Transition Support Programme for Newly Graduated Midwives in Limpopo Province, South Africa

by

Khathutshelo Grace Simane-Netshisaulu

Student Number: 11585560

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Department of Advanced Nursing Science
School of Health Sciences
University of Venda

Supervisor	**Co-Supervisors**
Prof M.S. Maputle	Prof M.L. Netshikweta
	Prof N.H. Shilubane

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DECLARATION

I, **Khathutshelo Grace Simane-Netshisaulu**, declare that the thesis entitled "**Transition Support Programme for Newly Graduated Midwives in Limpopo Province, South Africa**" is my own work, that all sources that I have used or cited have been indicated and acknowledged by means of complete references, and that this work has not been previously submitted by me for any degree at this or any other institution.

K.G. Simane-Netshisaulu	**:**	.....
Student Number	**:**	11585560
Date Signed	**:**	.....

DEDICATION

- This thesis is dedicated to my late parents, Gilbert and Sarah Simane, whose words of encouragement and push for tenacity always ring in my ears; and will always be my role models regarding commitment, hard work, dedication and perseverance. A special dedication goes to Albert, my husband, for his unconditional love and support.

- I sincerely relay my special feeling of gratitude to my sons (Maanda and Murendi) and daughters (Murunwa and Mukhethwa) who are always my source of motivation and strength. I appreciate their incredible and unconditional love, care and support.

- My special dedication goes to a special friend who had been there for me at all times. Had it not been for your support, I wouldn't have done it this way. Thank you very much.

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ABSTRACT

Introduction: For newly graduated midwives to function effectively with regard to provision of quality midwifery services, successful transition from student status to professional status should be enhanced. It is therefore important that transition support programmes be put in place in order to provide a baseline for guidance and support of newly graduated midwives.

Purpose: The purpose of this study was to develop a transition support programme to enhance effective support of newly graduated midwives during their transition period in Limpopo Province, South Africa.

Setting: The study was conducted in maternity units of selected regional hospitals and a tertiary hospital in all the districts of Limpopo Province, South Africa.

Methods: Phase 1: A qualitative, exploratory and descriptive design was used for the study. The population comprised of all newly graduated midwives who have undergone a comprehensive nursing programme (R425 of 19 February 1985, as amended) and qualified as nurses (General, Psychiatric and Community) and Midwifery from the universities and nursing colleges; as well as all professional nurses working at selected hospitals. A non-probability, purposive sampling method was used to select five newly graduated midwives who have been working for a period less or equals to one year following their successful completion of training, and were working in maternity units of the selected hospitals. Five professional nurses qualified as midwives and have been working in maternity units of the selected hospitals for at least five years, were also sampled through a non-probability, purposive sampling method. Data were collected through in-depth individual face-to-face interviews; a

voice recorder was used to capture information shared by participants, and field notes were also taken. An open-coding method was used to analyze data. Ethical principles and measures to ensure trustworthiness were considered. Major themes, themes and sub-themes were identified from the analyzed data. The following major themes emerged from data analysis: Experiences of being a newly graduated midwife in labour ward, Support provided by experienced midwives, Relationship between experienced and newly graduated midwives in labour ward, Expectations of experienced midwives from newly graduated midwives as well as Newly graduated midwives' views related to placement in the labour ward. Empirical findings revealed that newly graduated midwives viewed labour ward as a traumatic environment as it is very busy with serious shortage of staff. Graduates also expressed a professional nurse's role as stressful as it demands high level of responsibility and accountability which they did not have, resulting in frustration and anger. Newly graduated midwives felt that the support they received from the experienced midwives was ineffective, as they were neither mentored nor properly supervised and the environment was not conducive for learning. The relationship between graduates and experienced midwives was poor and some experienced midwives displayed negative attitudes towards the graduates. Results showed that graduates failed to meet experienced midwives' expectations as they were unable to function independently, resulting in failure to reduce the workload. Newly graduated midwives recommended that their placement in maternity ward be extended from a period of six months to a year in order for them to build confidence in midwifery practice.

Phase 2: Results of phase 1 of the study revealed transition support gaps which led the researcher to analyze 'effective transition support' as a core concept. Concept analysis was done in accordance with Walker and Avant's method; in order to clarify its meaning. The findings of both phase 1 and concept analysis guided the

development of a transition support programme aimed to enhance effective support of newly graduated midwives during their transition period. Development of a transition support programme was based on Duchscher's transition theory as well as ADDIE's model for training and instructional design, the steps of which were: analysis, design, development, implementation and evaluation. A developed transition support programme was validated using a quantitative approach, whereby exploratory and descriptive designs were employed. The main aim was to validate for effectiveness and applicability of a developed transition support programme. Validation was conducted in a similar setting as in phase 1, with the same population. Puposive sampling method was used to select participants who met inclusion criteria. A sample consisted of twelve (12) newly graduated midwives, thirty eight (38) experienced midwives of which thirteen (13) were operational managers. A self developed questionnaire was used for data collection.

The validation process was based on a framework for programme evaluation in public health by the Centers for Disease Control and Prevention. According to the validation results, the developed transition support programme met the standard as it can be easily implemented, it is practical, utilizable, appropriate and will benefit patients, family members, health care facilities and the community at large.

Recommendations: The developed transition support programme addressed the major challenges identified in the findings of the main study. Only aspects of the results which were not addressed by the developed transition support programme were covered in the recommendations. Recommendations were directed to the nursing education, nursing practice as well as future research.

Keywords: effective transition support, experienced midwives, newly graduated midwives, transition, transition support programme

LIST OF ACRONYMS

ANC	Antenatal Care
CDC	Centers for Disease Control and Prevention
DoH	Department of Health
JCC	Joint Commission Center for Hot Topics in Health Care
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NQNs	Newly Qualified Nurses
RSA	Republic of South Africa
SANC	South African Nursing Council
SDGs	Sustainable Developmental Goals
TSPs	Transition Support Programs
UVHDC	University of Venda Higher Degrees Committee
UVREC	University of Venda Research Ethics Committee
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
USA	United States of America
WHO	World Health Organization

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CHAPTER 1

Overview of the Study

1.1 Introduction and Background

When a midwifery graduate changes from a role of a student to that of a professional midwife, the profession as well as midwifery services benefit. The benefits are in the form of expected improvement regarding provision of quality midwifery services (Schytt and Waldenström, 2013). The World Health Organization (WHO, 2003) asserted that midwifery personnel carry an immense responsibility regarding provision of midwifery services; as they provide care in different forms, from before conception until the puerperal period. In the study conducted by Avis, Malik and Fraser (2012), participants reported that transition from being a student to becoming a professional causes mixed emotions for the newly qualified.

This is because a graduate is excited as s/he has successfully completed the training, but frustrated as s/he is faced with increased responsibilities that accompany a new role. According to Yanhua and Watson (2011), transition period is the time during which graduates undergo important adjustments in terms of knowledge, skills and responsibilities to enable themselves to interact productively with other members of the health team. Therefore, graduates need strong support from senior colleagues. According to Fraser and Avis (2011), the main concern about transition is the fact that graduates are faced with a situation whereby they have to start to be highly responsible, as they are no longer students.

The post they occupy demands that they demonstrate the competence, confidence and accountability for their own decisions and actions, as well as those of their subordinates. Clements (2012) as well as Schytt and Waldenström (2013) argued that the fact that graduates have successfully completed their midwifery training does not necessarily mean that they are able to practice what they have been taught. Graduates found it hard to cope with increased demands of a new role (Clements, 2012; Schytt & Waldenström, 2013).

Avis et al. (2012) and Delaney (2013) reflected on a similar version when reporting that graduates are not competent enough to provide quality midwifery services to patients. Hence, patients and family members raised concerns regarding their fitness for practice. Crombag, Bensing, Iedema-Kuiper, Schielen and Visser (2013) echoed the previous authors' views when reporting that it is important that newly qualified midwives be supported by means of structured programmes to enable them to cope with the new role.

Based on Holland, Roxburgh, Johnson, Topping, Watson, Lauder and Porter's (2010) review on midwifery training in the United Kingdom (UK), newly qualified midwives are not yet fit to perform as professional practitioners. This is because they still lack the confidence to make sound midwifery decisions. Hence, it is important that they be provided with the necessary support (Holland et al., 2010). Fraser and Avis (2011) concurred when they described the importance of either development of national standards or adoption of UK standards on which support of midwifery graduates can be based.

The usefulness of a preceptorship programme, for supporting newly qualified midwives was emphasized by McCarthy, Voss, Verani, Vidot, Salmon and Riley (2013). According to Young (2012), experiences and perceptions of midwifery

graduates with regard to their transition is determined by the type of professional relationship the lecturers have with the health care providers. Lack of ethical and professional agreement between lecturers and health care providers with regard to what is really expected of midwifery graduates, frustrates graduates (Young, 2012). Morrow (2009) supported Young (2012) when demonstrating failure to understand nursing managers who expected graduates to function as if they were experienced.

In their study conducted in Britain, Fraser and Avis (2011) recommended that management of transition experiences by managers should be executed, as this would serve as a support measure for the newly qualified midwives. Bacon (2010) also described the value of provision of support to midwifery graduates as they move from students' role to a professionals' role. The author further suggested that an effective way of provision of such support might be through preceptorship programmes.

According to Fraser and Avis (2011), midwifery graduates are able to manage normal midwifery conditions, and some are also able to diagnose abnormalities; but since transition is always associated with lack of confidence, graduates find it very difficult to manage midwifery complications as well as emergency situations. Avis et al. (2012) reflected a similar version when they reported that structured support of midwifery graduates is significant, even though they are considered competent on graduation; this will enable them to provide quality midwifery services.

