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Midwives transition to practice: Expectations and experiences

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1. Introduction

Much has been written about the first year of practice of nurses and other health professionals, yet little is known about the experience of newly qualified midwives. The few studies available focus on limited concepts such as transition to practice support programs, mentoring, and retention of midwives within the profession (Clements et al., 2013). What has been published suggests the evolution from student to qualified midwife is a challenging time (Avis et al., 2013; Kensington et al., 2016). Newly qualified midwives must find their 'own feet' whilst experiencing vulnerability, fear and professional uncertainty as they accept responsibility and accountability for critical clinical decision making (Clements et al., 2013).

Transitioning to specific areas of midwifery practice are a recurrent feature of published literature of newly qualified midwives' experiences in Australia (Clements et al., 2013; Cummins et al., 2015). Little is known about newly qualified midwives' transition to practice expectations and experience having undertaken their entire undergraduate Bachelor of Midwifery (BMid) clinical placement within a midwifery caseload practice where all women received continuity of midwifery care.

This study aimed to explore first year of practice expectations and experiences of a unique group of midwives who undertook their entire undergraduate clinical placement within a private midwifery caseload practice or an all-risk publicly funded rural midwifery caseload practice. In Australia, private midwifery caseload is where self-employed midwives offer maternity care to women from early pregnancy, during labour, birth and until six weeks postpartum on a fee-for-service basis. In publicly funded midwifery caseload practices women are cared for by a named midwife or small group of midwives (up to three midwives) who provide care from early pregnancy until six weeks postpartum.

2. Background

An integrative literature review using the structure developed by Whittemore and Knafl (2005) was undertaken to identify relevant knowledge about newly qualified midwives first year of practice expectations and experiences. The major databases CINAHL; Medline via EBSCOHOST; Ovid; PsycINFO; Proquest Nursing and Allied Health; Scopus; Health Reference Centre; and the Cochrane database were searched in February 2017. Five papers met the inclusion criteria and were appraised for methodological quality using 'Critical Appraisal Skills Programme [CASP] Tool for Qualitative Research. All were deemed high quality papers (see Table 1). Combined, the studies included 92 participants.

The major anticipated aims of the studies were varied. Clements et al. (2013); Hobbs (2012); Kitson Reynolds et al. (2014), focussed on newly qualified midwives cultural and professional experiences. Cummins et al. (2015); and Fenwick et al. (2012) aimed to explore enablers and impediments to newly qualified midwives' transition to employment in caseload models and standard hospital models of maternity care. Despite these differences there were some similarities in the studies' findings.

In all studies newly qualified midwives regularly experienced high levels anxiety and emotional exhaustion, due to increased responsibility, professional accountability, decision making and fear of failure (Clements et al., 2013; Fenwick et al., 2012; Kitson Reynolds et al., 2014). Busy, chaotic clinical environments where institutional needs, task completion, routines and rules took precedence over the needs and care of women heightened this anxiety (Fenwick et al., 2012; Hobbs, 2012; Kitson Reynolds et al., 2014). The incongruence between their midwifery philosophy and beliefs and the reality of mainstream medicalised maternity care often culminated in tension, dissatisfaction with midwifery, frustration and feelings of resentment particularly when there was pressure to relinquish their belief in normal birth and woman centred care in favour of institution-based care (Fenwick et al., 2012; Hobbs, 2012; Kitson Reynolds et al., 2014).

Commonly, the literature revealed, newly qualified midwives often found themselves in hostile and unwelcoming environments (Clements et al., 2013). Midwifery colleagues were often seen as custodians of power and influence over their sense of professional and personal safety (Fenwick et al., 2012). Participants described being influenced by other midwives' moods and personal characteristics and the environment (Clements et al., 2013; Fenwick et al., 2012; Hobbs, 2012; Kitson Reynolds et al., 2014). The need to maintain and 'accept' the hierarchal nature of the clinical environment was commonplace and took

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precedence over consolidation of learning and the growth of newly qualified midwives into safe woman-centred autonomous practitioners (Clements et al., 2013; Hobbs, 2012; Kitson Reynolds et al., 2014). Unsurprisingly, participants described a growing sense of frustration, isolation, and declining professional self-worth, confidence and competence (Fenwick et al., 2012).

