Core elements of transition support programs: The experiences of newly qualified Australian midwives

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A B S T R A C T

Aim: This article reports on newly qualified midwives’ experiences of the core elements of their transition support program: clinical rotations, supernumerary time, study days and midwife-to-midwife support.

Background: There is limited knowledge and understanding of how midwives transition from student to registered midwife and how best to support them during this time.

Method: A qualitative descriptive approach. Thirty-eight newly qualified midwives from 14 hospitals in the state of New South Wales, Australia participated. Telephone interviews and focus groups were used to collect the data. Content analysis was used to analyse the data set.

Findings: Despite being employed by different hospitals, most participants were offered transition support programs that shared common core elements: rotations to a variety of clinical areas, additional study days, supernumerary time and support from colleagues. Participants stressed the importance of planned clinical rotations and supernumerary time that allowed them to ease into the new clinical area. Study days provided an opportunity for graduates to focus on new skills and to connect with their peers. Support from colleagues, managers and educators was essential, though workloads often impacted on its availability.

Conclusion: The evidence from the project contributes to our understanding of newly graduated midwives’ support needs. As such the findings can be used to inform the development, implementation and evaluation of future transition support programs that better meet the needs of graduates, the women they care for and the facilities in which they work.

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Introduction

The transition from student to registered midwife is a critical period in a new graduate’s working life [1], and an exciting time representing the successful completion of the graduate’s study program. During this period the newly qualified midwife has to undergo significant adjustments to become an effective member of the multidisciplinary team [2]. This requires the development of existing and sometimes new skills, knowledge, attitudes, values and responsibilities [2–5]. The literature suggests that well-designed and implemented transition support programs increase confidence, enhance clinical competencies and improve retention rates of newly graduated staff [1,6–9]. As such transition support programs can significantly assist graduates to successfully take up their roles as registered clinicians [1,2,10,11].

A new graduate’s ability to successfully make the transition from student to practitioner is also important from a professional and workforce perspective. National attrition rates for newly graduated nurses and midwives are high [12,13]. In the context of worsening international and national shortages in both professions these losses cannot be sustained [1,8,12]. Transition support programs may offer a solution as the available evidence suggests that they not only improve graduate confidence and competence but also have a positive impact on staff retention [7,9,14].

In the Australian context, transition support programs are defined as “individualised, planned education process for registered nurses and midwives to support a safe and effective transition into a new practice area” [2]. In the United States of America (USA) such programs are referred to as “orientation programs” [6], while the United Kingdom (UK) uses the term “preceptorship programs” [10]. Although transition support programs may not always contain a taught or didactic component, most include a variety of core learning
strategies such as clinical rotations through different maternity settings, completion of a skills inventory, goal-setting for clinical rotations, provision of midwife-to-midwife support and opportunities for group discussion and reflection [10]. The newly developed framework for transitional support/preceptorship programs in the UK also asserts that programs should be individualised to meet the needs each practitioner [15]: a strategy recognised to be effective in assisting new graduates to meet their goals [16,17]. In addition Hughes and Fraser [17] argue strongly that transition support programs should commence as soon as possible following graduation. In their UK study a delay in commencing a support program was shown to result in increased levels of stress in the new graduate [17].

Despite the recognition that midwifery and nursing transition programs are ‘essential’ [1], there remains a lack of commitment by many Australian health authorities to their development, implementation and evaluation. The state of New South Wales is no exception. Each year large numbers of newly graduated midwives, educated via a variety of routes (for example undergraduate and postgraduate qualifications), are employed throughout the state to work within the maternity health care system. The content and duration of the transition programs these midwives are offered to support their evolution into professional practice vary greatly. Anecdotal reports within three Area Health Services in Sydney, Australia would suggest that this support can range from ‘a big smile and a welcome back’ to a 12-month structured program consisting of study days, rotations through all clinical areas and periods of supported practice.

The effectiveness of transition support programs currently offered to newly qualified midwives is unclear and under-evaluated in New South Wales. To date no evaluations of midwifery transition support programs have been published in the Australian professional literature. Moreover, international literature on the needs of the newly qualified clinician and the effectiveness of transition support programs is almost entirely related to the transition of newly graduated nurses rather than midwives.

This paper presents newly qualified midwives’ experiences of the core elements of their transition support program; clinical rotations, supernumerary time, study days and midwife-to-midwife support. These findings are part of a larger study that described newly graduated midwives’ expectations and experiences of their transition support programs during their first 12 months of clinical practice [18].