In a study conducted in Australia, researchers gave account that newly qualified midwives suffered frustration and did not experience any sense of belonging; as experienced midwives isolated them and did not attend to their concerns (Fenwick, Hammond, Raymond, Smith, Gray, Foureur, Homer & Symon, 2012). Based on the findings by Teoh, Pua and Chan (2013), midwifery graduates felt frustrated and

anxious, as they were expected to provide midwifery services in such unfamiliar environments without any support or assistance by the experienced midwives. It is therefore important that experienced midwives provide effective support to the newly qualified members (Teoh, 2013).

In their phenomenological study of the 'lived experiences of newly qualified Irish midwives', Hammond, Gray, Smith, Fenwick and Homer (2011) reported strikingly similar experiences to those elicited by Bacon (2010); and such included "lack of a humanistic approach, poor relationships between team members and inefficient management styles within the standard hospital context; which all led to distress among the newly qualified midwives." Lack of a humanistic approach was also reported by Avis et al. (2012), who indicated that newly qualified midwives described feeling confused and upset as the environment was at times unwelcoming; they were treated badly and unsupported and the hierarchical nature of midwifery in the hospital setting, contributed to their disempowerment.

In a study conducted in Sweden, Mooney (2007) reported that transition from a midwifery student to a professional midwife is both challenging and stressful. This is because of the difference between the new midwife's ideal role performance and the reality of practice. In addition, high perceptions of one's own competence at the moment of graduation and realizing that the perceptions are high when entering the world of work cause stress and a feeling of inadequacy (Doody, Tuohy and Deasy, 2012).

Based on the findings by Yanhua and Watson (2011), orientation and mentoring programmes that were available did not address midwifery graduates' learning needs, leading to frustration. The authors made a recommendation that support programmes should be drawn based on the learning needs of the midwifery graduates. Young

(2012) reported that the other aspect that caused frustration for the graduates was the discrepancies that existed between the two different worlds, that is, the academic world and the professional world. This situation puts newly qualified midwives in the middle of nowhere, as they are no longer members of the students' group, and neither do they belong to a group of professionals (Doody et al., 2012). The difficulties of transition from being a student to becoming a professional are not only observed internationally, but nationally as well.

In Nigeria, newly qualified midwives are left with no choice, but just to practice through trial and error, as there was nobody to rely on for support, supervision and mentoring which put patients' lives at risk. This was because of serious shortage of senior members and lack of equipment (Adegoke, Atiyaye, Abubakar, Auta and Aboda, 2015). In a study conducted in Swaziland by Dlamini, Mtshali, Dlamini, Mahanya, Shabangu and Tsabedze (2014), newly qualified midwives requested that they be supported as they indicated that they were inadequate as far as provision of midwifery services was concerned.

The reason for such a plea was that there was no structured programme for supporting their practice, not even an orientation programme was in place. Midwifery graduates expressed their frustration as they were expected to function as though they had experience. Lack of support for newly graduated midwives in Swaziland was also reported by McCarthy et al. (2013), who demonstrated concern that after graduation, no provision was made to support midwifery graduates in their new role as they expressed feelings of inadequacy and lack of confidence during the first months of service. According to Fraser and Hughes (2010), the South African Nursing Council (SANC) as well as the health care system of the Republic of South Africa, demand that registered midwife practitioners must be competent to be able to render quality and efficient services to patients.

The fact that competency is considered a national priority and statutory demand, made the researcher to ask herself: 'how prepared are the newly qualified midwives with regard to provision of midwifery services in the clinical settings' (Roziers, Kyriacos and Ramugondo, 2014).

The competence of the newly graduated midwives is further questioned, based on their ability to achieve Sustainable Development Goals (SDGs), most importantly the third goal (3), which is about promotion of good health and well-being. Achievement of the goal is determined by the performance level of the practitioners who are members of the multidisciplinary health care team (National Department of Health, 2016). O'Shea and Kelly (2007) asserted that lack of supervision and mentoring of graduates has negative implications on graduates' performance. This is because they are faced with high levels of responsibility and accountability, yet they lack experience.

This was supported by Davis, Foureur, Clements, Brodie and Herbison (2011) who reported that newly graduated midwives' feelings of inadequacy and fear of independent practice accompanied by lack of support by the senior staff members led to high levels of stress. This was because they lacked the ability to make decisions during the initial exposure to professional roles as their leadership and decision-making skills are still limited.

Motlolometsi and Schoon (2012) concurred when they reported a great need for newly graduated midwives to be mentored during their clinical placement. In a study conducted in Gauteng province, Ndaba (2013) argued that transition of students is difficult and associated with factors such as attitudes of experienced midwives, demanding role of a midwife and shortage of equipment; it is therefore necessary that they be supported. However, there seems to be no empirical evidence of transition of midwives from students to professionals in Limpopo Province.

1.2 Problem Statement

According to the Nursing Act (Act Number 33 of 2005), all newly graduated midwives who have undergone a comprehensive programme (R425 of 19 February 1985, as amended), should be placed in public hospitals to complete one year of compulsory service. The main aim of this compulsory placement is that they be supported, orientated and mentored in their new role. On completion of this placement, the newly graduated midwives become registered as independent practitioners by the SANC. During clinical accompaniment of midwifery students, the researcher met and interacted with some of the newly graduated midwives from a comprehensive programme, placed in maternity units for compulsory community service.

The newly graduated midwives verbalized frustrations as they were expected to practice as if they had experience in the clinical areas. On the other hand, experienced midwives usually raised concerns regarding lack of commitment and absenteeism on the part of newly graduated midwives. On observation, the researcher noticed that it was common to find the newly graduated midwives conducting deliveries alone without any supervision by the experienced midwives. In some instances, newly graduated midwives were left running the shifts as the professional nurse in charge.

The research conducted by Oosthuizen and Phil (2012) confirms that newly graduated midwives do lack confidence to demonstrate safe practice during their first year, and therefore require continuous verbal and physical support when making health-related decisions. However, there seem to be no empirical evidence of a programme for supporting newly graduated midwives during their transition period. It is in this light that the researcher aimed to develop a transition support programme to enhance effective support of newly graduated midwives during their transition period in Limpopo Province, South Africa.

1.3 Purpose of the Study

The purpose of the study was to develop a transition support programme to enhance effective support of newly graduated midwives during their transition period in Limpopo Province.

1.4 Research Objectives

The study was guided by the following objectives:

❖ Phase 1

- Explore and describe the experiences of newly graduated midwives regarding provision of midwifery services during their transition period;

- Describe the expectations of experienced midwives from newly graduated midwives during their first year of clinical practice; and

- Explore the support provided by experienced midwives to newly graduated midwives during their first year of clinical practice.

❖ Phase 2

- Develop a transition support programme to enhance effective support of newly graduated midwives during their transition period; and

- Validate a developed transition support programme for effective support of newly graduated midwives during their transition period.

1.5 Research Question

The study was guided by the following research question:

What kind of support is provided to newly graduated midwives during their first year of clinical practice?

1.6 Significance of the Study

Creswell (2009) stated that the significance of a study conveys the importance of the study for different audiences that may benefit from reading the findings of the study. The researcher assumed that the research findings of this study would lead to development of a transition support programme that will enhance effective support of newly graduated midwives during their transition period.

A developed transition support programme may enable newly graduated midwives to be more confident and competent regarding provision of midwifery services to patients, in Limpopo Province. It is also assumed that patients and clients may benefit from the study as they will receive quality midwifery services provided by competent newly graduated midwives. The institution may also benefit as the utilization rate may increase due to provision of quality care to patients.

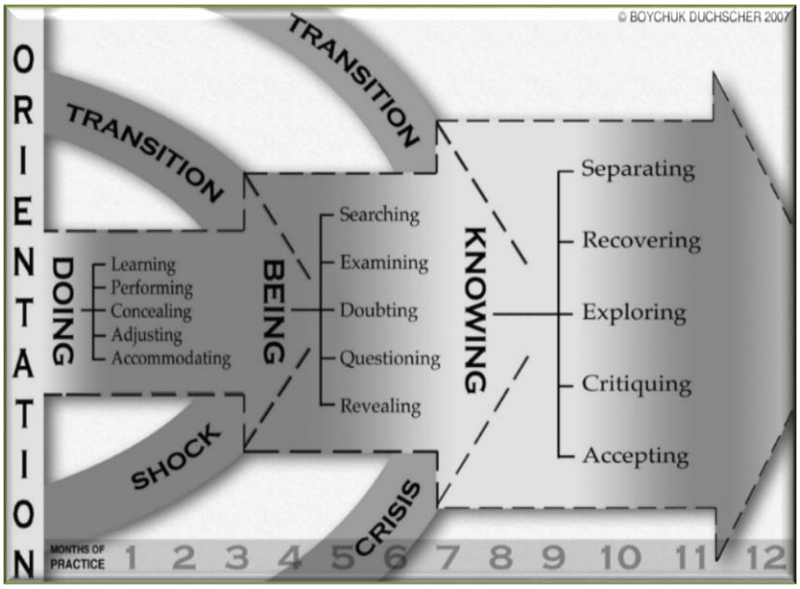
The period of hospital stay may also be reduced as a result of quality midwifery services provided to patients. Good interpersonal relationships between experienced midwives and newly graduated midwives may result in smooth running of services within the organization.

The Department of Health (DoH) may also benefit from this study as competent professional nurses will provide quality midwifery services to patients, thereby reducing maternal as well as neonatal complications, including deaths. This may also contribute to the achievement of Sustainable Developmental Goals (SDGs), particularly goal number 3 (DoH, 2016). Policy makers may consider formulation of a policy regarding consideration of transition support programme during placement of newly graduated midwives for community services.

1.7 Theoretical Framework

Burns and Grove (2009) define theoretical framework as an abstract, logical structure of a study which enables the researcher to link the findings to a nursing body of knowledge. In this study, Duchscher's (2008) stages of transition model will be applied as it incorporates a journey of becoming—where new graduates progress through the stages of doing, being and knowing. These stages are based on the orientation that a newly graduated midwife is expected to undergo for the first twelve months of clinical practice (Duchscher, 2008).

