***

Theme two, 'confidence and competence' emerged from thirteen studies in the review: Cummins et al. (2017) (Australia) and Wain (2017) (England); Pairman et al. (2016) (New Zealand); Kitson-Reynolds et al. (2014) (England); Avis et al. (2013) (England/other countries in the UK); Barry et al. (2013) (Australia); Mason & Davies (2013) (England); Davis et al. (2012) (Australia); Fenwick et al. (2012) (Australia); Hobbs (2012) (England); Skirton et al. (2012) (England/other countries in the UK); Van der Putten (2008) (Ireland); Fleming et al. (2001) (Scotland).

The lack of confidence among newly qualified midwives may occur when they have not yet developed the confidence or expertise to advocate for the women in their care. However, Van der Putten (2008) found that the newly qualified Irish midwives in their study advocated for the women in their care to achieve their birth plans, despite the dominance of the medical model of care that was restrictive regarding maternal choice. This advocacy occurred because the newly qualified midwives felt reassured by other midwives in the department, who shared the philosophy of woman-centred care by facilitating the women's birth plans wherever possible. In Hobbs (2012), the newly qualified midwives' submissiveness toward the more experienced midwives' 'old school' midwifery practices was a consequence of their uncertainty in their new roles as midwives. However, during the newly qualified midwives' progression in their first year of practice, they began to challenge midwifery practices that they disagreed with (Hobbs, 2012).

This theme contains the four subthemes that impacted the newly qualified midwives' confidence and competence to practice autonomously: 'type of midwifery education newly qualified midwives undertake before qualification' (Davis et al. (2012), Skirton et al. (2012), and Fleming et al. (2001); 'expectations of self and others' expectations' (Kitson-Reynolds et

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al. (2014) and Van der Putten (2008); ‘pressures of accountability/responsibility of being a registered health professional’ (Wain (2017), Clements (2012), and Hobbs (2012), and ‘environment and confidence to practice’(Cummins et al. (2017), Kitson-Reynolds et al. (2014), Avis et al. (2013), Barry et al. (2013), Fenwick et al. (2012), Skirton et al. (2012), and Van der Putten (2008).

### Type of Midwifery Education Undertaken Before Qualification

Four studies emerged as relevant to the subtheme of ‘type of midwifery education undertaken before qualification’: Kitson-Reynolds et al. (2014), Davis et al. (2012), Fleming et al. (2001), and Skirton et al. (2012). Midwifery education is offered at undergraduate and postgraduate levels to both nurses and non-nurses who aspire to be midwives (Skirton et al., 2012). The direct entry programme is for non-nurses, and the post-basic midwifery education programme is for previously trained registered nurses. The review found that the duration of a study programme may impact newly qualified midwives’ confidence and competence to practice autonomously upon their registration. Three studies, (Davis et al. (2012), Skirton et al. (2012), and Fleming et al. (2001), compared the two entry programmes in midwifery education: direct entry (three years) and post-basic (18 months). Fleming et al.’s. (2001) surveys, of 157 midwives at the point of their registration and 166 supervisors of midwives in Scotland, compared and contrasted midwives’ competencies with direct entry and post-basic qualifications. Fleming et al. (2001) found that, regardless of the newly qualified midwives’ midwifery education, they provided safe and competent care to women and their babies at low risk of complication. Similar findings were reported in a smaller survey by Davis et al. (2012) in Australia, which examined 80 newly qualified midwives’ confidence in 14 Competency Standards for the Midwife. Davis et al.’s (2012) study found that there was no difference in direct entry and post-basic midwives’ management of high-risk maternity situations, because

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both groups scored well on their confidence in undertaking core midwifery competencies in their decision and implementation skills in the management of high-risk cases at the start of their practice, and 12 months later.

Skirton et al.'s (2012) qualitative study was less extensive than Davis et al.'s (2012) and Fleming et al.'s (2001) studies because it had fewer participants but shared similar findings. Skirton et al.'s (2012) study consisted of 28 graduate midwives of the three-year programme and seven midwives that pursued the shortened programmes. There was no difference in the competence of midwives who pursued either programme. Additionally, Skirton et al. (2012) reasoned that both categories of midwives from the long and short programmes had the necessary competence to manage their patients within the scope of their midwifery practice.

However, in Skirton et al.'s (2012) study, the more experienced midwives perceived the newly qualified midwives, who were direct-entry midwives, as less competent than the post-basic midwives, because the direct entry midwives did not have any previous experience in nursing or working in a hospital setting. Nevertheless, Fleming et al.'s (2001), Davis et al.'s (2012) and Skirton et al.'s (2012) studies revealed direct entry and post-basic midwives at the undergraduate level both provided safe care to low-risk women. Furthermore, the more experienced midwives and the supervisors of midwives in Fleming et al. (2001) felt that all newly qualified midwives had the competence to provide care for low-risk women, irrespective of their midwifery education programme. Likewise, the newly qualified midwives in the reviewed studies did not report any feelings of incompetence related to the midwifery education programme they pursued as students.

It is the NMC's (2009), the MCNZ's (2014) and the NMBA's (2018) expectation that all midwives, irrespective of the midwifery education programme (direct entry or post-basic qualifications), should be competent to care for low-risk women due to the rigorous training that both groups undertake in their midwifery education. Although the Nurses and Midwives



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Act of Jamaica (2005) did not explicitly provide any information regarding the required competency of newly qualified midwives upon qualification, the Act states that “any person who is qualified under this Act to be registered as a nurse or a midwife may apply to the Registrar for registration” (p.6.01). The review found no differences in the level of competence of newly qualified midwives who pursued either the undergraduate or postgraduate midwifery education programmes.

### Expectations of Self and Others’ Expectations

Three studies were identified from the review in which the subtheme ‘expectations of self and others’ expectations’ emerged (Kitson-Reynolds et al. (2014) (England), Hobbs (2012) (England), and Van der Putten (2008) (Ireland). These three studies found that newly qualified midwives, on qualifying, have expectations of the type of midwife they would like to be and are eager to display their knowledge and skills in the practice area. Thus, newly qualified midwives enter the profession with a great deal of enthusiasm and expectations of the type of midwife they want to be (Hobbs, 2012). Similarly, the newly qualified midwives in Kitson-Reynolds et al. (2014) experienced “reality shock”<sup>1</sup> (Kramer, 1978; Kitson-Reynolds et al., 2014), in that “they experienced the reality of midwifery (the fact) rather than their idealised fiction” (Kitson-Reynolds et al., 2014, p. 664). Based on their reports that, on practicing midwifery, the newly qualified midwives found it was a lot harder than they had expected, that they did not realise how difficult it would be, and their experience had been negative. However, transitioning from student status to registered practitioner may be daunting and stressful for the newly qualified midwives. Consequently, these feelings of stress encountered by the newly qualified midwives were compounded by the reality of what was expected of them from more experienced midwives and the women they care for, such as caring for high-risk cases without

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<sup>1</sup> The term ‘Reality Shock’ is discussed in greater detail on pages 45-46 of this study.

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support (Hobbs, 2012). In Kitson-Reynolds et al. (2014), newly qualified midwives reported that they expected to do more or better than would usually be expected of them by taking on extra work to prove to the other midwives that they were not lazy. However, Van der Putten (2008) and Kitson-Reynolds et al. (2014) identified “others’” expectations as a causative factor that influenced newly qualified midwives’ confidence and competence to practice autonomously, because the more experienced midwives expected too much from them.

The newly qualified midwives in the UK in Kitson-Reynolds et al.’s (2014) study revealed that the more experienced midwives on the labour ward had high expectations. The senior midwives expected the newly qualified midwives to mentor students and manage clients with complex cases. Within the first week of qualification, the newly qualified midwives were expected to manage high-risk wards with 25 to 30 women and their babies. These high expectations from others caused an increase in anxiety and stress among the newly qualified midwives, which affected their confidence to practice autonomously and prevented their ability to consolidate their knowledge and skills in one area before moving to another (Kitson-Reynolds et al., 2014). Similarly, in Hobbs’ (2012) study, some of the more experienced midwives expected newly qualified midwives to take on roles and responsibilities out of their scope and competence, such as taking over the management of wards as they did when they were newly qualified. However, Hobbs (2012) concluded that the newly qualified midwives were aware of the tension that exists between contemporary midwifery practice and ‘old school’<sup>i</sup> midwifery practice, wherein the more experienced midwives held on to their old school midwifery practices. Newly qualified midwives in Hobbs (2012) reported performing artificial rupture of membranes (ARM) on women the minute they are ARMable rather than allowing the women to progress normally without interfering in the labour process. Newly qualified midwives preferred to base their midwifery practice on the normalcy of childbirth as

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promoted during their midwifery training at the university, not to ARM a woman without reason (Hobbs, 2012).

Nonetheless, this may be unfair as some of the newly qualified midwives may not have been able to work autonomously and may also need to be supported themselves. Moreover, the NMC in England and other countries such as NMBA in Australia recommend newly qualified midwives receive support during their transition to practice (NMC, 2015; NMBA, 2018).

Van der Putten's (2008) study of newly qualified midwives in Ireland reported that the women they cared for had implicit trust in them and high expectations of receiving perfect care. They also expected newly qualified midwives to provide them with one-to-one care with breastfeeding on busy postnatal wards (Van der Putten, 2008). Similarly, the newly qualified midwives in Hobbs (2012) contended that the women they cared for also expected woman-centred care. According to the Nursing and Midwifery Board of Australia's (NMBA) (2018) Midwives Standards for practice, woman-centred care considers women's circumstances. It aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. The Nursing and Midwifery Board of Australia also contends:

Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices.

Woman-centred care is the focus of midwifery practice in all settings

(NMBA, 2018).

When the women's expectations were not met, the newly qualified midwives reported feelings of frustration, stress, and anxiety; they could not live up to the women's expectation of receiving one-to-one care and did not have the time to give this type of care due to staff shortage.

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### Pressures of Accountability/ Responsibility of being a Registered Health Professional

The subtheme ‘pressures of accountability/ responsibility of being a registered health professional’ emerged in five studies from the review (Wain (2017) (England), Kitson-Reynolds, et al. (2014) (England), Clements (2012), Hobbs (2012) (England), and Van der Putten (2008) (Ireland). On registration, newly qualified midwives were accountable and responsible for providing safe care to the women in their care and must abide by their institution's policies and guidelines in their administering of care. They are also responsible for decision making. However, a lack of confidence may result in newly qualified midwives' inability to adapt to their new responsibilities, as reported in Wain's (2017) study in England. In Wain's (2017) study, newly qualified midwives expressed their trepidation regarding their new-found responsibility and accountability. As students, the newly qualified midwives were mentored and worked under their mentors' Personal Identification Number (PIN). Upon registration, the newly qualified midwives became directly accountable for caregiving, without the safety of their mentors' overall accountability. Fear of accountability ultimately affects newly qualified midwives' confidence and competence to practice autonomously (Zolkefli, Mumin, & Idris, 2020). The newly qualified midwives in Clements' (2012) study were also stressed and scared of being made accountable for their actions or the decisions made as qualified and practising midwives. Newly qualified midwives in Van der Putten (2008) also reported experiencing heightened stress due to their newly increased levels of responsibility and accountability, knowing that they were signing theirs and their students' discharges. If something goes wrong, they will be liable. This fear and lack of self-confidence, in turn, causes an increase in anxiety in newly qualified midwives and threatens their ability to cope (Fenwick et al., 2012).

The newly qualified midwives in Kitson-Reynolds et al.'s (2014) study felt devoid of autonomy and responsibility during their progression into their first year of midwifery practice.

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They experienced high anxiety levels due to their self-doubt and perceived lack of confidence. Kitson Reynolds et al. (2014) found that the participants of their study lacked autonomy as their decisions were not valued but were predominantly influenced by the delivery suite coordinators and/or the obstetric team. The lack of autonomy failed to improve their confidence in their decision-making capabilities after 12 months. Kitson-Reynolds et al. (2014) also highlighted the increase in anxiety and frustration for newly qualified midwives when faced with balancing the provision of care to women and mentoring junior students. Also, due to the newly qualified midwives lack of autonomy, Hobbs (2012) suggests that some newly qualified midwives may fit in with the care role-modelled by more experienced midwives due to the uncertainty in their role. However, as they become more experienced in their midwifery practice, the newly qualified midwives were more able to challenge practices with which they disagreed.

### Environment and Confidence to Practice

The environment within which the newly qualified midwives practice, and the level of support they receive during their transition, impacted their confidence and competence to practice independently. Five studies were identified relevant to the subtheme 'environment and confidence to practice' (Kitson-Reynolds et al. (2014) (England), Barry et al. (2013) (Australia), Fenwick et al. (2012) (Australia), Hobbs (2012) (England), and Van der Putten (2008) (Ireland).

The lack of autonomy reported by newly qualified midwives in some of the studies leads to heteronomy in the newly qualified midwives being influenced in their decision-making process by the more experienced staff, frequently causing a decrease in their confidence. Fenwick et al.'s (2012) study revealed that a hostile maternity unit environment eroded and undermined newly qualified midwives' confidence and increased their "fear of doing something wrong" (p. 2060). Moreover, the medical model's dominance and the hierarchical

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situation within the maternity unit environment also hindered newly qualified midwives' confidence throughout transition (Van der Putten, 2008). Due to the dominance of the obstetricians within the maternity unit, some newly qualified midwives felt powerless to advocate for their women and did not speak up for the women who did not want their labour accelerated (Van der Putten, 2008). Similar findings emerged during Barry et al.'s (2013) study in Australia, where newly qualified midwives on the labour ward were not allowed to make an independent decision when caring for their women, and the decision-making was dominated by the obstetrician and the labour ward coordinator. The newly qualified midwives in Barry et al.'s (2013) study were prevented from making independent decisions regarding the care of the woman, which led to them experiencing a reduction in their self-confidence. Kitson-Reynolds et al.'s (2014) study concurs with Barry et al.'s (2013) findings, as their participants also experienced a reduction in their self-confidence in a maternity unit where they were prevented from making an independent decision when providing woman-centred care. Kitson-Reynolds et al. (2014) reveal that some newly qualified midwives found working within the hospital environment traumatic. Fenwick et al.'s (2012) study reported that a hostile learning environment 'eroded' and 'undermined' graduates' confidence and exponentially increased their fear of 'doing something wrong' (p. 2060) because the newly qualified midwives felt unable to provide woman-centred care and sometimes felt they did not have the confidence to advocate for women as they should.

In an ethnographic study of seven newly qualified midwives conducted in England, Hobbs (2012) argued that the work environment, such as the model of care and the culture that exists within the maternity unit, might influence newly qualified midwives' smooth transition and their self-confidence in midwifery practice. This is because they may not be allowed to make independent decisions in the management of the women's care without the senior midwives or doctors interfering or not allowing them to care for them (Kitson-Reynolds et al.,

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2014; Hobbs, 2012). Furthermore, the literature suggests that the negative perception of hospital environments may be due to the hierarchical structure and culture, the unwelcome behaviour of some staff, and the medical model's dominance within the maternity environment (Kitson-Reynolds et al., 2014; Barry et al., 2013). Barry et al. (2013) and Kitson-Reynolds et al. (2014) suggest that an environment where the medical model dominates in comparison to the midwifery model of care (woman-centred care), newly qualified midwives' decision-making, self-confidence and ability to advocate for the women in their care is reduced. The medical model refers to doctor-led care, which is medically focussed rather than being women-centred or client-led care. Van der Putten's (2008) study also found newly qualified midwives experienced disempowerment to advocate for normalcy in women's care. In some instances, newly qualified midwives are expected to waive their ideals of working with the woman and conform to their institution's culture (Fenwick et al., 2012). Within the theme of 'confidence and competence', this review found areas that are likely to impact newly qualified midwives' confidence and transition into practice. These include the type of midwifery education programmes undertaken by the newly qualified midwives. However, the review found that irrespective of the midwifery programme undertaken by the newly qualified midwives, they were perceived as competent. The review also found that the newly qualified midwives, other midwives, and the women they cared for had high expectations. These high expectations from self and others impact these newly qualified midwives psychologically, making them experience frustration and stress when they perceive they have not met these expectations.

Similarly, the increased pressure of accountability and responsibility is attached to the newly qualified midwives' newfound professional status. Working on their own PIN, making decisions in challenging situations negatively impacts the newly qualified midwives' self-confidence during their decision-making. The medical model's dominance over the midwifery

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model of care, the hospital unit's culture, and maternity staff's behaviour were also identified as issues that influence newly qualified midwives' confidence and competence.

### *Theme Three: Support During Transition*

Cummins et al. (2017) (Australia) and Wain, (2017) (England); Kensington et al. (2016) (New Zealand); Pairman et al. (2016) (New Zealand); Cummins et al. (2015) (Australia); Dixon et al. (2015) (New Zealand); Foster & Ashwin (2014) (England); Avis et al. (2013) (UK: England, Scotland, Wales, and Ireland); Clements et al. (2013) (Australia); Mason & Davies (2013) (England); Clements (2012) (Australia); Clements et al. (2012) (Australia); Fenwick et al. (2012) (Australia); Davis et al. (2012) (Australia); Van der Putten (2008) (Ireland); Hughes and Fraser (2011) (England). This theme examined two subthemes: 'support programmes and retention' and 'cultural support and environment'.

#### Support Programmes and Retention

The subtheme 'support programmes and retention' examines the findings of three main support programmes that are extended to newly qualified midwives during their transition, as identified in the review. They were: Transition Support Programmes (TSPs) in Australia (Clements (2012) and Clements et al. (2012)), Midwifery First Year of Practice (MFYP) in New Zealand (Kensington et al. (2016), Pairman et al. (2016), and Dixon et al. (2015)), and Preceptorship in the UK (Wain (2017) (England), Foster and Ashwin (2014) (England), Avis et al. (2013) (UK: England, Scotland, Wales, and Ireland), Mason and Davies (2013) (England), and Hughes and Fraser (2011) (England)).

The Transition Support Programme (TSP) in Australia refers to a planned, individualised education process for newly qualified midwives, facilitating a safe and effective transition into a new area (Queensland Nursing Council, 2006). Transition Support Programmes offer clinical rotations, study days, supernumerary time, preceptorship, mentoring, clinical supervision, formal assessments of newly qualified midwives, and



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opportunities for newly qualified midwives to work within a midwifery continuity model of care. ‘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., 2016 in Cummins et. al., 2017, p. 106). In the UK, midwifery continuity of care refers to the same one or two midwives working collaboratively across the multidisciplinary team to administer care to women throughout their pregnancy (Dunkley-Bent, 2018). In TSPs, rotation duration varies from eight to 16 weeks. Study days ranged from one to seven days, midwife-to-midwife relationships involved the newly qualified midwives receiving support from the more experienced midwives (Clements et al., 2012).

In New Zealand, a Midwifery First Year of Practice (MFYP) programme is extended to all newly qualified midwives. The MFYP programme is a fully-funded government programme that was instigated in 2007 and made mandatory in 2015. The MFYP programme encompasses support during clinical practice with a funded mentor midwife whom the newly qualified midwives choose; it also provides financial assistance to newly qualified midwives towards their education. The MFYP programme provides support to all newly qualified midwives irrespective of their work setting in New Zealand (New Zealand College of Midwives, 2018; Chapman, 2018; Kensington et al., 2016). However, newly qualified midwives are required to undertake a quality assessment and reflection at the end of the programme to determine their successful transition and the effectiveness of the programme.

In the United Kingdom, preceptorship refers to a period of planned and formalised support wherein experienced midwives provide support for newly qualified midwives (RCM, 2017). Preceptorship is a structured transition period to assist newly qualified midwives in developing into accountable midwives, able to practice confidently in line with the Nursing and Midwifery Code (RCM, 2017). The recommended duration of preceptorship is a minimum

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of six months. However, the preceptorship period could be extended dependent on the newly qualified midwives' learning needs and circumstances (NMC, 2020 a). Thus, the Royal College of Midwives (RCM) recommends a preceptorship period in the first year of practice to newly qualified midwives. The RCM further recommends that preceptorship programmes provide the newly qualified midwives with support from an experienced midwife. Newly qualified midwives should be allowed protected supernumerary time, protected learning time, protected time with their preceptors, a period of orientation, and an individualised, formalised learning agreement (RCM, 2017). Additionally, as per the Department of Health (DoH) (2010), preceptorship programmes in the UK provides continuous professional development for newly qualified practitioners and helps to forge a relationship between the newly qualified practitioner and an experienced nurse.

Transition support programmes refer to formal programmes geared to support newly qualified midwives (Gray et al., 2016). The terms used for transition support programmes are preceptorship, mentorship, and orientation, and their usage is dependent on the country of practice (Gray et al., 2016). Although the terms may vary, they all have the same goal of supporting newly qualified midwives. Ten studies were found relevant to this subtheme (Hughes & Fraser, 2011; Clements et al., 2012; Clements 2012; Avis et al., 2013; Mason & Davies, 2013; Foster & Ashwin, 2014; Dixon et al. 2015; Pairman et al., 2016; Kensington et al., 2016 and Wain, 2017).

### **Transition Support Programme (TSP): Australia**

Two studies examined TSPs (Clements (2012) and Clements et al. (2012). The two studies were conducted in Australia, where Clements et al. (2012) was a part of a larger study conducted by Clements (2012). Clements' (2012) study aimed to describe newly graduated midwives' expectations and experiences of their transition support programmes during their first 12 months of clinical practice. Clements et al.'s (2012) aim was to report on newly

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qualified midwives' experiences of the core elements of their transition support program; clinical rotations, supernumerary time, study days, and midwife-to-midwife support. Both studies used the qualitative descriptive design, and data was collected using focus groups and telephone interviews. The data analysis method used in Clements et al.'s (2012) study was content analysis, while Clements (2012) used both latent and manifest content analysis to analyse their data. In Clements et al.'s (2012) study, 36 midwives participated, while 38 participated in Clements (2012).

Findings from Clements et al. (2012) revealed that 66% of newly qualified midwives reported that they had access to supernumerary time. According to McGowan (2005), 'Supernumerary status is referred to as a process by "which essential practical nursing skills are developed in a supportive learning environment facilitated by an experienced member of nursing staff' (2005, p.1100). However, Elcock, Curtis and Sharples (2007) believe that one's supernumerary status can diminish learning in practice rather than enhancing it because some persons may not utilise the time designated in "the development of the appropriate skills for learning in and from practice" (2007, p. 9). Supernumerary time helps newly qualified midwives to work alongside an experienced midwife and without being counted as part of the regular staffing (Clements et al., 2012). Although supernumerary time was promised, in Clements et al.'s (2012) study, one-quarter of newly qualified midwives reportedly abandoned the TSPs because it did not meet their expectations or deliver the supernumerary time, and lacked a rotation onto the labour ward or the continuity of care models as they had been promised initially.

Nonetheless, Clements (2012) reveals that 60% of newly qualified midwives remained in the TSP, as they claimed it was valuable, met their goals in terms of access to the clinical rotation and study days, and they felt supported. Both studies Clements 2012; (Clements et al., 2012) found TSPs enable 87% of newly qualified midwives to access study days, which

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enhanced newly qualified midwives' knowledge and skills and facilitated shared learning. Participating in the whole programme built the newly qualified midwives' self-confidence and allowed them adequate support from the more experienced midwives (Clements et al., 2012). A further finding showed that a lack of one-to-one support in the clinical areas in TSPs might increase stress and anxiety among newly qualified midwives, as postulated by Clements et al. (2012).

Clements (2012) reported more than sixteen per cent of newly qualified midwives still abandoned their transition support programme before the culmination of their first year into midwifery practice due to, either resignation from the midwifery profession or to work in midwifery continuity of care, because it did not meet their expectations or deliver the supernumerary time, lacked a rotation onto the labour ward or the continuity of care models as they had been promised initially. However, Clements et al. (2012) suggest that well-designed and implemented transition support programmes increase confidence, enhance clinical competencies, and improve retention. Additionally, Clements' (2012) study reveals that newly qualified midwives are reliant on the more experienced midwives for their support in improving their confidence. Furthermore, Clements (2012) argue that although the TSP helped graduates to take up their roles as registered clinicians successfully, some clinical sites did not have TSPs, and it did not meet the newly qualified midwives' expectations as the actual programme and newly qualified midwives experiences were not congruent. Findings from the two studies revealed that while TSPs for midwives exist in NSW, Australia, there appeared to be an unplanned approach to their design, functioning, and effectiveness.

### **Midwifery First Year of Practice Programme (MFYP): New Zealand**

Three studies that examined the Midwifery First Year of Practice (MFYP) programme were identified (Kensington et al. (2016), Pairman et al. (2016), and Dixon et al. (2015)). It was also noted that the three studies were performed in New Zealand and used the same

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Midwifery Register of midwives who qualified from 2007 to 2010 to obtain study participants.

However, only two of the studies had similar aims in that Pairman et al.'s (2016) aim was to identify the components of the MFYP that newly qualified midwives considered necessary using a survey method. Kensington et al.'s (2016) study is similar to Pairman et al.'s (2016) study, as both studies had the same aim. Still, Kensington et al.'s (2016) method of data collection differed in that they used qualitative surveys with open texts. The data collection method used by Kensington et al. (2016) allowed qualitative analysis to identify elements of the MFYP programme that newly qualified midwives found were essential and that supported them in their transition to a confident practitioner. In Pairman et al.'s (2016) study, they used quantitative surveys using a Likert scale for their participants' responses. Dixon et al. (2015) explored the retention of newly qualified midwives in midwifery practice following their participation in the MFYP from 2007 to 2010 in New Zealand.

Kensington et al. (2016) suggest that midwifery staff's support to newly qualified nurses help them consolidate practice skills, enhance their decision-making, and develop networks within the midwifery and wider health communities. Similarly, Dixon et al. (2015) found that the MFYP programme provided standardised support to all newly qualified midwives in New Zealand, yielding similar results. Pairman et al. (2016) identified a high satisfaction rate with the MFYP due to the provision of an individualised programme unique to each newly qualified midwife's learning needs. It was also noteworthy that 92.2% of newly qualified midwives in Pairman et al. (2016) stated that they felt supported during the labour and delivery of women and 93.9% felt supported throughout their clinical practice. Pairman et al. (2016) further reveal that the newly qualified midwives primarily received support from the midwives employed by the facility, midwifery practice partners, and midwives' mentors in the MFYP programme. The three studies in the review showed that an effective support programme during the transition of newly qualified midwives facilitates retention. Dixon et al.'s (2015) study shows that was

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an overall retention rate of 86.3% of newly qualified midwives who had participated the in MFYP programme, as they remained in midwifery practice five years post their graduation. Findings from the Pairman et al. (2016) study reveal that newly qualified midwives considered all of the four core elements clinical rotation, study days, supernumerary time and the midwife-to-midwife relationship useful; they reasoned that all aspects of the MFYP programme provided the newly qualified midwives with mentorship support, funding towards their education, and increased their confidence. Ultimately, the review found that midwives in New Zealand have taken on collective responsibility for supporting graduates (Kensington et al., 2016).

### **Preceptorship Programme: UK**

Six studies were identified as pertinent to preceptorship programmes and or preceptorship during the review. The six studies were: Wain (2017), Foster and Ashwin (2014), Avis et al. (2013), Mason and Davies (2013), Hobbs (2012), and Hugh and Fraser (2011). Preceptorship is like the TSP and MFYP programmes because it helps newly qualified midwives to consolidate their knowledge and skills in a supportive environment (Foster & Ashwin, 2014). However, preceptorship is not mandatory, and not all preceptorship programmes provide adequate support (Foster & Ashwin, 2014; Avis et al., 2012). Additionally, in the presence of organisational constraints such as staff shortages, implementing preceptorship can be challenging (Foster & Ashwin, 2014; Avis et al., 2013). However, various factors may contribute to or inhibit effective preceptorships, such as individualised programme and inadequate support from preceptors.

In England, Mason and Davies' (2013) study, which explored the strengths and weaknesses of preceptorship programmes, reveals that preceptorship allowed newly qualified midwives to work with their mentors or preceptors during their preceptorship. The newly qualified midwives reported their satisfaction with the period of preceptorship they received,

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as it allowed them to participate in group reflection and learn new skills (Mason & Davies, 2012). Foster and Ashwin (2014) explored newly qualified midwives' experiences of their preceptorship, and their findings corroborated Mason and Davies' (2013) findings. Similarly, positive experiences of preceptorship programmes were revealed in two other English studies, Avis et al. (2012) and Wain (2017). In both Avis et al. (2012) and Wain (2017), newly qualified midwives expressed that they felt supported during their preceptorship programmes, with newly qualified midwives in Avis et al.'s (2012) study feeling supported by access to an allocated mentor to work alongside who they could ask questions or go to for support.

Likewise, newly qualified midwives in Van der Putten's (2008) study conducted in Ireland expressed that a named mentor provided them with an explanation of terms of procedures and practices, provided clinical guidance and gave them confidence. Equally, in Foster and Ashwin (2014), newly qualified midwives also expressed that having a named preceptor during their preceptorship programme made them feel supported. Moreover, having a preceptor allowed the newly qualified midwives to obtain positive feedback, as Avis et al. (2012) found. Additionally, Mason and Davies (2013) contend that the experienced preceptors provide guidance to the newly qualified midwives and assist them in their decision-making skills, which improves their self-confidence.

Organisational constraints, such as limited availability or the unavailability of preceptorship schemes and insufficient preceptors to support newly qualified midwives in some hospitals, were perceived as barriers to preceptorship by Foster and Ashwin (2014). Similar constraints were identified in Avis et al.'s study (2012); however, their study reported the lack of preceptors was due to resignations, the reassignment of assigned preceptors from their preceptees to different maternity units, or due to preceptors being on long-term sick leave. Hughes and Fraser (2011) emphasised that effective preceptorship enhances staff retention, which is significant because Cummins et al. (2017) argue that newly qualified midwives would

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benefit from having a named mentor as support to help to build their self-confidence during their transition period. However, Hughes and Fraser's (2011) study reveals that, although some midwives have a named mentor, they rarely see them due to time constraints and conflicting schedules. Hughes and Fraser (2011) explored newly qualified midwives' and preceptors' views of the preceptorship and concurs with Foster and Ashwin's (2014) findings that the lack of support from a preceptor/mentor during preceptorship was due to unstructured preceptorship programmes and preceptors' unawareness of their role. Factors such as frequent moving of the newly qualified midwives to different maternity units to address staff shortages, improper skill mixes (Avis et al., 2012), insufficient time to consolidate, and inadequate induction periods (Foster & Ashwin, 2014) affected their transition into practice. Avis et al. (2012) and Foster and Ashwin (2014) identified that, although some hospitals state the existence of preceptorship programmes, in some instances they were unstructured, ad hoc, with informal arrangements for preceptorship, and with meetings initiated by the newly qualified midwives themselves, which affected their transition into practice.

Some newly qualified staff lacked support with midwifery skills, such as perineal suturing, as depicted in Wain's (2017) study, which explores the experiences of eight newly qualified midwives in England during their preceptorship. Hobbs (2012) found that a lack of support and encouragement due to the mentor/preceptor's lack of enthusiasm for the midwifery profession may cause newly qualified midwives to feel demoralised. Many studies reveal that inadequate support from preceptors impacts the newly qualified midwives' confidence and increases their anxiety and stress (Wain, 2017; Clements et al., 2012; Hughes & Fraser, 2011). Accordingly, the NMC recommendation is for all newly qualified midwives to be supported throughout their period of preceptorship in the UK (NMC, 2020 a). Several of the studies provide recommendations for preceptorship programmes. In their study, Avis et al. (2012) recommend for preceptorship programmes to be individualised, based on the newly qualified



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midwife's own learning needs to facilitate transition; they also recommend that for preceptorship programmes/schemes to be successful, they should be structured to facilitate appropriate rotation patterns. Similarly, Hughes and Fraser (2011) and the RCM, (2017) recommend for preceptorship programmes to be personalised, structured and operated by a designated Practice Development midwife. Mason and Davies (2013) study recommends preceptorship programmes because they help with the newly qualified midwives' integration into midwifery practice. From the review it was found that preceptorship programmes enhanced newly qualified midwives transition because it offered them support.

### Cultural support and Environment

The environment in which newly qualified midwives work may influence the level of support they need. A supportive environment is vital to ensuring the successful transition of newly qualified midwives into practice, as Skirton et al. (2012) posited. Such findings were also portrayed by Hobbs (2012), which revealed that the work environment might influence newly qualified midwives' smooth transition. Fenwick et al. (2012) also confirm that continuity with women and midwives also increased newly qualified midwives' self-confidence, and empowered and supported their successful transition.

Seven studies emerged from the review as pertinent to the theme 'cultural support and environment' (Cummins et al. (2017) (Australia), Cummins et al. (2015) (Australia), Clements et al. (2013) (Australia), Clements (2012) (Australia), Davies et al. (2012), Fenwick et al. (2012) (Australia), and Van der Putten (2008) (Ireland). From the review of the literature, studies concerning the midwifery model of care were identified that offer a supportive environment to the newly qualified midwives. Of the studies pertinent to the midwifery model of care, five were performed in Australia, one in New Zealand and one was undertaken in Ireland. The continuity of care model was dominant in the UK and Australia. The continuity of care model provides midwifery care to women throughout their pregnancy, labour, and

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delivery with the same one or two midwives (Cummins et al., 2013) and through well-functioning midwifery programmes (WHO, 2016). The midwifery continuity model of care offers woman-centred care and individualised midwifery support to women, thereby empowering them to make an informed choice in their care (MANA, 2016).

The review found that three of the research papers explored the experiences of newly qualified midwives during their placement in the Midwifery Continuity of Care Model in detail (Cummins et al. (2017), Cummins et al. (2015), and Clements et al. (2013)); however, the aim of the three studies differed. Clements et al. (2013) aimed to describe newly qualified midwives' experience of the labour ward and the continuity model of care. Cummins et al. (2015) explored the experiences of newly qualified midwives who worked in the continuity of care model, their support, and the barriers and enablers of their development. Cummins et al. (2017) examined midwives' mentorship experiences during their transition into the midwifery continuity of care model and was the first study of its kind to assess newly qualified staff mentorship experiences in the continuity of care setting during their transition. Cummins et al. (2017) reveals that newly qualified midwives could choose a mentor, someone they liked and felt comfortable with. The newly qualified midwives in the study could choose their mentors and this choice was more beneficial than allocation because it helped to forge (positive) relationships between the newly qualified midwives and their mentors. The act of students choosing their mentor is referred to as formalised mentorship (Lennox et al., 2008). Formalised mentorship ensures that the newly qualified midwives receive supervision throughout their working environments and helps in the forging of the relationship between the newly qualified midwives and the more experienced midwives.

Furthermore, Cummins et al.'s (2017) study found that mentorship provided support and helped the new graduate midwives build their confidence during their transition from student status to qualified midwife; they also had respect for their mentors. Moreover,

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Cummins et al. (2014) substantiate that mentorship helped develop the newly qualified midwives' confidence through their mentors' continued support. Similarly, Cummins et al. (2017) found that having a mentor they knew made it easier for the newly qualified midwives to seek their attention. Newly qualified midwives are reliant on the more experienced midwives' support to help build their self-confidence (Cummings 2017) (see pages 25-28 of this chapter). Therefore, a lack of support may hinder newly qualified midwives from building their self-confidence.