Method

This study used a qualitative descriptive approach. Content analysis was used to analyse data collected through individual telephone interviews and focus groups. Descriptive approaches aim to use rich description to “accurately portray the characteristics of people, situations, or groups and/or the frequency with which certain phenomena occur” [19, p 498]. Sandelowski [20] suggests that this approach is ideal when there is limited information on a topic, as it provides an accurate summary of the phenomena. In addition, Sandelowski argues that this method allows a researcher to stay close to their data facilitating the description of the phenomenon through the participations own words as opposed to the researcher interpreting though pre-existing frameworks.

Setting

The study was conducted within three New South Wales Area Health Services in Australia (designated A, B and C in this paper). Together these health services had a total of 19 public maternity hospitals with a combined birth rate of approximately 36,662 per year. Newly graduated midwives were employed at a total of 14 hospitals.

Area A included six hospitals, four of which provided a transition support program. Area B included seven hospitals, four of which offered a standardised area-wide transition support program. In Area C there were six maternity hospitals, all of which employed newly graduated midwives; however, only three of these institutions had a transition support program. Similarly to Area B, Area C ran a standardised transition support program across the sites that offered a program.

Although the standard duration of all 12 transition support programs was 1 year, there was wide variety in the level, intensity and type of support available to the midwives. The nature and scope of the transition support programs offered depended largely on the Area Health Service and the hospital at which it was offered. Table 1 provides an overview of the approach to clinical rotations and provision of study days at each hospital.

Participants

All newly graduated midwives employed within the three Area Health Services during 2008 were invited to participate in the study (n = 80). The midwives were educated through a variety of pre-registration programs; Bachelor of Midwifery (BM), Graduate Diploma of Midwifery (GD) and Masters of Midwifery (M) programs. Both the Gradate Diploma and Master programs offer post nursing qualifications (see Table 2 for more detail). In total, 29 midwives were willing to participate and consented to the study. In 2010, an additional 30 graduates received an invitation to attend a focus group. Seven midwives accepted and participated in this aspect of the study.

Recruitment

Individual participants

Each midwifery clinical site coordinator responsible for newly qualified midwives in 2008 received the appropriate study packages for their facility and was asked to disseminate the packages to the midwives. The packages included a letter of invitation, a participant information sheet, a consent form for telephone interview, an anonymous demographic questionnaire and two prepaid reply envelopes. Participants were asked firstly to complete and return the demographic questionnaire and secondly to return the signed consent form with a contact telephone number. Twenty-nine newly qualified midwives consented to participate.

Focus group participants

In 2010 new qualified midwives in areas B and C (n = 30) were approached via their midwifery clinical site coordinator and invited to participate in a one-hour focus group. In order to maintain the confidentiality new graduates in Area A were not targeted as this was the area in which the first author and researcher worked. New graduates were provided with an information sheet and consent form and asked to contact the research team if they were interested in being involved in the study. Seven midwives from Areas B and C consented to participate. Two focus groups were held to accommodate the midwives’ ability to participate.

Data collection

Telephone interviews

Telephone interviews were conducted towards the end of each midwife’s first year of clinical practice (n = 29). Telephone interviews were considered a reliable source of data collection for this study as the interview questions were deemed to be relatively
Six experienced midwives (research associates) conducted the interviews. Participants were asked to reflect on the structure, content and core elements of their transition support program along with the positives and negatives of the program, with each interview lasting between 30 and 45 min. The questions were based on a transition support program mapping exercise that had previously been undertaken by the team and a review of the current literature. A pro-forma was designed to promote uniformity in approach [16]. The pro-forma consisted of a number of open-ended questions based on the objectives of the study (see Box 1). Interviewers were provided with detailed instructions and helpful strategies to employ when interviewing, to promote consistency. Interview team members met before interviews and regularly communicated via e-mail and telephone during the interview process. Interviewers kept field notes and at the completion of the interview came together to review the process.

**Box 1** Questions related specifically to the core elements of transition support.

- Can you describe the elements of your transition program (for example clinical rotations, study days, supernumerary time, support)?
- Can you share with me your perceptions/experience of these elements?
- What has been your overall experience of the transition support program?