Positive attitudes, active engagement, compassion and role modelling of woman centred care were identified as characteristics of midwives who provided constructive learning experiences (Clements et al., 2013; Cummins et al., 2015; Fenwick et al., 2012). Supportive and trusting professional relationships positively impacted the newly qualified midwives' competence and confidence to practice autonomously and provide quality woman centred care (Cummins et al., 2015; Fenwick et al., 2012). Placement within a caseload model during the transition period supported learning, created a sense of belonging and aided personal and professional development more frequently than where newly qualified midwives were placed in traditional fragmented models of maternity care (Clements et al., 2013; Cummins et al., 2015; Fenwick et al., 2012; Hobbs, 2012; Kitson Reynolds et al., 2014).

In summary, all included studies discussed newly qualified midwives' experiences as they transitioned through their first year of clinical practice. Few studies provided specific detail about the types of clinical experiences newly qualified midwives were exposed to as a midwifery student and no studies explored the transition to practice after placement for all or most of their student clinical learning experience within a caseload midwifery model. This represents a significant gap in the literature.

3. Study context

This study sought to explore the transition to practice expectations and experiences of a unique group of newly qualified midwives. These newly qualified midwives came to midwifery from a standpoint of being unable to find full-time employment in the year following the completion of their Bachelor of Nursing (BN) degree (Carter et al., 2015). This distinct group of midwives gained midwifery registration by undertaking a BMid as participants of an innovative clinical placement model, the Rural and Private Midwifery Education Project (RPMEP). Grounded in a philosophy of woman centred care, the RPMEP embedded each student either within a private midwifery caseload practice or a rural publicly funded midwifery group practice for the two years of their full-time BMid degree (students received 1 years' credit for their completion of a BN). This enabled continuity of midwifery care to be at the core of every clinical placement learning experience (Carter et al., 2015).

Midwifery student's clinical placement experience in this model is unique in the Australian context. Initial work evaluating the program reported students perceived this clinical placement model as beneficial to learning, promoting confidence and competence (Carter et al., 2015). It is now timely to explore the expectations and experiences of these newly qualified midwives as they transitioned through their first year of practice as a midwife.

4. Research design

4.1. Methodology

Qualitative descriptive methodology is an appropriate method for this study. As an agency of social inquiry, this methodology is fast becoming a preferred approach to research in health where the contribution to healthcare is considered broader than just clinical outcomes (Holloway and Wheeler, 2017). Qualitative descriptive methodology offered an effective and flexible means of obtaining authentic accounts of first year of practice experiences of the participants. The value in using this approach lies within the honesty and truthfulness of data collected from an insider perspective (Colorafi and Evans, 2016). This research aimed to uncover and better understand the meaning this unique group of participants gave to their experience.

4.2. Participants and recruitment

Following ethical approval from Griffith University's Health Research Ethics Committee (NRS/47/13/HREC), the 17 midwives who completed their BMid as part of the RPMEP were invited to participate. Purposeful sampling was considered appropriate as the research focus was solely the transition to practice expectations and experience of this group of newly qualified midwives.

Assistance was sought from the Griffith University RPMEP Project Lead to establish initial contact with potential participants. A post on the RPMEP dedicated Facebook page introduced the study and sought permission to contact group members. The first author sent a written invitation, information sheet and consent form to interested participants who agreed to be contacted. Opportunities for questions and clarification were provided to potential participants by phone to support their decision-making and prior to the return of a signed consent form. Eight midwives consented to be interviewed by telephone. Participants were informed they could withdraw from the study at any time.

4.3. Data collection

Semi-structured digitally recorded telephone interviews undertaken by the first author were used to collect data between September and November 2016. Prior to data collection, the potential influence of researcher's role within the university attended by the newly qualified midwives was considered (Fusch and Ness, 2015). As a recently employed academic and not previously involved in teaching the midwives during their BMid program, the impact on participant interviews was considered minimal. As a clinician, current postgraduate student and novice researcher, the potential authenticity these roles could bring to the data collection process was considered useful in establishing rapport and establishing a feeling of ease in discussing the unvarnished reality of their transition to practice experiences.