The process of transition to professional practice among nursing graduates evolves in a fairly predictable manner from the honeymoon phase, where graduates are excited and exhilarated; through a shocking assault on their professional values that leaves them disoriented and disillusioned; and to the recovery and resolution phases, marked by a return of a sense of balance (Kramer and Schmalenberg, 1978; Duchscher, 2008). Figure 1.1 illustrates the stages of transition theory (Duchscher, 2008).



Source: Duchscher (2008)

Figure 1.1: The Stages of Transition Theory

1.7.1 The Stage of Doing

The model emphasizes that the initial 3-4 months of the new graduates' journey is an exercise that encompasses anticipating, learning, performing, concealing, adjusting and accommodating whatever they find in the realities of their new position. For the new graduates, there is little energy or time to lift their gaze from the very immediate issues or tasks set before them, and their shock state demands a concerted focus on simply surviving the experience without revealing their feelings of overwhelming anxiety or exposing their self-perceived incompetence (Duchscher, 2008).

The model is applicable to this study as newly graduated midwives enter their profession with unrealistic expectations such as being able to function as professionals. It is during this stage whereby, newly graduated midwives are expected to learn how to cope, adapt and adjust themselves to both the new environment and the new role as they have lost their student status to being professional nurses. Graduates at this stage are anxious and full of uncertainty regarding whether they will be able to meet the responsibilities of a new role or not. Poor relationship with the senior members of staff makes it difficult for them to disclose their sense of inadequacy.

1.7.2 The Stage of Being

Duchscher (2008) describes the second stage of professional role as encompassing the next 4-5 months of the new graduates' post-orientation period. This stage is characterized by a consistent and rapid advancement in their thinking, knowledge level and skill competency. During the course of this second stage, the newly graduated midwives would disengage, question, search, reveal, recover, accept and, ultimately reengage in their chosen career; the difference is that this time it is on their terms (Duchscher, 2008).

As this period progresses and the new graduates gain a comfort level with their professional roles and responsibilities, they are confronted by inconsistencies and inadequacies within the health care system that serve to challenge their unrealialistic perceptions about the profession. Unlike the first transition stage, where they required more prescriptive directives about what should be done in particular clinical situations, participants now express a desire for clarification and confirmation of their own thoughts and actions.

An increased awareness of the divergence between their professional “self” and the enactment of that self in their new role motivates a relative withdrawal of the new graduates from their surroundings. The primary task for these graduates at this stage is to make sense of their role as a nurse relative to other health care professionals and to find a balance between their personal and professional lives (Duchscher, 2008). The model is relevant to the study because newly graduated midwives at this stage begin to get used to their professional roles and responsibilities, even though they are still faced with challenges regarding a lot of uncertainties within the health care system.

They ask themselves many questions as they try to correlate their personal roles with professional ones; at the same time they integrate their professional nurses’ role with the roles of other professionals within the institution. Newly graduated midwives feel confident when they realize that they could make decisions and implement midwifery actions that are not only appropriate, but also safe.

1.7.3 The Stage of Knowing

According to Duchscher (2008), the stage of knowing focusses on achievement of a distinction between the newly graduated midwives and the experienced practitioners around them; and permits new graduates to join and start interacting with other

members of the health care team. Graduates are now familiar and used to the routine, they are also enthusiastic about their new role. They now present with a critical attitude (Duchscher, 2008). The model is applicable to this study as the newly graduated midwives at this stage are more familiar and comfortable with their professional positions; their relationship with the colleagues is improved. These enable them to explore their professional environment with a critical eye. It is during this time whereby everybody start feeling their impossible way of thinking and doing things as it is the way they have been socialized.

1.8 Definition of Concepts

1.8.1 Transition

Transition is the process through which new nurses and midwives move from the protected environment of academia to the unfamiliar and expectant context of professional practice (Duchscher, 2009). In this study, transition shall mean the process experienced by newly graduated midwives who have undergone a comprehensive nursing programme (R425 of 19 February 1985, as amended), when they move from student status to professional status; starting from the date of completion of training until they complete one year of clinical practice following their graduation.

1.8.2 Effective Transition Support

This is the support provided to the newly qualified professionals to maximize the usefulness of their study (Duchscher, 2009). In this study, effective transition support refers to the support provided by experienced midwives to newly graduated midwives, during their compulsory community service allocation in a maternity unit during their first year following their successful completion of training.

1.8.3 Experienced Midwives

Experienced midwives are trained health professionals who have an experience, to provide assistance and primary medical care to women throughout pregnancy, monitoring its course, attending labour and delivery, following the new mother for up to 28 days after birth, assisting with breast feeding, neonatal care and so on (Sullivan, Lock and Homer, 2011). In this study, experienced midwives are professional nurses, qualified as midwives and have been working as such in a maternity unit for at least five years.

1.8.4 Newly Graduated Midwives

Newly graduated midwives are nurses who have undergone their training based on the SANC Regulation 425 of 19 February 1985 (as amended) and qualified as nurses (general, psychiatric and community) and midwives (Ndaba, 2013). In this study, newly graduated midwives are professional nurses, who have graduated from a four year comprehensive nursing programme (either from a university or a nursing college), and are placed at the hospitals for compulsory community service during their first year of practice following completion of training.

1.8.5 Transition Support Programme

A set of structured activities aimed at accomplishment of objectives aimed at provision of support to newly qualified professionals in order to maximize the usefulness of their study during transition period, with details on what work is to be done, by whom, when and how (Delaney, 2013). In this study, a transition support programme is a planned series of performances that will be used in order to provide guidance and effective support to newly graduated midwives during their first year of clinical practice.

1.9 Organization of Chapters

The study consists of 6 chapters structured as follows:

Chapter 1:	Overview of the Study
Chapter 2:	Literature Review
Chapter 3:	Research Methodology
Chapter 4:	Presentation and Discussion of the Results
Chapter 5:	Concept Analysis, Programme Development and Validation
Chapter 6:	Summary, Recommendations, Limitations and Conclusion

1.10 Summary

Chapter 1 introduced the topic and provided a brief background, rationale and the problem statement. The purpose of the study, objectives, a research question which guided the study and significance of the study were outlined. A theoretical framework which formed the basis of the study was described and its applicability to the study highlighted; key concepts of the study were defined accordingly. Chapter 2 focuses on the literature review.

CHAPTER 2

Literature Review

2.1 Introduction

Chapter 1 offered an introduction to the topic, a brief background, rationale and the problem statement. Definition of key terms, the research question, purpose, objectives, research design and method were briefly described. Chapter 2 focuses on a discussion on literature review. The process of transition from a role of a student to a professional midwife's role has a very strong relationship with provision of quality midwifery care to patients and clients, irrespective of the type of training undertaken. Hobbs (2012) stated that graduates reported frustration resulting from the reality in the clinical practice where they are expected to correlate the theory they learnt in class with the practical conditions. It is during this stage whereby graduates are not only expected to manage patient care, but to take the responsibility for decision-making (Duchscher, 2009; Hobbs, 2012).

Based on the results of the study conducted in the United States of America (USA), Fenwick et al. (2012) revealed that 50% of the participants reported the incongruences between the midwifery services they learnt during training and the midwifery services in the real situation. According to Van der Putten (2008), fear and anxiety were representative of Irish midwives' transition to practice experiences. Newly qualified midwives experienced problems during provision of midwifery services because the environment in the clinical area was completely different from the environment they were exposed to during training (Schytt & Waldenström, 2013).

Coulm, Le Ray, Lelong, Drewniah, Zeitlin and Blondel (2012) asserted the importance of provision of support to graduates. “This was justified on a number of grounds that: newly qualified nurses and midwives are not fully fit for purpose at qualification; even when they appear to be competent they do not have self-confidence to be autonomous professionals (Stacey & Hardy, 2011; Young, 2012); mentoring and preceptorship aid the recruitment of Newly Qualified Nurses (Yanhua & Watson, 2011) and reduces the high level of turnover otherwise experienced (Hughes & Fraser, 2011).”

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Internationally, there are several models of support, and such include formal programmes of induction without an allocated preceptor; one-to-one personal preceptorship for the first few months after qualification; or a combination of the two (McCarthy and Murphy, 2010; Roxburgh, Lauder, Topping, Holland, Johnson and Watson, 2010). The consensus is that the preceptorship relationship is most important and that this is enhanced if it is supported by formal structures of support, including

peer support and mandatory training (Omansky, 2010). In the UK the form of support for newly qualified nurses (NQNs) has been accepted as mentorship and preceptorship since 1990 (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, UKCC, 1990).

According to the SANC's legislation (RSA, Act Number 33 of 2005 as well as Regulation, R425 of 19 February 1985, as amended), the duration of the professional nurse education and training programme is four academic years of full time study. On successful completion of training, the graduate shall have acquired general, psychiatric, community and midwifery qualifications. Theoretical and practical minimum requirements for the professional nurse education and training programme are such that a learner is required to achieve a minimum of 508 credits consisting of 121 fundamental component credits; 377 core component credits; and 10 elective component credits (Government Notice, No. R.1046 of 14 December, 2011, as amended).

A learner shall also undergo a minimum of 3000 hours of supervised experience in a clinical facility, which shall be spread over four academic years of the programme. Of these clinical hours, the minimum requirement for clinical placement in a maternity unit is 1000 hours of which 160 hours are for antenatal services, 600 hours for labour unit, 160 hours for postnatal unit and 80 hours for neonatal unit respectively (Government Notice, No. R. 1046 of 14 December, 2011, as amended).

On successful completion of training as a midwife, a newly graduated midwife shall have mastered the following midwifery skills: management of a woman during pregnancy, labour and pueperium; post-natal care as well as care of a baby (Government Notice No. R.1046 of 14 December, 2011, as amended). The South African legislation (RSA, Act Number 33 of 2005) prescribed that all newly qualified

midwives who have undergone a comprehensive programme (SANC Regulation, R425 of 19 February 1985, as amended) be placed in public hospitals to complete one year of compulsory service. It is during this compulsory placement where they need to be orientated, supervised and mentored in their new role before they are registered as professional nurses by SANC.