Uncomplicated. Telephone interviews have the additional benefit of good response rates while being cost-effective [19]. The team also believed that a telephone interview would be potentially less threatening for the participants reducing any sense of intimidation that might result from a face-to-face interview, particularly if participants had negative experiences to share.

A content analysis approach was used to analyse the telephone interview data. Focus groups allow for dynamic interactions which may not be achieved through regular interviews [22] and in this study, added depth to the data obtained from prior interviews. The two focus groups were facilitated by the first author. At the beginning of each group the participants were made to feel comfortable and welcome. The researcher re-affirmed that confidentiality would be maintained and that group members should respect each others’ contributions [23]. As the aim of the focus group was to confirm the emerging findings, elicited from the interviews, a list of questions was devised prior to the groups. The focus groups were recorded on an iPod and subsequently transcribed verbatim.

**Data analysis**

A content analysis approach was used to analyse the telephone interview and focus group data. Bryman [24] describes content analysis as the process of applying an objective systematic coding scheme to data, that often has predetermined categories, to condense it and make it systematically comparable. Content analysis can be either manifest, interpreting data which is visible, obvious and/or countable; or latent, interpreting the underlying meaning of the data [23]. Latent content analysis is similar to the inductive methods of thematic analysis where the researcher is required to construct meaning from the text and differs from traditional quantitative content analysis as the themes or categories can be constantly revised as data coding progresses. Both approaches aim to identify patterns which can be used to draw assumptions about messages and meaning that are represented and communicated [23].

In this study, telephone interview transcripts were read several times to allow for familiarisation with the content and to get a sense of the whole. All the data was entered into a Word Document. The next step of analysis involved the grouping of like words or statements that were related by their context and/or content [24]. It was in this way that concepts were elicited. This process was undertaken by the first and second author. Constant revision and grouping of the concepts, within the defined categories (for example ‘study days’) and discussion with the other member of the research team resulted in the formation of patterns that described midwives’ experiences and transcribing interviews can be advantageous, Russell and Gregory [21] maintain that it is not always necessary. The cost of audio-tape transcription may also be a factor when resources are limited.

**Focus groups**

Two focus groups were conducted in early 2010 to discuss the emerging findings elicited from analysis of the telephone interview data. Focus groups allow for dynamic interactions which may not be achieved through regular interviews [22] and in this study, added depth to the data obtained from prior interviews.

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**Table 1** Allocation of clinical rotations and study days for the midwives (as designated by the facilities).

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Clinical rotations (weeks)</th>
<th>Supernumerary time</th>
<th>No. of study days</th>
<th>Study days available</th>
<th>Study day subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>10–16</td>
<td>✓</td>
<td>3</td>
<td>Bachelor of Midwifery only</td>
<td>Basic health/nursing skills</td>
</tr>
<tr>
<td>A2</td>
<td>8</td>
<td>✓</td>
<td>4</td>
<td>All new grads</td>
<td>FONT®, midwifery skills, reflective practice, breastfeeding education</td>
</tr>
<tr>
<td>A3</td>
<td>8</td>
<td>✓</td>
<td>4</td>
<td>All new grads</td>
<td>FONT, midwifery skills, reflective practice, breastfeeding education</td>
</tr>
<tr>
<td>A4</td>
<td>12</td>
<td>✓</td>
<td>7</td>
<td>All new grads</td>
<td>FONT, midwifery skills, reflective practice, breastfeeding education, child protection</td>
</tr>
<tr>
<td>Area B</td>
<td>Duration not specified</td>
<td>✓</td>
<td>5</td>
<td>Graduate Diploma</td>
<td>FONT, breastfeeding education, midwifery skills</td>
</tr>
<tr>
<td>C9, 10, 11, 14</td>
<td>December 16 Only if new to Hospital</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Note: *TSP not available.*

<table>
<thead>
<tr>
<th>Bachelor of Midwifery</th>
<th>Graduate diploma</th>
<th>Master</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview</td>
<td>12</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Focus group</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

**Table 2** A summary of the new graduate midwife recruitment by educational preparation.

A2 8
A3 8
A4 12
Area B
C9,10,11,14
C12,13*

a TSP not available.
b FONT is mandatory training for all clinicians working within NSW public maternity services. FONT stands for: fetal welfare, obstetric emergency and neonatal resuscitation training.
struments. In one category, support, a number of sub-categories were identified that described the different midwife–midwife relationships newly qualified midwives had with colleagues.