A set of open-ended prompting questions developed by the first author and reviewed by the co-authors guided the interview process (see Box 1). Given the varied participant locations across Queensland, telephone interviews were considered the most appropriate means of data collection as they offered convenience, flexibility and privacy (Cachia and Millward, 2011). Field notes were also recorded during and after the interviews. On average the interviews lasted between 45 and 60 minutes and were transcribed verbatim.

4.4. Data analysis

Thematic analysis was used to analyse the data set. Data was broken down into discrete units and organised into clusters of like words and phrases. Using a constant comparative approach, data was continuously compared and refined to eventually form themes and/or subthemes (Boeije, 2002). As the 'like' groups became saturated with data possible links between the groups were explored. A mapping process was used to assist with this which subsequently supported the development of themes.

Review, discussion and debate with academic experts at each stage of data analysis strengthened the credibility of the research findings. Logical, traceable and clear documentation of the research process and deep reflection on the what, when and how of the data collected confirms trustworthiness (Holloway &Wheeler, 2017).

5. Findings

5.1. Participant characteristics

The eight participants in this study were all female aged between 18 and 34 years (mean = 27 years). All participants had completed BN and BMid degree programs. All participants lived and worked in Queensland and were employed in full-time (n = 2) or part-time (n = 6) midwifery positions in rural, regional or tertiary hospitals within six months of their BMid graduation (see Box 2).

6. Results

The participants in this study experienced some unique challenges during their first year of practice experience. Six separate but interlinking themes emerged from the data. The themes identify clear links between the participants unique entry into a BMid program having failed to gain employment as a nurse; their clinical placement immersion in a midwifery led continuity of care model; and their subsequent experience as a midwife transitioning into practice. The themes are described in detail below.

6.1. Midwifery - an unexpected career path

Within this theme participants described how they were motivated to consider midwifery as a career due to a shortage of jobs for newly qualified Registered Nurses (RN). They responded to the opportunity to complete the BMid program as they viewed this as a stepping-stone to gaining employment, something they had been unable to achieve following graduation from their nursing degree. Although not being well versed on midwives' roles and function, most participants approached the opportunity in a pragmatic way and saw completion of the program as means of enhancing their employability and skill set. One midwife expressed;

> *'I truly thought at the time that it was just – I couldn't get any jobs as a* grad *as a nurse, so I just thought this is a bit of an extra string on my bow and a sidestep nearly, as just something extra to have to try and maybe get me a job*' (M7).

Despite midwifery being an unexpected career path, participants spoke positively about their engagement in the program, particularly their experience in caseload midwifery. For many the program ignited a '*passion*' for midwifery. For example, one midwife said; '*I loved all of my experiences with the private midwives. I think it was the best thing that I could ever have done*' (M5).

6.2. The 'gift' of being embedded in caseload as a midwifery student

In this theme participants reflected further on how their clinical placement experience had influenced their transition to practice. They recognised their immersion within a caseload midwifery model afforded them a valued and rich learning environment. Discovering midwifery, whilst wrapped in continuity, ingrained in the participants' the capability to see everything through the eyes of the woman. The sustained exposure of working with different women, in different settings, across different locations, in a partnership approach with their mentor, was perceived to enhance communication skills and the participants' ability to establish rapport. In turn, they discussed learning the importance or '*power*' of informed decision making and advocating for women. This contributed to tenacity and resilience in their midwifery practice with one participant verbalising; '*You have to be able to advocate, speak up and say I'm not happy, - this isn't right or whatever. I think that's made me stronger*' (M8). Consistently working across their full scope, being part of the woman's entire childbearing journey, including the transition to motherhood, meant the midwives came to appreciate the longer-term ramification of decisions and care provided and what this might mean for an individual woman and her family.