According to Cummins et al. (2015), working within a midwifery model of care facilitates newly qualified midwives forging trusting relationships with their women and midwifery colleagues. This is because it reflects the midwife-mother relationship of caring and compassion. The forging of a relationship between the newly qualified midwives and the more experienced midwives may be possible because they share a similar philosophy of care, as found in Cummins et al. (2015). Additionally, Fenwick et al. (2012) found that positive midwife-to-midwife relationships within a supportive working framework empowered the newly qualified midwives.

Findings in Clements et al. (2013) reveal that the midwifery continuity of care model provided a supportive atmosphere for newly qualified midwives and enhanced their learning. Seemingly, the type of care given to the women by both the experienced midwives and newly qualified midwives is reflected in their behaviour towards each other. In Clements et al.'s (2013) study, there was a sense of social and professional belonging for midwives who were a part of the midwifery continuity of care model when compared to experiences of midwives within the traditional birth suite environment. Similarly, the findings of Cummins et al. (2015) validate Clements et al. (2013), as they reveal that the midwifery continuity of care model allowed for frequent meetings, which supported newly qualified midwives learning through their reflection

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on practice. Furthermore, reflection in practice helps develop newly qualified midwives' decision-making skills (Mason & Davies, 2013).

Newly qualified midwives in Cummings et al.'s (2015) study also reported that they felt socially accepted in a midwifery continuity care model, compared to their labour ward counterparts who experienced a greater anxiety level. Furthermore, working within the midwifery continuity of care model was perceived positively by the newly qualified midwives, compared to working within the labour ward where a medical model of care was dominant (Cummings et al., 2015). Clements et al. (2013) substantiated that newly qualified midwives viewed their labour ward rotation with greater trepidation than those rotating in the continuity of care model. Similar findings were found in Fenwick et al. (2012), who revealed that hospital-based care culture might contribute to the newly qualified midwives' negative perceptions of the hospital environment due to the hierarchical structure and the unwelcoming behaviour of the labour ward staff. This was due to poor communication, which hindered a supportive environment for the newly qualified midwives (Fenwick et al., 2012). Furthermore, such negative attitudes towards the newly qualified midwives resulted in their reluctance to ask questions or seek guidance for fear of being judged or labelled, exposing themselves, colleagues, and the women they care for to risk (Fenwick et al., 2012).

The midwifery continuity of care model is being established throughout Australia, with newly qualified midwives assigned to work in such settings (Clements et al., 2017). However, this review revealed limited opportunities for newly qualified midwives to work in the continuity of care model in Australia, as they are required to complete a transition to professional practice program before undertaking the midwifery continuity of care model (Clements et al., 2017); this is because they are perceived as lacking the skills necessary to care for high-risk clients.

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Hobbs (2012) argues that unsupportive and passive-aggressive behaviour towards the newly qualified midwives is unacceptable and demoralising to the newly qualified staff, who, on qualifying, were enthusiastic about performing within the scope of their midwifery practice. The same unsupportive behaviour towards newly qualified midwives was identified in Fenwick et al.'s (2012) study in Australia, with newly qualified midwives being ignored or left to struggle on their own, describing themselves as 'thrown in the deep end', 'chucked' or assigned to 'horrendous' cases and left to drown during challenging situations (p.2058). Additionally, Wain (2017) claims that the lack of support towards newly qualified midwives was due to staff shortage and the busyness of the maternity unit, while Hobbs (2012) argues that it was also due to mentors or preceptors not offering encouragement to the newly qualified midwives.

Based on my review of the included studies, the newly qualified midwives working in the continuity model of care environment, providing individualised care for their women, with no medical interventions, felt more supported when compared to the newly qualified midwives rotating within the labour ward, because of the support from their preceptors and their trusting relationships with their women and colleagues. However, to mitigate some of the negative experiences of newly qualified midwives, Hobbs (2012) recommends future planning of maternity services. Furthermore, Hobbs (2012) states it will necessitate consideration of how woman-centred care can be facilitated for all women and how a balance between the medical and midwifery models of care can be found. Accordingly, it is essential that newly qualified midwives receive support in such settings to build their self-confidence and facilitate their successful transition into midwifery practice.

Attrition of the more experienced midwives within institutions offering maternity care was also identified as a concerning issue that may impact the level of support newly qualified midwives receive at the start of their practice. Some newly qualified midwives are not autonomous and may lack self-confidence in their decision-making skills. Having an

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experienced preceptor to guide them will assist with the newly qualified midwives' decision-making and improve their self-confidence. It is also recommended that preceptorship programmes be available for newly qualified midwives, as they help to develop their confidence and competence, and assist their integration into the multidisciplinary health team. The review revealed that the continuity of care model played a vital role in the provision of social support to newly qualified midwives.

### **Orientation in the Jamaican Context**

In Jamaica, newly qualified midwives receive a formal period of clinical supervision referred to as orientation at the start of their employment. Orientation is a traditional way of assisting new graduates in their transition to practice (Rush et al., 2013). The orientation period for newly qualified midwives in Jamaica varies within hospitals and may be from one to twelve months. Nevertheless, the Ministry of Health (MOH) (2005) policy recommends that newly qualified midwives who pursue the direct-entry pathway should complete a one-year internship inclusive of three months of community orientation and nine months of orientation throughout the hospital. All newly qualified midwives are rotated within the maternity unit on the antenatal, postnatal, and labour wards, and the antenatal clinic during their orientation. The ward sisters and ward managers undertake the newly qualified midwives' supervision, while the orientation programme is managed and supervised by the hospital In-Service Educators. Post orientation, newly qualified midwives are assigned to work in the various maternity units based on their skills, knowledge, competence, personal preferences, and/or an established need for staff (Verbal Personal Communication with hospital matron, 2017).

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In their book chapter, Pitter et al. (2019) discussed how maternity care in Jamaica has changed over time. In addition to the impact of changes in midwifery education and legislative laws on midwifery, the chapter concludes with descriptive excerpts from two newly qualified midwives' transitional experience into midwifery practice into their first year of practice. Moreover, Pitter et al. (2019) revealed unstructured orientation programmes for newly qualified midwives in Jamaica. The newly qualified midwives did not have designated mentors or preceptors but were supported by senior midwives and nurse educators responsible for their orientation.

Furthermore, Pitter et al. (2019) identified various challenges that influenced the nurse educators' inability to precept or support newly qualified midwives during their orientation. These challenges included the nurse educators having to supervise other newly qualified midwives during the orientation period, or being assigned to different shifts, or performing other services and responsibilities, or engaged in other ward duties. Pitter et al. (2019) revealed that one newly qualified midwife described her orientation as "a joke" (p.151). She was given documents to read and introduced to staff members; however, the newly qualified midwife perceived her orientation would last two months but was oblivious as to whether the orientation was completed as she "assumed duty from day one" (Pitter et al., 2019, p.151). Pitter et al. (2019) argued that this contradicted the mandatory one-year "internship" specified by the Ministry of Health in Jamaica for registered midwives. Another challenge identified in Pitter et al.'s (2019) book chapter was that the two newly qualified midwives experienced uncertainty when performing vaginal examinations. Also, direct entry midwives had still not been assigned to the community, despite being employed for one and a half years since qualifying and practising.

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### **Summary and Evaluation**

The reviewed literature examined newly qualified midwives' experiences during their transition in their first year in clinical practice, post-registration. Three major themes emerged from the 17 qualitative studies and four quantitative studies reviewed, which included 'preparedness for practice', 'competence and confidence', and 'support during transition'.

The reviewed studies showed that there was no difference between the competency level of direct entry and post-basic midwives. Newly qualified midwives were generally fearful of the increased responsibilities and level of autonomy they had at the onset of their professional practice, which negatively affected their self-confidence. Support from fellow midwives within the working environment was found to be effective in empowering the newly qualified midwives, though there was also a great need for the intervention of mentors to facilitate a smooth transition of the newly qualified midwives into the clinical setting. Mentors were considered partly responsible for the newly qualified midwives' failure to expose them, as student midwives, to learning opportunities. Support during transition facilitated staff retention and promoted self-assurance and competence in the newly qualified midwives. Tailored support programmes were highly recommended.

The findings of the studies were incomparable in many instances on the basis of the newly qualified midwives' demographic profiles when compared with those in Jamaica. Firstly, the duration of the midwifery education programme was identified to be at least one year in Jamaica compared to the minimum 18 months for the shortened programmes in other countries. Additionally, in Jamaica, there are two pathways to midwifery education: certificate and undergraduate degree. However, only one identified study from the review examined newly qualified midwives who pursued midwifery education at a certificate level in Jamaica. The four-year programme was only implemented less than six years ago, and the competence and confidence levels of these newly qualified midwives in both the undergraduate and the



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certificate programmes in Jamaica is, as yet, unknown. Hence, the paucity of research makes this an area worthy of exploration.

Given the issues and having identified the variation in the duration of orientation in hospitals amongst newly qualified midwives in Jamaica, and the problem of newly qualified midwives assuming responsibility for maternity wards, at times, by themselves, and non-orientation in the community setting, it was appropriate to explore these issues further. However, what is unknown in Jamaica is the efficacy and impact of the orientation programmes on newly qualified midwives' transition into midwifery practice, which I aim to address in this thesis.

## Theoretical Framework

Several theories have been developed which aim to provide a description and explanation of the process of transition. Such theoretical perspectives are relevant for exploring the experiences of graduate nurse transition. Much of the theory is set in the context of newly qualified nurses. However, it is crucial to explore the origins of this theoretical work to determine which approach may be suitable to explore the transition of newly qualified midwives in this study.

I was mindful that the discussion and review of the theory underpinning this study may conflict with my phenomenological methodology. However, because this study explores the lived experiences of individual, newly qualified midwives' transition, and that the phenomenon of transition has been explored in detail before, failure to acknowledge previous work and existing research in this subject area would conflict with the research standpoint of Martin Heidegger (1927/2010). Heidegger advocates for a literature review before conducting a study to find out previous information. Ignoring Heidegger's recommendation of informing oneself

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with pre-existing literature on a phenomenon to be explored would be inconsistent with the aim of this study. Therefore, I used pre-existing literature and incorporated Duchscher's theoretical framework to inform my theoretical thinking throughout this study, which I will explain in detail below. Furthermore, acknowledgement and inclusion of transition theory will enhance this study and produce findings useful to midwifery practice and beyond.

Marlene Kramer's (1974) Reality Shock Theory, William Bridges' Transition Model (1991), Nancy Schlossberg's Theory of Transition (1984), and Judy Duchscher's (2007) Transition Shock Model and Stages of Transition Theory provide descriptions and explanations of the transition process. These theories provide an insight into how individuals transition into their new roles and situations and identify factors that inhibit or enhance their transition to provide strategies to facilitate an individual's smooth transition.

### ***Marlene Kramer's Reality Shock Theory (1974)***

Marlene Kramer's (1974) seminal work provides a framework for understanding the newly licensed nurses' transition into professional practice. Kramer's study focused on clinical practice realities as manifested and dealt with by new graduate nurses. Her study enhanced insight into what is now commonly understood as the first stage of transition. Kramer coined the term "reality shock" to describe:

specific shock like reactions of new workers where they find themselves in a work situation for which they have spent several years preparing for which they thought they were prepared and suddenly find they are not.

(1974, p. 8)

Reality shock is a term used to explain the anxiety, self-doubt, and confusion experienced by newly qualified nurses as they advance from the role of student to qualified nurse. Reality shock occurs where there is a conflict with what newly qualified nurses learned as students compared with their real-world experience (Duchscher & Cowin, 2006). Kramer's Reality

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Shock theory (1974) comprises four stages of the graduate nurse transition: honeymoon, shock, recovery, and resolution. The honeymoon phase refers to the first stage when the graduate nurse qualifies and begins working as a registered professional. In this phase, the graduate nurse goes through a period of excitement. The second phase refers to the shock phase; the nurse is in their most vulnerable state and experiences negative feelings as they realise their responsibilities and functions as a nurse. In the third phase, recovery, the nurse views their role and function positively. In the fourth and final stage, resolution, the nurse contributes to their profession as they can understand and see their role better.

Notwithstanding Kramer's work on transition having been in existence for over 40 years, newly qualified nurses still encounter challenges. Newly qualified healthcare professionals, especially nurses or midwives, will experience challenges inherent in the profession's dynamism. There will always be work-related challenges such as workload, the environment, work-related injuries, and/or some form of emotional strain. At the same time, the healthcare worker tries to adapt to the profession's stressors and demands.

Despite studies addressing reality shock in new graduate nurses and their success in the nursing profession, these two approaches fail to explore the nursing faculty role from students' perspectives in preparation for their professional role, as argued by Lisa Sparacino (2016). Kramer's Reality Shock theory is seen as a cyclic process whereby new graduates move from resolution to shock as they encounter new experiences. On the other hand, Duchscher's Transition Theory (2009) is non-linear and, as a result, it is not strictly progressive, while Bridges' Transition Model (1991) is considered linear rather than cyclic.

Kramer's work resonates with this study, which aims to examine newly qualified midwives' transition. However, due to Kramer's theory having a cyclic assumption of the transition of new staff, it would conflict with the study's methodology of interpretive

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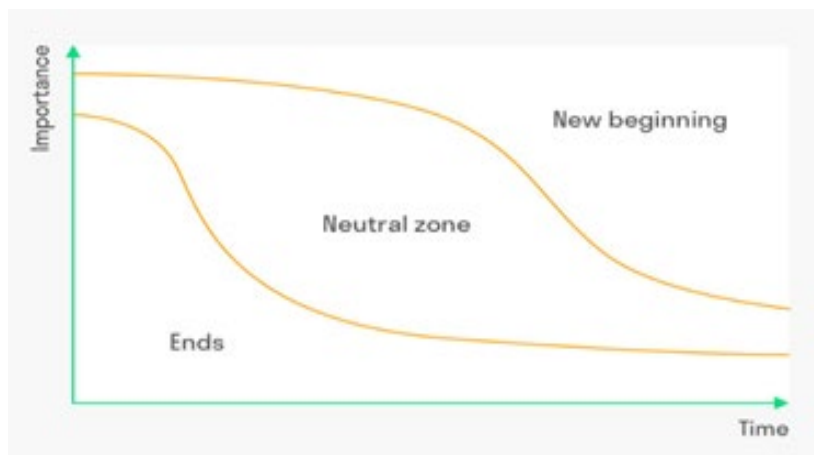
phenomenology because participants may undergo a transition linearly and not necessarily in the prescribed transition stages.

### *Bridges' Transition Model*

Bridges' Transition Model lacks focus on the specific transition processes of newly qualified midwives. However, the model is useful to this study because Bridges' Transition Model (1991) focusses on the changes people go through while transitioning into an organisation. Bridges' model consists of three stages, as shown in Figure 1.

**Figure 1**

*Bridges' Transition Model*



Source: Janse, B. (2019). *Bridges Transition Model*. Reprinted with permission.

Calhoun explains the three phases of Bridges' model in *Overcoming: A Theory of Accelerated Second Degree Baccalaureate Graduate Nurse Transition to Professional Nursing Practice* (2010): the first stage, 'end' occurs when an individual loses their identity; the second stage, 'neutral beginning' involves an individual letting go of any connections that they previously had and creates a new sense of identity; thus, there is a psychological shift. However, during the neutral beginning stage, some people may adjust more quickly than

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others. The third stage, 'new beginning', refers to when the individual has entirely accepted the changes and has developed the new skills necessary for the new work environment (Calhoun, 2010).

Bridges' Transition Model is people-centred, as the individual must recognise that a change is necessary for themselves. Moreover, Bridges' Transition Model focusses on the psychological changes that an individual goes through. Thus, Bridges' model is focused on the transition to change. That is the transition people make that leads to a change. Bridges defines change as an external event or situation that takes place (1988).

Bridges (1988) argues that change can occur quickly; he believes that transition is a psychological process which individuals internalise before coming to terms with the new situation. Therefore, Bridges' Transition Model has an individualised focus wherein an individual sees the necessity to change and then develop the skills needed for the passage from the old to the new. Given, Bridges' Transition Model is linear rather than cyclic (Graf et al., 2020) (see Figure 1). Bridges' Transition Model offers a similar explanation of transition as Kramer (1974) and Duchscher (2007). Duchscher (2007) is discussed in further detail see section p. 51-53. Some studies (Duchscher, 2007; Schoessler & Waldo 2006 & Calhoun, 2010) used it as a theoretical framework for graduate nurse transition research.

### **Schlossberg's Transition Theory**

Schlossberg's Transition Theory (1981) (see Figure 2) concerns adults' transitions through roles, situations, and relationships in their lives, and how they manage or cope with these changes. According to Pendleton, "as one moves from a period of relative stability to a transition, the response differs dependent on the individual's appraisal of the change" (2007 p. 45). Schlossberg and Sargent (1988) believe that the more an event changes adult roles, situations, and relationships, the more the individual will be affected by the transition.

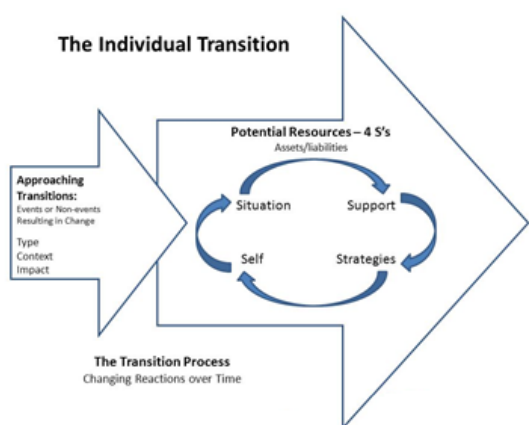
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Schlossberg's Transition Theory consists of four fundamental tenets: situation, self, support, and strategies. Schlossberg (1981) emphasises that "transition is not so much a matter of change as of the individual's perception of the change. A transition is only a transition if so, defined by the person experiencing it." (p.7).

**Figure 2**

*Schlossberg's Transition Theory*



Source: Anderson, Schlossberg & Goodman, 2012, p. 39. Reprinted with permission.

Chick and Meleis define transition as the "passage from one life phase, condition or status to another, embracing the elements of process, time span and perception" (1986, p. 239). Schlossberg believed that transitions could be anticipated or predicted, or otherwise unanticipated or unpredicted. Schlossberg also theorised that a transition, though expected to happen, could for some reason not occur, which she termed a non-event (in Stankey, 2018), meaning, that the transition does not necessarily have to occur because the person who wants to go through the transition can manipulate when it happens. Therefore, Schlossberg's Transition Theory allows a professional to plan and discuss in advance with their client when

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they want to transition, at their convenience. Consequently, transition can also be predicted and is not necessarily inevitable.

Though Schlossberg's Transition Theory is regarded as one of the more versatile and applicable in existence because it is easy to follow and relates to the counselling process as according to Stankey (2018) reasons that it might be considered too personal. According to Stankey (2018), Schlossberg's Transition Model could lead to self-doubt or confusion, as only the individual can determine or disclose to someone through a reflective process whether they think they have experienced a transition. Therefore, Schlossberg's Transition Theory is relative. Schlossberg's Transition Theory is considered relative because persons using Schlossberg's theory of transition may experience different outcomes when compared with others in similar situations.

Schlossberg theory is useful to identify coping strategies, it is applicable to a wide range of individuals, and it is written in plain language and is easy to understand as per Pendleton (2007). However, Schlossberg's Transition Theory does not focus on newly qualified midwives' specific transition processes, and it does not have a formal assessment tool that can be used to assess an individual's transition. Thus, a researcher who wants to assess an individual's transition based on Schlossberg Theory would have to create their own assessment tool. The fact that there is no standardized assessment tool can lead to subjectivity as the determination of where an individual is in their transition is left to the interviewer's interpretation.

Nevertheless, Schlossberg's theory is relevant to this study as all individuals throughout their career lifespan experience predictable and unanticipated transitions. Having a framework for understanding transitions can assist in providing useful strategies to help individuals cope. Because newly qualified midwives are likely to experience some form of change based on their

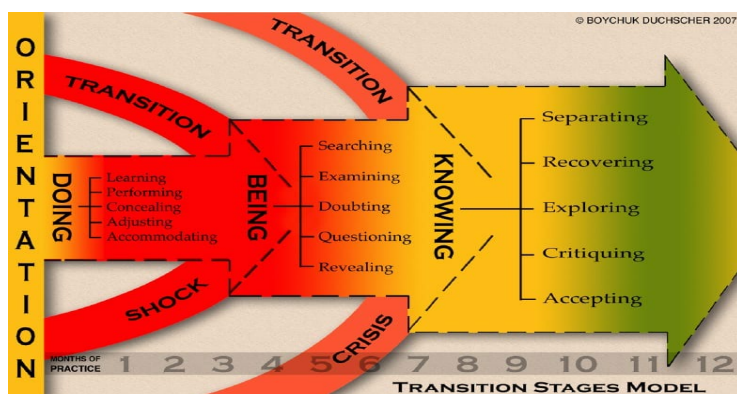
new role and new responsibilities, Schlossberg's Transition Theory could be applicable to this study.

### Duchscher's Stages of Transition Theory

Duchscher's Stages of Transition Theory (2008) emerged following seminal work by Kramer (1974) on the experience of "reality shock" among newly licenced nurses in the United States of America. Duchscher expanded considerably on Kramer's studies by undertaking extensive research on the preparation, transition, integration, and stabilisation of new graduate nurses working in the acute care setting (Duchscher & Windey, 2018). Duchscher (2008) expanded Kramer's (1974) findings regarding the main challenge for new graduates; Duchscher's study involved documenting the difficulties new graduate nurses experience when incorporating theory into their practice in their new working environments while developing their new professional identities. (Duchscher & Windey, 2018). Duchscher's Stages of Transition Theory (see Figure 3) focusses on the new graduate nurses' personal and professional transition.

Figure 3

*Duchscher's Stages of Transition Model*



Source: Transition Stages Model. Original copyrighted (2007) image provided by the author (Duchscher, 2007).



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Murray, Sundin and Cope (2018) posit that Duchscher's Stages of Transition Theory acknowledges that skill acquisition is experiential. As such, Duchscher's Stages of Transition Theory framework provides timelines upon which senior nurses may review the graduate nurses' expectations to understand and facilitate their transition and identify the barriers that impacted the new graduates' transition. According to Duchscher (2008), newly qualified nurses in acute care may encounter a range of physical, intellectual, emotional, developmental, and socio-cultural changes, and feelings of uncertainty and lack of confidence during their transition to practice. Three stages characterise Duchscher's (2008) Stages of Transition Theory: doing (initial three months), being (4-5 months post-registration) and knowing (12 months post-registration) (Duchscher & Windey, 2018). These stages are critical as they explain the transition processes in a sample like those in Duchscher's study, Calhoun's (2010) study and in this study. Duchscher's Stages of Transition Theory is non-linear, as an individual transition may not occur sequentially as per the transition stages model.

Duchscher claims that new graduate nurses may experience "transition shock", which occurs in the 'doing' stage of transition (2009). 'Transition shock' refers to an acute and dramatic socio-cultural, developmental, emotional, and intellectual change that a new graduate nurse may experience while transitioning from a nursing student role to their new professional role as autonomous practitioners (Duchscher, 2009).

### ***Justification for the use of Duchscher's Stages Transition Theory***

Duchscher's Stages of Transition Theory is time-bound and provides differentiation of the stages of transition, which makes the tracking of newly qualified midwives' progression into their practice more transparent. Hence, Duchscher's Stages of Transition Theory is better suited to this study than Kramer's Reality Shock theory, Schlossberg's Transition Theory and Bridges' Transition Model.

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Additionally, Duchscher's Stages of Transition Theory framework provided a structure that guided the development of this study and reviewed the research results, as endorsed by Engberg and Bliss (2005). Duchscher's Stages of Transition Theory offers a more comprehensive way to assess an individual's transition. It considers the physical, intellectual, emotional, developmental, and socio-cultural changes that the newly qualified midwives may encounter, unlike Bridges' Transition Model, which focusses solely on the psychological changes.

Thus, Duchscher's Stages of Transition Theory (2008) provides a comprehensive theoretical lens through which it is possible to view the phenomenon of transition among the newly qualified midwives in this study in Jamaica. My use of Duchscher's Stages of Transition Theory also helps to determine whether the newly qualified midwives in this study experience challenges like those experienced by new graduate nurses in Canada, as in Duchscher's situation-specific study, or whether their experiences are contradictory.

Consequently, Duchscher's Stages of Transition Theory (2008) will help me to evaluate the lived experiences of the newly qualified midwives in this study and is likely to reveal the extent and the intervals during which the newly qualified midwives may experience challenges and/or transition shock throughout their transition. Nonetheless, I am aware that newly qualified midwives in this study may each experience varied situations despite being at the same stage of their practice. Additionally, using Duchscher's theoretical framework in the context of this study will contribute to the further progression of new graduate nurse transition theory.

I appreciate that integrating a theoretical framework could conflict with the study's phenomenological methodology. This study explores the lived experiences of individual, newly qualified midwives; as such, the study's research questions are aligned with the transition theory and an appropriate literature review. Thus, the integration of a theoretical framework

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may limit the participants from being exploratory in their responses. Accordingly, I have chosen a semi-structured approach to my interviews allowing participants to be open in their responses, as discussed in this study's data collection (see Chapter 3).

### **Objectives of the Study**

1. To critically examine the preparedness for practice of newly qualified midwives in Jamaica.
2. To critically explore confidence levels of newly qualified midwives who are educated at either undergraduate or certificate level in Jamaica.
3. To critically examine the factors that may inhibit or enhance newly qualified midwives' transition into midwifery practice.
4. To critically explore the impact of the clinical environment on newly qualified midwives' transition.

### **CHAPTER 3: METHODOLOGY**

#### **Overview**

This chapter presents the rationale for my choice of design, including data collection and data analysis, and includes the consideration of verification and trustworthiness.

#### **Research Design**

##### ***Rationale for Qualitative Design***

I used a qualitative design that is exploratory because I sought an in-depth explanation of my participants' lived experiences in order to understand their views and perceptions (Robson & McCartan, 2016). Therefore, using a qualitative design enabled my study participants to convey their realities based on their personal experience of the study's phenomenon, as Creswell (2009) proposed.

##### ***Overview of Interpretive Phenomenology***

Phenomenology research is a form of qualitative research that captures and expresses the lived experiences or 'lifeworld description' from the study participants' perspective (Galvin & Holloway, 2015). Phenomenology emerged in the early twentieth century, with Husserl as the pioneer of this philosophical research tradition (Husserl, 1931/2013). Heidegger, his student, later developed ontological phenomenology. Both philosophers had opposing views of phenomenology.

There are two types of phenomenological approach: descriptive (eidetic) phenomenology and interpretive (hermeneutic) phenomenology. In the early twentieth century, Edmund Husserl developed a research approach referred to as descriptive phenomenology. Its central concept is that humans could be understood from 'inside' their subjective experience, which otherwise could not be replaced by any outside analysis or

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explanation (Todres & Holloway, 2010) and focusses on a group's shared lived experiences.

Van Manen states “Husserl’s aim for phenomenology was to capture an experience in its primordial origin or essence, without interpreting, explaining, or theorizing” (2017, p. 26).

Descriptive phenomenology offers philosophical and methodological support while capturing and expressing the study participants' lived experiences (Todres & Holloway, 2010). Husserl’s descriptive phenomenology contends that phenomenology is an eidetic method. Eidetic refers to the way individuals perceive their experience without the influence of any worldview or presumptions (Pietkiewicz & Smith, 2014). Given this philosophy, phenomenological studies are more concerned with how individuals describe their experience of a phenomenon, rather than interpreting their experience. However, the differences between the two are how they generate findings and augment professional knowledge (Lopez & Willis, 2004).

Descriptive phenomenology does not start with a hypothesis or any preconceived theory to prove or disprove. Instead, descriptive phenomenology researchers are open-minded about what they discover and, therefore, suspend their preconceptions and theories (Galvin & Holloway, 2015). To achieve this, Husserl (1931/2013) recommends bracketing, which involves individuals putting aside any presumptions or preconceived notion gained from prior knowledge of any concepts or experience so as not to influence their perceptions. By contrast, interpretive, or hermeneutic phenomenology developed by Martin Heidegger, suggests that peoples' understanding is based on what is previously known to them. Heidegger’s interpretive phenomenology theorises that an individual’s experience is influenced by their interactions with them being in the world (Tuffour, 2017). Hence, their presumptions will influence their worldview and perceptions of a phenomenon experienced. According to Tuffour (2017), Heidegger’s primary focus is on existential phenomenology which is the same as interpretive/hermeneutic phenomenology.

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Existential phenomenology refers to the preconceived notions humans have, which may influence their interpretation of a phenomenon. Heidegger aims to discover what humans already know (1927/2010). Interpretive phenomenologists believe that the researcher cannot successfully 'bracket' or suspend their preconceptions (Galvin & Holloway, 2015). My research adapted the Heideggerian hermeneutic approach, as discussed in the section below.

### *Choosing Interpretive Phenomenology*

I chose to use the Heideggerian hermeneutic approach for my study. According to Miles et al. (2013), Heideggerian hermeneutic phenomenology:

has been used widely to understand the meaning of lived experiences in health research. For midwifery scholars, this approach enables a deep understanding of women's and midwives' lived experiences of specific phenomena. However, for beginning researchers, this is not a methodology for the faint-hearted. It requires a period of deep immersion to come to terms with at times impenetrable language and perplexing concepts (2013, p.273).

Heideggerian hermeneutic phenomenology allowed me to obtain more than a description of the newly qualified midwives' experiences of their transition into midwifery practice and their interpretation of their experiences, as suggested by Miles et al. (2013) and Lopez and Willis (2004). The Heideggerian hermeneutic approach enabled me to deduce from my participants' interviews what their experiences mean to them (Lopez & Willis, 2004; Grand Canyon University (GCU), 2018). The Heideggerian hermeneutic approach also enhanced my understanding of the lived experience of the newly qualified midwives; it helped me develop new insights that were consistent with Miles et al. (2013). Additionally, The Heideggerian hermeneutic approach allowed me to interpret the lived experiences of my participants (Creswell, 2006).

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Interpretive phenomenology was suitable for my study. Using the interpretative phenomenology did not restrict me from conducting a literature review before initiating the research or from having specific research questions as recommended by Galvin and Holloway (2015). Being able to undertake a literature review allowed me to search for literature on the phenomenon being investigated, which enabled me to determine if there was a need for further research on the topic, guiding me on aspects of the study that needed to be explored. Being a midwife and having transition experience, it was difficult for me to bracket my presumptions, as Husserl recommended. I subsequently chose the Heideggerian Hermeneutic approach, which would allow me to use the notion of sensitising instead of bracketing (Galvin & Holloway, 2015). I initially considered ethnography, pure or descriptive phenomenology, and grounded theory methodologies for my study due to my research question. In the following section, I discussed my reasons for choosing Interpretative phenomenology and my reasons for rejecting the other methodologies.

### *Alternative Methodologies and Reasons for my Rejection*

According to Fetterman (2010), ethnography as a methodology, may require the researcher to engage with the study participants within an organisation or community for an extended period. Furthermore, Holloway and Galvin (2015a) posit ethnography strictly observes the study participants' culture and behaviour in their natural environment and involves the researcher conducting participant observation to collect data. However, Pope (2005) contends ethnography as a methodology requires copious amounts of contemporaneous notetaking, and he states that contemporaneous notetaking may lead to inaccuracies if the researcher omits any of the information collected. Nonetheless, I did not use an ethnographic approach for my study because its focus is to obtain participants' collective experiences within a specific culture. In contrast, phenomenology focuses on individual experiences, which allows

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me to collect individual, in-depth information of their lived experiences from each of my participants and perspectives on their transition into midwifery practice.

I considered using grounded theory methodology because from my scoping of the literature; I found that there was limited research regarding the transition of the newly qualified midwives as opposed the transition of newly qualified nurses which had multiple research studies on this group of healthcare professionals. Holloway and Galvin (2015b) emphasised that grounded theory is suitable when there is limited knowledge of the area being investigated. According to Starks and Brown Trinidad (2007), grounded theory generates theory from the range of the participants' experiences. According to Creswell (2012), grounded theory has three historical approaches: the emergent approach developed by Glaser and Strauss (1967) the Straussian or systematic approach developed by Strauss and Corbin (1998), and Charmaz's (2006) developed the constructivist approach. However, Creswell (2006) contends that of the three approaches - Charmaz constructivist and Strauss and Corbin' systematic approaches are the most popular to grounded theory. The grounded theory approach may be labour-intensive because it requires the researcher to be engrossed in coding, resulting in voluminous documentation. Ultimately, I did not consider using the grounded theory methodology because both the emergent and systematic grounded theory approaches dissuade the researcher from conducting a literature review before the start of the study to prevent the researcher from influencing the research, and instead advocates for the researcher to derive theory from the data. I needed to conduct a literature review on the transition experiences of newly qualified midwives to determine other areas that need exploration, as I had a limited time in which to complete my thesis. Not conducting a literature review may prevent the researcher from knowing the different areas that need exploration, as Creswell (2012) states, which may lead to the researcher inadvertently duplicating an existing study. However, I opted not to use any grounded theory approaches because my aim was not to generate theory based on the



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participants' range of experiences. Instead, I focus on the individual experiences of each of my participants.

## **Research Procedures**

### *Setting*

I conducted the study at three different hospital sites<sup>2</sup>: Lignum Vitae, Mahagony and Cedar Hospitals (see Appendix 8). However, though all three hospitals offered antenatal, intrapartum, and postpartum care to women, they differed in their bed capacity, the size and scope of services, and the areas where their newly qualified midwives were assigned for orientation. Paley (2005) recommends that studies be undertaken at one institution to facilitate the sample's homogeneity. However, using three different settings may reflect varied modes of care in different organisational cultures, which may impact newly qualified midwives' transition into practice. According to Guion, Diehl and McDonald (2011), using more than one location allows for the comparison of all three hospital settings to facilitate triangulation and enhance the findings' trustworthiness.

### *Access to the Research Sites and Participants*

I sought and gained access to the three hospital sites and participants on February 26<sup>th</sup>, 2019 and April 4<sup>th</sup> 2019, following the ethical approval for the study from The School Research Ethics and Integrity Committee (SREIC) of the University of Huddersfield in England (SREP/2018/059) (see Appendix 9) and the South East Regional Health Authority (SERHA) in Jamaica (see Appendix 10) via gatekeepers: The Chief Executive officer, Senior Medical Officer, the Director of Nursing and Midwifery Services, and In-service

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<sup>2</sup> Pseudonyms used for the names of the hospitals in which the study was conducted. Pseudonyms derived from names of trees grown in Jamaica.

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Coordinators/educators. See Appendix 11 -16 for the supporting documents used during the recruitment process of my study, such (an example of letters sent to the institutions, Inservice coordinator participant sheet, participant information sheet, participant consent form, participant contact details card, and participant letter of invitation). I sensitised participants and gatekeepers to my study during the recruitment process.