2.2 Themes and Sub-Themes on Which the Literature Review Was Based

Table 2.1 summarizes the themes and sub-themes on which the literature review was based.

2.2.1 Experiences of Newly Graduated Midwives Regarding Provision of Midwifery Services During Their Transition Period

As revealed by the literature, the experiences of the new graduates shape their transition from students to registered practitioners. A large part of this experience is based on the interaction new graduates have with their experienced midwifery colleagues. The literature reports that experienced midwifery practitioners play a significant role in the transition process of the newly graduated midwives (Carter, Sidebotham, Creedy, Fenwick and Gamble, 2013; Hood, Fenwick and Butt, 2010).

2.2.1.1 Reality of clinical practice

In the phenomenological study of the lived experiences of newly qualified midwives in Ireland, Van der Putten (2008) identified two main themes that represented the experiences of newly graduated midwives, and such were reality shock and living up to the expectations. Furthermore, Van der Putten (2008) described frustration encountered by graduates. This occurred as they were expected to familiarize themselves with the new environment; at the same time, had to meet the expectations of the experienced midwives as well as those of the patients (Van der Putten, 2008).

Table 2.1: Themes and sub-themes on which the literature review was based

2.2.1	**Experiences of newly graduated midwives regarding provision of midwifery services during their transition period**	
	2.2.1.1	Reality of clinical practice
		2.1.1.1.1 Emotional factors
		2.1.1.1.2 Physical factors
		2.1.1.1.3 Sociocultural and developmental factors
		2.1.1.1.4 Intellectual factors
	2.2.1.2	Incongruence between theory and clinical practice
	2.2.1.3	The context of hospital maternity care
	2.2.1.4	Negative attitudes of experienced midwives
	2.2.1.5	A workplace learning environment
2.2.2	**Expectations of experienced midwives from newly graduated midwives**	
	2.2.2.1	Autonomy in clinical practice
	2.2.2.2	Inability to relieve midwifery professionals
2.2.3	**Support provided by experienced midwives to newly graduated midwives**	
	2.2.3.1	Clinical support through mentorship
	2.2.3.2	Positive and supportive midwife to midwife relationship

In a study entitled 'Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses,' Duchscher (2009) described the shock which emerged as the experience of moving from the known and familiar role of a student to the relatively less familiar role of a professionally practising midwife. Important to this experience for the new graduate is the apparent contrast between the relationships, roles, responsibilities, knowledge and performance expectations required within the more familiar academic environment to those required in the professional practice setting. Kramer (1974) as well as Marquis and Huston (2009) revealed that newly qualified professionals experience specific shock-like reactions when they find themselves in a work situation for which they have spent several years preparing and

thought they were fully prepared, but suddenly realize they were not. Stacey and Hardy (2011) described the four phases of role transition from being a student to a registered professional as the honeymoon, shock, recovery and resolution. These phases are also applicable to this study as the newly graduated midwives start by undergoing orientation which only lasts for a few days.

During this period, they are not held accountable for patient care. After a few days of orientation, newly graduated midwives become shocked as they are expected to adjust themselves to the new environment where they are expected to function as professional midwives. It is during this stage whereby they are expected to provide care to patients and at the same time, play their administrative as well as teaching roles. All these result in shock as they fail to cope with the reality of clinical practice.

Towards the end of transition, graduates become more familiar and comfortable with their professional positions; and their relationship with the colleagues is improved. The model is applicable to this study as newly graduated midwives at this stage are more familiar and comfortable with their professional positions. As a result, they are able to explore their professional environment with a critical eye. Panzavecchia and Pearce (2014) further reported that participants seemed ill-prepared for the toll this initial transition would take on both their personal energy and time and on their evolving professional self-concepts.

According to the study conducted by Kramer (1974), formal education equips learners with ‘visionary ideals,’ and this makes new workers to feel completely unprepared for the reality of clinical practice; the author further indicated that shock or reaction to the contrast between expectations of practice and reality can be so marked that the individual may not cope with the situation. On the other hand, van der Putten (2008) found that the stress experienced was frequently associated with the sudden and often

unexpected increase in responsibility together with a heightened burden of awareness of their individual accountability. This was supported by Coulm et al. (2012) who reported about the study they conducted regarding the perceptions of newly qualified registered midwives in which she revealed that the transition period from a student to a registered professional is a difficult time in which practitioners manifest in feelings of trepidation, fear and anxiety when faced with the reality of clinical practice. In their studies, Stacey and Hardy (2011), as well as Young (2012) described how new graduates struggled with their changing role and new-found responsibilities.

Schytt and Waldenström (2013), who undertook a grounded theory study in the UK on 18 newly qualified midwives' experiences, discussed how the newly qualified midwives expressed their feelings of stress and anxiety regarding the registered midwifery role. The new graduates expressed concerns regarding their level of knowledge and skills, but also found the workplace challenging in terms of workload and staff shortages. Many believed they had been sheltered from the realities of the midwifery role, during their training period (Schytt and Waldenström, 2013).

Similarly, Schroeder, Petrou, Hollowell, Redshaw and Brockelhurst (2014) who interviewed ten newly qualified midwives in Connecticut, USA, described new graduates' feelings of anxiety and insecurity as they took up their new role. In their analysis, the authors clustered a number of concepts under the pertinent heading of "welcome to the real world" (Schroeder et al., 2014).

In a study about newly qualified midwives' transition to qualified status and role, Hobbs (2012) contended that 'reality of clinical practice' may be implicated in transition reversibility, and lead to abandonment of the chosen career pathway. This view was supported by Young (2012) who found that newly qualified midwives experienced domains of thrownness from being faced with a certain situation to the threatening

experience that is a catalyst for rejecting the nursing and midwifery profession altogether. Bernitz, Øian, Rolland, Sandvik and Blix (2014) reported that participants expressed shock, stress and vulnerability when they were given the title “Sister”. They desired the title, but were apprehensive because they believed the title implied that they should know what to do under any circumstances, a goal they considered unrealistic. Doody et al. (2012) reported shock as expressed by participants when experienced midwives did not welcome them and also presented with an unprofessional behaviour2.2.1.1 Reality of clinical practice

In the phenomenological study of the lived experiences of newly qualified midwives in Ireland, Van der Putten (2008) identified two main themes that represented the experiences of newly graduated midwives, and such were reality shock and living up to the expectations. Furthermore, Van der Putten (2008) described frustration encountered by graduates. This occurred as they were expected to familiarize themselves with the new environment; at the same time, had to meet the expectations of the experienced midwives as well as those of the patients (Van der Putten, 2008).. According to Duchscher (2009), participants’ expressions of transition reality shock were experienced as emotional, physical, intellectual as well as socio-cultural and developmental.

2.2.1.1.1 Emotional Factors

Based on Duchscher’s (2009) findings, the range, overwhelming intensity and labile nature of the emotions expressed by participants during the initial stage of transition was described as truly impressive. Using words and phrases or expressions such as ‘terrified’ and ‘scared to death’, the participants claimed that relentless anxieties were routine during the initial weeks of transition (Snow, 2013). Some level of trepidation concerning skill-level competence and the establishment of new collegial relationships

in newly graduated midwifery professionals is expected (Kumaran, Suji & Carney, 2014). However, stability, predictability, familiarity and consistency of both the introductory clinical experiences and the individuals with whom the graduates interacted significantly influenced their responses to the existing role transition stress (Kumaran et al. 2014).

In a study conducted by Feltham (2014), the majority of the new graduates who participated could feel their anxiety 'dancing on the edges of their words and memories', displaying overwhelming and, at times, physically and psychologically debilitating levels of stress especially during the initial 1–4 months during transition. Lewis and McGowan (2015) concurred when they reported that participants used the metaphor of drowning when both describing and visually representing the overwhelming experience of the first few months of transition.

In the study conducted by Feltham (2014), startling pictures were drawn and collages designed that clearly illustrated the loss of control and subsequent powerlessness associated with the transition shock experience. Duchscher (2009) further revealed that graduates consume a lot of energy when they make attempts to stabilize the emotional roller coaster on which they found themselves; resulting in a predictable, but nevertheless remarkable exhaustion by the third to fourth month of transition.

The primary fears for the new graduates during this stage of their transition were: (1) being 'exposed' as clinically incompetent, (2) failing to provide safe care to their patients and inadvertently hurting them and (3) not being able to cope with their designated roles and responsibilities (Kumaran et al., 2014). The dreaded outcome was rejection by their peers as valued and contributing members of the professional community. Understandably, new graduates went to great lengths to disguise their feelings of inadequacy from their senior midwifery colleagues (Kumaran et al., 2014).

The loss of support system that the new graduates employed during their undergraduate education was intensely felt. Not having immediate access to previous educators or peers to provide intellectual counsel, emotional support, or practice consultation and feedback potentiated the novice practitioners' feelings of isolation and self-doubt (Duchscher, 2009).

Lewis and McGowan (2015) reported that many new graduates expressed struggles with maintaining the practice intentions and standards that they had consolidated during their training. The majority of newly graduated midwives shared feelings of frustration and guilt about their inability to enact the practice principles they believed were a basic requirement of their professional role. There was a sense of culpability for the perpetuation of substandard practice that served as a powerful yet insidious role transition destabilizer (Lewis and McGowan, 2015).

2.2.1.1.2 Physical Factors

Reynolds, Cluett and Le-May (2014) reported physical responses of newly graduated midwives to the transition shock experience as grounded in the all-encompassing energy being consumed, when they tried to perform in their new role at the level expected of them without revealing how difficult this was for them. Odland, Sneltvedt and Sörlie (2014) concurred with Reynolds et al. (2014) when they reported that changes to established life-pattern routines resulted in unexpected burdens which were manifested by physical symptoms such as headache and ulcers.