The focus group data were transcribed and treated similarly. However, as the purpose of the focus groups was to validate the emerging themes, meaning units already identified around the core elements of the transition programs, were used as a template or analysis framework.

Trustworthiness

Qualitative research requires rigour in the form of an accurate representation of participants’ experiences [25]. Trustworthiness and authenticity are key elements to ensuring rigour within the research process. Polit and Beck [19] define the criteria for assessing trustworthiness in qualitative research as including credibility, transferability, dependability and confirmability. In this study these elements were addressed by; ensuring adequate data was collected to meet the objectives of the study; that sufficient detail was provided to ensure the reader could make an assessment of how the findings might ‘transfer’ into other contexts; promoting consistency between researchers and across data collection techniques; and finally verifying themes through a process of constant debate, discussion and justification for decisions made between the research team and other colleagues. Holding the focus groups was also a technique to enhance confirmability and thus trustworthiness of the findings.

Ethical considerations

An application for multi-site ethics approval was submitted to the relevant University Ethics Committees. In addition, site-specific approval was obtained from participating maternity units. Transition support program coordinators were asked to disseminate invitations, information and consent forms to potential participants. Participants also received a reply paid envelope enabling them to return consent forms and demographic questionnaires directly to the principal researchers. This strategy aimed to avoid any sense of coercion for participants and ensure that colleagues and line managers were not aware of their decision to participate or decline. Principal researchers were explicitly not line managers of any participants in this research.

Findings

Participant characteristics

The newly qualified midwives were all female and aged between 20 and 55. Of these, 44.7% graduated with a three-year Bachelor of Midwifery degree, 39.5% with a Graduate Diploma in Midwifery and 15.8% with a Master’s in Midwifery (12 month program post nursing qualification). The midwives were employed in 14 hospitals within one of three Area Health Services. Midwives frequently commented on the duration of the clinical rotation or rotation. Most would have liked to have spent longer in each area: and particularly in birth suite. You get pulled out to work when other areas are short... I need more experience in birthing (Xena).

Clinical rotations: difficult when the plan was changed

All transition support programs offered a planned clinical rotation, lasting between 8 and 16 weeks. Whilst 92% (n = 35) of the midwives reported having access to clinical rotations, the duration and variety of experiences offered differed greatly between sites and sometimes within facilities. Some midwives recounted being offered a comprehensive rotation plan that included birth suite, postnatal ward, maternity support program2, antenatal clinic, antenatal ward and midwifery continuity of care models. Others, however, appeared to have only been offered birth suite and postnatal wards.

When the rotation plan was known in advance the new midwife felt able to adapt, pre-empt and prepare for the next challenge. Pre-planned rotations provided a sense of familiarity and left the midwife feeling in “control” of her own professional development. This appeared to positively affect the midwives’ level of confidence, as one midwife stated: “Control is central. If I felt in control of the situation I felt confident. When I knew where I was rotating to I had time to plan... I came up with time management strategies for myself to feel in control”. (Bina)

Although the midwives were positive about rotation plans, and happy to receive a clear plan at the beginning of the year, plans were frequently interrupted or changed as a result of busy clinical environments and variable staff skill mix. This commonly left midwives feeling like “gap-fillers”, and struggling to meet their learning needs. The lack of structure heightened midwives’ sense of “anxiety”, of loss of control over their working life and of being unable to mentally prepare:

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

Midwives frequently commented on the duration of the clinical placement or rotation. Most would have liked to have spent longer in each area, and particularly in birth suite:

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

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

Supernumerary time: highly valued but not always available

Allowing newly qualified midwives to be ‘supernumerary’ (or extra to the normal staffing level), working alongside an experienced midwife or clinical educator, was a component of most transition support programs. Just over 66% (n = 25) of the midwives reported being afforded some supernumerary time. However,
based on an earlier scoping exercise it was estimated that some 80% (n = 29) should have had access to supernumerary time. When it was available, midwives reported that supernumerary time provided an opportunity to be “eased” into the clinical area rather than being “chucked into the deep end” (Carla). It presented midwives with space and time to ask questions, orientate and adjust to their new role without the pressure of taking on a full clinical load. One participant explained:

Being supernumerary really allowed me to acclimatise, it is so different when you are no longer a student... having to make decisions for yourself... you know it is all up to you... having someone with me those first few days... you know, to bounce ideas off... well, it just made me feel like ‘You know, I can do this’ (Tina.)