I foresaw issues with access to the hospitals because I did not work there and had no pre-existing relationships with the hospitals. Given this, I had to seek access via the gatekeepers. Clark (2011) defines gatekeepers as individuals usually tasked with protecting participants and mediating between the participants and the researcher to help them gain access. To alleviate this, I approached the Director of Nursing and Midwifery Services at the three hospitals, and I built up a rapport. I made myself familiar with their names and spoke politely to build a relationship to gain access to the research sites, as suggested by Gelling (2015). In addition, Bound (2012) recommends that the researcher provide gatekeepers with full details about their proposed research; hence, I informed the gatekeepers about the proposed study, the study's perceived risks and benefits to the participants, and offered clarification, as necessary.

Recruitment initially took place at two hospitals and commenced in February 2019 and lasted for two weeks initially. Initially, I met newly qualified midwife participants formally, in a group setting, during one of their orientation class lectures. However, asking the midwives to participate during their class lectures could make them feel pressured to participate in the study (Schrag, 2006). Therefore, to facilitate the midwives' voluntary participation and maintain their confidentiality, I requested that willing participants contact me directly with any queries and inform me if they agreed to participate in the study. Subsequently, I met with the midwives individually; however, only two newly qualified midwives from the two hospitals met the study criteria. The study criteria included all newly qualified direct entry and post-basic midwives

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who completed either the undergraduate or certificate programme and were in their first year of practice post-registration.

However, due to insufficient study participants, I then extended my recruitment to a third hospital. This commenced on April 11<sup>th</sup>, 2019 and lasted for approximately two weeks. The In-service Matron initially provided me with a list of newly qualified midwives employed by this hospital and their assigned wards. The Inservice Matron provided me with the list of midwives to avoid bias in choosing the participants. Additionally, because the potential participants are not familiar with the researcher, there is a potential problem that some of the midwives do not want to participate.

Subsequently, I contacted the maternity ward sisters for access to the midwives whose details were provided by the In-Service Matron; During my first meeting, I gave them a copy of the participant information sheet, and I discussed the study's nature and purpose.

From the recruitment within the three hospitals, twelve midwives were initially eligible to participate in the study. However, only eight eligible newly qualified midwives from the three hospitals combined consented to participate in the study.

### **Sample Size Determination**

There are different arguments concerning sample size in studies adopting a phenomenological methodology. John Creswell (2012) claims a sample size of 5-25 participants who have all experienced the same phenomenon is suitable for adopting a qualitative approach. Creswell (2012) contends that having a large enough sample size in qualitative studies increases the likelihood of the researcher obtaining sufficient data to adequately address the study's research questions and sufficiently describe the phenomenon of interest being investigated. Similarly, Pietkiewicz and Smith (2014) and Turpin et al. (1997) state that using participants with similar characteristics or variables (homogenous) allows the researcher to analyse any similarities or differences that may exist among them. However,

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Turpin et al. (1997) suggest a smaller sample size of six to eight participants prevents the researcher from being overwhelmed by a large amount of data. Nevertheless, even a sample of six to eight participants could generate a large amount of data, because some data collection methods, such as interviews, may generate copious amounts of data. Thus, Pietkiewicz and Smith (2014) believe there is no hard or fast rule regarding how many participants are in an Interpretive Phenomenological Analysis (IPA) study, as the principles of IPA recommend depth rather than breadth; IPA is more concerned with getting in-depth accounts from the study participants rather than having a large sample from which one is unable to obtain in-depth accounts. Therefore, when choosing my sample size, I wanted to have a manageable sample size that would allow me to do an in-depth analysis.

Most IPA studies tend to rely on a small sample size that is relatively homogenous, with participants who share similar characteristics as what is relevant is the depth of the analysis of a single case study, the richness of the individual cases, access to participants and/or time constraints (Pietkiewicz & Smith, 2014). Furthermore, Polit and Beck (2010 a) state that studies with a qualitative design aims to provide rich data regarding the participants' understanding of what they are experiencing without generalisations. The sample size for my study was eight participants; this small sample size was considered suitable because it allowed me to obtain diverse and in-depth opinions on the phenomenon I am investigating. It also allowed me to have a full appreciation of each participant's account (case). It also enabled me to provide a detailed case-by-case analysis, which is time-consuming with a much larger sample (Pietkiewicz & Smith, 2014). Additionally, this small sample would enable me to understand better complex human issues, which is more significant than the generalisability of results recommended for quantitative studies with larger sample sizes (Van der Putten, 2008), based on my study's aims and methodology.

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### **Sample**

My study included eight newly qualified, direct entry and post-basic midwives from three hospitals (see Appendix 19). For confidentiality reasons, I allowed each newly qualified midwife to choose a pseudonym from a list of Spanish names I created before their initial interview. I used Spanish instead of English names to ensure that none of the midwives in the study had names of midwives employed at any of the three hospitals. All eight newly qualified midwives were referred to by pseudonyms for consistency throughout the study during all three interviews. Direct entry midwives refer to midwives who have had no previous nursing background and pursue the midwifery programme. In contrast, post-basic midwives refer to registered nurses who have completed the midwifery education programme and have a dual qualification in registered nursing and midwifery. These newly qualified midwives pursued either a certificate or undergraduate degree programme in midwifery education in Jamaica and were in their first year of midwifery practice post-registration. Using a sample of newly qualified midwives in their first year of practice would allow me to explore their transition experiences throughout their first year of midwifery practice. I chose the eight participants by purposive sampling, with their consent, from the target population who were knowledgeable and most likely to provide relevant and in-depth information on the research topic studied (Van Manen, 2016). Between March 2019 and March 2020, I conducted a total of 24 interviews with the newly qualified midwives using an interview schedule) for each of the three interviews.

### **Data Capture**

#### ***Interviews***

In this phenomenological study, data was collected using in-depth, digitally recorded, face-to-face interviews with the participants' consent. Marshall and Rossman (2016) state that phenomenological interviews describe the phenomenon's meaning based on the individuals'

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lived experience. Therefore, interviews were ideal for identifying the lived experience of the newly qualified midwives in my study. Interviews allow an in-depth exploration of the phenomenon being experienced by the study participants (Van Manen, 2016) because the interviews allow the researcher to probe while enabling the participants to elaborate on information they perceive as important to them (Gill et al., 2008). Moreover, Ryan, Coughlan and Cronin (2009) posit that interview help the researcher probe participants to clarify their responses.

There are three types of interviews used to collect research data: structured, semi-structured and unstructured (Gill et al., 2008). Phenomenological studies primarily use semi-structured interviews because they are not rigid, allowing the participants to talk freely. A semi-structured interview allowed me to include questions about my research aims and objectives.

The collection of data from semi-structured interviews can be labour intensive. Participants may stray from the questions asked; however, a skilled interviewer and the appropriate interviewing technique can keep the activity focussed (Tod, 2015). To maintain the focus of a phenomenological study, Van Manen (2017) suggests that the interview questions should be structured to focus on the participants' lived experience of the phenomenon to be explored. I kept the interview focus by using my interview schedule as a guide. However, I found interviewing challenging; although I used semi-structured interviews to keep my interview focussed, some participants were not very talkative. As a result, I had to delve more during the interviews by asking probing questions to encourage the participants to divulge more information. The more interviews I conducted, the more relaxed the participants were, as they became more familiar with me and the nature of the interview questions.

Unstructured interviews lack guided interview questions. According to Van Manen (2017), a lack of well-guided phenomenological questions increases the researcher's likelihood

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of losing focus on the participants' lived experience of a human phenomenon. Similarly, Gill et al. (2008) posit that the lack of guided interview questions could lead to confusion and the interview taking longer than scheduled.

### ***Alternate Methods of Data Collection***

There are alternative methods of data collection suited for studies using an IPA methodology'. Focus groups help generate a rich understanding of participants' experiences and beliefs and allow the researcher to collect data in a group setting (Gill et al., 2008). However, collecting data in a group setting may give rise to a breach of ethical issues, such as privacy and confidentiality due to the disclosure of the participant's identities and responses. Moreover, communicative participants may dominate the discussion (Goodman & Evans, 2010). I excluded the use focus group as I wanted to capture all participants' lived experiences of their midwifery transition from their perspective without compromising their identity, and to increase the likelihood of participants being more open and honest with their responses. Furthermore, it was better for pragmatic reasons to do individual interviews, as the midwives worked different shifts. Due to staff shortage, it would have been more challenging to organise a focus group where all midwives could conveniently attend.

The use of diaries to obtain data for studies adopting IPA is appropriate. Diaries allow participants to maintain a log of events in their natural setting (Lavrakas, 2008) as experienced by the individual over time (Sheble, Thomson & Wildemuth, 2017), thus minimising the delay between events and the time it was recorded. Diaries kept in real-time are also less reliant on the participants' memory (Lavrakas, 2008). However, keeping a diary can also be challenging, as diaries can yield a voluminous amount of sometimes irrelevant information, which can significantly burden the participants and researcher alike. Diaries' use can also inhibit participants' recruitment and retention, as they assume the diaries will be time-consuming

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(Sheble et al., 2017). I initially proposed using diary methods to complement the interviews in my study to obtain rich data. However, some of the prospective participants stated it would be time-consuming to complete, hence, they may not be compliant. Consequently, I decided the most appropriate method was semi-structured interviews to collect the data.

### ***Interview Schedules***

I used an interview schedule to carry out the semi-structured interviews (see Appendix 18). The use of semi-structured interviews within the schedule was essential; it helped to keep the interviews focussed while ensuring I covered all of the same areas with each participant, as suggested by Van Manen (2016). The literature review determined the interview questions within the interview schedules for newly qualified midwives. Additionally, Duchscher's Stages of Transition Theory (2008) provided a framework that guided and provided direction for the interviews, which helped keep my research focused. My use of guided questions ensured that the study focussed on the lived meaning of the participants' experience of their phenomenon (Van Manen, 2016), because it allowed me to ask the participants questions based on my study's aims and objectives as per my interview schedule to maintain the interviews' focus. Likewise, the interview schedule used open-ended questions and permitted my participants to speak freely. The schedule allowed me to modify my questions and pose follow-up prompts based on the participants' responses, which could unearth unexpected information (Noon, 2018) that I would not have obtained if the interview questions were structured or rigid.

Interview guides can be restrictive and distracting for the researcher, and researchers can become reliant on them (Noon, 2018). Accordingly, I was mindful that the interview schedule was only a guide and should not hinder my participants from speaking freely about their experiences. I was aware that the improper sequencing of questions and inappropriate timing of the questions on the schedule could sabotage the interview (Tod, 2015), as



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participants could become emotional and prematurely end the interview. Therefore, I did not ask the participants questions about factors that may have inhibited their transitions, or questions concerning memorable experiences that could elicit an emotional response, at the beginning of the interview. Nonetheless, Tod (2015) recommends the need for researchers to continually judge the appropriateness of the timing of their interview questions and the participants' likely interpretation, while Bolderston (2012) posits the interviewer can rephrase the research questions depending on the individual participants.

### ***Data Collection Procedure***

The Stages of Transition Theory (Duchscher, 2008) provided a theoretical framework that guided my study's data collection process (see Chapter 2). According to Duchscher (2008), the newly qualified nurse goes through three stages during their transition into practice. Duchscher theorises that these three stages are nonlinear. I used this framework because it helped to track my study participants' progression into their practice in a consistent and transparent way. I conducted the three sets of interviews using the same participants at concurrent times in line with Duchscher's Stages of Transition Theory, as illustrated in Figure 4 below.

Figure 4

*Data Collection process in line with Duchscher's Stages of Transition Theory*

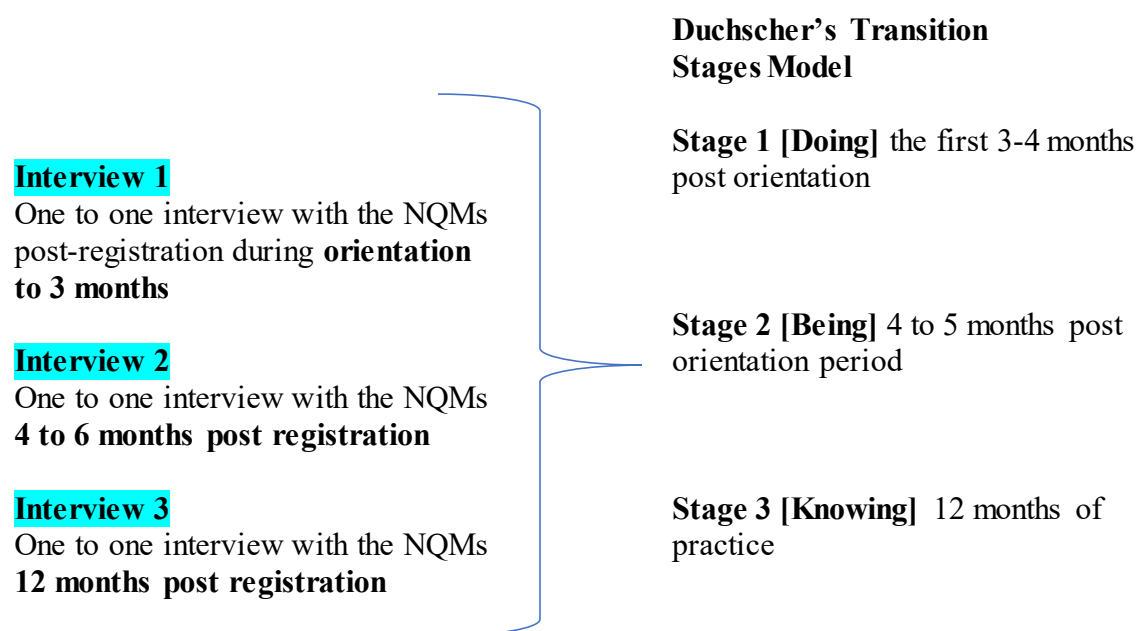


Figure 4: Data collection process in line with Duchscher's Stages of Transition theory

Adapted from "Benner's model and Duchscher's theory: Providing the framework for understanding new graduate nurses' transition to practice", M. Murray et al., 2019, Elsevier, 300, 2018 Elsevier Ltd.

### ***The Rationale for the use of Duchscher's Stages of Transition Theory in Data Collection***

Collecting the data via longitudinal or sequential interviews allowed me to study the phenomenon of transition over time, capture the same participants' evolving experience, and tracked changes and gaps in their lived experiences during their transition (Smith et al., 2009; Duchscher, 2008).

### ***Individual Interviews with Newly Qualified Midwives***

I did the interviews at set time intervals: within the initial three months, between four to six months, and 12 months post-registration into the newly qualified midwives' midwifery

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practice. The timeframe for data collection in this study was consistent with Duchscher's Stages of Transition Theory (2008), as previously discussed in Chapter 2 of this study. Conducting the interviews sequentially with each of the eight newly qualified midwives allowed me to explore the phenomenon of transition using the same sample of newly qualified midwives throughout the study, and enabled an in-depth, longitudinal exploration of the lived experience of study participants (Van Manen, 2016).

Johnstone et al. (2008) claim that new graduate nurses usually require support the first four weeks of practice and at the beginning of each clinical rotation. Accordingly, I started the interviews within the initial three months of the newly qualified midwives' practice, meaning that they would have had exposure to their practice setting and settled into their new roles, thus enabling them to speak to me about their lived experience (Lea, 2013). I interviewed all eight participants at three separate intervals, as detailed below.

### ***First Interviews***

The first interviews were conducted with eight midwives at the recruitment and commencement stage of the study between March 2019 and May 2019, during the initial three months post-midwifery registration. I aligned the first interviews with Duchscher's stage one (Doing) of the Stages of Transition theory (2008). During this stage, Duchscher theorises that the new graduate nurses in their new roles may feel fraught due to a new set of expectations and responsibilities, and encounter challenges within the healthcare system. Thus, these issues may conflict with the profession's ideals and cause new graduate nurses to become anxious. Accordingly, I wanted to explore whether the newly qualified midwives in my study had experienced similar challenges or if there were other issues identified by these participants.

### ***Second Interviews***

I conducted the second interviews with the eight participants when they were between four- and six-months post-midwifery registration. I started the second interviews in June 2019 and completed them in August 2019. During the second interviews, I sought clarity and verification of the information that the eight participants interviewed in the first interview series previously gave and added any new information as necessary. This approach was consistent with Smith et al.'s (2009) recommendation. The second interviews were in sync with the second stage of Duchscher's Stages of Transition Theory (Being), during which Duchscher claims the new graduate nurses were beginning to advance in their thinking, knowledge and skills. Accordingly, I asked the newly qualified midwives in my study: "*Can you tell me about your transition experiences since your last interview?*", to determine the development of their critical thinking in handling challenging situations, such as caring for a high-risk mother autonomously.

### ***Third Interviews***

I started the final set of interviews with the eight midwives in February 2020 and completed them in March 2020. I conducted the third interviews in line with stage three of Duchscher's Stages of Transition Theory (Knowing) (2008). During this stage, Duchscher reveals that the graduate nurses had an increased level of confidence in their new role, responsibilities, and routine, so at this stage, the newly qualified midwives in my study were asked, for example: "*Reflecting on the past year, how are you feeling about your transition experiences?*", as per my interview guide.

### ***Reflexivity during Data Collection***

Reflexivity in qualitative research refers to the researcher's reflection on their experience of the study phenomenon and their impact on all aspects of the research process

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(Creswell, 2012). Reflexivity is critical when researching your field. It helps readers of the research to understand the limitations and strengths of the researcher's interpretations based on the researcher's standpoint and provides context (Galvin & Holloway, 2015). Therefore, I stated my position to the participants, as it concerns my world views, perspectives, any prejudice, and the limitations that this could impose on the study, as Sutton and Austin (2015) suggested. I kept reflexivity throughout the data collection process while acknowledging my role as a midwife.

Additionally, I maintained a reflexive diary throughout the study to log my feelings and interactions with the participants (Pannucci & Wilkins, 2010), the reasons for the classification of the categories (Creswell, 2012), and interpretation of the data (Topping, 2010). As a midwife trained in England, I noticed a difference in midwifery education, the duration of the training, and competence assessment when comparing practice in England and Jamaica. Given the differences I had observed between the ways the midwives are assessed for their registration competency in each country, I wanted to observe the levels of confidence and competence of midwives in Jamaica related to their experience of transition and assessment.

Conducting the interviews longitudinally or sequentially generated rich data and in-depth responses. As I noted during the third interviews with my participants, these interviews lasted over an hour, compared to their first and second interviews, which lasted 20 to 30 minutes. In addition, conducting the interviews longitudinally or sequentially helped me develop my interviewing skills and forge a trusting relationship between myself and my participants. Greene (2014) and Smith et al. (2009) state that participants are less reserved and more open with their responses because they have developed a rapport and trusting relationship with the researcher and so may be more receptive to answer questions. However, because I was already known to some of the participants, as I had previously taught one of the midwives while

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some of the midwives were assigned to wards on which I precept my nursing students nurses. Given this, I was aware that interviewing participants I know can pose challenges such as the possibility of over disclosure, which may predispose the participant or researcher to a vulnerable situation n, as McConnell-Henry et al. (2010) stated. Therefore, I took various steps to address potential challenges relating to potential pre-existing power relations. I informed the newly qualified midwives that I also have experienced transition as a newly qualified midwife, but at the same time, I would not impose my experience on their experience and that it is theirs; it is individualised. According to Stanley and Wise (1991), the researcher providing the participants with information about themselves helps reduce the power difference between themselves and the participants and reassures them. Consequently, I reassured my participants that any information disclosed would be held in confidence (McConnell-Henry et al., 2010).

Furthermore, McConnell-Henry et al. (2010) argue that researching human experiences and maintaining confidentiality is perceived as a burden and can be more problematic when the researcher and the participant having a pre-existing relationship. However, what was interesting with this power relations was that I observed that the newly qualified midwives were timid to speak with me during their first interviews. As a result, I had to probe. However, throughout the subsequent interviews, I could see that the newly qualified midwives trusted me and realised that I was genuine.

On the contrary, I was aware that my interactions with the participants during the data collection process could impact the research due to my experience of being a qualified nurse, midwife, lecturer, and preceptor with my perceptions of transition, which could cause bias. However, I found it impossible to bracket my presumptions as a midwife because I had previously experienced transition as a newly qualified midwife and nurse. Though I may understand what it means to be a midwife, I needed to ensure that I suppressed my own

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experiences, ensuring that my participants' experiences came to the fore and not my own. Bracketing allows researchers to deliberately identify and suspend all their judgments or preconceived thoughts or knowledge to remain neutral about the phenomenon studied (Carpenter, 2011). However, bracketing is unsuitable to use with a theoretical framework as it necessitates that the researcher does not have any prior knowledge of the phenomenon researched. LeVasseur (2003) contends that bracketing is challenging and inconsistent in studies adopting an interpretative phenomenology methodology. Heidegger believes bracketing is impossible because individuals' thinking is influenced by their own existence and interactions with others around them.

Therefore, initially, I found it difficult to eliminate/separate my own experience of transition as a graduate nurse and graduate midwife from my interpretation/understanding of the experiences of the newly qualified midwives in my study due to my existing preconceptions of transition (Whitehead, 2004). However, I sensitised myself to what was different or missing from the participants' own lived experiences of their transition into midwifery practice compared to my own, as proposed by Galvin and Holloway (2015). My use of sensitising allowed me to gain new insights into my study's phenomenon. For example, when midwife Francesca was relating her experience of being alone on night duty unsupervised when a pregnant woman died, I immediately remembered experiencing a challenging situation during my initial practice, wherein a low-risk delivery developed into a high-risk case even though my mentor was present in the delivery room. Still, I was left alone to manage because my mentor panicked. I had to take the initiative and pulled the emergency buzzer for additional support. Here, I thought that Francesca and I had experienced a similar lack of support in our initial transition into practice during challenging situations. I had my mentor, and my case outcome was good because the mother and baby sustained no injuries, unlike Francesca in her

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situation: both the mother and her foetus died. I began thinking of how devastating this incident had been for Francesca and felt saddened that such problems persist despite earlier studies recommending that newly qualified staff be supported during their professional practice transition.

Reflecting on my interviewing skills allowed me to see my mistakes and rectify them for my subsequent interviews. Reflecting on my interviewing skills also allowed me to see how these mistakes in the interview experience for my participants and myself, prove consistent with Gesch-Karamanlidis' (2015) experience.

### **Transcription**

Davidson defines the transcription of qualitative data in research as “a process that is theoretical, selective, interpretive and representational” (2009, p. 37). Researchers should ensure that transcription accurately represents the complete verbal exchange between the interviewer and interviewee (Hagens, Dobrow & Chafe, 2009). Accuracy of transcription ensures the validity of the participants' accounts and the study's findings, while inaccurate transcription can invalidate your research findings.

### ***Reflexivity during Transcription***

My study adopted Heidegger's interpretative phenomenology methodology, which was exploratory and generated textual data that I had to transcribe verbatim. Verbatim transcription refers to a detailed transcription of every sound heard on the audio recording, such as laughter and stutters, inclusive of everything said by the speakers (Worthy, 2019). Initially, I found the verbatim transcription of the data challenging because I had to keep listening and pausing the recording numerous times and at different intervals to ensure accurate documentation of the recordings. Subsequently, I used an audio text converter, Otter.ai, to transcribe all my interviews, after which I replayed the recordings and made corrections.



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The use of the audio text converter reduced my transcription time significantly. However, the use of this technology did not replace my manual transcription, as it was not 100% accurate, and I had to proofread the transcript. Nevertheless, I did continue to use the audio text converter software, as I found it easier than transcribing the full recording manually (Indian scribes, 2018). The transcripts were transferred to and stored on my encrypted USB for data protection and ethical reasons, and then removed from my Otter.ai account. Transcription accuracy was paramount. Some of the participants' accents made transcription more challenging. I overcame the challenges with the accents by replaying the audio recordings at a slower pace to help me to decipher the participants' responses.

Additionally, the data transcription helped me see how the participants used semantics or linguistic expressions to ascribe meaning to their experiences. For example, Camilla<sup>3</sup> used semantics to ascribe meaning in terms of her support during her 12 months into midwifery practice; she said, "We were just thrown into it", inferring that she lacked support.

Smith et al. (2009) recommend that researchers transcribe their data to facilitate their complete immersion in the data. The IPA method allowed me to develop an interpretive relationship with the transcript through my full immersion into the data by listening to the voice recording of the individual interviews numerous times, re-reading the different transcripts, and reliving the conversation. Moreover, immersion in the data allowed me to become thoroughly familiar with the data as stated by Lathlean (2015); it assisted me in identifying the emergent themes and helped me to interpret the participants' experiences from their perspectives and helped me to learn about the participants' mental and social world, as endorsed by Smith and Osborn (2008).

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<sup>3</sup> Pseudonym used for participant

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Following the advice of Smith et al. (2009), I transcribed the interview data for my study, which also helped me to become more attentive during the interviews. In some of my early interviews, I spoke at the same time as the participant, which made transcription difficult. During transcription, I also realised that speaking at the same time as the participant caused me to lose opportunities to ask salient follow-up questions. In subsequent interviews, I became mindful of these difficulties and missed opportunities and transcription of the interviews became easier.

### **Ethical Considerations**

The School Research Ethics and Integrity Committee (SREIC) of the University of Huddersfield in England and the South East Regional Health Authority (SERHA) ethics committee in Jamaica granted ethical approval for me to conduct my study at the three named hospitals. The ethical approval confirmation can be found in pages 207 and 208 in the study. I informed all participants that they were not obliged to participate in my research and that they could withdraw from the study at any time (Health Research Authority, 2018).

### ***Privacy and Confidentiality***

The Health Research Authority (HRA) guidelines (2018) guided my research study regarding maintaining the study participants' privacy, confidentiality and obtaining informed consent before conducting the interviews (HRA, 2018). My research was also guided by my professional code of ethics (NMC, 2015), which warrants that I exercise professionalism, trust, and prioritise people when conducting my research study. To this end, I treated all the study participants fairly and communicated respectfully with the study participants, while respecting their privacy and confidentiality, as per my professional code of ethics from the Nursing and

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Midwifery Council (NMC, 2018) and the International Code of Ethics for Midwives (ICM, 2014).

During the transcription of the interview transcripts, I anonymised the names and locations of the three hospitals. Similarly, when I reported the research study's findings, I anonymised the participants and the hospitals. Anonymising the participants and the hospitals' names and locations protect and maintain confidentiality. I was responsible for maintaining the participants' confidentiality as only I knew which newly qualified midwives had consented to participate in the study. Maintaining the study participants' confidentiality was paramount to prevent any potential harm to the participants (Polit & Beck, 2010 b; Kaiser, 2009). I stored all data for my study within a locked cupboard, and only my supervisors and I had access to the data. Upon completing my postgraduate programme, I will dispose of all data using a secure, confidential waste company as per the University of Huddersfield guidelines. However, should my research be published, I will maintain the anonymised data securely on an encrypted USB for up to 10 years from my research publication date (University of Huddersfield, 2019).

### ***Informed Consent***

Polit and Beck (2010 b) define informed consent in research as a process by which participants receive adequate information concerning the research to understand the research study fully, thus enabling them to choose whether they agreed to participate voluntarily. Therefore, I informed the prospective participants of the study's purpose, nature, and benefit before starting my research, which allowed them to seek clarification of any queries or concerns they may have regarding the study. Furthermore, I was solely responsible for the recruitment of the study's participants as, if gatekeepers are involved in recruitment, participants may feel obliged to participate due to the seniority of the gatekeepers and the perception that refusal to participate could compromise their employment (HRA, 2018). Additionally, I provided all

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participants with a detailed participant information sheet (PIS) (see page 211) with the study's purpose, examples of the interview questions, information concerning data collection, data analysis and the possibility of publication of their anonymised verbal extracts. All participants were allowed over 24 hours to read the PIS form, after which I would return to discuss any concerns or questions they may have had. I also issued a consent form (see page 215), which I requested my participants to complete, initial and return to me directly. The consent form included confidentiality, anonymity, participants' right to withdraw from the study, details regarding the recording of interviews, and a notice regarding future publication. I revisited the consent form with all of my participants before the interviews commenced to ensure their full understanding.

### *Risks versus Benefits*

IPA involves the researcher delving into the participants' lived experiences of the phenomenon studied, which can lead to participants becoming emotionally distressed during or after the interview process (Ashton, 2014; Walker, 2007). Therefore, I made a prior arrangement with the Director of Nursing Services in the host hospitals regarding counselling services for employees at each institution. I proactively offered information on the support available, including contact numbers for the host hospitals and publicly accessible counselling service helplines (see Appendix 19 for the risk analysis done). According to Ashton (2014), my role as a researcher was to be empathetic and support my participants during their disclosures while also ensuring my participants' welfare, as per Walls et al. (2010). Accordingly, if participants disclosed issues of poor practice during their interviews, I would act in the best interests of the participants and the public. Acting in the best interests of the participants and the public would involve me speaking with the participant directly about the

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issue(s) divulged, reporting the issue(s) to relevant hospital personnel based on the hospital's policy, and offering to debrief and refer participants to the counsellors with their consent.

### **CHAPTER 3: Data Analysis**

#### **INTRODUCTION**

This section provides a step-by-step guide to the data analysis process. The provision of a step-by-step guide to data analysis assures the study's trustworthiness and eliminates the potential for bias (Polit & Beck, 2010 b). The step-by-step guide to data analysis also lends a degree of credibility to my research because it provides an audit trail that readers can use to appraise and replicate my study.

#### ***The Theoretical Underpinnings of IPA***

Analysing qualitative data with an IPA framework can be stimulating but challenging and time-consuming. Therefore, researchers are encouraged to immerse themselves within the data to emulate participants' viewpoints as much as possible (Pietkiewicz & Smith, 2014). Pietkiewicz and Smith (2014) also contend that IPA strives to provide an understanding and evidence of the participants' sense-making of the phenomenon being investigated while documenting the researcher's interpretations. In this way, it allows the researcher to move between their viewpoints (etic) and the participants' viewpoints (emic).

IPA involves three tenets: phenomenology, double hermeneutics and idiography (Pietkiewicz & Smith, 2014). Phenomenology seeks to understand the lived experience of individuals. Hermeneutics is the art and science of the interpretation or meaning that an individual ascribes to their experience. IPA is idiographic in that it mandates the detailed and systematic analysis of each study participant transcript by the researcher to determine each participant experience of the phenomenon being investigated before doing the general case analysis (Tuffour, 2017).

Smith et al.'s interpretive phenomenological analysis method (2009) allows for double hermeneutic or dual interpretation. Dual interpretation is a process whereby the researcher tries

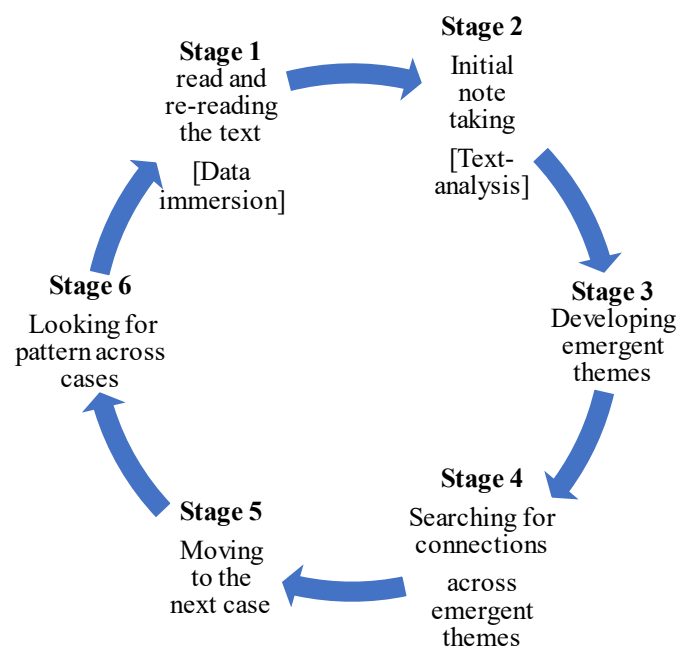
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to make sense of the meaning that participants ascribe to a phenomenon; the researcher then interprets the participant's interpretation of the phenomenon that they experienced (Smith & Osborn, 2008). Dual hermeneutics is linked with both the phenomenological and idiographic tenets of IPA, in that dual hermeneutics necessitates the researcher examining each participant's transcript independently, and then providing their interpretation of the meaning participants ascribe from their perspective of an event or phenomenon they are experiencing (Pietkiewicz & Smith, 2014). Therefore, dual hermeneutics involves two sets of interpretation: one from the researcher's outsider perspective (etic), and the other from the participant's insider perspectives (emic). The IPA method consists of six stages of inductive analysis for researchers, as illustrated in Figure 5.

**Figure 5**

*Stages of the Interpretative Phenomenological Data Analysis Method*



The process of how I analysed the transcripts for my study is discussed in the following section.

*Rationale for Data Analysis Process Undertaken*

I used Smith et al.'s (2009) Interpretative Phenomenological Analysis (IPA) approach to perform data analysis for this study because meaning is central to IPA. I chose IPA because it can be undertaken in the clinical setting, within any speciality, and because of its idiographic focus on individual participants' accounts (Cassidy et al., 2011). IPA is suited to my research because my research questions are focussed on my participants' lived experiences. As a result, IPA will enable me to make comparisons at an individual level or case by case, unlike thematic analysis. By contrast, Braun and Clarke (2006) maintain that a thematic analysis aims to identify common or repeated themes and patterns of meaning within a data set. Given that my sample is small (eight participants), using IPA helped me to better understand and gain a unique insight into each participant's lifeworld and lived experience, and to examine all my participants' personal experiences in greater detail.

Additionally, as someone who had not previously used a qualitative methodology, the IPA approach provided readily available guidelines and step-by-step instructions for data collection, analysis, and interpretation (Cassidy et al., 2011). It also helped me sift through and manage the voluminous amounts of data, which I found very helpful (Pietkiewicz & Smith, 2014). I reduced the voluminous data in stage 4 of the analysis by looking for connections between emerging themes and compiling themes for the whole transcript before looking for connections and clusters, as explained by Pietkiewicz and Smith (2014). At this point, I dropped some of the themes that were inapplicable to the emerging structure, or because they had a weak evidential base (Pietkiewicz & Smith, 2014), leaving me with a final list comprising numerous superordinate themes and subordinate themes. Finally, I further review the data, ensuring it is in sync with my study's objectives.



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Due to IPA's hermeneutic underpinning, it requires a robust interpretation of the participants' experience by the researcher to ensure that the participants' accounts are grounded in their unique experience, and not influenced by the researcher's standpoint (Brocki & Wearden, 2006). To ensure interpretations are not skewed or biased, Smith et al. (2009) recommend bracketing (setting aside one's presumptions) during the first steps of analysis by considering each case individually and having the researcher bracket the findings and initial thoughts from previous interviews. Therefore, using IPA helped me to interpret my participants' accounts by "stepping into their shoes" (Pietkiewicz, & Smith, 2014, p. 11) and setting aside any biases I had having experienced transition (Lannan, 2015). Furthermore, setting aside my own biases and standpoint and only presenting themes grounded in my participants' accounts, enabled me to objectively describe the phenomena under study (Van der Putten, 2008); this was very important because it assured my study's trustworthiness.