Established life pattern routines included modified living arrangements, terminated or advancing intimate relationships, and the acquisition of debt through the purchase of cars and homes (Odland et al., 2014). In addition to undergoing personal and developmental changes, these young professionals were being expected to make advanced clinical judgments and practice decisions for which they felt minimally

qualified but completely responsible, adding to more stress related symptoms (Odland et al., 2014). In a study conducted by Duchscher (2009), newly graduated midwives reported the physical strain they experienced regarding the new level of professional accountability. The physical strain was heightened by unclear practice expectations from managers and colleagues, inaccurate assumptions by the graduates of what a 'successful' transition would look like, unanticipated role-relationship struggles with colleagues, the physical demands of adjusting to shift work, and a virtual absence of normalizing feedback on which to base their experience and their role transition progress (Duchscher, 2009).

Fed by doubts and insecurities, these new practitioners seemed unable to control the relentless debriefing of their practice actions and decisions (Hyrkas, Linscott and Rhudy, 2014). Hyrkas et al. (2014) further reported that newly graduated midwives described spending their waking hours thinking about what had transpired on their last shift and preparing for what might happen on their next one. Sleep time was consumed by dreams about work, bringing about a state of 'perpetual work' that contributed significantly to their growing exhaustion.

2.2.1.1.3 Sociocultural and Developmental Factors

During the first 4 months, the primary sociocultural and developmental tasks for newly graduated midwives appeared to be finding and trusting their professional selves, distinguishing those selves from others around them, being accepted by the larger professional nursing culture, balancing their personal lives with their professional work, and finding a way to meld what they had learned during their undergraduate education with what they were seeing and doing in the 'real' world. Relationships with colleagues were critical forecasters of the transition shock experience (Bernitz et al., 2014).

Duchscher (2009) described transition reality shock experience for newly graduated midwives as mainly about finding their way in a world for which they had been prepared, but were not wholly ready. The disconnection between who they were as primarily women and young professionals and who they thought they were supposed to be as midwives, the behaviours they witnessed in the role models that surrounded them and how the realities of the practice environment facilitated, supported, reinforced, challenged or censored professional codes of behaviour dominated this initial transition period (Duchscher, 2009).

According to Panzavecchia and Pearce's (2014) report, as newly graduated midwives were functioning within a hypersensitive and self-critical state, they felt any and all tremors of disapproval, disrespect or doubt as they did likewise of acceptance, praise or simple encouragement. Regardless of the reasons, most participants alluded in some way to a desire to be included in the 'clique' that constituted the culture of their midwifery unit.

Panzavecchia and Pearce (2014) further reported that newly graduated midwives spoke of wanting, but not adequately receiving both affirming and critical feedback from either their senior colleagues or those they perceived to be in an evaluative role, such as managers and educators. In the absence of formal feedback, these novice practitioners looked for other indicators by which to measure the safety, competence and relative progression of their practice.

Based on the findings of Reynolds et al. (2014), a strong theme during the initial 4 months of graduates' introduction to professional practice was the evolution of a more mature, professional sense of self. This developmental change was both exciting and daunting to these young people, dictating modifications to established relationships with friends and family, and transforming the way in which they viewed themselves.

Several graduate participants talked about ‘growing up’, and reflected on their struggle to renounce the safety and security of a more protected, comfortable routine and less responsible way of life (Reynolds et al., 2014). Rush, Adamack, Gordon and Janke (2014) revealed that during the initial several months, newly graduated midwives found themselves distracted by the focus on tasks relative to the other nursing responsibilities with which they associated their professional role such as patient advocacy, teaching and counselling.

An underdeveloped level of organization and a desire to fit into the culture of the units where they worked fostered a focus on completing their tasks ‘on time’ (e.g., charting and other paperwork, answering phones, ordering tests) rather than spending quality time with patients and families (Rush et al., 2014). Relating to other professionals within the clinical environment was an energy-consuming adjustment. Struggling with moderate to low levels of self-confidence, these young midwives found it intimidating and ultimately devaluing to interact with both senior physicians and midwives whose behaviour reinforced hierarchical rather than collegial relationships (Reynolds et al., 2014).

Reynolds et al. (2014) further went on reporting that many described an oppressive hierarchy amongst the midwifery staff, and passive–aggressive styles of communication between midwives and physicians. In a related finding, considerable stress was involved in supervising, delegating and providing direction to other licensed and non-licensed personnel, many of whom were senior to newly graduated midwives in both practice experience and age. The graduates claimed that they had never been prepared to take on those roles or allowed to practise them during their undergraduate education (Reynolds et al., 2014).

2.2.1.1.4 Intellectual Factors

According to Duchscher (2009), introduction of the graduates to their new professional practice environment began with some form of orientation to the workplace, their midwifery role and the context within which they would be practicing. It is during this early period, whereby graduates maintained their high level of energy, eager and inspired by an exciting anticipation of finally being able to practise independently; being in a learning role was familiar to them and they held a curious fascination about what lay ahead (Duchscher, 2009).

Bernitz et al. (2014) reported that most of the graduates identified the intellectual stage as similar to the increase in challenge they had long experienced when moving from one student clinical rotation to another. Additional role expectations were interpreted as a more advanced conceptual application of that which they already knew, and as similar to the graduated progression which had been required of them as students from year to year (Bernitz et al., 2014).

Still not feeling the full weight of their professional responsibilities or nursing workload during this orientation period, the clear majority of the study participants were shocked by the change they experienced once orientation was completed and they were on their own in the real world (Bernitz et al., 2014). According to Rush et al. (2014), graduates' experience was rapidly and abruptly transformed from one of excitement and wonder to one of overwhelming fear, doubt and all-consuming stress.

Carter et al. (2013) revealed that some of the difficulty in making the switch from partial to full responsibility for these graduates lay in the approach of senior nurses, clinical educators and nurse managers to orientation. The authors further reported that the majority appeared to have a limited understanding of the relative inflexibility of the new graduates' practice capabilities, and expected that they would be able to manage the

workload of a seasoned practitioner within several weeks (Carter et al., 2013). Morgan, Mattison, Stephens and Medows (2012) revealed that what makes graduates to experience a lot of challenges during this stage is that no one ever mentioned to them that they would experience a transition, nor accounted for that experience either in the content or process of their professional initiation.

During the period of shock, the new midwives were able to manage reasonably a workload that consisted of a midwife-patient ratio of less than 1:8, a relatively controlled, balanced and stable level of acuity in their patients, and practice assignments that provided them with access to seasoned practitioner-assisted decision-making and clinical judgment (Pugh, Twigg, Martin and Rai, 2013). What was found most disturbing was a report by Barry, Hauck, O'Donoghue and Clarke (2013) which stated that graduates expressed concern about being placed in clinical situations beyond their cognitive or experiential comfort level. According to the findings of Pugh et al. (2013), graduates reported that they were slower than their colleagues in making decisions and completing their daily routines. That was because they spent much time 'thinking back' through what was for them relatively linear and prescriptive theory and instruction from previous undergraduate or current institutional educators.

2.2.1.2 Incongruence Between Theory and Clinical Practice

Delaney (2013) revealed that new graduate midwives identified a gap between what they had learned at university and what they witnessed in practice; this gap resulted in some experiencing a sense of dissonance as the values they had developed throughout their education were not supported in practice. The impact of this perceived dissonance between theory and practice on the new graduates cannot be underestimated as it may lead them to doubt and question their training and desire to remain in their chosen profession (Doody et al., 2012). Jordan, Fenwick, Slavin,

Sidebotham and Gamble (2013) used a questionnaire to survey a total of 245 newly graduated nurse-midwives in the USA, to question if a theory-practice gap existed. The authors reported that 50% of the midwives reported differences between actual and exemplary practice. The researchers further noted how confronting it could be for newly qualified midwives when they are exposed to midwifery practice outside the theoretical environment that is at odds with their own philosophy and/or beliefs.

For this reason, the authors suggested that educators and preceptors need to be cognisant of the discrepancy when planning clinical placements (Jordan et al., 2013). Panzavecchia and Pearce (2014) supported Jordan et al. (2013) when they reported that newly graduated midwives felt unprepared for dealing with emergency situations, they expressed their ability to manage emergencies from the theoretical perspective rather than dealing with a practical situation.

The need for the new graduate to navigate the theory-practice gap is also alluded to by Duchscher (2009), who studied the transition process for nurses over a ten-year period in Canada. In her latest work she confirmed the new graduate's experience of "role performance stress, moral distress, discouragement and disillusionment" during the transition period. Whilst appropriate support can assist the new graduate to some extent, Duchscher (2009) argues that this is an inevitable part of transitioning from student to practitioner, and as such senior students should be prepared within their training for this experience.

In a study conducted by Fenwick et al. (2012), participants described feeling frustrated, angry and emotionally distressed when they were unable to adapt to their new role due to apparent conflicting ideologies with which they came into contact when caring for women. This difficulty is illustrated by the discrepancy between what has been taught in the classroom and how care is given in practice. This was

supported by McCusker (2013), who reported that the dissonance between woman-centred care and the management of care provided in the hospital setting confuses the newly qualified midwives and diminishes the midwifery role. Fenwick et al. (2012) further went on reporting that newly qualified midwives in the study they conducted also found it difficult to comprehend why they were educated to question and use their initiative and yet in practice were required to obey orders and conform. As a result, newly qualified midwives did not feel adequately prepared for their roles in practice.

2.2.1.3 The Context of Hospital Maternity Care

In a study conducted by Bernitz et al. (2014), participants described the hospital maternity as a hectic, chaotic and incredibly busy environment where their workloads were diabolical and unmanageable. Poor staffing problems, high patient loads and shortage of beds exacerbated the situation. The authors further reported that participants described the labour ward as a high-risk environment where normal birth was a rare event and getting a baby into the world alive was what everyone worried about (Bernitz et al., 2014). In a study conducted by McCarthy et al. (2013), participants described the hospital maternity environment as highly structured where rules, routines and the completion of numerous tasks were a priority and the predominant focus.