> *'I feel gaining most of my experience in continuity of care was the best way to learn about midwifery because I followed women across the continuum – I was able to see the effects of interventions and how they played out for women. I was able to view everything from a woman-centred perspective. You see the outcomes of the interventions as well, so it was a valuable learning experience for me*' (M4).

6.3. No jobs - No real choice

Participants recalled feeling confident, ready for practice and keen to transition into a midwifery position within either a public or private caseload model as they approached the completion of their degree. The reality though, in terms of employment was very different. To a degree this reflected their earlier experience of graduating from their BN program. Contrary to their expectations they discovered there were no midwifery positions available to them to work in a caseload model. This left them feeling once again there were no jobs and they had no real choice. The lack of legislative support for newly qualified midwives to work to the full extent of their qualification as private practice midwives compounded the situation. For example, while one midwife did manage to find a position as a midwife with a group of privately practising midwives the restrictions on what she could and couldn't do were unworkable resulting in her leaving.

> *'It was particularly challenging because of the Medicare eligibility requirements. I had to have supervision all the time … I couldn't even do home visits alone. Not only was that annoying for me but for the women as well. I was obviously having to visit them either early in the morning or late at night just to accommodate other midwives*' (M1).

Compelled to seek employment further afield than private midwifery practice most participants applied for several diverse and different positions.

6.4. Lost in the system – a whole different world

Whilst it was encouraging that within six months of completing their midwifery degree all participants had gained employment, they acknowledged they felt they had little choice. Accepting a position within the fragmented public hospital system was considered a necessary compromise. The new reality of being a hospital employed midwife undertaking shift work, as opposed to working flexibly following a woman across the continuum of care resulted in the participants feeling lost in the system. They described '*working in a whole different world*' to their understanding of the art and science of midwifery. Initially they struggled and conceptualised their experience as '*daunting*' accompanied by an array of emotions such as '*terrified*', and '*nervous*'. Despite these feelings, the participants felt confident about their ability to adjust. However, as they settled into their new reality, working in this way was far more difficult and different than anything they anticipated. The following quote is reminiscent of all participant's experiences; '*I expected it to be challenging and different, but it was a massive shock and so much harder*' (M6).

Early in their transition to working in the hospital system participants recalled questioning whether immersion in caseload as a student had disadvantaged them. Taking a '*patient load*' attending shifts and completing task focussed care, within restrictive timeframes, was challenging and '*foreign*'. A lack of ongoing relationships, working in partnership providing individualised woman centred care and witnessing and/or being part of the outcome of their care proved disheartening; 'So *you just go to work, you do your hours and you go home. You don't see the end. You don't know what happened*' (M8).

The level of complexity and degree of intervention, irrespective of the clinical area in which they worked, was also challenging; '*Those interventions, that was probably the hardest part to come around to, and the*

expectation that I was just going to do that. So, it was dealing with accepting that' (M7). Participant's reported feeling '*overwhelmed*' and even though they considered they had the '*knowledge*' they questioned their ability and skill set. Feelings of inadequacy were heightened by a sense of '*being watched*' and their perception that some colleagues didn't fully trust they could provide the appropriate level of care and expected them to '*underperform*'. As one participant recalled: '*Lots of people had their doubts initially. It was almost like they were waiting for you to fall on your face, and then scoop you up again. But I like to think I didn't fall on my face*' (M2).

Finally, the dissonance between the participant's midwifery philosophy, beliefs and their experiences of working in a fragmented and medicalised system was the most disorienting. As students, the midwives had '*lived and breathed*' a woman centred primary focused evidenced based approach to care within a continuity midwifery model. Being faced with care they perceived lacked these features was distressing; '*I struggled with coming into a system where woman centred philosophies, birth is normal and informed decision making are not necessarily valued*' (M4).

6.5. Finding my way: drawing on what I knew to be true

Towards the end of their first year of practice participants described how they had commenced '*re-setting*' their expectations focusing less on the challenges they experienced and more on working in a positive way with each and every woman, as commented by one participant;

> '*You can break your heart over it and feel disappointed and feel ripped off and think that women aren't getting a good deal, or you can say okay, this is what I've got to work with and how can I make it the very best for the women that I've got for those short hours*' (M8).