### *Individual Case Analysis*

Smith et al.'s (2009) IPA method stage one to four informed the analysis of each participants' interview in my study. First, I transcribed and analysed each participant's interview transcripts separately, maintaining the idiographic focus of IPA. The initial analysis focussed on each participant individually. Next, I analysed each participant's second and third interviews separately, as I did the first interviews. Upon completing the analysis of all three series of interviews at the different stages for each participant, I did an individual case analysis of all eight participants' transcripts. Then, I began the process of cross-case analysis.

### *Cross Case Analysis*

As per stage six, in Smith et al.'s (2009) method of analysis, I completed a cross-case analysis by looking for patterns across the eight cases, while creating 'master themes' which reflected the experiences of the group of participants 'as a whole' to capture "the quality of the

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participants' shared experience of the phenomenon under investigation" (Willig, 2008 in Harris, 2012 p.49). I subsequently undertook a group narrative through a process of phenomenological reduction or bracketing. The group narrative entailed me looking through the Microsoft Word document I had created in which I outlined the subordinate themes and superordinate themes as they began to converge and diverge across the cases. After which I combined the narratives of all the participants, which was reflective of the experiences of the group of participants, in addition to capturing "the quality of the participants' shared experience of the phenomenon under investigation" (Willig, 2008, p.-62) (Harris, 2012). According to Galvin and Holloway (2015), phenomenological reduction refers to my being open to what I may discover in the data. At the same time, I tried to suspend my preconceptions to see new meaning emerging from the data. Consequently, I started to look at my participants' narratives to see how they were interpreting their own experience. At the same time, I told myself that it is my participants' experiences that matters and not mine, even though I had experienced transition myself as a newly qualified midwife, meaning I was able to gather emergent information from the data. I grouped the data to determine the superordinate and subordinate themes. Subsequently, I undertook both individual case and cross-case analyses of the data, as outlined in Appendix 20.

### ***Writing Up the Analysis***

Smith and Osborn (2008) recommend that the researcher outlines participants' meaning in a final statement with their concluding themes. Accordingly, during the final stage of the analysis, I provided a narrative account under the superordinate and subordinate themes with verbatim extracts from the participants to support my detailed interpretation and analysis of the

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participants' narrative account. I explained and illustrated the themes for my study, as suggested by Smith and Osborn (2008), which is depicted in Chapter 4: Findings of my thesis.

### *Reflexivity during Data Analysis*

Although Smith et al. (2009) and Collins and Nicholson (2002) advise re-reading the transcript to ensure the researcher's interpretation is grounded in the participants' account, I did find the process of re-reading the transcript labour-intensive initially. However, I found that listening to the audio recorded interviews during the first reading of the transcript helped me immerse myself in the data. Additionally, listening to the recorded interview while reading the transcript enabled me to refresh my memory of the conversation, ensuring that the text was grounded in the participant's data and helped me to validate the accuracy of the participant's account as per Smith et al. (2009). Moreover, I was mindful that any variation or inaccuracy in the transcript from the recording could lead to a misinterpretation of the participants' accounts.

The notetaking process enhanced the data analysis process, as it helped me reduce the data and make it more manageable (Green et al., 2007). Additionally, notetaking during the participants' accounts became more manageable due to my open-mindedness. According to Riggs, open-mindedness refers to an awareness of "one's fallibility as a believer" and the acknowledgement of "the possibility that anytime one believes something, one could be wrong" (2010, p. 172). My open-mindedness allowed for new themes to develop during the note-taking process, as I did not let my experience or beliefs about transition influence my study's analysis. However, during the interpretative analysis process, I found bracketing my presuppositions of transition challenging, as mentioned previously in this chapter, so I used sensitising, as recommended by Galvin and Holloway (2015), to sensitise me to what is missing or different in the phenomenon under investigation.

Performing an analysis of each case helped me to become familiar with each participant's transcript; additionally, it allowed me to do an in-depth analysis of single cases, which allowed me to see the transcripts as they are and prevented me from missing pertinent themes within each participants' transcripts. During the cross-case analysis stage, I still had voluminous amounts of data despite the phenomenological reduction. As a result, I devised a colour-coded system, which helped me significantly to distinguish between the commonalities and divergences in the participants' experiences; without this system, the analysis could have been overwhelming (Harris, 2012). Furthermore, the transcription helped me to become familiar with the data and facilitated the emergence of realisations and ideas during the analysis (Bailey, 2008).

During the analysis, I decided it would be better to combine all the themes that emerged from the transcripts of each participant's series of three interviews to gain an insight into each participant's overall transition, rather than to evaluate their transition in stages. This approach was more aligned with my study's phenomenological approach, which aimed to determine each participant's personalised experience of their transition rather than to develop a new theory or refute Duchescher's Stages of Transition Theory.

### **Quality Issues in Qualitative Research**

#### ***Rigor***

In social research, regardless of the study design, the quality and soundness of research may be open to criticism as sources of error and bias may not be exclusively eliminated (Almansour, 2015). This may be due to the researcher having their own standpoint or worldview on the research or phenomenon being investigated. Therefore, Sutton and Austin (2015) recommended that the researcher make their position explicitly clear and coherent for readers from the start by informing the readers of their background and biases. Burns and Grove

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(2001) posit that qualitative research critique requires an appraisal of the rigour in the documentation, procedural rigour, and ethical rigour. In my study, I established rigour in terms of documentation because I ensured a correlation between the research process's steps, in terms of the research question and the phenomenon of interest, through to the recommendations and implications for practice. To evince procedural rigour, I provided an explanation and overview of the precise, appropriate data collection technique used in my study to reduce bias and misinterpretations. Additionally, I provide information concerning the ethical measures taken to deal with confidentiality and the participants' rights while conducting the study.

### ***Trustworthiness***

Trustworthiness is a criterion used in judging the quality of research that adopts qualitative approaches (Wellington & Szczerbinski, 2007). Shenton (2004) claims that because qualitative studies' findings' credibility and reliability cannot be addressed in similar ways to studies adopting a naturalistic approach, qualitative studies' trustworthiness is frequently challenged by positivist researchers. Consequently, I established trustworthiness in my research based on the four criteria of trustworthiness according to Guba's (1981) framework: transferability, confirmability, dependability, and credibility, as is written in the section below.

### ***Transferability***

Transferability refers to how qualitative research findings apply to other settings apart from where the data was generated (Almansour, 2015, p. 62; Polit & Beck, 2010 b). My study's scope is limited due to its small sample size; it was done in only three hospitals. Hence, my research findings were not generalisable to other settings. However, my study's findings may be generalised to any other situations where a transition is undertaken based on new midwives' experiences globally. Nonetheless, to achieve transferability, I intend to share my study's

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findings in the three hospitals where I conducted the study, because my study's aim is not for statistical significance.

### ***Confirmability***

Confirmability refers to the neutrality of the qualitative research findings and whether they represent a balance of perspectives, views, and experiences among the participants (Polit & Beck, 2010b; Lincoln & Guba 1985). I established confirmability in my study by providing a balance of perspectives and experiences for all my study's eight participants in my study's findings. Additionally, my supervisors examined both my transcripts and my data analysis process at every stage to ensure that my interpretations were supported by the data and were not the result of my own biases or assumptions (Almansour, 2015). My use of a reflexive journal also established confirmability, as it included my reflection concerning the study and events in the field (Anney, 2014). The reflexive journal helped with my decision-making in developing some of the themes for my study. For example, Camilla's repeated use of the phrase "we were thrown in", throughout her three interviews, helped me when I started to analyse her transcripts as repeated use of that phrase helped develop my initial themes.

### ***Dependability***

Dependability provides readers of the research with detailed information of the research study's methodological process to assess whether data are supported by the mechanisms of its collection and analyses (Almansour, 2015; Polit & Beck, 2010 b). I ensured the dependability of my study by providing a comprehensive account of the methods I used to collect data, how I recruited my study participants, an in-depth explanation of the data analysis process used in my research, and the methodological issues I encountered in the methodology section of my thesis to facilitate the replication of my study. Additionally, I included any limitations encountered while undertaking my research (Almansour, 2015). According to Shenton (2004),

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to establish dependability, the researcher must ensure that details are provided to enable duplication of the study. I interviewed all the participants using the same interview schedule, asking the interview questions in the same sequence for each participant, to establish dependability in my study (Matlala & Lumadi, 2019) (see page 220).

### ***Credibility***

Credibility is an essential criterion in determining the trustworthiness of qualitative studies' trustworthiness. It requires the researcher to link the research results with reality and prove the authenticity of the research results by testing or measuring what it had intended to establish as per Shenton (2004) cited in Girdher (2019). I achieved credibility in my study by including reflexivity throughout, by describing and interpreting my experiences. I also demonstrated credibility in my research by providing the audit trail to enable others to duplicate your research. Consultation of the participants during their subsequent interviews (after any initial interviews), and my related validation of their transcripts relate to the audit trail/duplicability According to Guba (1981), using different qualitative research strategies helps address a study's credibility. Accordingly, to enhance the credibility of my research, I included triangulation, reflexivity, respondent validation, peer debriefing, and an audit trail.

### ***Triangulation***

My study used triangulation in that I obtained data from participants from three different hospital sites. This allowed me to cross-reference data received from the other areas as per Guba (1981).

### ***Reflexivity***

To assure my study's credibility, I maintained reflexivity throughout my research by keeping my viewpoint. I was aware that my position as a midwife, nurse and lecturer who had

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experienced transition myself could influence the study. Therefore, as per Guba's (1981) recommendation, during my study's data collection, transcription, and analysis process, I established reflexivity as discussed in this chapter (see pages 71-75; 75-77 & 86-87).

### ***Respondent Validation***

To further improve my study's accuracy, credibility, and rigour, I utilised respondent validation or member checking during data collection. According to Easton, McComish and Greenberg (2000), member checking entails the participants reviewing their responses and eliminates researcher bias when analysing or interpreting the study results (Anney, 2014). Throughout the first interview and subsequent interviews, I provided the participants with an opportunity to add further comments and verify their responses to enable them to clarify any ambiguous or unclear information (Almansour, 2015). Hagens, Dobrow and Chafe, (2009) advise against participants' verification of the interview transcripts, as they believe it could lead to a level of distress, discomfort, or conflict between the researcher and their participant, depending on the nature of the study. At the same time, Anney (2014) posits participants may reject the researcher's interpretation due to the manner in which they are presented or, if they disagree with a researcher's transcription of the interview or perceive the researcher's interpretations as socially undesirable. However, any disagreement from the participants may pose an ethical dilemma as the researcher is obligated to use all the participants' data. Furthermore, Hagens et al. (2009) argue that bias is created if there is any removal, inconsistency, or loss of valuable data due to an interviewee/participant choosing to challenge or remove their own responses.

### ***Peer Debriefing***

I applied peer debriefing in my study, wherein the research panel assessors tested my insights and exposed areas of my research that could be more robust and rigorous. In addition,



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my supervisors reviewed the transcripts for accuracy and offered feedback (Polit & Beck, 2010 b; Guba, 1981). The feedback and guidance received from my supervisors and other academic staff members have subsequently improved the quality of my work, as recommended by Anney (2014).

***Audit Trail***

An audit trail provides a detailed record of the steps taken while conducting the study. To enhance the trustworthiness of my research, I provided an audit trail of my research processes to enable other researchers to replicate and check the authenticity of my research, as recommended by Polit and Beck (2010 b) (see Appendix 21 for the audit trail of an analysed interview transcript, participant: Camilla).

## **CHAPTER 4: Findings**

### **Introduction**

The study explored the lived experiences of newly qualified midwives' transition during their first year of midwifery practice in Jamaica. In this Chapter, the findings are presented in accordance with identified superordinate themes and the research objectives. It will conclude with a summary of the key findings. The study findings were determined using Smith, Flowers and Larkin's (2009) Interpretative Phenomenological Analysis (IPA). The findings reflect the participants' lived experiences and the meaning they ascribe to their transition into midwifery practice. The results were achieved by deploying the double hermeneutic lens of IPA. The findings revealed my interpretation of the participants' understanding of their lived experiences, as recommended by Smith et al. (2009).

The findings were firstly presented in accordance with the four study objectives: 1) to critically examine the preparedness for practice of newly qualified midwives in Jamaica, 2) to critically explore the confidence levels of newly qualified midwives who are educated at either undergraduate or certificate level in Jamaica, 3) to critically examine the factors that may inhibit or enhance newly qualified midwives' transition into midwifery practice, and 4) to critically explore the impact of the clinical environment on newly qualified midwives' transition. The findings are then organised into the four superordinate themes identified during the analytic process (see page 100). In presenting the participants' verbatim narratives, utmost care was taken to use pseudonyms and not reveal the context. This was in keeping with issues surrounding confidentiality.

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### *Participants' Summary*

The results for this study were developed from the data collected from three series of face-to-face, in-depth interviews with newly qualified midwives in their first year of midwifery practice, post-registration. The interviews were completed at set time intervals: the initial three months (March to April, 2019), four to six months (March to July, 2019), and after twelve months (March to February, 2020). There were eight female participants in this study, Abigail, Beatrice, Emma, Flores, Francine, Francesa, Camilla and Daniella<sup>4</sup>. The participants' ages ranged from 21-39 years. The participants' education ranged from graduate to basic certification, as one participant earned a Bachelor's degree and seven earned Certificates. The graduate programme had a duration of four years, while a certificate programme lasted one to two years. The programmes were predominantly post basic with one being direct entry. The participants qualified as midwives in December 2018, except for two, who qualified in 2016. Seven participants started practising in January and February 2019, with one who began one year prior in December 2018. There were four full-time employed participants, two were employed part-time, and two were on contract.

### ***Findings for Research Objective 1: To critically examine the preparedness for practice of newly qualified midwives in Jamaica.***

The results for this objective were achieved from the first and second interviews, at the initial three months and four to six months post-registration, respectively. Participants were asked to describe their level of readiness as qualified newly midwives. Two themes emerged from their responses: education and training and mental preparedness.

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<sup>4</sup> Pseudonyms the newly qualified used throughout the study.

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### *Education and Training.*

Abigail and Beatrice believed that they were comfortably prepared for their roles as midwives. Abigail believed that the training she received became very useful in her new capacity. Emma also felt prepared because of her education in the field, though she admitted that in order to maintain readiness, she kept abreast of her function through continuous reading. Flores was very confident in her knowledge of the theory; however, she admitted that more practice was needed for the practical, which she would get on the job.

Francine, the only participant with a graduate degree, revealed in her first interview that she was completely prepared for her new role as a midwife, which she attributed to her vast knowledge in the area. This preparedness was achieved through the “extensive training” (Francine Interview 1, 25.04.2019) that she received, coupled with rigorous clinicals, which gave her real-life experiences that she now applies to her work.

The noticeably least prepared participant was Francesca, who revealed in her first interview to taking almost two-year break after the completion of her programme. Her delay in getting registered was due to her having two outstanding home deliveries to complete. However, Francesca was registered on the condition that she obtain the outstanding deliveries on qualifying. Returning to her career after such a long break has definitely challenged Francesca’s memory; she admitted that she has been re-introducing herself to the practice as she carried out her daily responsibilities. Francesca’s lack of preparedness was further compounded by the lack of support she received from other midwifery colleagues.

In contrast, some participants believed that they were barely prepared, because the midwifery education training programme provided an overwhelming amount of information in a limited time, making it difficult to effectively absorb the relevant information. It was on the job where Camilla started to grasp an understanding as she learned her responsibilities. Camilla said:

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We had to rush to cram everything, so being here now in practice is what I am now learning. I am now absorbing information, and putting things into practice, ... When I was training [I] had to be just learning to pass the exam. (Camilla, Interview 1).

***Psychological Preparedness.***

Beatrice believed that it was important to get her mind ready and to be in the right mindset to deal with the environment in which she works. Beatrice said: “first of all you have to mentally prepare yourself to deal with the situation” (Interview 1, 25.04.2019). As for complete preparedness, each of the participants in the initial interview, except Francine, agreed that there was room for growth and development. Two participants summed up the ongoing need for growth, with Camilla stating: “there are some things that I will continue to read to improve my knowledge” (Interview 1, 08.05.2019), and Beatrice commented, “I know there is room for improvement” (Interview 1, 25.04.2019).

In the second round of interviews, the emphasis was on staff shortage, especially among the senior midwives; this resulted in increased levels of responsibility placed on the newly qualified midwives, who, who would have preferred to be closely supervised until enough experience had been gained. The participants revealed that at six months in, there was still much work that needed to be done; however, they acknowledged improvement in their practice even though they were still considered to be in the learning phase.

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***Findings for Research Objective 2: To critically explore confidence levels of newly qualified midwives who are educated at either undergraduate or certificate level in Jamaica.***

Participants were asked to describe their confidence levels since they have been qualified as midwives and began practising. The themes that emerged from their responses were timidity and optimism.

### ***Timidity.***

All the participants indicated that their confidence levels were low, particularly during the initial stages, which resulted in some level of fear in making decisions. On one occasion, Beatrice stated: “when I just started practising, I wasn't that confident. So, if something went wrong, I'd call another midwife” (Beatrice Interview1, 25.04.2019). Another participant, Daniella, stated that the level of confidence she demonstrated was dependent on the area in which she worked. She outlined her preference for the antenatal as opposed to postnatal areas in midwifery, so she displays more confidence in those areas. On the other hand, Daniella is less confident in areas such as the nursery and labour wards.

### ***Optimism.***

Despite their initial low confidence levels, many of the participants displayed optimism, which resulted in improved confidence over time. The participants were becoming more familiar with the operation and intricacies of the practice; however, they were mindful that transition is a process and that there is always room for improvement. In answer to the question, *can you explain your confidence level since you began practising as a midwife?* in interview 1, Emma said: “it's improving, at first, I was a bit nervous but it's improving with practice for each day I get better and better, it's improving” (Emma, Interview 1, 29.04.2019). Flores best summed up by saying “it is a process in terms of building confidence as a midwife” (Flores, Interview 1, 07.08.2019).

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***Findings for Research Objective 3: To critically examine the factors that may inhibit or enhance newly qualified midwives' transition into midwifery practice.***

The participants were asked to identify the factors that have or are likely to inhibit or enhance their transition. From the participants' responses, several ideas emerged, which included lack of support and human resources as inhibiting factors, and learning experience, work environment and motivation were seen as enhancing factors. Some participants, however, did not experience any inhibiting factors.

For the inhibiting factors, some participants felt abandoned by their supervisor in situations that required their attention, especially considering their lack of confidence during the initial stages. 'In some instances, patients were verbally abusive and disrespectful to the newly qualified midwives, and Beatrice reported, "they say mean things to you" (Beatrice Interview, 25.04.2019). Although she understood their frustration, considering their situation, it made Beatrice understandably uncomfortable. Limited staff and inexperienced student nurses were also discussed. The participants stated that they felt overwhelmed when executing several responsibilities concurrently due to staff shortage. Then, there are the student nurses and student midwives, with varying levels of experience, who work alongside the newly qualified midwives on the ward as part of their clinical practice. The participants would have to closely monitor the students while executing their responsibilities, which, they revealed, was very challenging. The transition from a student midwife to a newly qualified midwife was also seen as an inhibitor for some participants who were still performing in student mode and were constantly dependent on others; they had to remind themselves that they were now qualified midwives, and as such, their responsibilities had changed, and much was expected of them.

For the enhancing factors, participants responded positively to opportunities to work in the same institution in which they were trained, as they found it easier to transition due to their familiarity with the policies and procedures. In other instances, participants lauded the support

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received from their supervisory staff and fellow midwives combined with the staff assignments, which they believed enhanced their experience and ultimately increased their confidence. The only graduate midwife emphasised her appreciation for being accepted by her certificate trained midwife colleagues, which gave her a sense of belonging in her team. For one participant, starting in the antenatal clinic was seen as beneficial, as it enhanced her transition into practice, which in turn, allowed her to transfer into other areas of midwifery confidently.

### ***Findings for Research Objective 4: To critically explore the impact of the clinical environment on newly qualified midwives' transition.***

For this objective, participants were asked to reveal their experiences of the areas worked during orientation. Numerous perspectives were given. One participant believed that her orientation was not good, as she did not have the opportunity to rotate within obstetrics, which was her preference, and be able to fill the checklist. Other participants believed that the orientation programme should be formalised to enable a smooth transition for the newly qualified midwives; they further added that with a formal programme, information would be better retained by the newly qualified midwives, thus improving their transition.

Other participants had generally positive experiences. In one instance, the participant acknowledged that she was previously employed in a different speciality paediatrics; with her transition to midwifery, orientation was very beneficial, as it kept her informed of what was expected in practice. Other participants revealed that there were orientation classes in the orientation programme, and a checklist in which skills were graded by the midwife or sister in charge in each area in which a midwife works. The classes and monitoring helped the newly qualified midwives to improve on their weak areas, thereby improving their (overall) performance.



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**Main Themes**

There were several themes that emerged from the overall findings of the study which were guided by the objectives. These themes were grouped into five superordinate themes (see Table 1).

**Table 1**

*The Summary of the Superordinate and Subordinate Themes*

<b>Superordinate Themes</b>	<b>Subordinate Themes</b>
1. Being a midwife and expectations	a. Personal expectations of being a midwife. b. 'Others' expectations
2. Transition shock	a. "Period of fear to a period of accepting"
3. Confidence and competence to develop autonomous midwifery practice	a. Developing maturity and confidence managing emerging situation b. Lack of self-confidence: holding self-doubts and marginalisation of staff.
4. Support and a sense of belonging	a. Supportive environment: "at no point is your back left bare". b. Supportive relationships c. Sense of belonging d. Divine support e. Women support f. Lack of support: environment, heavy workload, and orientation.
5. Theory Practice Gap	a. Developing expertise/clinical knowledge

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### **Superordinate Theme 1: Being a midwife and expectations**

During the three interviews with all eight newly qualified midwives, they talked about their expectations and the reality of midwifery practice, and about being a midwife before they qualified and upon commencement of practice. The participants' expectations were mostly personal. In some instances, and to a lesser extent, the participants' expectations were based on what others expected of them, i.e., women and staff. The newly qualified midwives formed their expectations of receiving support based on their peers' feedback, compared to the previous job, financial expectations, training/education, and prior experiences.

#### ***Subordinate Theme 1 a: Personal expectations of being a midwife***

This subordinate theme concerns the newly qualified midwives' personal expectations and how they formed their expectations. The midwives expected to receive support and guidance during their initial period of practice. Some of the midwives developed personal expectations based on feedback from their peers working within a supportive unit and environment, while some personal expectations developed based on a preconceived notion that their pay as a midwife would be better compared to their previous jobs. Additionally, some of the midwives' personal expectations derived from their financial obligations. There was also an expectation, which some developed from their training and education, that the newly qualified midwives would have the opportunity to engage in their mandated clinical rotations. Furthermore, others developed personal expectations from previous experiences.

The consensus amongst the participants was that they expected to receive support throughout their initial transition into midwifery practice. For example, Abigail and Emma expressed their need to be guided. Abigail wanted someone to "scoop her up"(Abigail, Interview 3, 19.02.2020). During the first interview, Abigail appeared concerned when describing her expectations of receiving support; her use of the term 'scoop' was fascinating

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and reminiscent of a mother's treatment of a baby who seeks to be nurtured until they have gained a level of independence:

I want them to kind of scoop you up a little and carry you along the journey a little more, and not just [...] because I'm a junior midwife, I am working in charge of the ward already, and I don't think that's fair to me because I barely know it. I just coming, I just want to learn and all of that.

(Abigail, Interview 3)

Abigail's first interview was particularly revealing of her (initial) uncertainty/lack of confidence:

...um [long pause], I expected to have kind of um like a little orientation, a little more help, a little teaching seeing that you just completed, and I mean it's not like you don't know, you learn a little, but you are not sure [of] a lot of things still, but you still learning, but a little education is more education, is more help starting out, that was what I expected.

(Abigail, Interview 1)

Abigail's repeated use of the word 'just' and the phrase 'a little' here seems to be hedging and downplaying her knowledge and experience at the junior level. However, Abigail was clearly indicating a desire for support, like orientation, and someone to help her along.

Daniella's expectations seem to have developed based on her peers' personal accounts of the hospital's supportive work environment. For Daniella, the need to work in an environment where she receives guidance and support appears to be paramount in her quest to consolidate her practice:

Alright, so I got what I expected because I wasn't trained here any at all, but some of my fellow batchmates were trained here...came here for

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training, and they tell me that oh gosh, you would love it here. These people always help you, and they always try to help, and they always try to teach, so coming here I had that in mind when I come here that was exactly what I got.

(Daniella, Interview 1)

On the other hand, some of the participants made comparisons to form personal expectations. Based on Daniella's account, she developed the expectation of higher pay compared to her previous job: "Expectations for me ... first of all I expected a larger pay [laughs] ... which is not there" (Daniella, Interview 1).

In contrast to Daniella, Francine's personal expectations were more about the influence of financial obligations: "even though I am a bachelor's midwife, I get the same pay as a certificate midwife. That now would be a factor for me because I have a student loan to pay " (Francine Interview 1). It seems logical that people expect more pay for a higher level of qualification, like Daniella, but perhaps not because they have financial obligations. This is suggestive too that Francine believes she is worth more because of the cost of her education. Daniella reported that there is an expectation for direct-entry midwives to have the opportunity to work in the community on qualifying after their hospital rotation. Throughout Daniella's interviews, she expresses her expectations of working in the community with optimism. However, from Daniella's final interview account, her expectations of working in the community changed, seemingly influenced by other midwives' experience of not getting an opportunity to work in the community. In her third interview, Daniella appears to have reached acceptance of the fact that her personal expectations of working in the community will not be realised soon:

Too many people in front of me [pause] cause if I come here and you have persons working here for six, seven years, and they want to go community

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and being applying, and it's not going through ... you think I'm going to come here working for one year [and] a couple of months and get through to go community like that? [pause] No, it's a, it's a line. So, you come, you join the line, you wait your turn.

(Daniella, Interview 2)

One newly qualified midwife's personal expectation seems to have been influenced by her preconceived notion as a student of being treated indifferently based on her midwifery qualification. Francine frequently pauses, seemingly a sign of her being reflective on the issue, and of her trying to make sense of her expectations:

I was more expecting persons to be [short pause] maybe in a way discriminated umm [pause] with me being [pause] me actually having a degree and working amongst persons with a certificate doing the same job as me.

(Francine, Interview 3)

On the contrary, personal expectations were formed based on the midwives' views of their clinical skills and capabilities. Francesca felt she would not meet the women's expectations as she perceived she did not have the experience:

[I am] afraid about ... not meeting the expectation of patients 'cause you are in the white ... you are supposed to know everything ... you don't know everything ... some things come with experience.

(Francesca, Interview 1)

Some midwives' personal expectations developed based on the misconceptions they had before beginning their midwifery practice:

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I thought first that it was just about delivering babies, and that was it. So that was what I was really expecting. I just deliver a baby and mommy get the baby and that's it [laughs].

(Beatrice, Interview 1) This subordinate theme revealed that midwives' self-made expectations developed intrinsically and extrinsically from their interaction with others. These factors included the support they expected to receive, either by comparing or receiving information from peers, or comparing their midwifery pay with their previous job. However, in some instances, the participants' expectations developed due to their financial obligation, the information they received during their midwifery education and training, and previous experiences as students.

***Subordinate Theme 1 b: 'Others' expectations***

This subordinate theme, 'Others' expectations, considers the newly qualified midwives' accounts in which they revealed their perceptions and beliefs about the expectations of other midwives and the women they cared for during their transition. Here, it was more about expectations based on education. Throughout the interviews, some participants expressed the expectations the other midwives had of them: "they would have somewhat expected me to know the basic things even though it's a specialised area" (Camilla, Interview 3).

One participant further tried to make sense of the other midwives' expectations of a bachelor's degree trained midwife versus a certificate trained midwife. For Francine, the challenge to prove her capabilities as a bachelor's degree midwife seemed a welcome one, and one she appeared to view without trepidation:

At first, it was the expectation, the high expectations being a degree midwife, so they say okay, you have a degree in midwifery let's see how different you are from the certificate midwives. Let us see what is it that you have to offer that is different; what is unique about a degree midwife? So, I came with that

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in mind to show them that okay, as a degree midwife, I can practice as a midwife, and I am also capable of doing work just as a registered nurse [short pause] that was mainly it for me.

(Francine, Interview 3)

Daniella reported that other midwives had expected the newly qualified midwives to start coping in six months:

after orientation, they are like you did do this during orientation so you should be able to move a little bit faster than how you were moving in orientation. So, I guess the expectation was to kind of start coping after that six months in.

(Daniella, Interview 2)

One midwife described her interaction with one of her clients who wanted her to do comprehensive care for her baby “around the clock”:

Yeah, especially in that feeding thing when you're encouraging them to breastfeed and they wanted you to feed the baby or do everything for them, come and change diaper, come around the clock, the baby is crying, take up the baby.

(Abigail, Interview 3)

The overall findings of the superordinate theme ‘being a midwife and expectations’ are that the participants’ expectations are seemingly derived from things they heard as students and their perceptions of their skills, which helped to shape their expectations during their transition into midwifery practice. The more qualified midwives expected for newly qualified midwives to practice competently within the scope of their practice; however, they had a much higher expectations of the degree trained midwives in comparison to the certificate trained midwives. The midwives also reported the high expectations of some of the women they cared for.

**Superordinate Theme 2: Transition shock**

This theme refers to “transition shock”, which is synonymous with Duchscher’s (2009) Transition Shock Theory. Transition shock refers to an acute and dramatic socio-cultural, developmental, emotional, and intellectual change that a new graduate nurse may experience while transitioning from a nursing student role and adapting to their new professional role as an autonomous practitioner.

***Subordinate Theme 2a: “Period of fear to a period of accepting”***

This subordinate theme exposes the newly qualified midwives’ initial fears at the start of their midwifery practice on realising the weight of responsibility for others amid their lack of practical experience and being accountable for their actions or decisions. The reality of autonomous working and being accountable led to some participants becoming fearful during their initial practice. One participant described the shift in her fear to her acceptance of her new role:

Yes, we have been taught but now putting this thing in practice, knowing that you are working on your own license. So, at first, it was a period of being scared. I was very much afraid of what to expect, what to look for. Then it moves from a period of being afraid to that period of accepting like this is actually the reality, and you have to do what you must do, these patients are in your care, and you will be held responsible if anything goes wrong. So, I moved from a period of fear to a period of accepting.

(Beatrice, Interview 3)

Daniella reported being fearful at the start of her practice in delegating duties to other midwives; she reportedly used to “doing everything else that people did not want to do” (Daniella, Interview 2). Responsibility also seems a vital issue for Daniella in the delegation



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of duties as per her reported fear of her ability to take decisive actions and exercise her assertiveness during the delegation of responsibilities to the other midwives:

At first, I used to be more timid when I'm giving assignments. Like "you want to do this today? You want to do that today?" and people like, "oh no, I do not want to do this. I don't want to do that" and then nobody, people always want to leave like the hardest stuff not wanting to do it, and then I used to pick up myself, and I've been doing everything else that people don't want to do. So now I realise I say no, no, no. Some of the times you have to take ground and make a stand and say all right, I've made the assignment, and this is what you're going to do.

(Daniella, Interview 2)

From this subordinate theme participants were initially fearful of working independently. However, as they progressed during their transition into practice, they reported experiencing a shift in their thinking and an acceptance of their role and responsibilities as qualified midwives.

**Superordinate Theme 3: Confidence and competence to develop autonomous midwifery practice**

This superordinate theme relates to the newly qualified midwives' perceived shift in their confidence and competence during the period of their transition, their experiences of managing situations, and eventually leading to their perceived autonomous practice.

***Subordinate Theme 3a: Developing maturity and confidence managing emerging situations***

Central to many of the participants' accounts is the allusion to their improved self-confidence as related to the increase in knowledge and experience they have acquired, and their support through mentoring and supervision since the start of their midwifery practice. The self-

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confidence results are the outcomes that participants ascribed to their experiences, e.g., telling patients what they might do, advocating for the women in their care, and not needing someone else to direct them. From the interviews, most newly qualified midwives linked their ability to manage high-risk midwifery cases and their confidence building to their acquired knowledge and experience and the support/mentoring/help/supervision they received during their transition into midwifery practice.

Participants in the study expressed how they have grown in their knowledge and experience in caring for their patients throughout their first year of midwifery practice. Camilla said:

I've become more confident in taking care of my patient, more confident in doing stuff for my patients, more confident in telling them, in educating them because of the increased knowledge that I have obtained and due to the increased experience.

(Camilla, Interview 2)

Flores shared similar sentiments: "My confidence level has really, really improved by having all these experiences and learning from them" (Flores, Interview 2).

Additionally, improvement of self-confidence has enabled one participant to advocate for her patients:

...but like I'm on nights now I realised that I advocate for my patients. I don't know if it's because it's a one-to-one basis [laughs] with the doctor but in terms of day when you have this group of doctors, and you have to talk, no, but I think I'm getting there 'cause I think if I should come back on day duty, I think I will be able to advocate for them. So, it is not like I'm not advocating is just that I don't talk.

(Emma, Interview 3)

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Some newly qualified midwives were given supervisory responsibilities to mentor students while consolidating their own skills. One midwife reported a boost in her confidence on account of having to supervise junior staff:

the first time I was asked to supervise the delivery of a pupil midwife. Yes, it gave me the confidence to say, okay, I've been supervising you, I see that you know you're doing what you're supposed to do so, let me put you in a position now where you're taking on more responsibility and let me see how you do. So that was another good moment for me.

(Flores, Interview 1)

During the interviews, some midwives expressed an ability to manage independently without supervision:

I can see where I've grown. I have become more mature; I'm actually putting what I've learnt into practice; I can basically manage myself when my superiors are not here. I can take control of things, and I know the basics.

(Beatrice, Interview 3)

In Daniella's account, she professes her matured confidence in her ability to work autonomously and to extend her assistance to others: "I don't need any help these days anymore. Now I am helping other persons" (Daniella, Interview 2).

Francine expressed an initial fear of managing complex midwifery cases, but reported improved capability of dealing with complex issues:

I would shy away from a risk patient meaning like the cardiac patients, the urology patients, but now I will demand that I want those patients to care for them, yes.

(Francine, Interview 3)

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Emma also experienced initial fear in managing complex cases, but associated her improvement in her capabilities to her acquisition of experience and knowledge during practice:

...so probably before like a pre-eclamptic patient or so I would be more timid in terms of taking care of the patients on my own. I have to get supervision or so, but now I have the experience, I have more knowledge and stuff like that. So, I'm able to care for that patient [short pause] without supervision.

(Emma, Interview 3)

Newly qualified midwives reportedly experienced an improvement in their self-confidence in managing high risk maternity cases then when they just started their practice.

Initially, some newly qualified midwives were too timid to manage high-risk midwifery cases such as pregnant women with complex medical issues; however, they overcame their fear as they progressed in their midwifery practice. Knowledge and experience are fundamental to the newly qualified midwives' confidence in managing high-risk cases.

***Subordinate Theme 3b: Lack of self-confidence: holding self-doubts and marginalisation of staff***

Lack of self-confidence emerged as a subordinate theme and a significant factor that impacted the newly qualified midwives' transition into midwifery practice according to their interview accounts. Some participants' lack of self-confidence is attributed to their self-doubt in managing emergencies and their experience of deficient knowledge in their midwifery practice:

I know for sure I have the knowledge, but I still think I would need more confidence in that area to manage emerging situation. I think that's where my downfall is, right? To, just to know, to know when to act in emergency

situations but if things are stable enough for me, then I'm more able to manage better.