The authors revealed that participants reported struggles they encountered when they perceived women to be treated as ‘commodities’ and ‘just another part of the routine’ whereas throughout their training they have been educated to put the woman at the centre of care. This, according to participants, was considered as the result of a system that prioritised the ‘management of complaints’ rather than care of a woman and her family. Rush et al. (2014) concurred with McCarthy et al. (2013) when they reported that midwifery within some hospital environments was considered to be

hierarchical in nature and one where there was an obvious 'pecking order'. These findings also resonate strongly with an Australian study that explored "the experience of gaining clinical competence" of eight midwifery graduates, who identified how some maternity institutions' hierarchical structure contributed to their disempowerment (McCusker, 2013). The authors further reported that communication patterns, support as well as orientation processes were described as 'poor'; as the new graduates had little information shared with them on a range of issues from general hospital systems to clinical care processes (including how to function in a busy environment).

The reality of busy clinical areas left participants feeling frustrated, dissatisfied and guilty as they felt they were unable to provide quality woman-centred care (Tingstig, Gottvall, Grunewald and Waldenström, 2012). McCusker (2013) concurred with Tingstig et al. (2012), when they reported that a hostile learning environment 'eroded' and 'undermined' graduates' confidence, exponentially increased their fear of 'doing something wrong' and intensified their anxiety. Such feelings were accompanied by acute physical reactions such as palpitations and stomach pains. This left some participants emotionally distressed, exhausted and struggling to cope.

Lack of structure heightened newly qualified midwives' sense of anxiety, loss of control over their working life and inability to mentally prepare themselves for provision of quality patients' care. This was revealed when newly qualified midwives reported being positive and happy about rotation plans which were clearly reflected at the beginning of the year, unfortunately, plans were frequently interrupted or changed as a result of busy clinical environments and variable staff skill mix leading to frustration (Snow, 2013). Feltham (2014) signaled a similar explanation by reporting that newly qualified midwives were often used to cover shortfalls or gaps in the roster; which results in increased stress levels due to unpredictability of the situation as well as limited time to prepare for the change.

Newly graduated midwives expressed feelings of stress and being overworked due to busy and extremely chaotic maternity environments (Sullivan et al., 2011). These observations were confirmed by a number of the experienced midwives in their telephone interviews, who also alluded to clinical environments that were busy and under pressure and therefore not always suited to provide the level of support and guidance required by the newly graduated midwives. (Rush et al., 2014).

2.2.1.4 Negative Attitudes of Experienced Midwives

In a study conducted by Seibold, Licqurish, Rolls and Hopkins (2010), participants reported descriptions of negative behaviours exhibited by experienced midwives that left graduates struggling to work, learn and cope within the maternity environment. The authors further revealed participants' descriptions of the communication patterns that engendered feelings of guilt, blame and exclusion. Frequently, the context of these behaviours was during a clinical task or skill and sometimes in front of the women which added to the participants' distress (Seibold et al., 2010; Sullivan et al., 2011).

Sullivan et al. (2011) further reported that participants described having received 'mixed messages' and of being 'chastised' for how they performed. For example, one participant said, 'somebody pointed their finger in my face and told me not to do something, even though I'd been taught the day before to do it that way'. A more subtle example was elicited from another participant when she said 'I just wanted to use hot packs and good positioning... then right at the end the midwife said ''well if she has a third degree perineal tear, hope you're happy to have that on you' (Sullivan et al., 2011). According to some participants' reports revealed by Sullivan et al. (2011), some midwives displayed such attitude like, as they (new graduates) were now midwives they had to 'toughen up' and 'get on with it'.

As a result, participants shared their sense of purposefully being given 'horrendous' cases, that is, working with challenging patients and situations (Seibold et al., 2010; Sullivan et al., 2011). In their study on "the experiences of newly qualified midwives in England, Hughes and Fraser (2011) reported that newly qualified midwives experienced a sense of isolation and exclusion and worried about being labelled as 'troublemakers' if they spoke out.

This heightened their nervousness and anxiety. Perceptions of being 'blamed' and feeling 'guilty' over poor clinical outcomes were associated with an increasing sense of 'incompetence' and an inability to fulfil their dream of being midwives (Hughes and Fraser, 2011). The supervisory relationship is a professional relationship which if the knowledge and skills of the supervisor dominate; human relationships, emotions, and biographical experiences of the supervisee can be inhibited from being taken into account (Cho, Lee, Mark and Yun, 2012).

2.2.1.5 A Workplace Learning Environment

The clinical environment is an important factor that has the potential to influence a graduate's transition to practice. During the transition period, new graduates expect support and supervision from experienced midwives as they are exposed to clinical areas in order to develop skills and confidence (Tingstig et al., 2012). This is supported by McCarthy et al. (2013) who reported how the participants stressed how crucial it is for the beginning practitioner to work alongside experienced staff where they are able to watch, listen, learn and practice in an effort to make the most of the learning opportunities available. This is consistent with Dixon, Tumilty, Kensington, Campbell, Lennox, Calvert, and Pairman (2014), who revealed that newly graduated midwives expect to be supervised and supported by the experienced practitioner as they believe that their findings are not different from those of student midwives.

Tingstig et al. (2012) further revealed that one of the perceived expectations newly graduated midwives have is that they will be guided and mentored as they make decisions about patients in their care. Newly graduated midwives felt like ‘‘gap-fillers’’, when they were just tossed from one shift to another as a result of busy clinical environments as well as shortage of staff, and that made them to struggle to meet their learning needs (Schytt and Waldenström, 2013). Feltham (2014) supported Schytt and Waldenström (2013) when he reported that due to pressures of a busy ward environment, newly qualified midwives reported that they were treated as independent practitioners, nobody bothered to guide them and that negatively affected their performance.

Lack of structure heightened newly qualified midwives’ sense of anxiety, loss of control over their working life and inability to mentally prepare themselves for provision of quality patients’ care. This was revealed when newly qualified midwives reported being positive and happy about rotation plans which were clearly reflected at the beginning of the year, unfortunately the, plans were frequently interrupted or changed as a result of busy clinical environments and variable staff skill mix. As a result, midwives felt like ‘‘gap-fillers’’, and struggled to meet their learning needs (Morgan et al., 2012).

Hughes and Fraser (2011) conducted a study in South of England; while Schytt and Waldenström (2013) performed focus group interviews with nine newly graduated nurses in London. Both groups of midwives affirmed their expectations of being respected members of a team and how they valued feedback from their colleagues with regard to their actions and progress (Hughes and Fraser, 2011; Schytt and Waldenström, 2013). This is supported by Rush et al. (2014), who reported that the skills and knowledge required by the beginning practitioner need to be learned via interaction with, and absorption into, the professional culture along with an

understanding and appreciation of the rules that are used within it. Jordan et al. (2013) concurred with Malouf and West (2011), when they stated that a newly qualified midwife needs to become exposed to the embodied and hidden knowledge, through effective modelling by experienced midwives. Rawson (2010) argued that newly qualified midwives are often a valued source of evidence-based knowledge as they come fresh with enthusiasm and ideas to the midwifery environment. James (2013) pointed to a similar scenario when he stated that completion of midwifery training heralds the start of profession-long learning and developing, adapting knowledge and developing expertise.

Rawson (2010) further stated that experienced midwives are the ones who are responsible for assisting newly qualified midwives to maintain and develop their competence as well as acquiring new skills as they develop professionally. Failure to development newly qualified midwives, increases risks of clinical incidents and adverse outcomes Rawson (2010).

According to a study conducted by Dixon, Calvert, Tumilty, Kensington, Gray, Campbell and Pairman (2015), newly qualified midwives valued the opportunity to rotate to all clinical areas; as rotation allowed them to build-up professional networks whilst developing skills and experience across all aspects of midwifery care. Kensington; Campbell; Gray; Dixon;Tumilty; Pairman; Calvert and Lennox (2016) concurred by stating that clinical rotations are designed to offer new graduates an opportunity to consolidate their practice as well as acquire and develop skills across the full scope of midwifery practice.

Dixon et al. (2015) further stated that graduates preferred to know the rotation plan in advance in order to adapt, pre-empt and prepare for the next challenge. Pre-planned rotations provided a sense of familiarity and left the newly graduated midwife feeling

in ‘‘control’’ of her own professional development, therefore positively affecting the new graduate’s level of confidence (Dixon et al., 2015). Kensington et al. (2016) supported the previous researchers when he reported that new graduates should have access to the well-planned and organized clinical rotations to develop the confidence and competence; which will enable them to make positive contributions to the workload.

2.2.2 Expectations of Experienced Midwives from Newly Graduated Midwives

Experienced midwives’ expectations from the new graduates may have a significant impact on the opportunities and experiences available to them during their transition to practice; and may therefore affect their performance (Jordan et al., 2013). In a study conducted in Australia, Yanhua and Watson (2011) revealed that experienced midwives in the clinical setting judged all newly graduated midwives as being competent to provide ‘normal’ midwifery care in all areas regardless of qualification. In terms of the graduates’ ability to manage complications, experienced midwives identified that these would develop over time. As a result, newly graduated midwives were expected to have better time management skills and be more comfortable in the ward environment (Yanhua and Watson, 2011).

Coulm et al. (2012) reported that it has been acknowledged that the Bachelor-prepared midwives are adequately equipped for midwifery practice, and that differences are not apparent between them and their postgraduate peers who are also registered nurses. As a result, researchers feel that these new graduates need no transition support as they are well prepared and, besides, more midwives have graduated via this undergraduate route (Coulm et al., 2012). In contrast, New Zealand authors Schytt and Waldenström (2013), asserted that it is unacceptable to expect undergraduate prepared midwives to have all the necessary skills on qualification

because they do not have the additional nursing experience or knowledge. In their opinion piece they state that structured transition programmes need to be on offer in order to support them safely and effectively into practice (Yanhua and Watson, 2011). According to Mollart, Skinner, Newing and Foureur (2011), the experienced midwives in the clinical setting judged all newly graduated midwives as being competent to provide 'normal' midwifery care in all areas regardless of qualification and experience.