The participants began to find their way and draw on what they knew to be true. Lessons learned from being embedded within a continuity model became key at this point. The participants realised providing continuity had afforded them many benefits which they could contribute to the care of women regardless of the context they were in. For example, one midwife said;

> '*I found that rather than looking at the women as patients and tasks it was more beneficial to actually go - I can still kind of bring continuity into this and to get to know their families and work with them for the short time they're there*' (M6).

All participants felt their clinical experiences within the caseload practices provided them with a strong identity as a midwife. As the participants settled into their new environments, they drew on their midwifery core values to manage their diverse experiences. The following sentiment was common in the dataset;

> '*I remember thinking that it wasn't about changing the hospital system, it wasn't about trying to get around the change, it was doing it in a way that fitted my own philosophy and how I wanted to midwife basically. Fitting my way of being a midwife around the structure of the hospital*' (M7).

6.6. What the future holds

As the interviews ended, participants were guided to consider what the future held for their future midwifery careers. Overwhelmingly, participants indicated their plan to remain in midwifery with most expressing an unwavering commitment to continuity of care and a desire to work in caseload; '*Continuity is something that I'd like to move back into*' (M2). However, despite the challenges most midwives acknowledged the learning they had gained across their first year of practice and for the short term were content to continue in their current roles.

> '*I think I would like to stick around at this hospital for a little while longer. I feel that there's still a lot more I need to learn. But definitely going back to my local area and doing more of the continuity of care, being a caseload midwife in the next few years is probably my goal*' (M6).

7. Discussion

This study provides insight into the first year of practice expectations and experiences of midwives with a unique position of learning to be a midwife while embedded within caseload midwifery practice for the duration of their undergraduate BMid degree. Upon graduation, and contradictory to their expectations, employment within caseload midwifery models of care were lacking. Current evidence suggests providing opportunities to undertake clinical placement within caseload models supports holistic learning and motivates newly qualified midwives to seek this employment opportunity on graduation (Sidebotham and Fenwick, 2019). Having little choice, most of the midwives in this study gained employment within mainstream hospital services. Transition to practice experiences proved challenging for this specific group of midwives. Some of their challenges were like those experienced by all newly qualified health professionals – time management, culture shock and feeling out of their depth (Avis et al., 2013; Laschinger et al., 2016).

Initially, the participants found themselves in a position of disadvantage as all they knew and understood about 'being with women' was challenged. Transitioning from being nurtured by one midwife or a small number of midwives working within a caseload model of midwifery care to a busy unfamiliar hospital environment, rostered to different clinical areas, adapting to shift work and the management of heavy 'patient loads' was in direct contrast to the way they had worked in partnership with women in the community and proved difficult.

In midwifery specific literature, newly qualified midwives report feeling overwhelmed and burdened by conflicting ideologies between their formal learning and the reality of their new work environment (Fenwick et al., 2012; Kitson Reynolds et al., 2014). The participants in this study were no different experiencing a 'crisis of confidence' which was further compounded by feeling underprepared for the ethos, nuances and organisation focussed standpoint of fragmented institution based maternity care.

Impacting the participants feelings of professional safety on entering the 'system' were the attitudes and expectations of midwives with whom they worked. In related literature this experience is commonplace (Clements et al., 2013; Fenwick et al., 2012). For several participants a dichotomy existed between those midwives in their workplace that expected them to perform at a higher level when compared to peers with a more traditional pre-registration clinical placement experience and those midwives who believed they weren't prepared well enough for their hospital-based role. A sense of being 'outsiders' combined with feeling constantly judged, the participants feelings of self-confidence and sense of belonging were eroded overshadowing their transition to practice experience.

The participants perceived a lack of understanding about caseload midwifery by the hospital staff led to distrust affecting working relationships between themselves and their colleagues. The loss of deep connections and partnerships they were used to experiencing with women and their mentors during their student caseload placement only heightened feelings of distress and disillusionment. Contemporary Australian literature suggests the inability to be the kind of midwife they want to be and feeling dissatisfied with the way maternity care is provided are two main reasons given by midwives who consider leaving the profession (Harvie et al., 2019).