(Camilla, Interview 1)

Self-confidence is linked with having specific knowledge and skillsets, and other abilities acquired or innate. However, the harbouring of self-doubt may reduce one's self-confidence.

In Abigail's third interview, she recalls an occasion which she reported negatively affects her confidence where she recognised an issue and could name it, but could not recall all the details, Abigail rationalises that a deficiency in knowledge may impact one's self-confidence:

I remember I saw the pseudo menstruation in the diaper, so because I do not remember about the hormones and whatever, I just know that it's hormonal changes that caused it. I do not remember the exact thing that they told us in class and all of that. So, before she could even ask me, I just said its pseudo menstruation, tell her the name, spell it for her and tell her she could find it on Google [laughing].

(Abigail, Interview 3)

The offering of support in the form of correction or a condescending manner may cause resentment and make learning and transition difficult. Although she received support, Abigail questioned how it was done in terms of trying to build her confidence while she was still learning: "when they're correcting you, they could do better at that" (Abigail, Interview 3).

Power differentials and the marginalisation of staff was noted in the participants' accounts. Abigail gave a heart-wrenching, teary-eyed account of a Sister's belittlement of a direct entry midwife, recalling her disparagement: "That one is an idiot, that one does not have no sense, this one sensible" (Abigail, Interview 3). Abigail condemned the Sister's conduct, emphasising the need for mutual respect:

you cannot just walk around classifying people like that. Just help everybody along the way. I don't like that part; scoop me up and teach me, you know even if you think I know it, I still need to know and the one that you are calling an idiot you really need to help them instead of calling them an idiot when you see that they don't know.

(Abigail, Interview 3)

From the newly qualified midwives' accounts of developing their self-confidence, they initially fear working autonomously to manage complex situations however during their transition into practice they gradually overcame such fears. The newly qualified midwives' garnered self-confidence through their acquisition of knowledge and experience, and the support and supervision they received. However, self-doubt and staff humiliation factors inhibited some newly qualified midwives' self-confidence and transition into midwifery practice in this study.

#### **Superordinate Theme 4: Support and a sense of belonging**

This superordinate theme is linked to the institutional support the newly qualified midwives receive and its influence on their transition into midwifery practice. This theme also relates to the newly qualified midwives forging relationships with their counterparts and the more experienced midwives, which gives them a feeling or sense of belonging. The literature review revealed that most of the participants interviewed on the status of support regarded their experience of support positively (see Chapter 2 of this study). On the contrary, the newly qualified midwives in this study reported lack of support as an inhibitory factor in their practice transition. From the participants' perspectives, they attributed this lack of support to heavy workloads, staff shortages, and orientation process issues. On the other hand, having a feeling

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of connectedness and acceptance was seen as important to some participants who valued their relationships with their colleagues, and this evidently influenced their performance in practice.

***Subordinate Theme 4a: Supportive environment: "At no point is your back left bare"***

Within this subordinate theme, the newly qualified midwives reported support through their institution's support/supportive system, coupled with peer and managerial behaviours. From the midwives' accounts, the forging of relationships with other midwives helped to facilitate their transition; their support experience meant receiving assistance with tasks and information on policies and procedures.

One participant viewed the support she received within her clinical environment in a holistic manner. Based on the participant's report, she received emotional and physical support, which enabled her transition into midwifery practice: "The support is good. Emotionally, physically, mentally, the support system is good" (Beatrice, Interview 3).

Flores also spoke of the support system at her institution positively and emphasised the level of support she received at the institution had a good balance:

We were never left alone; we had supervision, adequate supervision for the deliveries; we had supervision as well. It wasn't handholding, but we were not left up to ourselves so, it was a good balance.

(Flores, Interview 3)

Likewise, for Beatrice, her supportive experience meant she received assistance with her workload:

...at no point is your back left bare; no one will leave you alone with that heavy patient; if there is an admission to come and you are there, and somebody is assigned another task, you will just do the admission for the person.

(Beatrice, Interview 1)

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Support relates to the support that the newly qualified midwives reported they received from peers and managers. For some midwives, support from their peers meant receiving clarification to any questions or challenges they may have had: "if I meet up any challenges, I can ask, and I can get clarification, and I can add that to my experience and be a better midwife" (Francesca, Interview 1). Emma's comments echoed Francesca's:

I've been getting the support, so persons are always there for you to ask questions, any clarifications you can get that, and it's a learning process so every day you would learn something new.

(Emma, Interview 1)

Interestingly, one midwife reported that, in the absence of peer or managerial support, her alternative source of support is the internet: "if the other staff member doesn't know, I would go to the Staff Sister directly, or I would turn to Google" (Francesca, Interview 3).

One participant expressed receiving managerial support from the sister in charge:

"The support comes from the managerial staff, the nurse, the Sister in charge of the ward and I can take a leave and say the entire nursing staff on the ward" (Francine, Interview 3). Francine further commented:

because anything I don't understand, I can ask the sister and she clarifies with me any issues, any issues that I may have on the ward I can always go to her and clarify it with her or justify any issue.

(Francine, Interview 3)

Based on Francine's report, it appears that receiving support and mentoring motivates participants and gives a sense of security to accomplish the required task, as experienced by Camilla: "I didn't feel fearful, because I had a person working with me, helping me to do what I need to do, because we can't work alone, we have to work together" (Camilla, Interview 2).



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On the other hand, support was not always expected, as one midwife explained when asked the type of support she had expected to receive after qualifying: "Well, I expected to receive none [...] because in school there's sometimes you on the clinical area and [you] ask questions [but] you do not receive support, supervisory support" (Francesca, Interview 1).

The findings revealed that a supportive environment enhanced the newly qualified midwives' transition into their midwifery practice.

***Subordinate Theme 4 b: Supportive Relationships***

This subordinate theme concerns the newly qualified midwives' reports of their experiences in the forging of relationships with their peers, their personal relationships with divine being and relationships with the women. There also seemed to be a reflective aspect regarding the constancy/availability of others and their readiness to help without being asked. For Abigail, support meant responsiveness to questions, but she also reflects on the impossibility of doing things 'right':

Well, supervisors always the same, but the ward supervisor not like that. Support from her is very good, and support from other colleagues is very good. But other supervisors are just always the same. You just never can do everything, too, right. All when you think you are doing it right and everything is all right; it's just never enough. But ward supervisors support very good, and other colleagues support is very good.

(Abigail, Interview 2)

Francine's also shared a similar perspective of the supportive relationship she experienced:

The support system I can say is great that one I cannot lie or deny, because persons seeing that I come on the ward, persons are willing to work with me. Also, if I ask a question, if I don't understand something and ask for clarification, they are willing, they don't [...] shy away, they don't walk away, they're willing to educate me as I go along and so far, we have a good relationship.

(Francine, Interview 3)

The participants reported experienced positive relationships with their fellow colleagues which helped their transition into midwifery practice.

#### ***Subordinate Theme 4 c: Sense of Belonging***

Peer or practise relationships between the senior and junior staff acted as a catalyst for the newly qualified midwives' motivation and transition into practice. One participant described her experience, which depicted her sense of belonging:

no one showed me a bad face [did not mistreat her], and I think that contributed to my transition. I would wake up every morning expecting to come to work and know that I would have a good day.

(Beatrice, Interview 1)

Being the only graduate midwife in her group, Francine alluded to the importance of having a good relationship with others, including feeling accepted among her peers, which she perceived to be very important. This feeling of belonging has allowed Francine to execute her duties confidently, as she was guided along the way:

the acceptance of the nurses here because even though I am here with a bachelor's degree, no one is here saying that you know you're a midwife ... you

are a bachelor's midwife and bashing [criticising] because of the degree ...  
they're very accepting and welcoming, and I really appreciate that, and they are  
willing to teach me as I go along.

(Francine, Interview 1)

The participants positive account of the other midwives being accepting of them and not showing them a 'bad face' as stated by Beatrice and her looking forward to going to work was powerful and it seemingly enhancing their transition in practice.

#### ***Subordinate Theme 4 d: Divine Support***

Divine intervention was also a kind of support that was described by participants. Personal resources, such as religion and midwives having spiritual beliefs were perceived as enhancing the midwives' transition into practice. Some midwives sought solace through their religious faith as a means of support during their transition:

So, the transition I'm just taking it a day at a time and just trusting the process  
and trusting God that what and wherever I fall short, He will be there to catch  
me; and if He's not there, He will set the right persons to be there to support,  
to guide because you know, teamwork makes the dream work and so we all  
can achieve in the end.

(Beatrice, Interview 3)

Similarly, one of the newly qualified midwives was left to manage a challenging situation with a mentally ill pregnant woman who reacted to her antipsychotic medication, and her relatives became unmanageable. From Camilla's report, she seemed to be struggling with her management decisions:

I had to be praying and asking God what to do because I was very much, I  
wouldn't say fearful, but I was more on the concerned end because I wanted to

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really know what to do, what to say to them, how to get things under calm and then I had other things battling with like in terms of finishing the report and also the 24-Hour Report to send off and all those things and also to manage my time and also to take care of my patient that I had assigned myself to so that was a challenging evening for me.

(Camilla, Interview 3)

In this theme it revealed that in the presence of uncertainty and/or in moments of crisis when managing the ward, participants sought divine intervention as a means of their support to assist them with conflict resolutions and in the daily tasks.

***Subordinate Theme 4 e: Women Support***

The interviews revealed interesting details about the impact of the newly qualified midwives' relationships with the women they cared for. Based on the participants' experience, as a façade, they seemed to rationalise and downplay the women's negative behaviour, seemingly as a defence mechanism for dealing with the negative attitudes. However, such negative attitudes towards the midwives appear to cause conflict between their inner selves and their professional roles; based on the participants' accounts, they became frustrated. One midwife downplayed a woman's negative attitude as a façade, as the woman's way of dealing with the situation:

factors that inhibited my transition. All right, so I would link it directly to people again [laughs]. Like um some patients, as I'm saying that some of them, they can be very unfriendly at times[pause] um they say mean things to you [laughs] well sometimes it not, it's not intentional.

(Beatrice, Interview 1)

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On the contrary, Abigail, rationalises biological factors as the cause for the women's negative behaviour:

I don't know if it's the hormones that go haywire after or everything, but everybody's kind of jumpy and angry and antsy and upset, and the simplest thing you say or do gets patients mad, and they want to get off at you and become rude and all of that.

(Abigail, Interview 3)

The findings within this theme revealed that the women's' negative behaviours in the form of unfriendliness and rudeness towards the newly qualified midwives adversely impacted some of them transition into practice.

***Subordinate Theme 4 f: Lack of support: environment, heavy workload and orientation.***

This subordinate theme concerns numerous factors reported by the newly qualified midwives, which contributed to their lack of support. The participants reported lack of collegial support, improper skill mix, staff shortage, and heavy workloads as inhibitors of their transition into practice. Other issues identified included the orientation process, such as lack of structure, not being offered rotations within the obstetrics units, and newly qualified midwives being left to work independently, without supervision. One participant believed that some staff were not supportive, but wished that their negative behaviour did not infiltrate the rest of the staff who were:

you would have a few rotten apples in the big bunch. Hopefully, it does not spread to rotten all, but so far, most persons are willingly helpful, but then you have one and two that really don't care to assist you or anything like that.

(Daniella, Interview 1)

Abigail's comments echoed Daniella's:

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So, serving medications, doing dressings, everything that nursing or midwifery entails, caring for patients in general admission and stuff would be left on you and people in rooms hiding and those things and not working. Calling names, looking for people, nowhere to be found, and the work is left on you.

(Abigail, Interview 3)

Some midwives spoke of the lack of institutional support during their transition into midwifery practice: "We were thrown in, so we didn't have a choice but to get with the system and to get with the culture shock that is present" (Camilla, Interview 2).

The lack of senior midwives in the unit due to resignation and migration of senior midwives from the workforce negatively impacted the support that the newly qualified midwives received during their transition into midwifery practice. Beatrice explained:

you have to like depend on yourself for the most part because the senior nurses are going and the junior ones, like myself, we basically lean on each other, trying to learn from each other.

(Beatrice, Interview 2)

Staff shortages led to some newly qualified midwives feeling tired, burnt out, demotivated, and overwhelmed at times:

the short staff that is um the main issue, so you find that sometimes you feel extremely tired, exhausted and feel burnt out and stuff. So sometimes I am demotivated, don't want to come to work but I just have to tell myself that this is what I wanted a long time ago and I'm actually there now.

(Emma, Interview 2)

Daniella also shared a similar experience to Emma's:

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Sometimes I'm overwhelmed depending on what you have to do it's not just getting patients, there are other things on the ward that you are assigned to do [pause] so, you have to get them done and in turn take care of your patients and provide patient care, good patient care too so, it's a bit overwhelming at times.

(Daniella, Interview 1)

Most of the midwives reported experiences of heavy workloads. Although Francesca reported having a heavy workload during her previous interviews, in her third interview she appears to downplay the work status, work status, which indicates her acceptance of a heavy workload as the norm:

All right, so normal workload. You come to work; you check your patients; you make sure there are no abnormalities or if you see any abnormalities, you call the doctors so they can sort it out and you continue to do your checks.

(Francesca, Interview 3)

One participant alluded that a shift in her knowledge and confidence during her transition from novice to expert made coping with her workload easier:

workload, as I said just make it easier because the more experience you get you kind of find, let me not say tricks and trade [pause] let me not say shortcuts, but you find ways of means of coping better because you're so used to an area.

(Daniella, Interview 3)

During their transition into practice, some participants reported that the workload was greater in some clinical areas due to complications and the assigned staff's capabilities:

The workload is more so especially for the postnatal ward I think we should get more staff for here because it's really hectic sometimes and if we have mummies with complications or babies [short pause] complications, we have

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to have more hands on board to assist [short pause] more support from persons  
in charge.

(Emma, Interview 3)

The capabilities of the staff with whom they were assigned were also a factor that helped the  
newly qualified midwives to cope with their workload during their transition to practice:

what I've realised now, it all depends on the shifts in which you work. So, to  
me, when you have like a morning shift, there is a lot to do depending on the  
ward, you're on.

(Daniella, Interview 2)

However, Daniella also commented that workload was dependent on the shift:

I figured that the most, the easiest, the workload are much better at night when  
you work like an overnight shift. That shift, yeah, you come in, you see your  
patients, your patients go to sleep. That's the thing and then the only thing when  
you wake up in the morning now you have your medications to serve and your  
final checks, and that's it.

(Daniella Interview 2)

The unstructured format of the orientation programme negatively impacted the newly  
qualified midwives' transition in practice. Camilla explained: "[it] is like we were just thrown  
into it, and we had just to adjust as we go, we didn't have a formal thing to transition in"  
(Camilla, Interview 1).

The lack of rotation throughout the obstetrics units and supervision during the  
orientation period posed a disappointment to some midwives.



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Orientation process was extended to non-obstetrics units, of which some midwives did not approve. Abigail reported her disappointment in being assigned to a non-obstetric ward on which she had previous experience of due to her status as a post-basic midwife:

as I said, you would have been better umm being on orientation for the three months throughout the block instead of being on the Gynaecology ward itself and considered on orientation, 'cause you are not really rotating through obstetrics.

(Abigail, Interview 1)

However, some midwives expressed their appreciation for the orientation process on non-obstetrics units. Daniella voiced her amazement at being assigned to non-obstetrics units, which she perceived to be beneficial because she did not have experience in these units before becoming a direct-entry midwife:

I saw the Director of our program did something that was amazing. I think she thought it would [not] have been great, but it was. She tried to rotate us as midwives amongst maternity and also to the Paediatric Ward, but what she also included was she sent us to the renal unit.

(Daniella, Interview 1)

Additionally, there were some participants who perceived the orientation as important, having undertaken their midwifery education elsewhere:

the orientation process, I believe is a very important one because especially for me coming from a previous, another institution, it is [quote-unquote], new to me, a lot of things are new as I was working in paediatrics, now this is adult, and this is a speciality.

(Flores, Interview 1)

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Although some midwives were left unsupervised during their orientation and had to manage challenging situations without supervision, Beatrice spoke of a growing sense of autonomy:

I think it was a good little experience and even though I was on orientation, so there were times that I actually forgot that I was on orientation because I was just there working independently on my own.

(Beatrice, Interview 3)

Nevertheless, the absence of supervised practice can lead to detrimental overcome. Francesca recalled her experience of a woman's maternal death in her care while working alone on the first night shift during her orientation:

I was alone. It was my first night, first night on night shift there [pause] on orientation as the doctor was about to examine her, she crashed. The patient became unresponsive. So, I went to call an Anaesthetist [pause] we did not get any till a couple of minutes later and others on the ward came to help.

(Francesca, Interview 2)

Some midwives deemed the orientation process unnecessary. Initially, Beatrice contended that the orientation programme was too long and unnecessary:

the orientation programme, I think, um for me, I think the orientation time was too long. I don't think I needed three months of orientation, um but then come to think of it I think originally Sister had said four weeks (Beatrice, Interview 1)

Beatrice further emphasised her need to start practising without the need of returning to the classroom during her orientation period:

I've learned the stuff already. I basically need to practice them now. So, I do not see the need for me to go back to the classroom. I was on the ward

practising, so I think that was the right thing to do. So, you're basically practising what you preach now.

(Beatrice, Interview 3)

From the subordinate theme the findings revealed mix reactions from the newly qualified midwives concerning their orientation. However, from their overall report one midwife spoke positively about her orientation that it was important most of the newly qualified midwives reported their orientation experience with negativity such as it being unstructured, unnecessary, not receive any support and supervision.

### **Superordinate Theme 5: Theory Practice Gap**

Another area that the newly qualified midwives found meaningful in their transition experience was acquiring further knowledge and expanding their skillset. However, at times during their transition, the participants' knowledge deficit was troubling to them.

#### ***Subordinate Theme 5a: Developing expertise/clinical knowledge***

This subordinate theme identified issues that influence the clinical skills and experience of the participants. Such matters included knowing what to do in real life, the perceived gap between the theory learnt as a student versus the reality in practice, the benefits experienced in consolidating theoretical knowledge and skills into practice and learning through socialisation and performing skills.

There seemed to be less pressure on the midwives once they had finished studying and could concentrate on practice. One participant perceived that not having to study and going into clinical areas helped her to transition:

well, the fact that I don't have to be like going into the clinical areas and then coming home to study and all those things ... I have like more time to actually focus ... it's getting easier ... the focus is just one place instead of all over the place.

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(Francesca, Interview 1)

Conversely, a delay to practice midwifery may affect one's ability to turn theoretical knowledge into practice, to know what to do in real life. Acquiring professional skills and not using them increases the risk of losing them. This was the situation as reported by Francesca whose delay in practicing as a midwife affected her transition.

you remember some of the things, but when you get back in practice it's like you trying to remember exactly how certain things work again ... so it's like you come back to school, so you going to be asking a lot of questions.

(Francesca, Interview 1)

Flores also experienced a delay between qualification and beginning practice in her midwifery practice which was due to personal reasons. Nonetheless both Flores and Francesca have identified that they are getting back into practice and so they have learning needs:

As far as theory is concerned, I am prepared in that regard, practice, I am ... put it this way, getting back into it, because I'm a new midwife in regard in terms of practice ... so qualify, but now, just practising. So, I'm still at probably the novice stage but looking forward to learning more [laughs].

(Flores, Interview 1)

Unlike Francesca, Daniella did not seem to have an issue knowing what to do in real life. In reality, for her, there is a perceived gap between the theoretical knowledge gain and what happens in practice:

Let me tell you, theory in regard to transitioning, can't help, the theory will not help. The theory is telling you how it should be, the government system. This is the real world. It is never like the book. You never, I have never come upon

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a situation, and it is just like what the book says. There is always something different from what the book says.

(Daniella, Interview 2)

Like Daniella, Beatrice seems to have experienced a differential gap in what she learned as a student but never encountered in her practice as a midwife: "We did a lot of stuff in school, and I have not seen some of [it]" (Beatrice, Interview 3).

Interestingly, for some midwives, consolidating their practice was reportedly beneficial:

I found that [pause] I have learnt a lot more than I did in school. I don't know if it's umm, well I think it's more about how the area runs itself [pause] than the actual practices on the patients.

(Francesca, Interview 2)

Like Francesca, Emma seemed to have experienced similar rewards regarding her consolidation of theory to practice, which she reported as knowledge gained in practice:

We still in the learning phase. So, you know, every day you learn something new. So, as you go along, you learn, but I try to prepare myself most times and try and read whenever I can, not every day but whenever I can manage to brush up on certain things.

(Emma, Interview 1)

Francesca:

I have come to realise to go back to some of these conditions on the ward, to read up just to get more clarification on them; cause alright sometimes you don't see them as much so the management kind of goes out of the brain for me, so I need to go back to reading those conditions.

(Francesca, Interview 3)

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Abigail has also benefited from consolidating the theory learned into her practice. Abigail alludes to the theory-practice gap on several occasions during her interviews, in performing mandatory midwifery skills such as vaginal examination. Abigail stated that she gained competency in her midwifery skills through the consolidation of theory into practice:

It was from midwifery while doing the programme itself; I don't know, I just didn't get it at that point. I just was, I just felt like I was not getting it. But in seeing that you on the antenatal ward and you have to do it basically every day ... when you were in school, you weren't doing it every day, it's just for when you go to labour ward, and sometimes it's just to get them to sign off that you are doing it.

(Abigail, Interview 2)

On the contrary, based on Camilla's account, she did not seem to have experienced such rewards of consolidating the theory she learned into her practice. Instead, she had to learn through observation, that is through socialised practice from the senior midwives: "Basically, I had to really kind of adopt what the senior midwives did, just by eye contact or kind of eyeball them" (Camilla, Interview 3); Camilla further stated "whichever area you go, you just have to learn the ropes there; whatever they do, that's what we do" (Camilla, Interview 2).

Newly qualified midwives' attitudes in terms of their clinical preferences seemingly influenced their transition into midwifery practice, as revealed by their lack of enthusiasm and frustration in some instances:

I don't like the labour and delivery units. It's not my best units. I don't like doing deliveries. They're like they don't understand how a midwife doesn't like doing deliveries but as a midwife, you have to appreciate other things. It's not about just taking out a baby. Anybody can take out a baby; it's not no big deal taking out a baby. I love to care for the mother before delivery when you see

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the conditions, and you actually get a chance to sit down and care for these conditions and see how they manifest.

(Daniella, Interview 2)

Beatrice also expressed a preference: "I prefer postnatal, and that is where I work because I get a chance to help the mothers with their baby, help them to transition in this postpartum period" (Beatrice Interview 1).

This subordinate theme revealed that a delay in midwifery practice could affect theoretical knowledge due to participants forgetting what they learned during their training. Furthermore, some newly qualified midwives had difficulty adapting to their new role. In contrast, others reported experiencing an increase in their knowledge during practice when compared with when they were in school, while some had to learn through socialised practise. The study also found that midwives had a preference in terms of the working environment, which can impact how well they function and transition.

### Summary of Results

The study's findings revealed that the newly qualified midwives' first year in practice was fraught with a range of emotional and functional challenges. These challenges were due to the clinical environment in which they practised, the issues they encountered and their interactions with staff members and patients. The study also found that some newly qualified midwives expected to receive more support from senior staff. However, based on the study's findings, in the absence of senior midwives, the newly qualified midwives had to rely on their peers during their initial practice to assist their confidence-building and clinical competence. The findings also revealed newly qualified midwives' experiences of some of the challenges they encountered, such as working unsupervised, alone on a shift during orientation, which resulted in deadly consequences, maternal death and staff abuse by relatives. Maternal death

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and staff abuse by patients' relatives have implications for the midwife and the organisation and place the women's and midwives' lives at risk. The experienced midwives had high expectations of the degree trained newly qualified midwives.

The findings exposed a theory-knowledge gap among some of the newly qualified midwives, which was attributed to a break between training and practice. The study found that some newly qualified midwives who reportedly experienced a delay in their midwifery practice, expressed having learning needs which they linked to their delay in practice. Despite a delay in the midwives' initial practice, they did not complete any return programme and seem to struggle to recall everything. Additionally, major inhibitory factors in the transition of the newly qualified midwives were the lack of human resources in terms of staffing. Direct entry midwives spoke positively of their orientation on non-obstetrics wards as beneficial. In contrast, the post-basic midwives expressed their disappointment at being rotated within gynaecology wards during their orientation period because they had previously worked and gained extensive skills and knowledge in these areas.

Also, the study revealed that some participants perceived their orientation programme as non-existent, useless, lacking structure, taking place on the non-obstetrics ward, and as taking too long, while others thought it was good. The study's findings showed that the direct entry midwives are often discriminated against by the post basic midwives and perceived as unknowledgeable. The study also found that the senior midwives belittled the newly qualified midwives, which impacted their self-confidence. Moreover, the study revealed that some newly qualified staff found some of the patients' attitudes towards them unpleasant, but the newly qualified midwives appeared to be tolerant and able to maintain their professionalism.

Based on this study's findings, the newly qualified midwives' transition into confident practitioners at different stages during their midwifery practice. Additionally, despite the challenges at the end of their first year of midwifery practice, most participants were able to



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work autonomously and no longer perceived themselves as novices, but as competent practitioners.

## **CHAPTER 5: Discussion, Implications and Conclusion**

### **Overview of the results**

This chapter presents 1) a summary of the main findings, 2) a discussion of the research objectives and findings based on the themes identified, 3) a discussion of each theme compared with the findings in the literature review. The chapter concludes with the implications for newly qualified midwives and recommendations.

### **Overview**

The phenomenon of interest in this study is the lived experiences of newly qualified midwives' transition during their post qualification in Jamaica. The study focussed on the midwives' preparedness for practice, confidence levels, factors influencing their transition and the impact of the clinical environment on their transition. I present a discussion of the findings of my study in relation to existing literature. The discussion of the implication for practice is presented in addition to the conclusion drawn for the research. The purpose of the study was to provide more in-depth insight and understanding of transitional experiences of newly qualified midwives into midwifery practice throughout their 12 months post-registration in Jamaica. The following discussion will look at the five main themes areas.

### **Summary of the Major Findings**

The study found that the newly qualified midwives encountered various challenges; however, they remained positive about pursuing their midwifery careers. The study's findings indicated that newly qualified midwives were able to cope despite challenging situations, as they showed resilience. The interviews also found that newly qualified midwives were not confident to practice independently initially. Throughout the three interviews, the participants gradually experienced increased confidence and were more assertive to advocate for their

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women and manage high-risk cases autonomously. The newly qualified midwives were able to consolidate their learning throughout their one-year transition into midwifery practice.

In addition to the collegial support, the clinical environment enhanced the newly qualified midwives' transition into their midwifery practice. However, several factors negatively influenced newly qualified midwives' transition into practice, such as their expectations of becoming midwives and other staff's expectations. Additionally, some factors inhibited their smooth transition into midwifery practice, such as staff shortage, unstructured orientation programme, the lack of support from senior staff and lack of self-confidence and holding self-doubts concerning their capabilities.

### **Research Objectives and the Superordinate Themes Identified in the Study**

This section will examine the themes identified in relation to the research objectives. The first research objective was to examine the newly qualified midwives' preparedness for practice. The results showed that their expectations significantly influenced their preparation. This superordinate theme revealed that the newly qualified midwives had expectations of their midwifery practice whilst as students and at the start of their practice. The expectations the newly qualified midwives had of the midwifery profession emerged intrinsically through their own mindset, both intrinsically and extrinsically from their interactions with others which and influenced their transition experience. The intrinsic expectations developed from the expectations the newly qualified midwives formed about themselves. At the same time, their extrinsic expectations were derived from what their peers, women they care for, and the senior midwives' expected of them. The study found that, initially, the participants had variable expectations of becoming a midwife. For example, most midwives in this study expected senior midwives' support, while others expected larger pay and rotation within the community. However, according to the study's findings, only one of the newly qualified midwives expected to work in the community as a midwife. With direct entry, midwives

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were kept as part of the hospital workforce to alleviate staff shortages. According to the Ministry of Health (MOH) (2005), newly qualified midwives, especially the direct-entry midwives, receive nine months of hospital orientation and three months in the community. However, due to the staff shortages, the participants did not receive the mandated orientation period within the three hospitals studied.

The second research objective explored the level of confidence shown by the newly qualified midwives, to which the findings identified the existence of transition shock as a featured concern. The newly qualified midwives reported a shift in their confidence and competence during their transition and their experiences of managing situations and eventually led to their autonomous practice. Initially, some midwives were afraid to work independently. Still, as they transitioned into their practices, they gradually worked autonomously and reported an increased level of self-confidence, even when managing high-risk cases. In many instances, most of the midwives were working in charge when assigned on duty.

The third research objective examined factors that may inhibit or enhance the transition of the newly qualified midwives. The findings revealed that several factors were considered hindrances among the newly qualified midwives, including lack of support and human resources. Evidently, some expectations were also found to be inhibitors, as the support and guidance that was expected by some of the participants were not evident in practice. There was also the challenge of staff shortage, which resulted in increased workloads and responsibilities for the newly qualified midwives. When faced with negative experiences, some participants reported that those negative experiences positively impacted transition. Learning experiences, work environment and motivation were seen as enhancing factors.

The fourth research objective explored the impact of the clinical environment as it relates to newly qualified midwives' experience with orientation. Some newly qualified

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midwives applauded the orientation programme, highlighting its benefits, which essentially improved transition; however, orientation was a negative experience for some who believed it was too informal and ineffective in ensuring a smooth transition for newly qualified midwives.

### **Literature Review and the Superordinate Themes Identified in the Study**

The following section will explore the research questions' major themes in relation to the research literature, including the theoretical framework. The existing literature presented a foundation for positioning the study within a meaningful framework. While the literature contained no direct reports of the lived experiences of newly qualified Jamaican midwives' transition into practice, comparing and contrasting emerging themes based on the experiences studied in other countries is useful to identify the implications of this study.

The first superordinate theme identified in this study concerns the expectations of being a midwife. Based on the participants' accounts, one of the main personal expectations of the newly qualified midwives was to receive guidance and support from the more experienced midwives during their transition period. This study's findings were congruent to Hobbs (2012) findings because the newly qualified midwives shared similar expectations of the more senior midwives in their study. In this study, one newly qualified midwife reported the personal expectation that midwifery would just be about conducting deliveries. However, Yanti et al. (2015) contend that being a midwife is more than just seeing the birthing process; it involves providing holistic, woman-centred care to the woman, baby, and family.

The high expectations the senior midwives had of the newly qualified midwives appear significant in this study. Participants in the study reported the senior midwives had higher expectations of the capabilities of those midwives holding a Bachelor of Science in Midwifery versus the certificate-trained midwives. Senior midwives' high expectations of their junior counterparts' capabilities were also reported in Hobbs's (2012) study. In Hobbs (2012) study,

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although there was no distinction between direct entry or post basic trained newly qualified midwives, the senior midwives expected the newly qualified midwives to take charge of the ward. In contrast, in Kitson-Reynolds et al's (2014) study, the senior midwives had a lower expectation in the newly qualified midwives' capabilities trained at the direct-entry programme.

Another challenge for the newly qualified midwives which affected their positive transition into midwifery practice, was the high expectations of the women in their care regarding the level of care they needed the newly qualified midwives to administer to them amid a busy maternity unit. Furthermore, such expectations from the women impacted the newly qualified midwives and affected their transition into midwifery practice due to the frustration that it caused them. Findings from Van der Putten's (2008) study also corroborated my study's findings as newly qualified midwives in Van der Putten's study also reported experiencing stress and frustration due to women on the postnatal wards' expectations of receiving one to one care with breastfeeding although the postnatal ward was busy.

The second superordinate theme identified in this study concerns Transition shock, which was synonymous with Duchscher's Stages of Transition Theory (2008). The initial findings in this study were that most participants were fearful of starting their practice in the initial stages. But, after one year of practice, most of the participants expressed feelings of competence, as they were no longer fearful. In addition, most of the newly qualified midwives who took part in this study revealed that they were working in charge when assigned on duty by the time the study concluded. This evidence of growth and the dissolution of fear was consistent with Van der Putten's (2008) and Hobbs (2012) studies.

Based on the experiences reported by the newly qualified midwives in this study, they have all gone through some transition. These transitions included combinations of intense socio-cultural, developmental, emotional, and intellectual changes along with feelings of uncertainty and low confidence. This was in keeping with Duchscher's Stages of Transition

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theory (2008),—which theorised newly qualified staff are faced with several challenges, including lack of support, low self-confidence, increased work, limited resources, and an unfriendly work environment, among others. These challenges forced the newly qualified midwives to quickly adapt, resulting in the socio-cultural, developmental, emotional, and intellectual changes mentioned above, in accordance with Duchscher's Stages of Transition theory (2008). These changes were classified as 'doing', 'being' and 'knowing', which occur during specific periods, of the initial three months of practice post registration, four to six months post registration, and 12 months post registration, respectively. These stages were evident in my study too. My participants went through them at different times, which supports the theory that transition is non-linear, as was purported in Duchscher's Stages of Transition theory.

The third superordinate theme identified in the study concerns newly qualified midwives' perceived shifts in their confidence and competence, their experiences of managing situations and their eventual transition into autonomous practice. The newly qualified midwives initially expressed fear of working independently and or making autonomous decisions. However, as the newly qualified midwives transitioned into their practice, they gradually became accustomed to working autonomously and taking the initiative, which increased their self-confidence over time, even when managing high-risk cases.

The findings of my study indicated that one participant did not advocate for her client at her initial start of practice due to her shyness. My study's findings were contrary to Van der Putten's (2008) and Hobbs (2012) study because the newly qualified midwives in both studies fear advocating for their patients due to their perceived lack of self-confidence, knowledge, and skill leaving them feeling disempowered. On the other hand, the newly qualified midwives in Fenwick et al.'s (2012) study could not advocate for their women because they were expected to conform to the institution's culture and waive their ideals. This suppression of

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the newly qualified midwives' woman-centred approach led to a reduction in their self-confidence and ability to cope in practice (Fenwick et al., 2012).

The findings of this study suggest that after the initial three months of the newly qualified midwives being into practice, they reportedly felt more confident in managing high-risk patients without supervision. The newly qualified midwives' ability to work autonomously after orientation was consistent with the NMC (2009) expectation. The literature indicated that newly qualified midwives engaging in more clinical experience increased their competence and confidence (Van der Putten, 2008). This study's findings revealed that most newly qualified midwives could safely cope with challenging clinical situations; however, they reported a lack of self-confidence and self-doubt regarding their capabilities in most instances. These findings were consistent with Skirton et al.'s (2012) study in which the newly qualified midwives reported having notions of uncertainty in their competency. The findings were also consistent with Pitter et al. (2019), which reported that newly qualified midwives experienced challenges performing core midwifery competencies such as vaginal examinations. Although the newly qualified midwives in this study reported having theoretical knowledge, they stated that they did not get some things right every time. The newly qualified midwives in this study perceived confidence as an issue due to them harbouring self-doubt; this affected their assertiveness in executing necessary tasks, such as performing vaginal examinations, CTG interpretations and second stage complications. My study revealed that the newly qualified midwives still felt self-doubt even after a year of practice (by interview 3). My findings were consistent with Davis et al.'s (2012) and Wain's (2017) reports. Such fear was linked to their newfound responsibility and accountability made them felt pressured. Newly qualified midwives reportedly felt overwhelmed due to the level of complexity and degree of intervention they encountered although they considered themselves knowledgeable, they harboured self-doubt in their abilities and skill set (Griffiths et al., 2019).