On average, however, supernumerary experience was fairly minimal, and one to two days when a midwife entered a ‘new’ clinical area was the standard. Several notable exceptions, saw midwives afforded supernumerary periods of between two and four weeks, the latter at one site offering four weeks in a continuity of midwifery career model in a supernumerary capacity.

By contrast, midwives who were not allocated supernumerary time viewed this extremely negatively. Words such as “abandonment”, “disinterest” and “disappointment” were commonly used to express their feelings. One of the participants, educated through a Masters program, commented:

“You can talk about anything you need to... there was no rule... you don’t feel judged”...

Thirty-three midwives (87%) stated they had access to study days. The midwives reported the number of study days on offer ranging from one to seven, with most attending between two and four study days spread throughout the transition support year. Study days most commonly accessed by the midwives were the two mandatory New South Wales Health workshops, followed by ‘midwifery skills days’ encompassing skills such as the application of a fetal scalp electrode and how to perform artificial rupture of membranes. Breastfeeding, venepuncture and cannulation study days were also highly rated, with perineal r left the midwife feeling in epiphanies only accessed by a few.

While developing new skills and knowledge at the study days was highly valued, so was the opportunity to share experiences. Study days held exclusively for the midwives gave the opportunity to spend time with peers, and “debrief” was greatly appreciated. When the midwives talked about debriefing they referred to the opportunity of being able to discuss and share their experiences, talk through clinical cases and reflect on their practice in the safe environment of their peer group; “In the group you learn together; if something didn’t go perfectly everyone can talk about it... that way we all learn from the experience.” (Carla). Another midwife, Sam, referred to the level of support and safety she felt: “You can talk about anything you need to... you don’t feel stupid... you don’t feel judged”. Sharing the “ups and downs” was considered to greatly assist them during their transition support program.

Midwife to midwife support: the importance of relationships with colleagues

At the end of their transition support programs midwives articulated their concept of support as one where they worked within a ‘supportive environment’. This included being provided with “guidance”, “time”, “advice”, and “understanding” from colleagues that were “willing to help”. “Developing relationships” within a “positive culture” where education and learning were valued was also important. A culture that readily provided opportunities to “learn” was considered beneficial, not just for midwives but for the entire maternity unit. Nonetheless, the focus was very much on relationships the midwives shared with colleagues. For example, when Kim was asked what support meant to her she stated; “having someone to go to with a problem, who has the time to spend with you to work through and discuss with you”.

Midwifery managers: mixed messages and workloads

The feedback from the midwives regarding the level of support provided by the midwifery managers was mixed. While some commented that they received the bulk of their support from managers, others reported them to be “distant”, “disinterested” and “unhelpful”. The managers were seen by the midwives as being busy with the constant juggle of managing high clinical workloads along with either a lack of staff or a poor skill mix. When asked what they would like from the managers, the midwives talked about those in “positions of authority” remembering what it was like to be a “beginner” and ensuring appropriate clinically workloads. These comments were often made as a result of midwives feeling overwhelmed and overloaded. For example, there was evidence that some midwives were left in charge of a clinical area, most commonly the postnatal ward, well before they felt ready for this responsibility. Mandy recounted her experience which was similar to others:

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

Midwifery educators: essential but in demand

The role of the midwifery educator was acknowledged as important to the midwives. Having an allocated educator working with them on the first day of each clinical rotation rated very positively as it provided the midwives with one-on-one time where they did not feel rushed. Other positive examples included educators devising individualised plans to support particular learning needs.

Despite these positive comments there was a general sense that there were not enough educators to go around, limiting access to this type of support; “It is there if you want it but not routinely in place: you have to ask”; (Mina) The midwives also articulated their perception that in some units the educators’ primary focus was the student midwives, not the registered midwives.

Experienced midwives: a potential lifeline

The midwives considered their relationships with their experienced peers as very important and significant to their development as a midwife. Most reported that it was these midwives who provided the most support and from whom they learned the most. Support appeared to be multifaceted. For some, it entailed having someone physically present that could “answer a question”, “provide guidance in a difficult situation” “check an examination”...
and/or “ask about anything I am unsure of. . .knowing they are there” (Quinn).