Snow (2013) concurred with Mollart et al. (2011) when he reported that, in a study conducted in England, midwifery graduates were placed as the most experienced midwives on the shift and were expected to take a full clinical load." This led to increased anxiety due to fear of making mistakes, lack of knowledge and experience, lack of organizational skills together with the accountability associated with the new role (Rush et al., 2014).

2.2.2.1 Autonomy in Clinical Practice

The experienced midwives in the clinical setting judged all newly graduated midwives as being competent to provide 'normal' midwifery care in all areas regardless of qualification. In terms of the graduates' extended skill base and the ability to manage complications, experienced midwives identified that these would develop over time (Carter et al., 2013). Feltham (2014) revealed that senior midwives reported discouragement over graduates' inability to function as professionals.

Furthermore, participants stated that they would prefer working on their own because graduates become a burden, especially those who need assistance even in simple procedures. Mason and Davies' (2013) study found that experienced midwives had very high expectations of newly qualified midwives once they were in practice, along with an assumption that qualified meant "all knowledgeable". Dixon et al. (2014) concurred when he highlighted how practising midwives' expectations of newly

qualified midwives were unrealistic; suggesting that pressures of the ward environment, being able to adapt and integrate quickly, and the added responsibility of accountability were particularly overwhelming. This is confirmed by Feltham (2014), who reported that newly graduated midwives do not feel safe to remain with the ward alone. They need time to familiarize themselves with the new work situation and to develop the competence necessary to assume full responsibility (Feltham, 2014).

Avis et al. (2012) revealed that on qualification, participants realized that the protection and support offered by their preceptors during their training was abruptly withdrawn, and such withdrawal made them feel like they are abandoned resulting in clinging to the experienced midwives for support. This was supported by Jordan et al. (2013), who reported the assimilation anxiety experienced by newly graduated midwives as they are suddenly expected to assume responsibility for their own patients, together with a loss of sheltered academia which made them feel vulnerable.

2.2.2.2 Inability to Relieve Midwifery Professionals

In their study of newly graduated midwives in New Zealand, McCarthy et al. (2013) revealed that graduates struggled to fit in as they lacked confidence and were incompetent to positively contribute to the workload. As a result, the experienced midwives struggled with the workload (McCarthy et al., 2013). Green (2014), supported McCarthy et al. (2013) when reporting that experienced midwives expected newly graduated midwives to play a major role in as far as reduction of workload was concerned. Unfortunately, they did not.

According to Handley and Dodge (2013), working with the graduates was reported to be too demanding as the midwives end up having double the workload; they are expected to provide midwifery services to patients, yet they should at the same time cater for the needs of the graduates. Magnusson, Westwood, Ball, Curtis, Evans,

Horton, Johnson and Allan (2014), concurred when reporting that midwives were excited thinking that the presence of graduates will have a positive impact on addressing the issue of shortage of staff; instead the opposite proved to be the case. Midwives raised a concern that they had to attend to both the patients and the graduates as they needed to be supervised closely.

New Zealand authors Panzavecchia and Pearce (2014) asserted that it is unacceptable to expect undergraduate prepared midwives to have all the necessary skills on qualification because they do not have the additional nursing experience or knowledge. In their opinion piece they state that structured transition programs need to be on offer in order to support them safely and effectively into practice (Panzavecchia and Pearce, 2014).

2.2.3 Support Provided by Experienced Midwives

2.2.3.1 Clinical Support Through Mentorship

Following a review of a mentoring programme they were involved in, Sullivan et al. (2011) recommended that one strategy to assist newly qualified practitioners to prepare for the complex health care context is through mentoring partnerships. Seminal work by Fenwick et al. (2012) presented the process of mentoring whereby individuals are guided, taught and influenced in their work.

According to a study conducted by Van der Putten (2008) on “the lived experiences of newly qualified midwives”, participants identified the importance of good clinical support for newly qualified midwives; the need for a formal mentorship programme was acknowledged as being extremely important. Participants also felt that allocation of a named mentor or preceptor was very important. Procter, Beutel, Deuter, Curren, de Crespigny and Simon (2011) supported Van der Putten (2008) when they

recommended that nursing must strengthen the support connections for the newly qualified at all levels and develop an everyday mind set of the mentoring culture. In a study conducted by Haggerty, Holloway and Wilson (2012), newly qualified midwives expected the professional midwives to offer some level of support. The findings of the study revealed that at the end of their transition support programs midwives articulated their concept of support as one where they worked within a 'supportive clinical environment'; which included being provided with guidance, time, advice and understanding from colleagues who were willing to help (Haggerty et al., 2012).

Feltham (2014) reported that newly qualified midwives felt mentorship was important in aiding clinical skills enhancement as they would be able to develop their skills with support and guidance from an experienced midwife rather than being dumped in the clinical practice area. This is supported by Willis (2015) who found that newly qualified midwives expressed concerns at lack of practice skills and feelings of 'not knowing enough' which affected their confidence. This highlights the need for a robust mentorship programme to be available for all newly qualified midwives as well as the need for further work to be undertaken to ensure that perceived gaps in knowledge have been addressed prior to registration (Willis, 2015).

Avis et al. (2013) suggested that due to the increasing complexities of midwifery practice, further skills need to be acquired and consolidated post-qualification. The authors suggest that newly qualified midwives should be given support following registration, and the support should be in the form of programmed mentorship which should be implemented for at least one year. Rush et al. (2014) supported the idea, suggesting that a mandatory mentorship year be implemented for all newly qualified nurses in the UK. Hobbs (2012) highlighted the positive effects mentorship has on newly qualified midwives. In response to this, Hobbs (2012) developed a 12-month mentorship package using a model that promotes 'motivation', 'facilitation' and

'support' using 'conscious reflection upon experience' with the aid of learning outcomes specific to the individuals and that of the organization. It is evident from this work that mentorship is a valuable tool in consolidating practice on qualifying as well as bridging the link between workplace and education, working collaboratively in order to improve midwifery education and continuing professional development. According to Snow (2013), clinical support of newly graduated midwives result in successful role transition, this does not only improve the experience for newly graduated midwives, but also improve patient safety and outcomes.

Lewis and McGowan (2015) defined mentorship as a one-to-one relationship between a more experienced staff member and a less experienced junior member focussing on support, development of job related skills and career advancement within a hierarchical organization. The primary aim of mentoring in midwifery has been described as being concerned with confidence building, teaching, role modelling and socialisation of the new graduates (Lewis and McGowan, 2015).

Haggerty et al. (2012) described mentoring as characterised by the mentee taking an active role in the relationship rather than the mentor so that "empowerment and personal accountability" are enhanced. Lewis and McGowan (2015), concurred with Haggerty et al. (2012) when reporting that the purpose of the mentoring relationship is to enhance the mentee's development by inspiring the mentee to a greater understanding of the role.

Lewis and McGowan (2015) further indicated that the learning process is shared, in the sense that the mentee is learning about a role or increasing expertise whereas the mentor is learning about the process of stimulating developmental changes. A degree of self-motivation by the mentee is integral to the success of the mentoring partnership of which the greatest advantage is to enhance the transition process (Hughes and

Fraser, 2011). Yanhua and Watson (2011) concurred that the mentor-mentee relationship should occur with a new graduate being paired with a more experienced nurse practitioner. Malouf and West (2011) reported that newly qualified midwives who received clinical support during their time of exposure, experienced the full range of midwifery skills resulting in a boost in their confidence.

These findings are consistent with those of Sullivan et al. (2011), who reported that good clinical support must be accompanied by effective communication and personal commitment between the mentor and the mentee. This makes the partnership to be successful. Rush et al. (2014) expressed a similar understanding when they reported that support and mentorship offered to newly graduated midwives during their transition period influenced their professional development, leading to the development of professional identity as well as increased reflection on practice.

In a study conducted by Panzavecchia and Pearce (2014), newly qualified midwives applauded the fact that they were considered to be 'supernumerary' (extra to the normal staffing level), whereby they worked alongside an experienced midwife or clinical educator, as a component of transition support programs. Supernumerary time provided an opportunity for the newly qualified midwives to be supported into the clinical area rather than being throwed in the clinical area. This is because it presented midwives with space and time to ask questions, become orientated and adjust to their new role without the pressure of taking on a full clinical load (Panzavecchia and Pearce, 2014).

2.2.3.2 Positive and Supportive Midwife to Midwife Relationship

Mason and Davies (2013) described positive professional relationships as the source for confidence and competence building, as well as enhancement of one's ability to maintain focus in the process of normal birth. Whilst positive relationships are, and

should be, found in all work environments the findings of the study by Lewis and McGowan (2015), demonstrated that models of midwifery continuity of care, such as group practice (or caseload midwifery), provide an enhanced opportunity for relationships to be established, not only with women but also with midwifery partners. The supportive nature of these three-way relationships appeared to play a critical role in assisting the newly qualified midwife to feel safe when taking up her new role (Lewis and McGowan, 2015).

In a study conducted by Kensington et al. (2016), newly graduated midwives considered positive relationship with their experienced peers as very important and significant to their development, as it provided them with the opportunity for supervision, guidance, support and orientation. Not only do positive relationships benefit newly graduated midwives but the entire maternity unit including even patients (Kensington et al., 2016). Tastan, Unver and Hatipoglu (2013) reported that in a study they conducted, newly qualified midwives expressed their desire to access supportive supervisors who are approachable, trustworthy and have clinical credibility, rather than negative experiences that deeply affect their long term expectations.

A study conducted by Fenwick et al. (2012) in one of the Australian maternity units revealed that the midwifery culture of some institutions remains highly contested with newly qualified midwives struggling to provide woman-centred care and often challenged by the risk-averse nature of maternity care; therefore, positive midwife-to midwife relationships during transition from student to registered midwife is important. Fenwick et al. (2012) further reported on the study they conducted whereby the newly qualified midwives confessed to have been working in a very supportive environment with a positive culture, in which they were provided with guidance, time, advice, and understanding from colleagues that were willing to help.