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Furthermore, Davis et al. (2012) found newly qualified midwives' lack of self-confidence as a factor that impacted their clinical competence, such as their inability to care for high-risk women and their babies. The NMC (2020) recommends that those who mentor students should be practising, qualified and experienced midwives who have completed the mentorship course before participating in students' mentorship.

Staff marginalisation, especially the direct entry midwives, was another aspect of superordinate theme three, which addressed issues that eroded the newly qualified midwives' self-confidence. One newly qualified midwife in this study reported a dislike for some of the ward sisters' behaviour towards the direct entry midwives. From my study findings, such behaviour was deemed unpleasant and consistent with Fenwick et al.'s (2012) study. In Fenwick et al. (2012) study, some newly qualified midwives were side-lined, belittled, treated like children and subjected to passive-aggressive behaviours (rolling of eyes) during their transition to practice by the more experienced midwives. This study revealed that the marginalization of staff and the newly qualified midwives doubting of their capabilities negatively influences their transition into practice. This was consistent with Fenwick et al. (2012) study. Theme three of this study, which essentially addressed confidence and competence, was described in stage three of Duchscher's Stages of Transition theory, and found that at this stage, graduate nurses had an increased level of confidence in their new role, responsibilities, and routine. Therefore, stage three of transition entails more of a reflection of the process and includes an assessment of growth. My study revealed similar findings to the third stage of Duchscher Transition theory because seven of the eight midwives verbalised that they experienced an increase in their self-confidence and practice in comparison to when they started when they were timid about working autonomously.

The fourth superordinate theme identified in the study, support and sense of belonging, addressed the extent to which newly qualified midwives were assisted while integrating into

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the practice. This study found that newly qualified midwives worked in a supportive environment, with most of their colleagues' support and a lesser degree, with support from the managerial or supervisory midwives. This type of support improved their transition, as they were able to receive encouragement and reinforcement in challenging areas, thereby building self-confidence. These findings were consistent with Cummings (2017), Cummings et al. (2015), Fenwick et al. (2013) and Hobbs (2012), who assessed the positive factors that enhance newly qualified midwives transition into practice in their studies. This study found that newly qualified midwives expressed positivity in terms of the support they received when assigned in units adopting the social model of care, in which they also felt socially accepted. The newly qualified midwives reported that working in a supportive environment helped to establish a midwife-to-midwife relationship, which enhances their transition experience.

This theme also examined how the newly qualified midwives' transition was enhanced by their relationships with colleagues and/or a sense of belonging. Clements' (2012) study performed in Australia revealed that newly qualified midwives rely on the more experienced midwives to improve their confidence. Furthermore, Hobbs' (2012) findings, also validated by Cummins et al.'s (2015), showed that the environment in which the newly qualified midwives worked enhanced the forging of trusting relationships with their work colleagues and the women in their care. Cummins et al. (2017) found that support during transition helps build newly qualified midwives' confidence and assist them in forging a positive relationship with their women. These findings were consistent with my study's findings.

This fourth theme also examined lack of support due to an unsupportive environment, heavy workload, and some staff hiding and leaving work for others as a deterrent to midwives' transition into their midwifery practice. Fenwick et al.'s (2012) study found that a hostile maternity unit environment can erode and undermine newly qualified midwives' confidence and exponentially increased their "fear of doing something wrong" (p.2060). In the study, some

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of the newly qualified midwives voiced that the workload was overwhelming and that at times they felt demotivated and did not want to attend work. Participants also alluded to heavy workloads, especially in the postnatal wards, the lack of staff and inadequate skill mix due to the senior midwives' migration, and grave staff shortages, which impacted the care level they could provide to the women, as inhibiting factors. These findings were consistent with Fenwick et al. (2012), in which the newly qualified midwives also experienced heavy workloads on the antenatal and postnatal wards, describing the workloads as “diabolical and unmanageable” and the antenatal clinics as “jammed packed” (p.2056). Furthermore, Hunter et al.'s (2015) study of maternity support workers and midwives in the UK revealed that the heavy workload on the postnatal wards further impacted midwives' core responsibilities, such as assisting women with breastfeeding intervention.

Additionally, Wain (2017) claims that the lack of support towards the newly qualified midwives in her study was due to the maternity unit's staff shortage and busyness. Larkin, Begley and Devane's (2012) qualitative study on women's experiences of childbirth in the Republic of Ireland corroborated Wain's (2012) findings, stating that the maternity units' busyness affected the women's experience in the level of care they received while in-patients on the labour ward, with women, often being left alone and unsupported. Similarly, in Bradley et al.'s (2015) Malawian study, a critical incident review revealed concerns about staff shortages, and workload were essential factors for over 40% of staff who stated their intention to leave.

Heavy workloads and staff shortages also led to the newly qualified midwives in this study reporting feeling of burnout and demotivation, an increase in stress and anxiety among newly qualified midwives; this was consistent with various other studies (Fenwick et al., 2012, Van der Putten, 2008). Additionally, findings from my study revealed that the migration of senior midwives impacted staff availability and the workload, and the quality of support

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available to the newly qualified midwives. Given this, newly qualified midwives in my study reported having to learn from each other' due to the migration of senior midwives. However, peer support may lead to socialised learning which is considered a socialised practice that perpetuates practices and cultures and is unsuitable for developing midwifery practice but perpetuates the status quo.-This may have more efficacy in those maternity contexts where the medical model of care is utilised. Over time, midwives practising in these environments become well- acquainted with the medical model of care thus eroding their competence in managing the normal process of childbirth (Kaur Bharj & Marshall, 2019). My study's findings resonate with Skirton et al. (2012) study as newly qualified midwives in their study also learned throughout socialised practice.

Rotation issues during the orientation of the newly qualified midwives was identified as another major finding in my study that impacted the newly qualified midwives' transition into practice. In my study, the rotation on non-obstetrics units was viewed with adoration by some direct entry midwives because they did not have prior knowledge and skills working within these environments. On the contrary, some of the post-basic midwives reported it as a hindrance to consolidating their midwifery skills and knowledge because they had already garnered clinical experiences in those areas, given that they were trained as nurses before, which hindered their transition into practice.

In my study, most of the direct midwives did not have an opportunity to rotate within the community. My study's findings resonated with Avis et al.'s (2012) study. Although newly qualified staff had a chance to rotate in the obstetrics unit: labour ward, antenatal clinic, antenatal and postnatal wards, their rotation within the community was minimal. Similar findings were also reported in Kitson-Reynolds et al.'s (2014) study wherein the newly qualified midwives experienced interruptions with their community placement due to addressing the hospital staff shortage. These interruptions during their community placements

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prevented the newly qualified midwives from consolidating their “knowledge and skills in one particular area before moving to another” (p. 665).

This study further revealed that newly qualified midwives were faced with challenging situations and a lack of support from senior midwives during their initial transition into practice. In two instances in my study, two midwives in two different hospitals were working unsupervised on a night shift; one had a maternal death while the other had to try and diffuse an ensuing situation with abusive relatives of a client. Several studies corroborated with my study findings of newly qualified midwives being left unsupported to manage challenging situations and high-risk maternity cases (Foster & Ashwin, 2014; Kitson-Reynolds et al., 2014; Avis et al. 2012; Fenwick et al., 2012; Hobbs, 2012 and Van der Putten, 2008),

Providing adequate support for the newly qualified midwives is tantamount to them consolidating their midwifery skills during their initial transition because some of them require guidance. However, for preceptorship support to be impactful and beneficial to new staff preceptors themselves must possess the right attributes and aptitude that would help them perform in this demanding and challenging role, as per Borimnejad et al. (2018, p.121). Furthermore, findings from Whitehead et al. (2016) study also indicate that preceptors should have received the prerequisite training to precept new staff, and they should also be experienced.

The findings of the fourth superordinate theme revealed in this study were consistent with Duchscher’s Stages of Transition theory (2008) in that one midwife’s transition experience revealed that transition provided her with emotional, physical and mental support. According to Duchscher (2008), newly qualified midwives encounter transition shock during the initial three months, including the experience of emotional issues while adjusting to their new role.

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The fifth superordinate theme concerns theory-practice gap. It was clear in my study that some of the midwives lack competency in core midwifery skills; those midwives openly acknowledged that they needed to learn more. This knowledge deficit was also reported by the newly qualified midwives in the Kitson-Reynolds et al. (2014) study. In this study, some of the newly qualified midwives found that working in practice was different from the theory learned in training, while others reported they knew more than when they were in school. Borrelli's (2014) study revealed a good midwife should have theoretical knowledge, professional competencies, personal qualities, communication skills and moral/ethical values. However, in my study, some of the newly qualified midwives also learn on the job by observing the practice of other midwives. This is socialised practice, and this practice was also revealed among the newly qualified midwives in the Skirton et al. (2012) study. Furthermore, according to Parsons and Griffiths (2007), learning through socialised practice based on tradition or practice conventions rather than on evidence-based practice increases litigation potential in adverse events.

Findings from my study also revealed that newly qualified midwives who had a delay in practising were allowed to undertake the same regular orientation programme as the recently qualified midwives. From the study one of these two midwives reported having learning needs. The Nursing and Midwifery Board of Ireland (NMBI) an independent, statutory organisation that regulates the nursing and midwifery professions in Ireland, recommends that a midwife who has not practiced for five years should pursue a return to practice course, although it is not mandatory. This was not the case in my study.

The study is important because it presents results that have not been identified in other research to date. In this study, orientation occurred in non-obstetrics wards, such as the gynaecology ward, neonatal units, paediatric and haemodialysis in two out of the three hospitals. Additionally, orientation for the post-basic midwives differed from the direct entry

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midwives in one out of the three hospitals at which the study was completed. This study shows that transition is non-linear, which is evident because one midwife was expecting to be supported, “scooped up” (Abigail, Interview 1 and 3)<sup>5</sup>, at twelve months into her midwifery practice while other midwives reported having gained the confidence to practice autonomously when they were just six months into their midwifery practice.

Nevertheless, this study’s findings largely replicate data found in similar studies; for example, newly qualified midwives in Jamaica’s experiences were similar to some of the other studies’ midwives. Additionally, newly qualified midwives in Jamaica were left on their own to manage challenging situations. In most cases, orientation programmes were informal or unstructured consistent with other studies. In Jamaica, the newly qualified midwives also encountered belittlement from senior midwives, just like the other studies. The midwifery orientation period within the three hospitals was different, and so was the timeframe. The orientation process for direct entry midwives was varied and not aligned to the MOH (2005) policy document, which recommended that direct entry midwives should be placed in a one year ‘internship’ programme and to be rotated within the hospital setting for nine months and only three months in the community. It was also found that direct entry midwives were deemed incompetent by senior midwives, consistent with previous studies. Based on the findings, the newly qualified direct entry midwives did not complete their community orientation even after one year into practice. My study’s findings were consistent with Pitter et al. (2019) as the direct entry midwife in their study reported that even one and half years post-qualifying, she had not had her community experience. There was a consensus from the midwives within the three hospitals that the significant shortage of midwifery staff influenced the type of care they administered to the women. The study revealed that in Jamaica,

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<sup>5</sup> Abigail mentioned ‘scoop up’ in two interviews 1<sup>st</sup> and 3<sup>rd</sup> interview

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newly qualified midwives had to learn through socialised practice in some instances due to the staff shortage and the unstructured, or the lack of, orientation programmes.

From the study, many of my themes overlap with much of my data showing a circular dependency on the issues identified. However, there was the mutuality of lack of support/staff shortages/heavy workloads/lack of confidence in many of the studies that were identified in the literature review.

### **Implications of the Study**

This study's findings have implications for newly qualified midwives, hospital administrators, and, by extension, the Nursing Council of Jamaica. There was a consensus from the midwives within the three hospitals that the significant shortage of midwifery staff influenced their confidence, competency and the type of care they administered to the women. The study found that most of the newly qualified midwives reported feeling prepared for practice. They also were competent and confident to practice within one year of their practice. However, their transition was fraught with challenges such as staff shortages and an increasing workload which was reported due to the migration of senior midwives. Other factors identified that inhibited their transition into practice were a variation in the orientation programme across the three hospital sites and a variation in orientation among the two categories of midwives: direct-entry and post-basic midwives. Rotation during the orientation was at times on non-obstetrics wards, which the direct-entry midwives found beneficial as they had no prior experience working within the hospital.

On the other hand, the post-basic midwives did not find being orientated on non-obstetric wards beneficial to them. The study also revealed that most of the direct-entry newly qualified midwives were not given an opportunity to rotate within the community as part of their orientation. Neither were the direct-entry midwives working in the community due to the



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hospital shortage of midwives. The study also revealed that there was support from some senior midwives, but most of the support the newly qualified midwives received came from their peers. The study showed that the midwives learned through socialised practice. The findings revealed that there would be a need for training and policy development in terms of a structured orientation for newly qualified midwives that offers support and minimises the incidence of maternal deaths.

### **Strengths and Limitations of the Study**

This study's noticeable strengths included the unique insight into this phenomenon of newly qualified midwives' transition into midwifery practice. The participants were honest and forthright about their experiences, thus providing me with detailed information to analyse their experiences effectively and objectively. There is also only one previous study in Jamaica in this area, making this study very timely and beneficial.

Several limitations to this approach were acknowledged. The phenomenological approach used gave voice to eight new midwives and their transition experiences over one year. However, based on the qualitative nature of the research, and the small sample size, the study's findings cannot be generalised to other hospitals outside of the area in which the study was conducted. Second, the study included only one direct entry, degree trained midwife. Consequently, I could not make a proper comparison with the other seven midwives trained at the certificate level, of which five were post-basic midwives. Finally, I was unable to determine the competency level of the study participants.

During the study, myself, the researcher, as a Senior Lecturer, trained Registered Nurse, midwife and preceptor to BScN nursing students, precepted the students during their obstetrics placement within the same hospitals at which the study was conducted. Accordingly, due to my seniority and having interacted with these midwives while precepting students, I could have influenced the participants' responses, and this could have affected their relationship with me.

However, there was no evidence of my influence on the study's results from the participants' responses during the interview sessions.

### **Recommendations**

The recommendations were formed based on my own practice experience, by the literature review findings and the findings of this study. Given this, I proposed the following practice recommendations:

#### **Structured Orientation Programme**

1. The need for Inservice Midwifery Educators within each hospital to organise structured and tailored orientation programmes, irrespective of the midwifery education; programmes should be designed to suit the individual newly qualified midwife's learning needs, consistent with Avis et al.'s (2012) recommendation. Structural orientation programmes should include appropriate rotation patterns within obstetrics units.
2. Ensure that newly qualified midwives are orientated within the obstetric wards instead of non-obstetric wards for the first three months of their orientation period.
3. After the first three months, the direct-entry trained midwives should be rotated within the gynaecology, paediatric and neonatal units. This is because they did not have any prior experience working as a trained nurse in these units also due to these units' close links with the obstetric units, and they may be required to work on these units. Additionally, rotation in these units is likely to enhance their knowledge of these units' operational procedures.

### **Preceptorship Support and Supernumerary Time**

4. Offer a preceptorship training programme to all midwives so that they understand their role and effectively precept newly qualified midwives.
5. Assign the newly qualified midwives to at least two preceptors and arrange for the newly qualified midwives and their preceptors to be assigned the same off duty in the first two months of their orientation, to facilitate continuity. Having a named preceptor is likely to help the newly qualified midwife to adapt and transition into their new role effectively and will provide an opportunity to forge a working relationship with their preceptors. Likewise, having named preceptors will enable a preceptor to provide positive, informed feedback on their evaluation of a newly qualified midwife's clinical performance, as this would allow them to work with their preceptee more frequently and offer them support and positive feedback (Avis et al., 2012). Named preceptors would be better equipped to provide summative evaluations as newly qualified midwives progress during their initial transition, enhancing their skills and improving their knowledge.
6. Preceptor support provides written feedback on the newly qualified midwives' progress and any identifiable learning needs reported to the In-Service Educators.
7. Allow scheduled study days and supernumerary time with their preceptors where newly qualified midwives can be allowed to participate in reflective practice.

### **Development of an Orientation Framework**

This study's findings established a need to develop a framework that could structure a formal programme for newly qualified midwives' development (see also Avis et al., 2012). The orientation programme should include newly qualified midwives' orientation into the community. As part of the framework, the more experienced community midwives should be

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rotated monthly to help with the shortage of midwives within the hospitals, which would also allow them to update their knowledge and skills. The community midwives' rotation in the hospital setting could enhance the community midwives' ability to provide effective preceptorship to newly qualified midwives during their orientation into the community, thus improving the transition of the newly qualified midwives into the Community practice.

### **Return to Practice Programme**

There is a need for policy development to facilitate a Return to Practice programme for midwifery practitioners who delay their midwifery practice post-qualifying to be implemented in tandem with In-service Educators. These programmes should collaborate with the Nursing Council of Jamaica and the institutions offering midwifery education in Jamaica to ensure that midwives' knowledge and skills are current, to safeguard the public and themselves.

Further research is needed to explore the direct entry midwives' perspective of their experiences working within the community setting and their challenges as direct entry midwives. Further study is also necessary to determine degree-trained midwives' competency level compared to the certificate midwives in Jamaica.

### **Conclusion**

This study provides insight into the transition experience of newly qualified midwives in Jamaica. The newly qualified midwives in this study encountered several challenges during their transition, with the primary issues being limited support and increased autonomy during their learning phase. Nonetheless, they relied upon the support of each other and showed resilience. Based on the study's findings, there was no difference in the practice of direct entry and post-basic midwives. However, a more robust orientation programme that offers support was necessary to enable newly qualified midwives to transition confidently and autonomously into their midwifery practice.

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**Appendices**

**Appendix 1 -Table Illustrating Use of the PEO Tool**

PEO Tool	Search Terms
P-population and their problem	newly qualified midwives OR graduate midwives OR new midwifery practitioners OR newly qualified midwives' transition into practice
E- exposure	Transition, preceptorship; orientation, mentorship; transition support programmes
O-outcomes or themes	Views OR Perceptions OR experiences

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**Appendix 2- Table Showing Search Strategy**

<b>Database searched</b>	<b>Keywords/phrases &amp; combination</b>
CINAHL contains citations and articles specific to Nursing and Allied Health	('Newly qualified midwi*' OR 'graduate midwi*') OR 'graduate support programmes'
ERIC contains citations from education journals	('Newly qualified midwi*' OR 'graduate midwi*') OR 'graduate support programmes'
MEDLINE contains references to journals in life science	('Newly qualified midwi*' OR 'graduate midwi*') OR 'graduate support programmes'
Science Direct contains full-text databases	('Newly qualified midwife OR 'graduate midwif' OR 'new midwi* practitioner') AND (transition OR orientation OR preceptorship OR mentorship OR 'graduate support programmes' OR 'transition support programmes') AND experience* OR views OR perceptions
EThOS contains Doctoral Theses	Transition experience AND Midwife
Cochrane Library contains primarily systematic reviews	('Newly qualified midwi*' OR 'graduate midwi*') OR 'graduate support programmes'

Revised Database Search: November 05, 2018-December 29, 2020

Keywords searched (Appendix 2) were newly qualified midwives, graduate midwives, new midwifery practitioners, new midwi\* graduate, newly qualified midwi\*, graduate midwi\* preceptorship, mentorship, orientation, transition and transition support programs, graduate support programme. Synonyms of these keys words such as recently qualified midwives were created and used interchangeably to search the previously mentioned databases

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**Appendix 3- Table Showing Eligibility criteria**

<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Studies that included newly qualified midwives in their first year of practice	Studies with participants (student midwives and student nurses)
	Studies that included other health professionals and nurses in the first year of practice
Studies in Acute hospitals and community	
Experiences, perceptions, views	
Studies that included newly qualified midwives experience of their orientation, preceptorship or mentorship	
Qualitative and quantitative studies, mixed-methods studies, systematic reviews	
Studies published in the English Language. from what kinds of countries- International-similar health services?	Studies published in a language other than English
Peer-reviewed articles	
Original research	

Appendix 4: Showing Data extraction sheet

Table 5: Data extraction sheet: Characteristic of studies

	Author, Title, date of publication and country	Study aims and research questions and Methods and Sample	Data Collection & Analysis	Themes – findings	Critical Appraisal
1.	<p>Barry, J., Hauck, Y.L, O’ Donoghue, T. &amp; Simon Clarke, S. (2013)</p> <p>Newly graduated midwives transcending barriers: A grounded theory study</p> <p>Western Australia</p>	<p>The research question guiding this study was as follows: ‘How do newly graduated midwives deal with applying the philosophy of midwifery in their first six months of practice?’ The aim was to generate a grounded theory around this social process.</p>	<p>In-depth Semi-structured interviews Digitally recorded.</p> <p>Participant and interviewer’s journals provided supplementary data.</p>	<p>Substantive theory of transcending barriers generated: three themes from the theory:</p> <ul style="list-style-type: none"> <li><i>*Addressing personal attributes.</i></li> <li><i>-first stage of the transcending barriers</i></li> <li><i>-this is intrinsic:</i></li> <li>-Newly qualified midwives (NQMs) develop an understanding of Midwifery philosophy during training and clinical placement</li> <li>-their own experience of childbirth, personally acquired knowledge</li> <li>-their philosophy is to provide support in empowering, educating, and advocating for the woman throughout antenatal, intrapartum, and postnatal period.</li> <li>-NQMs acknowledgement of <i>constraints:</i> in the delivery of women-centred care</li> <li>-proud of midwifery status and are aware of their need to learn more.</li> <li>-NQMs anxious during their initial transition period: have <i>concern</i> of</li> </ul>	<p>Barry et al (2013) did not mention seeking of ethical approval for the study. Furthermore, all research involving humans should apply ethical principles to protect study participants from any harm. The sampling technique used in Barry et al. (2013) was not mentioned.</p>

				<p>letting down the woman and takes a new thinking if they are unable at offer support to the woman their desired standard.</p> <p>-NQMs personal attributes, confidence, competence, and insight contributes to the NQMs ability to deliver high-quality woman-centred care.</p> <p>-NQMs experienced transformation of their anxieties in positive emotions when they start work on consolidating their midwifery skills and can deliver high level of woman-centred care</p> <p><i>*Understanding the 'bigger picture'</i></p> <p>Stage two of substantive theory. This is extrinsic factors that may influence a NQMs ability to deliver women-centred care.</p> <p>-NQMs are more aware provision of woman-centred care involves more than their personal attributes. In this stage from their exposure in the clinical environment they become aware that other factors can impact on their functionality as a midwife in either negatively or positively in their delivery of women-centred care. This stage involves the woman having trust in their midwives. Alternatively, obstetrician dominating women care</p>	
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				<p>with instrumental delivery KIWI, vacuum extraction (medical model of care having dominance over midwifery model)</p> <p><i>*‘Evaluating, planning and acting’.</i>          This is final stage of the transcending barriers, where NQMs come to a decision based upon their personal and professional views and previous evaluations, and where NQMs align their expectations with their workplace encounters/ experiences. In this stage they reflect on their aspirations and decides what is important to them if they are unable to reconcile any their expectations and aspirations with their reality, they may consider changing it move into forming plans.</p>	
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<p>2.</p>	<p>Continuity of Care: Supporting New Graduates to Grow into confident practitioners.</p> <p>Continuity of Care: Supporting New Graduates to Grow into confident practitioners.</p>	<p>To describe how newly qualified midwives experienced their rotation into the birth-suite and continuity of midwifery care model.</p> <p>38 newly qualified midwives</p> <p>Qualitative Descriptive</p>	<p>Telephone interviews and focus groups.</p> <p>Content analysis</p>	<p>*Labour ward environment- newly qualified midwives elicited greater apprehension than those rotating in midwifery continuity model of care</p>	<p>Clements et al. (2013) method sampling but not detail. However, provided detail of data analysis. The authors provided an insight of the personal position of the researchers. This is essential in studies with qualitative design.</p>
<p>3.</p>	<p>Cummins, A.M., Denney-Wison, E. &amp; Homer, C.S.E. (2015).</p> <p>Australia</p> <p>The experiences of new graduate midwives working in midwifery continuity of care models in Australia</p>	<p>To explore the experiences of the new graduate midwives who have worked in midwifery continuity of care, particularly concerning the support they received, and, to establish the facilitators and barriers to the expansion of new graduate positions in midwifery</p>	<p>Semi-structured interviews-face to face, Skype or telephone</p> <p>Thematic analysis NVIVO</p>	<p>*Newly qualified -valued relationship with the women and group of midwifery colleagues they worked with</p> <p>*Feelings: ‘becoming a real midwife’.</p> <p>*Trusting relationships- enable support-conversation in the corridor with a more experienced midwife or a medical colleague consolidate skills and knowledge</p> <p>-supported by the group</p> <p>-feeling prepared to work in midwifery continuity of care.</p>	<p>Cummins et al (2015). The findings from this study are limited to Australian midwifery continuity of care models. As a qualitative descriptive study there is the potential for further interpretive work. The study did recommend an area for research: to discover why new graduate midwives need to complete a transition support programme or have a certain number of years' experience</p>

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		<p>continuity of care models.</p> <p>Qualitative descriptive</p> <p>Sample: Thirteen newly qualified midwives</p>		<p>*Weekly, fortnightly, or ad hoc meetings- offered support and helps cohesiveness of the group.</p> <p>*Reflections upon practice at team meetings -help clinical decision-making skills.</p> <p>*Working in continuity care models supports their learning and development into midwifery practice.</p>	<p>before working in midwifery continuity</p>
4.	<p>Cummins, A.M., Denney-Wilson, E. &amp; Homer, C.S.E. (2017).</p> <p>Australia</p> <p>The mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia</p>	<p>To explore the mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia</p> <p>Sample: 13 newly graduated midwives working in either their first or second year of practice around Australia in midwifery continuity of care models</p> <p>Qualitative descriptive study</p>	<p>Semi-structured interviews were conducted predominantly by phone or skype, with only two interviews conducted face to face.</p> <p>Thematic analysis: NVIVO</p>	<p>*Having a mentor important and knowing them made it easier for the newly qualified midwives to call their mentor at any time.</p> <p>*The new graduate midwives had respect for their mentors and the support</p> <p>*helped build their confidence in transitioning from student to midwife.</p> <p>*With the expansion of midwifery continuity of care models in Australia mentoring should be provided for transition midwives working in this way</p> <p>*‘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.</p>	<p>This study was the first study to be undertaken in Australia on mentoring. Thus, the study produced insight and new perspective on the mentoring experiences of newly graduated midwives as they transition into continuity of care. Study produced sound was methodologically evidence.</p>

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<p>5.</p>	<p>Kitson Reynolds, E., Cluett, E. &amp; Lee-May, A. (2014)</p> <p>England: South Coast UK</p> <p>Fairy tale midwifery—fact or fiction: The lived experiences of newly qualified midwives</p>	<p>To elicit the lived experience of newly qualified midwives from the point of registration to 12 months post-registration.</p> <p>Sample: 12 student midwives who gained first posts across a number of NHS Trusts</p> <p>Interpretive phenomenology informed by Van Manen</p>	<p>Semi-structured interviews</p> <p>Digitally recorded</p> <p>Smith’s et al (2009) interpretive phenomenological analysis (IPA)</p>	<p>Two themes identified:</p> <p><i>*Fairy tale midwifery fact or fiction</i></p> <ul style="list-style-type: none"> <li>-Devoid of autonomy and responsibility</li> <li>-high levels of anxiety</li> <li>-reality shock</li> <li>-idealistic view of the midwife</li> <li>-expectation of self and others</li> <li>-false promises-self-inflicted.</li> </ul> <p><i>*Submissive empowerment-between a rock and a hard place</i></p> <ul style="list-style-type: none"> <li>-no regard given to newly qualified community midwives with respect to the tasks they must finish when they are called in the hospitals to assist with workload.</li> <li>-newly qualified midwives had to assume the responsibility of high-risk maternity cases heightened anxiety</li> </ul> <p><i>*Being a part of the club.</i></p> <ul style="list-style-type: none"> <li>-at 4months into transition newly qualified midwives wanted to impress their senior midwifery colleagues.</li> </ul>	<p>The interpretive phenomenology design was appropriate for the aim of the study. The study did recommend the need for further research.</p>
<p>6.</p>	<p>Foster, J &amp; Ashwin, C. (2014)</p>	<p>To explore newly qualified midwives’ experiences of</p>	<p>Digitally recorded semi-structured interview</p>	<p>* Induction period-unstructured and inadequate.</p> <p>*Reflect and learn session supportive.</p>	<p>In Foster and Ashwin (2014) study gave insight revealed that there was limited</p>

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	<p>England</p> <p>Newly qualified midwives' experiences of preceptorship: a qualitative study</p>	<p>preceptorship at a local NHS Trust from 2009 to 2012 and, using qualitative data, to further develop the midwifery preceptorship programme and improve the success of its implementation at Trust level.</p> <p>Grounded Theory</p> <p>Ten newly qualified midwives</p>	<p>Constant Comparison</p>	<p>*Insufficient time to consolidate practice in one area- complete preceptorship, induction and intravenous medicines documentation.</p> <p>*Lack of support with a preceptor during preceptorship.</p> <p>*Named preceptor offers support.</p> <p>*Supernumerary time -75 hours valuable.</p> <p>*Preceptorship did not meet the needs of some newly qualified midwives.</p>	<p>empirical studies available specific to preceptorship in midwifery. The authors provide information on the potential area for further research. The study mainly provided information supported by anecdotal evidence that newly qualified midwife's felt anxious and unsupported during their transition.</p>
<p>7.</p>	<p>Fenwick, J., Hammond, A., Raymond, J., Smith, R., Gray, J., Foureur, M., . . . Symon, A. (2012)</p> <p>Australia</p> <p>Surviving, not thriving: a qualitative study of newly qualified midwives' experience of their</p>	<p>To explore the experiences of newly qualified midwives and describe the factors that facilitated or constrained their development during the transition from student to registered midwife.</p> <p>Qualitative descriptive</p>	<p>Tape-recorded interview</p> <p>Thematic analysis/ constant comparative analysis</p>	<p>*participants' experiences/perceptions of the context and culture of hospital-based maternity care described using metaphors.</p> <p>*Factors enhancing transition: positive midwife to midwife relationships and supportive environment; continuity of care/carer models; continuity with women and midwives increased their self-confidence.</p> <p>*Factors inhibiting transition: -type of midwifery culture institution -influence newly qualified midwives' ability to provide woman-centred</p>	<p>Fenwick et al. (2012) study offer information on the experiences encountered by the newly qualified midwives and the culture that exists within some maternity units. One of the researchers was newly qualified and participated in the research. This could affect the interviewing technique used and the trustworthiness of the study. However, the researchers used a rigorous approach in data analysis, constant comparative analysis</p>

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	<p>transition to practice</p>	<p>Sample: Sixteen graduates from one Australian University Convenience Sample</p>		<p>care, learning, confidence &amp; competence development. -poor midwife to midwife relationship and difficult work environment. *Hierarchical structure &amp; the culture of the maternity environment &amp; unwelcoming behaviour contributed to disempowerment and negative perception of the hospital environment. *The expectation for newly qualified midwives to waive their ideals of working with the woman to work instead with the institution. *Inability to provide woman-centred care- frustration, anger and emotional disturbance. *Work in the continuity of care/carer models *Place women, themselves &amp; colleagues at risk-fear of being judged; reluctance to seek guidance.</p>	<p>with the group of researchers and a round-robin approach. Not a representative sample of all the midwives in Australia as they were from the same university and worked at a Metropolitan Hospital in Sydney. No mention of the ethical issues addressed in the study only that ethical approval was given for the study to be conducted. Fenwick et al. study identified a gap in the literature that further research is needed to understand the impact of different working environment on newly qualified midwives' transition into midwifery.</p>
8.	<p>Avis, M., Mallik, M. &amp; Fraser, D. M. (2013).  UK: England, Scotland, Northern Ireland and Wales</p>	<p>To present a description of the transition experiences of Newly Qualified Midwives and to identify some impacts of the various preceptorship</p>	<p>Semi-structured diary kept for up to 6 months  Content analysis This was not stated but based on the explanation in the study</p>	<p>*Completion rate-28 (52%) in the 3-year programme and 7 (38%) in the shortened programme graduates. Themes: *Induction period *Preceptorship support * The transition experiences from student to employee.</p>	<p>In this study, the researchers used a case study methodology. Initially, 79 consented to participate in the study. However, only 35 newly participated. Low completion rate. However, the method of data collection diaries proved challenging as</p>

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	<p>'Practising under your own Pin' - a description of the transition experiences of newly qualified midwives.</p>	<p>schemes that respondents encountered.</p> <p>Case study</p> <p>35 newly qualified Midwives in 18 work sites IN all countries in the UK. Each preceptor and supervisor of midwives for newly qualified midwife completed short questionnaires. about their preceptees performance, and a further sub-sample of newly qualified midwives and preceptors participated in a semi-structured interview.</p>		<p>*Presence of midwifery support Ad hoc programmes; unstructured and non-standardised</p> <p>*Reality shock on commencement into midwifery practice was undocumented in the diaries</p> <p>*Lack of confidence-prioritizing care, managing challenging cases</p> <p>*Knowledgeable and competent to provide midwifery care</p> <p>*Slow pace-development of confidence</p> <p>*Competent to practise under their Pin</p> <p>-individual transition journeys require time and structured support to build confidence to deliver quality care to mothers and their babies</p> <p>*Concluded:</p> <p>- no evidence that graduates are not competent to provide safe midwifery care to women and babies at the point of registration, but they do lack confidence.</p>	<p>some of the newly qualified midwives had difficulty to meet timelines for completion of the diaries. The method of data analysis was not clearly stated in the study.</p>
9.	<p>Hobbs, J. (2012) England</p> <p>Newly qualified midwives' transition to</p>	<p>To ascribe meaning to the everyday experiences of midwives during their first year of practice as they</p>	<p>Observant participation and interviews in the field. Data collection</p>	<p><b>Old school midwives (entrenched viewpoint)</b></p> <p>*Expected newly qualified midwives-practice as themselves. -take on roles and responsibilities out of their scope</p> <p>- highly critical of the newly qualified midwives' performances and their</p>	<p>In Hobbs (2012) study, a few shortcomings were identified regarding the study's methodology. The researcher offered a detail description of the data analysis process; however, the method of data</p>