For others, it involved experienced midwives making them feel welcome and part of the team. As one midwife expressed:

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

Sometimes the level of support provided by the experienced midwives was associated with a sense of internal conflict. Whilst the midwives were reliant on support, some simultaneously experienced a sense of guilt for potentially increasing the experienced midwives’ workload. Helen identified her appreciation of this additional demand on staff: “All the midwives have been so fantastic and it is just luck that they are all willing to work so hard”. Notwithstanding the many positive examples in the data set, a number of reported interactions with experienced staff were considered as unsupportive; “Some midwives are much more supportive than others. Some were very unhelpful; when you would go to them with a problem they would undermine your confidence” (Kim). Some midwives felt continually under surveillance from experienced midwives. This was often accompanied by the perceived threat of disapproval should they ‘step out of line’. One Bachelor of Midwifery midwife described her experience:

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

Interactions of this nature often added to the new midwives’ anxiety and impacted their ongoing development. However, the overall impression was that experienced midwives offered the most comprehensive clinical support to the midwives, for which they in turn were grateful.

Discussion

Supporting newly graduated midwives’ transitioning from student and beginning practitioner to qualified, confident clinician is essential to the quality and safety of maternity services. In this study, midwives in their first year of practice identified core elements of the transition support programs they were offered: clinical rotations, study days, supernumerary time and support from other midwives.

Clinical rotations: providing adequate clinical experience for midwives?

Clinical rotations are designed to offer new graduates an opportunity to consolidate their practice. In this study the newly qualified midwives valued the opportunity to rotate to all clinical areas. Rotation allowed midwives to build-up professional networks whilst developing skills and experience across all aspects of midwifery care. Comparable findings were reported by van der Putten [5], whose qualitative phenomenological study explored the experience of six newly graduated midwives in Ireland. These midwives also valued the opportunity to develop skills across the full scope of midwifery practice and acquire skills from a variety of experienced midwives.

However, problems arose when the pre-defined rotation was changed, often the result of shortfalls in staffing. The effect was two-fold. Firstly, anxiety and stress levels increased as the midwives felt unprepared for the clinical challenge. Secondly, midwives felt undervalued as they perceived others regarded them solely as ‘gap-fillers’ and not part of the team. Similar challenges have been identified with nurse graduates. For example Duchscher [26], a Canadian researcher, found that new nurses were often used to cover shortfalls or gaps in the roster. The unpredictability of the situation and limited time to prepare for the change exponentially increased their stress levels. Australian nursing research has also shown that numerous and sometimes short clinical rotations leave the graduate struggling to ‘fit in’ and unable to develop the confidence and competence to positively contribute to the workload [27,28]. While these researchers conclude that new graduate nurses should be offered only one clinical rotation Duchscher [26], who has been researching graduates experiences for over ten years, states that regardless of number, new graduates should have access to well-planned and organised clinical rotations.

Also of concern is the potential for adverse clinical events where new graduates may not have the required level of skill or expertise. The recent New South Wales Clinical Excellence Commissions’ Patient Safety Team [29] report, focusing on the supervision of inexperienced staff at the point of care, identified the challenges and risks of replacing experienced staff at short notice. Where skill mix was not optimal, inexperienced members of staff were often required to fill the gaps.

Supernumerary time – a chance to acclimatise

Giving the new graduate an opportunity to orientate and become familiar with the clinical environment is a fundamental aspect of transition support programs [2,10]. Being able to achieve this without the burden of carrying a clinical workload with new graduates being ‘supernumerary’ to established staff numbers, has become recognised as an essential element of a transition support. The analysis in this paper highlighted some inconsistencies between promised supernumerary time and the midwives’ actual experiences. The discord between the rhetoric and reality is seemingly not uncommon [17,30].

Hughes and Fraser [17], in their UK study of newly graduated midwives and their preceptors, found variances between what new midwives were told would be on offer and their actual experience. They found that supernumerary time was either shorter than expected or not available at all [17]. Like the new midwives in this current study, the repercussion of such a discrepancy was a sense of abandonment which raised the stress levels of the new graduates. This perhaps shows the incongruity between what is expected by the graduate and what is actually available. For example, newly graduated midwives in the MINT report remarked that, supernumerary time was not available, although they could positively seek support from experienced midwives in the team [30].