Unfamiliar environments entrenched in different ways of working where intervention and fragmented medicalised maternity care were commonplace left the participants feeling out of their depth and experiencing dissonance between their core midwifery values and

philosophy. Initially, they reported a sense of culture shock that left them feeling overwhelmed, despondent and lost which is similarly described in current literature (Hobbs, 2012). However, they soon learned to draw on the many skills and knowledge that studying in continuity bestowed on them to provide quality woman centred care irrespective of the context.

Learning the art and science of midwifery through a continuity model afforded the participants several capabilities that not only supported the care they provided women, but also their journey through their first year of practice. The participants articulated their aptitude around establishing and maintaining rapport with women, leading to strong trusting partnerships. This level of rapport enabled them to advocate for women within the hospital system to ensure women's needs, desires and choices were respected.

As the participants' confidence improved, they gradually came to 'accept' the system was overwhelming and to survive and grow as professionals they needed to think carefully about how and when to respond. Drawing on their deep connection with women and commitment to informed choice, the participants successfully responded to the organisational model of fragmented maternity care by transforming routine practices and task-based care into opportunities for empowerment, informed choice and woman centred care. Hunter (2004, p. 320) refers to this as "covert autonomy". By honouring and staying close to their philosophy the participants perceived they were able to effect positive change for women entrusted to their care. Taking this approach, the participants found work satisfying and this eventually culminated in feeling more accepted within the work environment, strengthening their sense of fitting in. The trust the participants had in the power of the midwife-woman relationship, became an effective coping strategy to overcome a way of working that challenged everything they knew and believed about midwifery (Hunter and Warren, 2014).

Despite evidence of benefits of continuity of midwifery care for women, babies and midwives (Fenwick et al., 2018; Perriman and Davis, 2016; Sandall et al., 2016), reorientation of mainstream services to increase continuity models has been slow. A 2013 cross-sectional survey of Australian maternity services identified only 31% offered caseload midwifery with less than 10% of women able to access this type of care (Dawson et al., 2016). It is therefore unsurprising most participants in this study were unsuccessful in their ambition to gain a position within a caseload model of midwifery care.

Significant legislative barriers also exist to prevent newly qualified midwives moving into private practice upon graduation. Private practice midwives are required to fulfil evidentiary requirements that address the Nursing and Midwifery Board of Australia (NMBA) Safety and Quality Guidelines for Midwives (NMBA, 2017), including 5000 hours mandated clinical practice experience (equivalent of three years full-time work), completion of an additional qualification for endorsement to prescribe scheduled medicines and obtaining a collaborative arrangement with an obstetrician in order to practise. Any midwife working in a private practice that doesn't meet these requirements must be supervised in all aspects of the care she or he provides childbearing women (NMBA, 2017).

Most other health professional groups have the freedom to choose to practice privately upon graduation. For example, physiotherapists, and dentists, are free to establish themselves as independent practitioners based on meeting the requirements of their initial qualification with evidence of professional indemnity insurance and recency of practice (Dental Board of Australia, 2015; Physiotherapy Board of Australia, 2016). Recency of practice for these health professional groups (dentists – undefined number of hours in the preceding five years and 150 hours in the past year or 450 hours in three years for physiotherapists), contrasts significantly to the 5000 hours required for midwives to enter private practice (Dental Board of Australia, 2015; Physiotherapy Board of Australia, 2016; NMBA, 2017). There is little doubt this is a major hurdle to transitioning to private practice for newly qualified and/or early career midwives. In contrast in New Zealand students complete a large proportion of their program working alongside a caseload midwife. Forty-eight percent of midwives graduating from these programs move straight into continuity models of maternity care (Pairman et al., 2016).

7.1. Limitations

While offering a new and unique perspective, these findings need to be interpreted within the limitations of the study. The small number of participants means generalisation isn't possible. Exploring other midwives' experiences of working with the participants would have provided additional insight. Despite this, these findings add to the growing body of work on the impact of facilitating continuity of midwifery care placements within midwifery education.