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<p>qualified status and role: Assimilating the ‘habitus’ or reshaping it?</p>	<p>interact with their work environment.</p> <p>Qualitative ethnography study</p> <p>Seven newly qualified midwives</p>	<p>occurred in the participants’ workplace.</p> <p>Discourse analysis</p>	<p>delivery of care to their women-newly qualified midwives unassertive in comparison to themselves.</p> <p>*Lack of mentor /preceptor support-demoralized</p> <p>*Rite to Passage in transition (12 months post-registration) NQMs reflective, critical challenged the more experienced midwife’s management.; newly qualified midwives’ behaviour likely to change the culture existing in some maternity units.</p> <p>*Model of care in maternity unit culture impacts NQMs self-confidence and transition into midwifery practice.</p> <p><b>Service and sacrifice (core/shared dispositions)</b></p> <p>*Commitment to job duty of care, colleagues, delivering 100% to their women -working long hours minimal breaks, helpful midwife respected-taking on more caseload than time permits- Bourdieu Sian terminology, ‘service and sacrifice.’</p> <p><b>Being with the woman and making a difference</b> (new ways of thinking)</p> <p>*Emulate tendencies aligned with the midwives they wanted to be-ignore</p>	<p>analysis was unclear. The sampling method used in the study was a non-random sampling. However, the study did not state explicitly which sampling method was used as there are many non-random sampling techniques. The method of data collection observant participant though aligned with ethnography methodology, could influence, or change the newly qualified midwives’ behaviour as they were aware that their every move was being observed. No implication for practice or recommendation for further</p>
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				<p>other experienced midwives with negative propensities.                  *Enthusiastic to provide women-centred (being with the women) rather than doing things for the women-advocates normalcy less likely to intervene in the labour and delivery process of their women.</p>	
10	<p>Fleming, V. Poat. A. Curzio, J. &amp; Douglas, V. &amp; Cheyne, H. (2001)</p> <p>Scotland</p> <p>Competencies of midwives with single or dual qualifications at the point of registration in Scotland</p>	<p>To compare competencies of midwives with single or dual qualifications at the point of registration in Scotland</p> <p>Self-completing survey</p> <p>157 midwives at the point of registration</p>	<p>Glasgow Royal Maternity Hospital (GRMH) Skills inventory</p> <p>Mann-Whitney and Kruskal Wallis analysis of skills at point of registration in prenatal, labour, postnatal, neo-natal and extended skills areas</p> <p>SPSS</p>	<p>*Both single and dual entry qualified midwives were able to provide care to mothers and their babies in low-risk situations.                  *Direct entry midwives needed support but not unanimous.</p>	<p>The study design was appropriate.                  The research produced sound. The study provided insight into the competences of single and dual trained midwives. No further area for research implied. Findings of study can be generalized.</p>

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		166 Supervisors of midwives			
11	<p>Skirton, H., Stephen, N., Doris, F., Cooper, M., Avis, M., &amp; Fraser, D. M. (2012). UK: England, Scotland, Northern Ireland and Wales</p> <p>Preparedness of newly qualified midwives to deliver clinical care: An evaluation of pre-registration midwifery education through an analysis of key events</p>	<p>To determine whether the student midwives' educational programme had equipped them to practise competently after entry to the professional register.</p> <p>A prospective, longitudinal qualitative study Phase (3)</p> <p>35 newly qualified midwives (28 graduates of the three Year programme and seven of the shortened programme). 38 did not return diaries-busy</p>	<p>participant diaries to collect data.</p> <p>Six months after they commenced their first post as a qualified midwife.</p> <p>Diary entries were analysed using thematic analysis</p>	<p>Four Themes identified:</p> <ul style="list-style-type: none"> <li>*<i>impact of the event on confidence</i></li> <li>*<i>Gaps in knowledge or experience</i></li> <li>* <i>Articulated frustration, conflict or distress</i></li> <li>*<i>Factors that helped the Newly qualified midwives deal with a key event and the contribution of midwife teachers.</i></li> </ul> <ul style="list-style-type: none"> <li>-knowledge gained in the university</li> <li>-practice placement undertaken as a student midwife</li> <li>-practice placement as a registered nurse (shortened programme)</li> <li>-practice as a student in a skills laboratory</li> <li>-support at time of event</li> </ul> <p>*Newly qualified midwives have the technical knowledge and skills to practice safely.</p> <p>*Lack confidence in key areas, however with positive reinforcement by supportive colleagues will help play vital in assisting them to develop as practitioners</p>	<p>Skirton's et al. study is a longitudinal study had a high attrition rate. However, this is a methodological issue that likely to may occur in longitudinal studies. However, the attrition of study participants may impact on the trustworthiness of the study as the remaining participants differs from those that drop out of the study. The method of data collection using diaries lead to rich and voluminous data which may be labour intensive to collate. No further areas that require exploration was mentioned. The researchers did not explain her relationship between the study participants. Data analysis was not rigorous; she did not critically examine their role. Though the thematic analysis used was clear how the categories/themes were derived from the data. The study failed to include any the contribution the study makes</p>

					to existing understanding and did not identify any new areas for research
12	<p>Davis, D, Foureur, M., Clements, V., Brodie, P. &amp; Hobison, P. (2012)</p> <p>Australia</p> <p>The self-reported Confidence of newly graduated midwives before and after their first year of practice in Sydney Australia</p>	<p>To examine the confidence of newly registered midwives, who had been prepared for registration using two different educational routes, at the beginning and end of their new graduate year.</p> <p>Pre and post surveys</p>	<p>Survey-International Confederation of Midwives &amp; The National Competency for Midwives</p> <p>Stata V10</p> <p>Convenience</p> <p>All new graduates Employed in 3 areas health services in early months of 2008</p>	<p><i>Preparation of midwives:</i></p> <p>*No differences between newly graduates who undertake the undergraduate and postgraduate midwifery education programmes.</p> <p>* post-graduate, newly qualified midwives' more confident in some competencies than other midwives (BiMid)</p> <p>-due to content and structure of the programme, staff attitude, previous experience in hospital setting transferrable skills to midwifery.</p> <p>-undergraduates struggle- having only been in hospital setting as a student, inadequate levels of support, too many responsibilities, and staff have a poor attitude towards them</p> <p>*Graduate midwives scored poorly in confidence level on both surveys at the beginning and end.</p> <p>*New Zealand newly qualified midwives can work in the midwifery model of care or continuity of care models (self-employed); limited.</p> <p>*Mentorship programmes.</p> <p><i>Confidence gained.</i></p> <p>*Levels of self-reported confidence improved over the first year during</p>	<p>The tools used to collect data (self-reported survey) in this study was not validated and was solely designed for use in this study. This could affect the validity of the research findings and lead to social desirability biases. Social desirability biases refer to study participants' tendency of submitting favourable responses (Kimberlin &amp; Winterstein, 2008). Similarly, the low return rate of both the pre and post survey of 24% and 25% respectively in Davis et al study. Caution of use of the study findings as low return rates in surveys is indicative of non-response bias, and non-representativeness of the research sample. Thus, impacting on the validity and reliability of the study findings (Fincham, 2008).</p>

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				<p>newly qualified midwives' transition into practice. Both groups showed an increase in their first year of midwifery practice.</p> <p>*The way newly qualified midwives are supported to consolidate their midwifery skills and to gain confidence in undertaking their competencies needs to be improved.</p> <p>*Approach to support newly qualified midwives is ad hoc and geared towards the institutional needs rather than individual needs of the student midwives.</p>	
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13	<p>Pairman, S., Dixon, L., Tumilty, E., Gray, E., Campbell, N., Calvert, S., Lennox, S. &amp; Kensington, M. (2016)</p> <p>New Zealand</p> <p>The Midwifery First Year of Practice programme: Supporting New Zealand midwifery graduates in their transition to practice</p>	<p>To assess and explore the MFYP programme and identify which components New Zealand midwifery graduates considered important and supported them to develop confidence as a midwifery practitioner in their first year of practice.</p> <p>Survey</p> <p>415 Graduate midwives who participated in the MFYP programme from 2007 to 2010 was undertaken</p>	<p>Survey tool Using Likert scale</p> <p>Descriptive statistics- SPSS 21</p>	<p>*180 responded to the survey (43.4% response rate)</p> <p>*Factors facilitating development in professional confidence in graduate midwives: mentor support and the financial support for education</p> <p>*92.2% of respondents felt supported while caring for their women during labour and delivery-93.9% during clinical practice</p> <p>*Main support: midwives employed to the facility, midwives' mentors in the MFYP programmes, midwifery practice partners</p> <p>*MFYP- helps increase newly qualified midwives' confidence in the first year of practice</p>	<p>The study response rate was reasonable. It provided insight into the subject area. Hence its findings were useful. The study also recommended further research.</p>

14	<p>Dixon, L., Calvert, S., Tumilty, E., Kensington, M., Gray, E., Campbell, N., Lennox, S. &amp; Pairman, S. (2015).  New Zealand  Supporting New Zealand graduate midwives to stay in the profession: An evaluation of the Midwifery First Year of Practice programme</p>	<p>To explore the retention of new graduates in midwifery practice following participation in the Midwifery First Year of Practice programme  Retrospective cohort study using longitudinal observational data collected from programme participants.  All new graduate midwives (415) who had participated in the MFYP programme between 2007 and 2010</p>	<p>Register of Midwifery First Year of Practice (MFYP) participants between the years 2007 and 2010 Data cross-referenced with the Midwifery Council of New Zealand register and workforce data for 2012.  Comparison of demographic factors and undergraduate school of midwifery compared using <math>\chi^2</math> tests of independence (categorical variables).  Mann-Whitney test compared</p>	<p>*Programme effective-358 (86.3%) midwives who participated in MFYP remained in midwifery practice five years post-graduation nationally. Despite age, ethnicity, midwifery education pursued, place of work or practice setting. *Provides a universal standard of support to midwives in New Zealand-conducive to the New Zealand midwifery context. *Trend- younger midwifery graduates - reduction of graduate age over the five years of the study.</p>	<p>The study provided sound evidence as data as robust data was collected from the Midwifery Council registration database and the MFYP programme database of participants. To the contrary the study was unable to compare newly qualified midwives did not participate in the MFYP programme</p>

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			median age (continuous variable).		
15	<p>Kensington, M., Campbell, N. Gray, E., Dixon, L., Tumilty, E., Pairman, S., Calvert, S. &amp; Lennox, S. (2016)</p> <p>New Zealand</p> <p>New Zealand's midwifery profession: Embracing graduate midwives' transition to practice</p>	<p>To explore the midwifery graduate's perspective of the MFYP programme to identify which elements were important and supported them in their transition to confident practitioner.</p> <p>Qualitative Survey</p> <p>The 415 participants of the MFYP programme between the years 2007 to 2010 inclusive.</p>	<p>Questionnaires</p> <p>Thematic analysis</p>	<p>*Newly qualified midwives in the study were:</p> <ul style="list-style-type: none"> <li>-supported to consolidate practice skills and decision making.</li> <li>-helped to develop networks within the midwifery and wider health communities.</li> </ul> <p>*An unexpected finding of the study was that: support was provided by the whole midwifery community for all graduates, irrespective of whether they were employed or self-employed.</p> <p>*mentoring relationship was considered an important source of support.</p> <p>*Lack of support due to:</p> <ul style="list-style-type: none"> <li>-hospital staff shortages no one available to ask questions.</li> </ul>	<p>Kensington et al (2016) study survey response rate was 43.4% of the 415 new graduates who participated completed the programme between 2007</p>

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		<p>Qualitative Survey</p> <p>180 participants Responded to the survey</p>		<p>-negative attitudes of individuals -a hostile hospital culture.</p> <p>*Of the 31 graduates, there were nine who commented they did not feel supported and a further 22 who suggested that there were some issues with support.</p>	
16	<p>Clements, V. (2012) Australia</p> <p>Latent and manifest content analysis</p>	<p>To identify the type of support offered to newly graduated midwives during their transition year and to increase knowledge and understanding of new midwives expectations and experiences of this support.</p> <p>Descriptive qualitative study was undertaken in three phases</p>	<p>Telephone interviews</p> <p>Focus groups</p> <p>Interviews</p> <p>Latent and manifest content analysis</p>	<p>*No programme at some sites *Clinical rotations &amp; study days *Expected support from qualified midwives to improve confidence *Increase stress and anxiety: *Discrepancy between the TSPs and newly qualified midwives' expectations *Lack of promised supernumerary time *Limited access to midwifery continuity of care models *60% Newly qualified midwives felt supported and that their goals were met with the TSP</p>	<p>Clements (2012) did not include a detailed section on how the data was analysed. It was only briefly stated in the methods section of the study.</p>



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		<p>In phase one 14 Maternity hospitals within three Sydney Area Health Services (AHS) provided details of their TSPs. In phase two, 31 newly graduated midwives participated in telephone interviews (18 at the beginning of their transition year and 29 at the end). An additional 7 Participated in focus groups. In phase three interviews with 16 experienced midwives Canvassed perceptions of the support their facility offered the new graduates.</p>		<p>*Abandonment of TSP by more than 16% of newly qualified midwives before the end of their first year in clinical practice</p>	
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17	<p>Mason. J and S. Davies (2013). England A qualitative evaluation of a preceptorship programme to support newly qualified midwives.</p>	<p>To evaluate the strengths and weaknesses of one programme of preceptorship, as perceived by a cohort of NQMs, their preceptors and managers. Practice development evaluation  Six newly qualified midwives Four managers Six preceptors</p>	<p>Individual interviews and focus groups with a longitudinal element  Thematic analysis</p>	<p>Three themes identified: <i>*Developing competence and confidence</i> <b>First interview:</b> awareness of skill deficit <b>second interview:</b> clear of expectations -ability to care for women with complex needs-value of simulation, reflection in learning new skills and consolidation of knowledge-study days in supportive environment valuable-fear of litigations -acquisition of midwifery skills <i>*Support</i> group reflection supports transition-helps with learning - a good relationship is to everyone. -Enhance peer building-appreciation-peer/preceptor support, relationships with managers and obstetrician enhance confidence- bullying impacts on their functionality. <i>*Organisational constraints</i> -staff shortage -concerns with senior staff retention to support newly qualified midwives <i>*Preceptorship programme aided NQMs to develop confidence and competence and to integrate well with the multidisciplinary team.</i></p>	<p>In Mason &amp; Davies (2013) data analysis, sampling and ethics not discussed in detail. In studies involving humans ethical issues should be adhered to protect the participants. No recommendation for further research made. However, the study did produce insight into the subject area.</p>
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**THE LIVED EXPERIENCES OF NEWLY QUALIFIED MIDWIVES TRANSITION DURING THE FIRST YEAR OF MIDWIFERY PRACTICE IN JAMAICA**

<p>18</p>	<p>Clements, V., Fenwick, J. &amp; Davis, D. (2012).  Australia: New South Wales  Core elements of transition support programs: The experiences of newly qualified Australian midwives</p>	<p>To describe newly qualified midwives' experiences of the core elements of their transition support program; clinical rotations, supernumerary time, study days and midwife-to-midwife support.  Qualitative descriptive  Thirty-eight newly qualified midwives from 14 hospitals in the state of New South Wales, Australia</p>	<p>Telephone interviews and focus groups.  Content analysis</p>	<p>*Conflict- promised ideal preceptorship *Core elements of transition support programmes identified: -clinical rotations, supernumerary time, study days, midwifery support *Rotation-build professional network-build skills across the full scope of midwifery practice-acquire various skills from different midwives; Change rotation-stress, gap fillers; feeling of undervalued; potential for adverse issues-inadequate skills and expertise *Supernumerary-acclimatise Incongruence/variances in graduates' expectations and what was promised, is available-shorter than expectations or unavailable *Study days- beneficial: improvement in knowledge- facilitate shared learning among graduates; helps to learn, build confidence, professional development and establish a professional network *Midwife to midwife relationships: expected support from more experienced midwifery-beneficial; support from colleagues, managers and educators was important but workload impacted on its possibility.</p>	<p>The study described data analysis, data collection in detail. The study also discussed the trustworthiness. Ethical considerations were also addressed in the study. Only 36% of the total participants who were invited participated. Given these findings should be used cautiously as the results may not be transferrable as one cannot know whether the others who did not participate would have deferred from those that participate.</p>
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**THE LIVED EXPERIENCES OF NEWLY QUALIFIED MIDWIVES TRANSITION DURING THE FIRST YEAR OF MIDWIFERY PRACTICE IN JAMAICA** 199

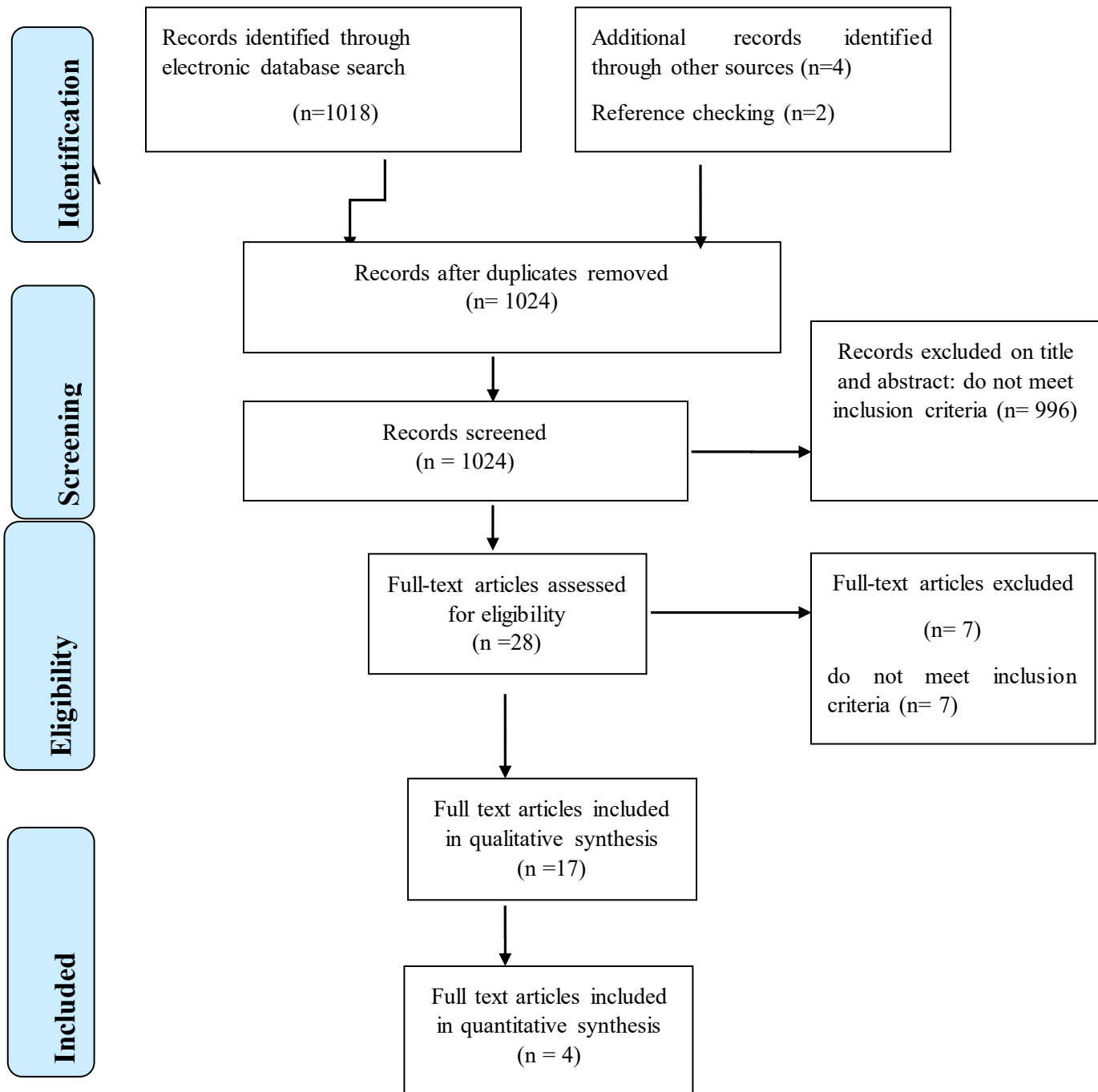
19	<p>Hughes, A.J. &amp; Fraser D.M. (2011)</p> <p>England</p> <p>‘SINK’ or ‘SWIM’: The experiences of newly qualified midwives in England.</p>	<p>To explore newly qualified midwives and preceptors’ views of the preceptorship period</p> <p>Qualitative Survey</p> <p>62 participants: (40 newly qualified midwives; 20 Preceptors &amp; 2 Practice Development midwives)</p>	<p>Initial questionnaire</p> <p>Focus group- 14 group</p> <p>*One to one interview X 1</p> <p>Thematic analysis (focus groups)</p>	<p>*Difficult transition- student to midwife, long delay in practising on qualifying.</p> <p>*Preceptorship programme operated by designated Practice Development midwife-offered structured programme</p> <p>*Factors inhibiting effective preceptorship -misunderstanding of purpose, experience &amp; coordination of placement</p> <p>*Factors enhancing preceptorship-Practice Development Midwives, personalised programmes.</p> <p>*The effectiveness of the period of preceptorship programme significant in newly qualified midwives’ retention in midwifery practice.</p>	<p>Hughes &amp; Fraser’ recent (2011) study methodologies was appropriate, and the study provided sound insight on preceptorship as it revealed and supported that there is inadequate preceptorship for newly qualified midwives hence necessitating for further research in this area. The response rate from the questionnaires from newly qualified midwives and preceptors were low.</p>
20	<p>Wain, A. (2017)</p> <p>England</p> <p>Examining the lived experiences of newly qualified midwives during their preceptorship</p>	<p>To evaluate the experiences of newly qualified midwives during their preceptorship at the Trust.</p> <p>Interpretative phenomenology analysis (IPA)</p>	<p>Semi-structured interviews.</p> <p>Interpretative phenomenology analysis (IPA)</p>	<p>Six themes identified:</p> <p>*<i>Confidence and competence</i> working under own PIN; responsibility and accountability; ability to consolidate assist confidence.</p> <p>*<i>Support</i>-busy unit-lack of support to supervise skills e.g. suturing, and greater support from midwifery staff.</p> <p>*<i>Feelings during the transitional period</i> -vulnerable, stressed, much more autonomous than a nurse.</p>	<p>Wain (2017) study used only one sample of midwives due to the study being done in partial fulfilment as part of the author’ university so it was subjected to the prerequisites of the university. Findings of the study was limited to the NHS trust where the research was conducted. The study could have been influenced by the researcher’ relationship</p>

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		<p>Eight newly qualified midwives</p> <p>Purposive sample</p>		<p><i>*Time-supernumerary</i> -limited or no shifts with a mentor; the different shift from a mentor; staff shortage mentor reallocated.</p> <p><i>*Perceptions of the preceptorship programme</i>- promised structured preceptorship programme for newly qualified midwives from overseas or a different trust; preceptorship supports confidence.</p> <p><i>*Changes to the preceptorship programme</i>- individualised, protected time with mentors.</p>	<p>with the participants. Given she was a supervisor of midwives, part-time lecturer, and work colleagues to the participants. There was no detail given regarding reflexivity in the study and how the researcher maintained the trustworthiness of the study. Though the author stated that the relationship of the participants did not influence the interviewing process in terms of how the participants answered.</p> <p>Wain (2017) study did make a recommendation for further research on preceptorship to help newly qualified midwives acclimatize to their new role and becomes competent and confident practitioners</p>
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Appendix 5: Figure Showing Flow chart of the search strategy and Study selection

Fig 1. PRISMA flow chart of the search strategy and study selection



Source: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement*.

Appendix 6- Hawker et al. (2002) Quality assessment Tool

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1. Abstract and title: Did they provide a clear description of the study?
  - Good     Structured abstract with full information and clear title.
  - Fair     Abstract with most of the information.
  - Poor     Inadequate abstract.
  - Very Poor     No abstract.
2. Introduction and aims: Was there a good background and clear statement of the aims of the research?
  - Good     Full but concise background to discussion/study containing up-to date literature review and highlighting gaps in knowledge.  
Clear statement of aim AND objectives including research questions.
  - Fair     Some background and literature review.  
Research questions outlined.
  - Poor     Some background but no aim/objectives/questions OR Aims/objectives but inadequate background.
  - Very Poor     No mention of aims/objectives.  
No background or literature review.
3. Method and data: Is the method appropriate and clearly explained?
  - Good     Method is appropriate and described clearly (e.g., questionnaires included).  
Clear details of the data collection and recording.
  - Fair     Method appropriate, description could be better.  
Data described.
  - Poor     Questionable whether method is appropriate.  
Method described inadequately.  
Little description of data.
  - Very Poor     No mention of method, AND/OR  
Method inappropriate, AND/OR No details of data.
4. Sampling: Was the sampling strategy appropriate to address the aims?
  - Good     Details (age/gender/race/context) of who was studied and how they were recruited.  
Why this group was targeted.  
The sample size was justified for the study.  
Response rates shown and explained.
  - Fair     Sample size justified.  
Most information given, but some missing.

- Poor        Sampling mentioned but few descriptive details.  
Very Poor        No details of sample.
5. Data analysis: Was the description of the data analysis sufficiently rigorous?
- Good        Clear description of how analysis was done.  
Qualitative studies: Description of how themes derived/ respondent validation or triangulation.  
Quantitative studies: Reasons for tests selected hypothesis driven/ numbers add up/statistical significance discussed.
- Fair        Qualitative: Descriptive discussion of analysis.  
Quantitative.
- Poor        Minimal details about analysis.
- Very Poor    No discussion of analysis.
6. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?
- Good        Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed.  
Bias: Researcher was reflexive and/or aware of own bias.
- Fair        Lip service was paid to above (i.e., these issues were acknowledged).
- Poor        Brief mention of issues.
- Very Poor    No mention of issues.
7. Results: Is there a clear statement of the findings?
- Good        Findings explicit, easy to understand, and in logical progression.  
Tables, if present, are explained in text.  
Results relate directly to aims.  
Sufficient data are presented to support findings.
- Fair        Findings mentioned but more explanation could be given.  
Data presented relate directly to results.
- Poor        Findings presented haphazardly, not explained, and do not progress logically from results.
- Very Poor    Findings not mentioned or do not relate to aims.
8. Transferability or generalizability: Are the findings of this study transferable/generalizable to a wider population?
- Good        Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).
- Fair        Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.



- Poor Minimal description of context/setting.  
Very Poor No description of context/setting.
9. Implications and usefulness: How important are these findings to policy and practice?
- Good Contributes something new and/or different in terms of understanding/insight or perspective.  
Suggests ideas for further research.  
Suggests implications for policy and/or practice.
- Fair Two of the above (state what is missing in comments).
- Poor Only one of the above.  
Very Poor None of the above.

Source: Hawker, S., Payne, S., Kerr, C., Hardey, M., & Powell, J. (2002). Appraising the evidence: reviewing disparate data systematically. *Qualitative health research*, 12 (9), 1284-1299. [Appendix D, p.1296]

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**Appendix 7- Table Showing Results of the quality assessment for the qualitative and quantitative studies (n = 21)**

Study	Abstract /Title	Introduction Aims	Data collection	Sampling	Analysis	Ethics/Bias	Results	Generalisability /Transferability	Implications /Usefulness	Total	Grade
Barry et al. (2013)	4	2	2	1	1	1	3	1	1	20	C
Clements et al. (2013)	4	3	3	1	3	2	3	1	1	19	C
Cummins et al. (2015)	3	3	3	3	3	2	3	2	3	25	B
Cummins et al. (2017)	2	3	2	1	3	3	3	1	1	19	C
Kitson Reynolds et al. (2014)	3	4	3	3	3	3	3	3	4	29	B
Foster & Ashwin, (2014)	4	4	2	2	1	2	3	2	3	23	C
Fenwick et al. (2012)	4	4	4	4	4	1	4	1	4	30	A
Van der Putten, (2008)	3	3	4	3	2	4	4	2	4	25	B
Avis et al. (2013)	3	3	3	2	3	3	3	2	4	28	B
Hobbs, J. (2012)	4	3	4	3	2	3	3	2	2	26	B
Fleming et al. (2001)	4	4	3	4	3	4	3	3	2	31	A
Davis et al. (2012)	4	4	3	4	3	2	3	2	1	26	B
Skirton et al. (2012)	4	3	3	3	2	2	3	2	3	25	B
Pairman et al. (2016)	3	3	3	2	3	3	3	2	3	25	B
Dixon et al. (2015)	3	3	3	3	2	2	3	3	2	24	B
Kensington et al. (2016)	4	3	3	2	2	3	3	3	3	26	B
Clements (2012)	3	3	3	4	4	3	3	2	4	29	B
Mason, J and S. Davies (2013)	3	3	2	1	3	2	3	1	2	20	C
Clements et al. (2012)	4	3	3	2	3	1	3	3	2	25	B
Hughes & Fraser (2011)	3	3	3	1	2	4	4	2	3	25	B
Wain, A. (2017)	4	4	4	4	4	1	4	1	4	30	A

Adapted from: Lorenc *et al.* (2014).    **Key:** A: 30-36-High quality    B: 24-29- Medium quality    C: 9-24- Low quality

**Appendix 8-Table Showing the Characteristics of Hospital Sites Selected for the Study**

Table 3.4.1 Characteristics of Hospital Sites Selected for this Study

<b>Hospital Classification</b>	<b>Hospitals<sup>6</sup></b>	<b>Orientation areas for NQMs</b>
Type A Referral Hospital	Lignum Vitae	COM, P/N, AN, ANC, LW, NURS
Type A Referral Hospital	Mahogany	AN, PN, ANC, LW, NURS, DORM
Type B Hospital	Cedar	PN, AN, ANC, LW, NURS, PAED, COL, DIA

**KEY**

DORM-Domiciliary Unit

COM-Community

COL-Colposcopy Clinic

PAED-Paediatric Ward

DIA- Dialysis Unit

AN-Antenatal Ward

PN- Postnatal Ward

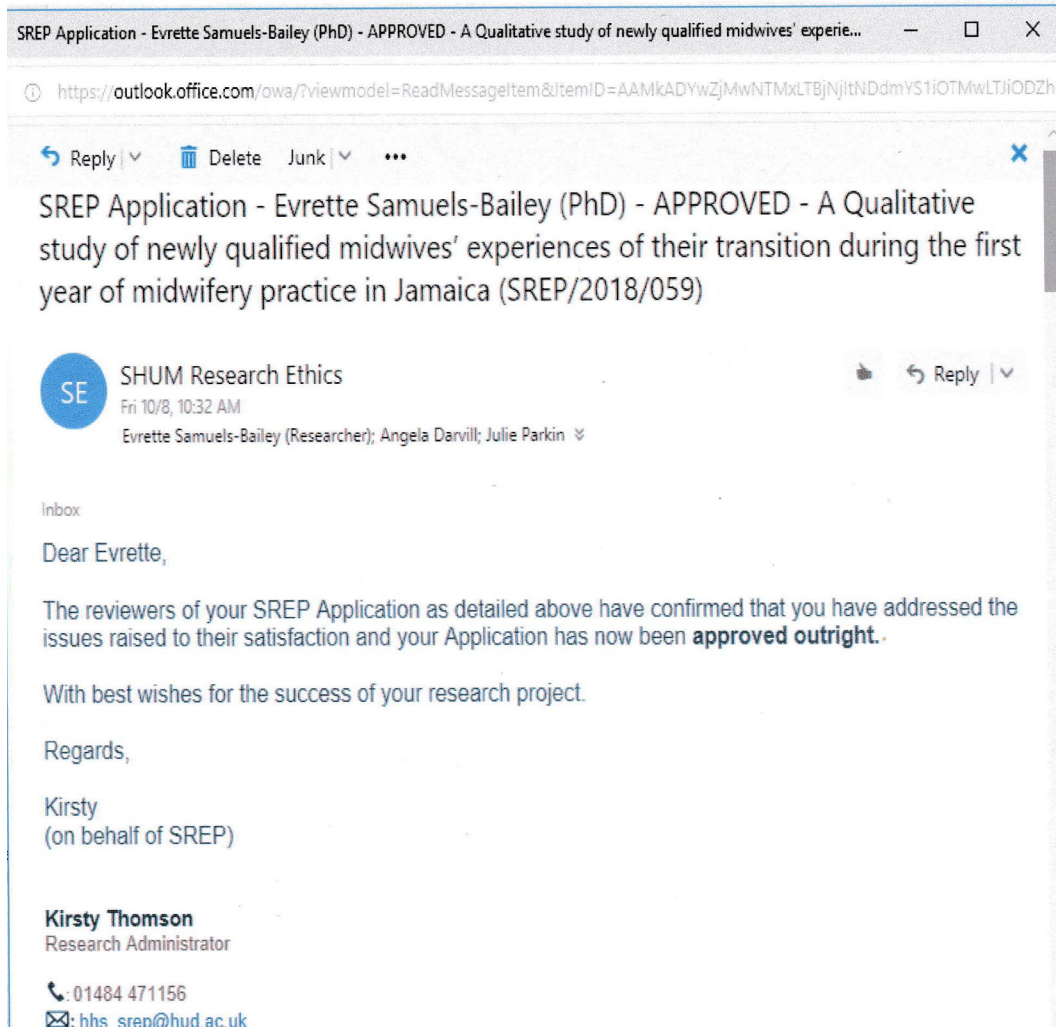
ANC-Antenatal Clinic

NURS- Nursery



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<sup>6</sup> Pseudonyms used for the names of the hospitals

Appendix 9- Ethical Approval: (SREIC) - University of Huddersfield



Appendix 10- Ethical Approval: SERHA- Jamaica



**South East Regional Health Authority**  
Regional Office  
The Towers, 2<sup>nd</sup> Floor, 25 Dominica Drive, Kingston 5  
Voice: (876) 754-3439 Fax: (876) 825-4012, Emergency: 1-888-GO-SERHA  
Website: [www.serha.gov.jm](http://www.serha.gov.jm) E-mail: [email@serha.gov.jm](mailto:email@serha.gov.jm)

2018 October 26

Evrette Samuels-Bailey (Mrs)  
Senior Lecturer  
Allied Health Coordinator  
Excelsior Community College  
Faculty of Pure and Applied Sciences  
Phone: 928 - 5070-1/ 876-312-3882

Dear Mrs. Bailey

**RE: Evaluation of Research Proposal " A Qualitative study of newly qualified midwives' experiences of their transition during the first year of midwifery practice in Jamaica"**

The South East Regional Health Authority is pleased to inform you that ethical approval has been granted for you to carry out the above captioned research. Please communicate with the Chief Executive Officers and the Senior Medical Officers at the

If you have any further questions, please feel free to contact the Regional Surveillance Unit by email at [serharesearchproposals@gmail.com](mailto:serharesearchproposals@gmail.com) or by way of telephone 876-346-0480.

**Kindly forward a copy of the study to this office upon completion of the research.**

Best wishes for a successful study.

Yours truly  
**SOUTH EAST REGIONAL HEALTH AUTHORITY**

*M. Bourne*  
Dr. Duetris Bourne *For: Dr. Sandra Chambers*  
Regional Technical Director *Acting RTD.*

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Board of Directors: Mr. Philip Armstrong (Chairman); Ms. Maureen Golding (Regional Director); Dr. Duetris Bourne (Regional Technical Director); Mr. Erol Greene, (CEO Actg. KPHVJH); Dr. Natalie Whyte (Senior Medical Officer Actg., KPH); Mr. Philip Henriquez, Mrs. Lisa A. Scores Lewis; Ms. Belinda Williams, Ms. Carolyn Chuck, Dr. Norman Dunn (Vice Chairman); Mr. Peter Jarvis; Dr. Patricia Charles-Freeman, Councillor Owen Palmer, Mrs. Manva Lawson Byfield

Appendix 11- Example of Letter to Stake Holders



Dr .....