Study days and support networks – a valued addition

Offering new graduates the opportunity to attend educational days during their transition support program is strongly recommended [10]. The value of such days was clearly evident in this study’s finding, from a content perspective and in bringing the newly graduated midwives together to facilitate a shared learning environment. As described in the literature, the importance of opportunities to reflect and share experiences was appreciated and had a positive effect on new midwives’ learning, confidence, development and the establishment of professional networks [26,31].

Steele [32] highlights the essential nature of professional networks in maintaining high quality up-to-date clinical care. By providing opportunities for formal and informal reflection and information sharing, practitioners are able to develop personally and professionally in a supported environment. Furthermore, the
Midwife-to-midwife relationships: the epitome of support

New qualified midwives in this study expected to receive support from a number of different people during their transition year. While managers and educators were mentioned, it became clear that new midwives were most likely to identify experienced midwifery colleagues as their most significant support. This is a consistent finding in the international literature [17,35]. Boud and Middleton [36] in their discussion paper of workplace learning review the prevalence of peer-to-peer learning. They draw attention to the diverse experience and knowledge held within an organisation by individuals who do not have traditional educational roles, and argue the value of learning from these individuals. The findings of this study support Boud and Middleton’s assertions. The midwives reported feeling reassured knowing they had someone to go to with their problems or questions; who had time to spend with them; and most importantly would not make them feel inadequate. These aspects of supportive relationships have been reported elsewhere [17,35,37,38].

There were of course exceptions. Whilst many newly qualified midwives reported positive experiences, the findings also indicate that, at times, they refrained from seeking advice or guidance from the experienced staff. This aligns with other work that contends the new graduate on one hand does not want to add to the workload and burden of already overworked staff, or on the other to appear lacking in knowledge or competency [26,39]. Malouf and West [40] report that the new graduate nurses in their study expressed reluctance to ask for assistance for fear of being regarded as incompetent or ignorant and as a result unsafe. Such situations highlight the importance of raising awareness amongst experienced staff that inexperienced clinicians may be reluctant to seek guidance if they are concerned about being treated unfairly and/or labelled incapable [29,40].

Limitations

This study has limitations that require consideration when interpreting its findings. While the findings of qualitative studies are not considered generalisable readers are invited to consider how our findings might be transferable to other contexts. A small number of midwives participated in this study (36% of those invited) and we do not know whether this group might have differed in some way to those who did not participate. While some consider telephone interviews limited due to an inability to gauge non-verbal reactions they also have their advantages. In particular, participants may have found telephone interviews less intimidating than face to face interviews and therefore may have felt more able to be honest with the researchers. In this study a variety of researchers conducted interviews and while this approach can impact on consistency, we implemented a number of strategies to mitigate any negative effects including the use of an interview pro-forma and regular researcher meetings. This study also focused on midwives employed in urban settings and we acknowledge that the experiences of newly qualified midwives in rural and remote areas of Australia and within the private health system may be different. Having said this, however, given the lack of information and evidence on transition support programs for Australian midwives, the findings do provide a unique insight into midwives’ experiences as well as the foundation for further investigation.

Recommendations & conclusion

While there is a dearth of midwifery-specific literature in this area, it appears that some form of structured support is essential during the transition from student to registered practitioner. The study findings demonstrate that structured support, which included a number of core elements, is highly valued by new midwives and plays a role in assisting them to successfully make the transition from student to registered practitioner. However, the findings of this study suggest that there can be a discrepancy between the ideal or what is promised, and the reality. Workloads in the contemporary maternity care context impact on the new graduate’s experience, as does the quality of the support offered to these midwives by their midwifery colleagues.

Newly graduated midwives should be offered structured support during their transition. Properly designed and implemented transition support programs are an ideal way to do this. Thought should be given to how transition support is designed. The evidence would suggest that the first months of the transition year are critical to the newly qualified midwife. A well-structured and supported four-month intensive period offered to the new midwife, as soon as possible following graduation, may be more appropriate than a 12 month program [26,41,42]. This period should provide the new midwife with supported clinical rotations, skills education days, a named preceptor, opportunities for debriefing and regular formal and informal feedback. It is suggested that after this initial period new midwives should be offered structured support that is tailored to their own individual learning needs.

Transition support programs have been demonstrated to be cost-effective, to improve recruitment and retention and to promote confidence and competence in the new graduate. It is essential to the quality and safety of our maternity services and the future of the midwifery profession to support newly graduated midwives to become strong and confident midwives of the future.

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