8. Conclusion

This small insightful qualitative descriptive study adds to knowledge surrounding first year of practice transition experiences of newly qualified midwives. After being embedded within a caseload model for most of their clinical practice experience the midwives in this study graduated feeling confident and well prepared to work across their full scope. All wanted to transition into midwifery practice within a caseload model. Opportunities to work in this way, however, were limited both within the public and private sector. These new midwives are key to the professions' ability to reorientate maternity services to ensure all woman, regardless of risk, can access midwifery led care within a supportive multidisciplinary team.

New midwives must be supported to transition straight into caseload models for which they are well prepared. The lack of opportunity to work in this way could contribute to attrition from the profession if not addressed. It is time to seek regulatory change to current legislation preventing newly qualified midwives from working in private midwifery practice. Further research inquiry in this field would contribute to the growing body of evidence that supports the educational preparation of midwives to work across the full scope of their practice in partnership with women.

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Declaration of competing interest

This manuscript and the study on which it is based is the original work of the authors. This data has not been analysed or published elsewhere and is not in the process of being considered for publication in another journal. We declare that the content of this paper is original; that each author meets the criteria for authorship as set out in the Author Information Pack and has seen and approved the manuscript being submitted. The study received ethical approval and we declare that no author has a conflict of interest.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.nepr.2019.102641.

Appendix.B

Table 1
Summary of appraised articles.

Author/Title	Design/Setting	CASP Appraisal
1. Hobbs, J. (2012) Newly qualified midwives' transition to qualified status and role: Assimilating the 'habitus' or reshaping it	DESIGN: Qualitative ethnographic approach SETTING: West Country UK, major maternity department	Include - CASP 10/10
2. Clements, V., Davis, D., & Fenwick, J. (2013) Continuity of Care: Supporting New Graduates to Grow into Confident Practitioners	DESIGN: Qualitative descriptive explorative design - part of a larger study. SETTING: 14 public maternity hospitals in Sydney	Include – CASP 9/10
3. Cummins A. M, Donney-Wilson, E. & Homer, C.S.E. (2015) The experiences of new graduate midwives working in midwifery continuity of care models in Australia	DESIGN: Qualitative descriptive design SETTING: A variety of clinical settings across Australia - tertiary hospitals 'to' stand-alone birth centre midwifery CoC models of care in NSW	Include – CASP 10/10
4. Fenwick, J., Hammond, A., Raymond, J. Smith, R., Gray, J. Foureur, M., … Symon, A. (2012) Surviving, not thriving: a qualitative study of newly qualified midwives' experience of their transition to practice	DESIGN: Qualitative descriptive design SETTING: Participants from one hospital in metropolitan Sydney	Include – CASP 10/10
5. Kitson-Reynolds, E., Cluett, E. & Le-May, A. (2014) Fairy tale midwifery—fact or fiction: The lived experiences of newly qualified midwives	DESIGN: Interpretive phenomenology SETTING: A number of National Health Service Trusts across the UK	Include – CASP 9/10

Box 1
Promoting Questions

1. Can you share with me what your expectations for your first year of practice as a newly qualified midwife before you commenced employment were?
2. Tell me about your experience as a student midwife in the RPMEP program.
3. Tell me how you have found your first year of practice experience
4. Can you share with me what you consider were the greatest influencing factors on how you experienced your first year of practice?

Box 2
Participants Workplaces

Participant	Workplace Note: One participant obtained a position in a private midwifery practice initially, and later transitioned into a hospital-based position but isn't specifically identified here to maintain her confidentiality
1.	Working in regional hospital
2.	Working in Regional Hospital – grad program rotating through all areas
3.	Working in large tertiary hospital – rotating through all areas before moving to a team midwifery model and then into a midwifery group practice.
4.	Working in rural hospital
5.	Working in large tertiary hospital – grad program
6.	Working in large tertiary hospital – rotating through birth suite and postnatal
7.	Working in large tertiary hospital – rotating through birth suite and postnatal
8.	Working in large tertiary hospital

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