Acting Senior Medical Officer

.....Hospital

Jamaica

October 18, 2018

Dear Dr. ....

**Re: Proposal- A Qualitative study of newly qualified midwives' experiences of their transition during the first year of midwifery practice in Jamaica.**

I am Evrette Samuels-Bailey, a student at the Huddersfield University in England; in partial fulfilment of my study, I at this moment request your permission for the above-captioned research study to be conducted at your institution, .....Hospital within the maternity unit.

Dr Angela Darvill and Dr Julie Parkin of the University of Huddersfield in England will supervise the research study. However, .....will be my local supervisor.

Please find enclosed a copy of my proposal.

Sincerely,

Mrs Evrette Samuels-Bailey

Lead Researcher

Appendix 12- Example of In-Service Coordinator Information sheet



**Title of Project:** A Qualitative study of newly qualified midwives' experiences of their transition during the first year of midwifery practice in Jamaica.

**In-Service Coordinator Information SHEET (Example)**

Dear In-Service Coordinator,

I am a full-time research student currently undertaking my studies at the University of Huddersfield in the United Kingdom. I, at this moment, request your assistance in the distribution of the enclosed envelopes to all the newly qualified midwives who have 1-3 months of working experience.

Ethical approval was given on [10.08.2018] through the University of Huddersfield Ethics Committee, SREP in the United Kingdom and South East Regional Health Authority (SERHA) in Jamaica.

I have given my contact details to the participants. However, in the event the newly qualified midwives may be seeking clarification on any area of the study, please find enclosed a copy of the 'Participant information sheet' for your information.

Please do not hesitate to contact me directly should you have a query or unable to answer any questions posed by prospective participants about this study. Alternatively, you can advise the participant to contact me directly using the contact details I have provided.

If the newly qualified midwives are interested in taking part in this research study, they have been asked to complete the consent form and contact details card and return it to me via the provided envelope or via yourself.

The participant information sheet informs the newly qualified midwives of the purpose of this study and what will happen to them if they take part. In addition to this gives details of the conduct of the research.

Please feel free to ask me for clarification or to provide information before you distribute the information packs to the newly qualified midwives.

I would be grateful for your assistance.

For further information, please contact me as follows:

Name of the researcher: Evrette Samuels-Bailey

Contact details of the researcher:

Telephone: 1876-779-8029/1876-312-3882 or 1876-926-5070

Email: [evrette.samuels-bailey@hud.ac.uk](mailto:evrette.samuels-bailey@hud.ac.uk)

**Appendix 13- Example of Participant Information Sheet**



**Title of Study:** A Qualitative study of newly qualified midwives' experiences of their transition during the first year of midwifery practice in Jamaica.

**INFORMATION SHEET (Example)**

You are being invited to take part in a study of newly qualified midwives' experiences while transitioning into midwifery practice. Before you decide to take part, it is vital that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

**What is the study about?**

The study seeks to explore newly qualified midwives transition experiences during their first year of midwifery practice post registration.

**Why is the research being done?**

The purpose of this study is to provide a deeper insight and understanding of the experiences of newly qualified midwives transition into midwifery practice from the point of their orientation to 12 months post registration.

**Why have I been approached?**

The researcher has approached you to ask for your participation in the research study as the researcher is giving this information sheet to eligible participants within the Maternity Unit located at XXX institution. If you are eligible to participate in the study, your views and input into the subject being investigated would be valuable and will be held in strict confidence, and your anonymity maintained.

**Why your views are important?**

Your views are critical as it can help the researcher explore transition which has the potential to find ways that may lead to a smoother transition for midwives into professional practice and enhance their retention.



**Do I have to take part?**

It is your decision whether or not you take part. If you decide to take part, you will be asked to sign a consent form, and you will be free to withdraw at any time, and without giving a reason. Unless explicitly stated otherwise, the researcher will use previously collected data in the study. That is if at the point of the participants' withdrawal data analysis had already been done it will no longer be possible for the researcher to withdraw the participant's data as such the data will be used in the study. You have the right to decline to answer certain questions. The researcher cannot predict the exact questions during the interview, and as such you have the right to refuse to answer questions.

A decision to withdraw at any time, or a decision not to take part, will not affect your employment.

**What will be involved if I take part in this study?**

If you consent to take part in the study, you will be asked to complete the contact information card and the consent form and return to the researcher in the enclosed envelope. You would also be required to take part in three (3) interviews. The interviews will be digitally recorded with your consent and will last for approximately one hour each session. The first interview is scheduled to take place from January to March 2019; the second interview will take place from April to May 2019, and the third interview will be in January 2020. The interviews will be held in a private room with only the participant and the interviewer. The researcher will disclose the local venue for the interview with the participants on their consent to participate in the interview.

Example of questions that the researcher will ask participants at the interview:

1. Can you tell me something about your midwifery education and preparing for practice as a qualified midwife?
  2. Tell me about your expectations of transition into midwifery practice before practising as a qualified midwife
  3. Can you tell me about your experiences of transition during your midwifery practice so far?
- You will need to confirm the previous information you gave to the researcher before data analysis

**Will my identity be disclosed?**

All information disclosed within the interview will be kept confidential unless you indicate that you or anyone else is at risk of serious harm, in which case the researcher would need to pass this information to the Director of Nursing Services or other relevant personnel as per your hospital's guidelines. The researcher will use identification codes and pseudonyms rather than your name on all data and recordings and documents linking you to study; identification codes will be kept separate from data and kept in locked storage to maintain participants' confidentiality further. The pseudonym assigned to you will be different from any staff names employed to the maternity units at both hospitals proposed for the study to maintain your anonymity. The pseudonym selected by you at the start of the study will be the same one used throughout the study.

**What will happen to the information?**

On completion of the research study, the researcher anticipates publishing the research in a journal or report and may need to use your words or quotations in the presentation of the results. However, the researcher will maintain your anonymity, and your permission for this is included in the consent form.

**How will the information be stored?**

Any information about you will be stored and kept electronically will be password protected and encrypted. The researcher will keep all hard copies of data collected in a locked storage cabinet in Jamaica and by the University of Huddersfield guidelines. The researcher will store other data on a password-protected university server and back it up on the University of Huddersfield 'Unidesktop Digital Workspace'. These data will only be accessed from the locked area when being utilised for analysis by the researcher and be securely returned when not being used. The researcher will store your personal data for the duration of the study with your express written consent. The researcher will destroy all your personal data as soon as the study has been completed. The researcher will store the recordings of the interviews and transcript in its original form for ten years as per the university's requirement after the completion of the study. After that, the researcher will shred all the stored recordings of interviews and transcripts and disposes of it in accordance with the University of Huddersfield guidelines and with the assistance of a confidential waste company.

**Who is organising and funding the study?**

The study is organised and self-funded by the Lead Researcher, Evrette Samuels-Bailey, in partial fulfilment of a postgraduate programme at the University of Huddersfield, England. The lead researcher will handle the day-to-day conduct of the study.

**Who will be the persons responsible for the conduct of the study and General Data Protection Regulation (GDPR) compliance?**

The Lead researcher, Evrette Samuels-Bailey, supervisors: Dr Angela Darvill and Dr Julie Parkin (UK) and .....(Jamaica) are the persons responsible for the conduct of the study and GDPR compliance. All members of the research team are bound by the ethical and data protection commitments explained in this form.

**Who has reviewed the study?**

The University of Huddersfield Research Ethics Committee (SREP) in England and the South East Regional Health Authority (SERHA) Ethics Committee in Jamaica will review the study.

**What happens next?**

Please feel free to discuss this information with others (e.g., your family, co-workers, or personnel at your institution) before your consent to participate in the study. You can also contact the research team directly (details below) for further clarity. If you would like to take part, please complete the

enclosed contact form and consent form and return them to the researcher in the envelope provided. If you agree to take part in an interview, the researcher will contact you to arrange a time, venue and date that is best for you. The interview will be conducted at the hospital, your place of work while you are there in a private room. The researcher will do all interviews.

**Contact for further information**

If you would like to ask any questions about the study or require any further information, I would be glad to speak to you. My telephone number is 1876-928-5070 Extension 3325 or 1876-779-8029 and 1876-312-3882, and my educational institution email is [evrette.samuels-bailey@hud.ac.uk](mailto:evrette.samuels-bailey@hud.ac.uk).

My work address is: Excelsior Community College  
School of Nursing and Allied Health  
137 Mountain View Avenue  
Kingston 3  
Jamaica

Other researchers (Supervisors/Principal investigators) included in the project are:

Dr Angela Darvill: E-mail: [a.darvill@hud.ac.uk](mailto:a.darvill@hud.ac.uk) Dr Julie Parkin: E-mail: [j.parkin@hud.ac.uk](mailto:j.parkin@hud.ac.uk).

Local Supervisors: .....

**Thank you for taking the time to read this information sheet, and I hope you will be able to come and share your experiences**

Appendix 14- Example of Participant Consent Form



**Title of Research Project:** A Qualitative study of newly qualified midwives' experiences of their transition during the first year of midwifery practice in Jamaica.

Study Number: XXXXXX

Participant Identification Number for this study: XXXXX

Name of Researcher: Evrette Samuels-Bailey

**Please initial box**

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary, and you are not obliged in any way to participate, if you require any further details, please contact the researcher.

I confirm that I have read the information sheet dated..... (Version.....) for the above study.

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I have been fully informed of the nature and aims of this research as outlined in the information sheet version ....., dated .....

I understand that I have the right to withdraw from the research at any time without giving any reason and that unless I specifically stated otherwise, the researcher will use previously collected data in the study.

I understand that if at the point after data collected has been analysed and I choose to withdraw from the study such data will still be used in the study.

I understand that the information collected about my experiences and views will be used to support other research in the future and may be shared anonymously with other researchers.

I give permission for my words to be quoted (by use of a pseudonym)

I agree to be interviewed.

I agree with the interview to be digitally recorded.

I agree with the interview being transcribed.

I agree for my personal data to be stored for the duration of the study.

I understand that my personal data will be destroyed as soon as the study is completed.

**THE LIVED EXPERIENCES OF NEWLY QUALIFIED MIDWIVES TRANSITION DURING THE FIRST YEAR OF MIDWIFERY PRACTICE IN JAMAICA**

I understand that the information collected will be kept in secure conditions for ten years at the University of Huddersfield.

I understand that the information held and maintained by the University of Huddersfield may be used to help contact me or provide information about my experiences and views on the issue being studied.

I understand that no person other than the researcher/s and facilitator/s will have access to the information provided.

I understand that my identity will be protected by the use of a pseudonym in the report and that no written information that could lead to my being identified will be included in any report.

I understand that it may necessitate the researcher to use my words or quotations in the presentation of the findings in the publishing of the research study in journals or reports which may risk my identity be known

I understand that the researcher would require me to validate previous information I had given

I agree with the researcher to return to me for validation of information that I had previously given   
 I am aware that the exact questions cannot be predicted during the interview and as such,   
 I have the right to decline to answer questions

I understand that the study will be conducted in three phases for a duration of one (1) year in which I would be required to participate in three (3) interviews at different intervals, first three months; 4-5 months post-employment and 12 months post-employment.

If you are satisfied that you understand the information and are happy to take part in this research, please put your initials in the box aligned with each sentence and print and sign below.

Signature of Participant:	Signature of Researcher:	Signature of Witness:
Print:	Print:	Print:
Date:	Date:	Date:

(One copy to be retained by Participant / one copy to be kept by Researcher)

**Thank you for taking the time to read this information.**

**Appendix 15- Example of Participant Contact Details Card**



**Title of Project:** A qualitative study of the lived experiences of newly midwives' transition during the first year of midwifery practice in Jamaica.

**Participant Contact Details Card (Example)**

(Will be provided on an A5 size piece of card.)

Name:

Address:

Home telephone:

Mobile Telephone:

Email address:

Please return to:

Name of researcher: Evrette Samuels-Bailey

Contact details of researcher:

My work address is:

Excelsior Community College

School of Nursing and Allied Health

137 Mountain View Avenue

Kingston 3

Jamaica

Telephone: 1876-779-8029 or 1-876-926-5070 Ext. 3325

Email: [evrette.samuels-bailey@hud.ac.uk](mailto:evrette.samuels-bailey@hud.ac.uk)

Appendix 16- Example of Participant Letter of Invitation



**Title of Project:** A Qualitative study of newly qualified midwives' experiences of their transition during the first year of midwifery practice in Jamaica.

**Participant Letter of Invitation (Example)**

Dear .....

I would like to invite you to take part in a research study. The purpose of the study is to provide a deeper insight and understanding of the experiences of newly qualified midwives transition into midwifery practice from the point of their orientation to 12 months post registration.

Please find enclosed a participant information sheet (version...) for you to read carefully. It will give you an understanding as to the reason for the study and what would it involve for you. You can discuss the study with others if you want. While the Director of Nursing Services or the In-Service Coordinator may not be the distributors of this information pack, please feel free to contact them or me if you need further information or needing clarification of the study.

Participation in the study is voluntary. Therefore, if you are interested in taking part in this research study, please complete the consent form and contact details card (enclosed) and return to me via the provided envelope or hand deliver to the Director of Nursing Services or the In-service coordinator within two weeks of the date of the invitation.

Thank you for taking the time to read this information.

Name of the researcher: Evrette Samuels-Bailey (Researcher)

Contact details of the researcher:

Telephone: 1876-779-8029/1876-312-3882 or 1876-926-5070

Email: [evrette.samuels-bailey@hud.ac.uk](mailto:evrette.samuels-bailey@hud.ac.uk)

**Appendix 17-Illustrating Study Participants Demographics**

	<b>Participants Pseudonym</b>	<b>Midwifery Education</b>	<b>Midwifery Qualification</b>	<b>Registered</b>	<b>Started Midwifery Practice</b>	<b>Category staff</b>
1.	Francesca	DE	Certificate	12/2018	17/12/2018	Midwife
2.	Daniella	DE	Certificate	12/2018	15/01/2019	Midwife
3.	Emma	PB	Certificate	12/2018	07/01/2019	Nurse Midwife
4..	Abigail	PB	Certificate	12/2018	18/02/2018	Nurse Midwife
5.	Camilla	PB	Certificate	12/2018	02/2019	Nurse Midwife
6.	Beatrice	PB	Certificate	12/2018	07/01/2019	Nurse Midwife
7.	Francine	DE	Bachelor's	12/2018	25/02/2019	Midwife
8.	Flores	PB	Certificate	12/2016	25/02/2019	Nurse Midwife

**KEY**

PB-Post-Basic

DE-Direct Entry



**Appendix 18 - Table Showing Interview Schedule**

**First Interview:** First 3 months of midwifery practice (January-March 2019)

1. Can you tell me something about your midwifery education and preparing for practice as a qualified midwife?
2. Tell me about your expectations of transition into midwifery practice before practising as a qualified midwife
3. Can you tell me about your experiences of transition during your midwifery practice so far?

**Second interview:** 4-6 months of midwifery practice (April-May 2019)

At the beginning of this interview, the researcher will review with the participants the information that they gave the researcher during their last interview. Following the review of information, the researcher will then ask the participant the following questions:

1. Have your expectations of midwifery practice changed since our previous contact?
2. Tell me about your experiences of transition since our last interview?

**Third Interview:** 12 months of midwifery practice (January 2020)

At the beginning of this interview, the researcher will review with the participants the information that they gave the researcher during their last interview. Following the review of information, the researcher will then ask the participant the following question:

1. Reflecting on the past year, how are your feelings now about your transition experiences?

Appendix 19- Risk Analysis and Management Form

THE UNIVERSITY OF HUDDERSFIELD: RISK ANALYSIS & MANAGEMENT

<b>ACTIVITY: Conduction of Interviews</b>			<b>Name: Evrette Samuels-Bailey</b>	
<b>Hospital</b>			<b>Date:</b>	<b>Review Date:</b>
<b>Hazard(s) Identified</b>	<b>Details of Risk(s)</b>	<b>People at Risk</b>	<b>Risk management measures</b>	<b>Other comments</b>
Loss/ theft of data	Security of data	Interviewees	<ul style="list-style-type: none"> <li>• Electronic data to be stored only on password secured computer equipment and storage devices in a locked filing cabinet that can only be accessed by the researcher in Jamaica.</li> <li>• Digital cameras and Dictaphones with audio recordings to be transported in a lockable case.</li> </ul>	Laptops, and other electronic data storage devices to be transported in the locked boot of a car when the researcher is in the field.
Risk of distress	Personal wellbeing	Interviewees	<ul style="list-style-type: none"> <li>• To liaise in advance of the study with the Director of Nursing Services and identify a support system that is in place at the two hospitals for the participants to access if they experience any distress during or after their interview.</li> <li>• To give the participant the contact information for a counsellor</li> </ul>	
Display screen equipment	Poor posture sat working for prolonged periods resulting in musculoskeletal problems,	Researcher	<ul style="list-style-type: none"> <li>• To ensure all workstations (home and school) are set up correctly to prevent musculoskeletal issues; visual/physical fatigue. Appropriate rest breaks.</li> </ul>	

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	visual/physical fatigue			
Nosocomial Infection	Personal wellbeing	Researcher	<ul style="list-style-type: none"> <li>To ensure immunisation status is up to date to facilitate personal health and well-being.</li> </ul>	
Technical computer issues	Malfunctioning of computer or data storage device	Researcher	<ul style="list-style-type: none"> <li>To store data/interviews on an external hard drive and back up information.</li> <li>To store data/ interview on the researcher' personal storage space provided by the University of Huddersfield via the 'UniDesktop Digital Workspace'.</li> </ul>	
Slips trips or falls	Obstructions, trailing cables on thoroughfares throughout the proposed hospitals for the study	Researcher	<ul style="list-style-type: none"> <li>Researcher vigilance in public areas</li> <li>Regular review of working space to ensure health and safety</li> </ul>	

Appendix 20- Showing Table with Stages involved in IPA analysis

Stage	Activity
<p><i>1: read and re-reading the text [Data immersion]</i></p>	<p>In this stage The data analysis starts with a close examination of the first one of Camilla’s transcript. I read Camilla’s transcript several times to begin the analytic process.</p>
<p><i>2: Initial notetaking [Text-analysis]</i></p>	<p>In this stage: I re-read the text and did a line-by-line analysis while making notes of particular words and phrases that stood out in the version of Camilla’s interview transcript. In the right-hand column of the transcript in Microsoft words, I list all the words, phrases and ideas and convergence pattern, and interesting comments using descriptive, linguistic, and conceptual comments pertinent to Camilla’s experience while being mindful of my study’ phenomenon. I coded my initial notetaking or exploratory comments into three areas: <b>Descriptive Coding</b> <i>Descriptive comment:</i> This is involved me summarising or noting keywords or phrases that stood out in the participants’ transcript due to its frequency, connotation, or perceived importance to either the participant or researcher when the participant described the phenomenon of concern. <b>Linguistic Coding</b> This level of analysis focused on linguistic comments. Therefore, I reflected on the participant’s language usage, such as any specific and or repetitive words, pronouns, and metaphors. Additionally, I considered the participant’s voice, manner of speech, pauses and</p>

	<p>laughter during the interview and other linguistic elements the participants used to describe the experience.</p> <p><b>Conceptual Coding</b></p> <p>This third level of coding involved <i>conceptual comments</i>. Here I asked questions of the data and moved towards any theoretical underpinning relevant to what the participant said as per Smith et al. (2009) recommendation.</p> <p>I used coding conventions such as italics for linguistic comments, the standard text for descriptive comments and the underlining of conceptual comments during notetaking.</p> <p>Appendix 4 provides examples of the three types of coding I performed on each transcript.</p>
<p>3: <i>Developing emergent themes</i></p>	<p>In this stage:</p> <p>I carefully examined the notations I made in the first transcript's right-hand column as per Stage 2 above. I then look for emerging themes and patterns derived from the original transcript's excerpts that mostly capture my study's phenomenon. In that, <i>some of the emergent themes were the same as that of the first notes</i>. Using excerpts from the original transcript ensures that the emerging themes are grounded in the data and reduce data volume [phenomenological reduction].</p> <p>I then opened a blank document on Microsoft words and entitled it: <i>Case #1: Camilla Interview #1</i>. I then list all the emergent themes or phrases chronologically in the table's left-hand column as they appear in Stage 2 without trying to make connections between each theme. Simultaneously, I placed the original text's corresponding excerpts in the right-hand column with its affixed page and line numbers.</p> <p>I then colour coded the list of emergent themes according to the theme group they seemed to represent. After this, I transferred them to theme tables in a new word document, displaying each theme</p>

	<p>group in a separate table and presenting tentative ‘superordinate’ titles (Harris, 2012).</p> <p>There is an interpretative element to this stage as it involved a recollection of what I, learned through the exploratory comments in stage 2 as per Smith et al. (2009).</p>
<p><i>4: Searching for connections across emergent themes.</i></p>	<p>This stage introduced structure into the analysis, and here is where theme analysis begins.</p> <p>In this stage on the same Microsoft document entitled: <i>Camilla’s interview # 1:</i></p> <p>I began this stage by looking for commonalities or connections between the themes developed in Stage 3 as above.</p> <p>I then began to cluster the themes and group similar themes together while being careful not to omit or replicate any theme. I gave each cluster a descriptive label.</p> <p>I accompanied all the themes by short verbatim excerpts from the original interview transcript.</p> <p>I then do a close examination of the themes and group them in superordinate (most important) and subordinate (less relevant but still useful).</p> <p>This process assisted me in the identification of the key themes which stood out within the transcript.</p>
<p><i>5: Moving to the next case</i></p>	<p>In this stage:</p> <p>the remaining seven interview transcripts of the other seven participants, [Daniella, Emma, Beatrice, Francine, Francesca, Flores, and Abigale] were individually analysed using the steps outlined in Stages 1 – 4.</p> <p>After completing the analysis of all the first interviews for each of the eight participants, I repeated the entire process, Stage 1-4 for all the remaining second, and third interviews of the eight participants.</p>

<p><i>6: looking for patterns across cases</i></p>	<p>In this Stage:</p> <p>I searched for connections across individual cases. Links were made and differences noticed between the superordinate themes of each participant while each participants' experiences were still viewed as personal and unique.</p> <p>I then created a table in Microsoft words in which I outlined the subordinate and themes and superordinate themes as they began to converge and diverge across the cases. This assisted me in combining the narratives of all the participants, <i>which was reflective of the experiences of the group of participants, in addition to capturing "the quality of the participants' shared experience of the phenomenon under investigation"</i> (Willig, 2008, p.62) (Harris, 2012).</p> <p>I created a new Microsoft document in which I transferred all the 'superordinate' themes from all eight participants and grouped them according to their colour codes. Colour coding the themes helped me to visualise the representation of the theme clusters easily.</p> <p>I then printed and separated all the themes so I could easily move them around to make 'connections between the participants'. I made tentative connections and gave superordinate titles to each subtheme I created' (Harris, 2012, p.49).</p> <p>I then revisited these subthemes concerning each participant's transcripts and interpretative summaries and regrouped if deemed necessary (Harris, 2012).</p>
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Appendix 21 Table showing Case # 1: Camilla 3rd interview

Emergent Themes		Notes -Stage 2
<p>“I wasn’t given a formal guideline”</p> <p>“Eyeballing and just watch”</p>	<p><b>I:</b> Can you tell me about the support that you have received so far or is receiving?</p> <p><b>P:</b> if, if I should say.... if I [long pause] if I should say support, it would more be a <u>minimal end</u> as I have said before <i>I was more thrown</i>, is like you have to know already I guess because maybe I register....I am a registered nurse already <u>they would have maybe expect</u> and I would have been in charge as a registered Nurse already, <i>they would have somewhat expected me to know the basic things even though it's a specialized area, they would still expect...I, I well that's what I got that they would have expect for me to know the basic stuff already.</i> The basic [short pause] guidelines or the basic strategies as to how you go about being in charge. Seeing that I've been doing that before as a RN. I was <i>..I didn't really get a formal guidance to say how to do such and whatever</i>, maybe like for example for the narcotic drugs like you just to really know when to order drugs and at one point in time, we have to order formula for the babies that that have to be supplemented, So I was advised to ensure that on a particular or in the morning shift we would usually order from the milk kitchen. That was basically like an insight, an insight was given but in terms of the guide and how to manage the ward, I would have gain that basically from my RN experience. <i>I wasn't really given a formal guideline as to how to manage in the specialized areas.</i> I can honestly say that I learned be based on what the senior midwives did. Right. So, I was <i>basically I had to really kinda adopt what the Senior midwives did. Just by eye contact or kina eyeball them. It was more on the eyeballing and just to watch to see how they in the specialized areas specifically go about things.</i> But <i>I wasn't given a formal guideline as to what to do.</i> But I would ask questions, I would make queries to get advice cause I am a person who loves to ask questions and that is how I gain some amount of confidence and knowledge as to what to do, and I would advise the Senior midwives or my supervisor.</p> <p><b>I:</b> So, when you did ask the senior midwives for their support, what was their reaction?</p> <p><b>P:</b> They gave me vigilant feedback. But as I said, <i>I didn't really get a formal or in-depth guideline as to how to go about managing the ward.</i> But I was given vigilant... <i>I was given a vigilant feedback I was given brisk.</i> What's the word risk or on the quick end then I was waiting...take a long period of time over time, yes.</p> <p><b>I:</b> Okay, on the same area of support, what types of support would you have liked or maybe expected to receive?</p>	<p>Linguistic comments: Repeated use of the words and phrases:</p> <p><i>I was more thrown</i> <i>didn't really get a formal guidance</i></p> <p><i>I wasn't really given a formal guideline as to how to manage in the specialized areas</i></p> <p><i>I wasn't given a formal guideline as to what to do.</i></p> <p><i>I didn't really get a formal or in-depth guideline as to how to go about managing the ward</i></p> <p><i>I still would have appreciated more, maybe on a more on a formal in depth, as to how to go about in a specialized area</i></p> <p><i>also provide a formal guideline as to how to manage the ward</i> <i>Eye contact</i> <i>Eyeballing and just watch</i></p>



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<p><b>“I was old before I became young”</b></p>	<p><b>P:</b> Maybe just like a formal rundown as to what to do in a specialized area [long pause] maybe constant reinforcement. But I didn't really think...you see because <u>I've already gained from RN experience, I didn't really think I needed...</u> I was in desperate need for guidelines because I would have had some confidence from the RN experience already. <u>But I still would have appreciated more, maybe on a more on a formal in depth, as to how to go about in a specialized area...</u>and as I said before, most of it was from my RN experience. But I would have maybe appreciated something more on the formal end or maybe constant guideline or reinforcement, as to how to guide me throughout from my supervisors or [?16.45]. I basically <i>have to eyeball and just learn to adapt as to what to do</i> but I would have maybe appreciated. But I would also say I'm not saying that I'm making excuses them maybe it was maybe due to time management or because of the work pressure and all that or maybe the time wasn't really made, or the time wasn't or was unable to be made in order to facilitate that type of teaching and guidelines</p> <p><b>I:</b> Do you care to say why you were placed into this supervisory role, to explain why did they put you into this?</p> <p><b>P:</b> I was, and I thank you for that question. <i>I was placed in supervisory duty because people kept resigning nurses kept resigning and I was forced to become a senior midwife on the ward before I became junior</i> [laughs] so I was old before I became young [laughing]. So, people kept resigning and [? 17.49] basically it was due to a lack of staff on the ward or inadequate staffing. <i>I was forced to move up to senior and to supervise</i> and then of course you know you have juniors that we have to supervise as well. So, I would say maybe it' due to primarily, lack of staff or short staff so that was the pressure. And so, as a result, nobody took the time to really [short pause] or in depth to say let me guide you to see what you do or expected to do. That's what I would have expected but I guess in the time of shuffling, people leaving and all of that they just had to just do a quick fix...you know, so</p> <p><b>I:</b> So how would you feel about being pleased in a supervisory..., What is your feelings about this?</p> <p><b>P:</b> um [laughs]. Oh Lord. I don't really like to be as...I think I've said it before in the previous interviews <i>I really don't like to be in a leadership position.</i> From a divine end, I believe, God is preparing for a <i>leadership position</i> which for me personally <i>I don't like to be in charge...</i>yeah. So, <i>I don't like to be in leadership</i> but coming from the RN experience being in charge as a registered Nurse, <i>I am now more appreciating it</i> because [short pause] [sighs] <i>I am now more appreciating it because it enhances growth.</i> It allows you to grow as a nurse or as a midwife, <i>it allows you to grow. It allows me to when I'm faced with challenges, it allows me to grow</i> because it goes, it shows me that yes, I am, I will be <i>faced with challenges</i>, but yet still I can overcome them. So now I am at a much better place that I don't.... <i>I no longer to be flustered ....</i> I do not.I know <i>there's no need for me to be flustered anymore or to be fearful</i> because challenges will come and the fact that I was thrown into uumm</p>	<p>Linguistic comments: use of repeated phrases</p> <p><i>I was placed in supervisory duty because people kept resigning nurses kept resigning</i></p> <p><i>I was forced to become a senior midwife on the ward before I became junior</i> [laughs]</p> <p><i>I was old before I became young</i> [laughing].</p> <p><i>I was forced to become a senior midwife on the ward before I became junior</i></p> <p><i>I was forced to move up to senior and to supervise</i></p> <p><i>I really don't like to be in a leadership position</i></p> <p><i>I don't like to be in charge.</i></p> <p><i>I don't like to be in leadership</i></p> <p>Linguistic comments:</p> <p><i>I no longer to be flustered</i></p>
<p><b>“I learned to move beyond my fears”</b></p>	<p><b>P:</b> Maybe just like a formal rundown as to what to do in a specialized area [long pause] maybe constant reinforcement. But I didn't really think...you see because <u>I've already gained from RN experience, I didn't really think I needed...</u> I was in desperate need for guidelines because I would have had some confidence from the RN experience already. <u>But I still would have appreciated more, maybe on a more on a formal in depth, as to how to go about in a specialized area...</u>and as I said before, most of it was from my RN experience. But I would have maybe appreciated something more on the formal end or maybe constant guideline or reinforcement, as to how to guide me throughout from my supervisors or [?16.45]. I basically <i>have to eyeball and just learn to adapt as to what to do</i> but I would have maybe appreciated. But I would also say I'm not saying that I'm making excuses them maybe it was maybe due to time management or because of the work pressure and all that or maybe the time wasn't really made, or the time wasn't or was unable to be made in order to facilitate that type of teaching and guidelines</p> <p><b>I:</b> Do you care to say why you were placed into this supervisory role, to explain why did they put you into this?</p> <p><b>P:</b> I was, and I thank you for that question. <i>I was placed in supervisory duty because people kept resigning nurses kept resigning and I was forced to become a senior midwife on the ward before I became junior</i> [laughs] so I was old before I became young [laughing]. So, people kept resigning and [? 17.49] basically it was due to a lack of staff on the ward or inadequate staffing. <i>I was forced to move up to senior and to supervise</i> and then of course you know you have juniors that we have to supervise as well. So, I would say maybe it' due to primarily, lack of staff or short staff so that was the pressure. And so, as a result, nobody took the time to really [short pause] or in depth to say let me guide you to see what you do or expected to do. That's what I would have expected but I guess in the time of shuffling, people leaving and all of that they just had to just do a quick fix...you know, so</p> <p><b>I:</b> So how would you feel about being pleased in a supervisory..., What is your feelings about this?</p> <p><b>P:</b> um [laughs]. Oh Lord. I don't really like to be as...I think I've said it before in the previous interviews <i>I really don't like to be in a leadership position.</i> From a divine end, I believe, God is preparing for a <i>leadership position</i> which for me personally <i>I don't like to be in charge...</i>yeah. So, <i>I don't like to be in leadership</i> but coming from the RN experience being in charge as a registered Nurse, <i>I am now more appreciating it</i> because [short pause] [sighs] <i>I am now more appreciating it because it enhances growth.</i> It allows you to grow as a nurse or as a midwife, <i>it allows you to grow. It allows me to when I'm faced with challenges, it allows me to grow</i> because it goes, it shows me that yes, I am, I will be <i>faced with challenges</i>, but yet still I can overcome them. So now I am at a much better place that I don't.... <i>I no longer to be flustered ....</i> I do not.I know <i>there's no need for me to be flustered anymore or to be fearful</i> because challenges will come and the fact that I was thrown into uumm</p>	<p>Linguistic comments: use of repeated phrases</p> <p><i>I was placed in supervisory duty because people kept resigning nurses kept resigning</i></p> <p><i>I was forced to become a senior midwife on the ward before I became junior</i> [laughs]</p> <p><i>I was old before I became young</i> [laughing].</p> <p><i>I was forced to become a senior midwife on the ward before I became junior</i></p> <p><i>I was forced to move up to senior and to supervise</i></p> <p><i>I really don't like to be in a leadership position</i></p> <p><i>I don't like to be in charge.</i></p> <p><i>I don't like to be in leadership</i></p> <p>Linguistic comments:</p> <p><i>I no longer to be flustered</i></p>

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<p><b>“no longer flustered”</b></p> <p><b>“I’ve learned to delegate”</b></p>	<p>supervisory duties, I was still able and <i>I was faced with challenges</i> I was still able to make.... I gained more.... I gained proper judgement, I gained more judgment and more [? wisdom/understanding/ knowledge 20.53] as to what to do. Right. So, yeah. So, I, <i>I learned to move beyond my fears....</i> and so, <i>the fact that the challenges came, I learned to move beyond my fear and concern</i> that I may have had or anxieties along the way. And so, it has been a good experience...uumm as... as I said, as I said before, it has facilitated me into growing into the profession because the fact that I'm faced with challenges I have learnt to... to move beyond being fearful.</p> <p><b>I:</b> Right. Okay, so you said that you had a fear and anxiety. Can you explain those, what those were?</p> <p><b>P:</b> Fear being in terms of you being in the area, charge nurse and something happened, like, for example, an emergency on the ward. <i>Not knowing what to do and that type of thing, you know, that type of anticipation I [? 21.22] you as you know, because you being in charge you are the one that everybody goes to...you are like "the go to person". So, you really have to know what to do. So, <u>I had that fear you know as to say if an emergency happens, what do I do being that I am in charge and I am supervising the entire ward and being the most senior person on the ward. I still need to know what to do. If an emergency should happen, and still supervising other things on the ward and time management was another thing for me as well. I experienced some amount of challenge where that was concerned. I experience time management issue as well because of the demands of the ward [pause]</u></i></p> <p><b>I:</b> You want to give me...</p> <p><b>P:</b> <i>I learnt how to delegate</i> as well. <i>I learned how to ask persons</i> to ask other nurses or other staff to hand over so that I could be able to manage my time better. <i>I've learned to delegate</i>, and I've learned to ensure that it was done that the delegated...the activities delegated were done...so [long pause]</p>	<p><i>there's no need for me to be flustered anymore or to be fearful</i></p> <p><i>I learned to move beyond my fears</i></p> <p><i>I learned to move beyond my fear and concern</i></p> <p><i>the fact that the challenges came, I learned to move beyond my fear and concern</i></p> <p>Linguistic comments: <i>I learnt how to delegate</i></p> <p><i>I've learned to delegate</i> <i>I've learned to ensure that it was done that.</i> <i>The activities delegated were done</i></p>
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