Tastan et al. (2013) articulated a similar opinion when they reported that positive reciprocal relationship between experienced midwives and newly graduated midwives promotes interaction and an exchange of ideas based on trust and respect. The authors further reported that the newly graduated midwives felt reassured when they knew 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 (Tastan et al., 2013).

Fenwick et al. (2012) concurred with Sullivan et.al (2011) when they reported that newly graduated midwives, practising within the context of positive relationships with experienced midwives, spoke of being able to openly question practice and extend themselves in an environment where someone would always be available to support them. One participant reported: 'It makes a big difference to your learning if they're supportive, you feel confident in pushing yourself if you know that someone is there who will catch you if you fall'. The authors further reported that participants described how positive interactions reflected a sense of fairness and quickly worked to increase their confidence and feeling of competence (Fenwick et al., 2012).

In a study conducted by Cho et al. (2012), it was evidenced that positive midwife-to-midwife interactions within supportive working environments helped to restore participants' sense of confidence in her ability and capacity to manage childbirth and the related procedures. In their study, Sullivan et al. (2011) reported about experienced midwives who had positive attitude to both the new graduates as well as to the patients. Midwives who were inclusive and willingly shared their knowledge, skills and expertise were highly valued (Sullivan et al., 2011). Fenwick et al. (2012) concurred with Sullivan et.al. (2011), when they revealed that the ability of experienced midwives to demonstrate true regard for the newly qualified midwife's learning experience and their emotional well-being was central to their participants'

feelings of personal and professional development. When participants had some sense of continuity of relationships with other midwives as well as with women, feelings of safety and engagement were engendered; and would always ask for a review from the experienced midwives when they were not sure about something (Cho et al., 2012).

Whilst many newly qualified midwives reported positive experiences, the findings also indicate that, at times, newly qualified midwives refrained from seeking advice or guidance from the experienced staff (Hillman and Foster, 2011). This aligns with Reynolds et al. (2014)'s report, that contends that 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.

Malouf and West (2011) 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 (Malouf and West, 2011). Newly graduated midwives described some of the professional midwives as being very unhelpful; as they made midwives to feel like they were under continuous surveillance from experienced professional midwives (Reynolds et al., 2014).

The kind of relationship that existed between experienced midwives and newly graduated midwives, determined the graduates' decisions as to who to approach for assistance. In a study conducted by Hillman and Foster (2011), newly graduated midwives reported intimidation by senior midwives, which they associated with fear of challenges that may result from working with graduates regarding correlation of theory

with practice. Lewis and McGowan (2015) concurred with Hillman and Foster (2011), by reporting that experienced midwives feel threatened to work with new graduates and as a result they become unfriendly towards them. In their study, Panzavecchia and Pearce (2014) reported that experienced midwives found it very hard to work with newly graduated midwives claiming that they are slow therefore make it difficult for them to manage busy delivery suites; resulting in unfriendliness and rudeness. Establishment of a firm foundation of good and positive supervisory relationship and support system will enable newly qualified midwives to confidently embrace the challenges and never ending learning opportunities that the real world of midwifery practice presents (Fenwick et al., 2012).

This is supported by Reynolds et al. (2014), who reported that effective supportive supervision enhances professional confidence to newly graduated midwives. Lewis and McGowan (2015) reflected a similar version when they revealed that a proactive, supportive supervisor who has sound leadership, clinical expertise and facilitative skills can raise standards of practice, develop confident, capable practitioners and demonstrate the value of midwifery supervision as a statutory function.

According to Lewis and McGowan (2015), newly qualified midwives need a longer term, professional and supportive relationship than preceptorship alone can offer. Investing time in newly qualified staff helps them to work confidently, safely and competently in a dynamic profession. Midwifery supervision provides a statutory framework where profession long support and development can be given (Lewis and McGowan, 2015).

2.3 Summary

Chapter 2 focused on the discussion on literature review. Discussion was based on the experiences of newly graduated midwives regarding their transition, expectations

of experienced midwives from the newly graduated midwives and support provided by experienced midwives towards newly graduated midwives. In Chapter 3, research methodology used for the purpose of this study is described.

CHAPTER 3

Research Methodology

3.1 Introduction

The previous chapter discussed literature on which the study is based. This chapter focuses on research methodology applied for phase 1 of the study which is guided by the following objectives: exploration and description of the experiences of newly graduated midwives regarding provision of midwifery services during their transition period; description of the experienced midwives' expectations from newly graduated midwives during their first year of clinical practice and exploration of the support provided by experienced midwives to newly graduated midwives during their first year of clinical practice.

3.2 Research Setting

Research setting refers to the physical location and conditions in which data collection takes place in a study (Polit and Beck, 2012). The study was conducted in maternity units of selected hospitals in Limpopo Province, SA. Limpopo Province is situated at the northeastern corner of South Africa and shares borders with Botswana, Zimbabwe and Mozambique. The province is considered poor with an estimated population of 5,693,564 (Ndaba, 2013). About 87% of the population reside in rural areas. Over 97% of the population is classified as black Africans, while Whites constitute 2%, Coloureds 0.4% and Indians 0.5%, respectively (Roziers et al. 2014). The province is divided into five districts, namely: Vhembe, Mopani, Capricorn, Waterberg and Greater Sekhukhune; of which Mopani, Vhembe, and Greater Sekhukhune are the most rural.

Figure 3.1 presents a map of Limpopo Province with its districts and selected hospitals.

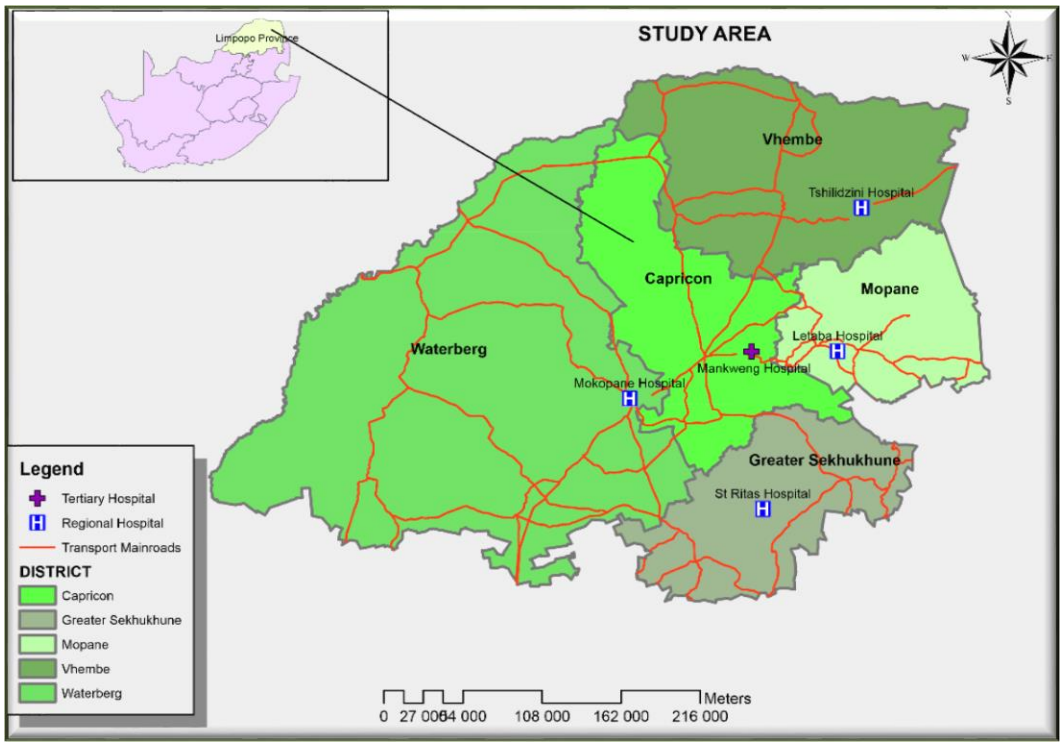


Figure 3.1: Districts of Limpopo Province with selected hospitals

There are 44 hospitals that are spread among the five (5) districts of Limpopo Province. The hospitals are classified as tertiary, regional, specialized and district. One regional hospital was selected from each district, except for Capricorn district that does not have an approved regional hospital. In that case, one tertiary hospital was selected.

This was done in order to gain a demographic mix, which was also accessible, while ensuring a broader study area. Educational institutions that produce newly graduated midwives under study in Limpopo Province are the University of Venda, University of Limpopo as well as Limpopo College of Nursing.

3.3 Research Design

Research design refers to a plan or blueprint of how one intends to conduct research (Polit and Beck, 2012). A qualitative research approach was used to address Objectives 1, 2, and 3. Objective 4 was addressed through a concept analysis as well as ADDIE's model for training and instructional design based on the stages of Duchscher's transition theory; whereas objective 5 was addressed by a quantitative research approach based on a framework for programme evaluation in public health by Centers for Disease Control and Prevention (CDC). A summary of how the study was approached is outlined in Table 3.1.

Table 3.1: Summary of the research approach

	Objective	Research Design	Population	Sampling Approach	Data Collection	Data Analysis
PHASE 1 EMPIRICAL PHASE	**1**	Qualitative	Newly graduated midwives	Non-probability purposive	In-depth individual face-to-face interviews	Open-coding method
	2					
	3		Experienced midwives			
PHASE 2 PROGRAMME DEVELOPMENT AND ITS VALIDATION	**4**	Concept analysis by Walker and Avant and Programme development based on ADDIE's model and Duchscher's transition theory	Data from experienced midwives as well as newly graduated midwives		Literature review and literature control	
	5	Quantitative research conceptualizing CDC programme evaluation approach	Newly graduated midwives, and Experienced midwives	Purposive	Questionnaire	Descriptive statistics

3.4 Phase 1: Empirical Phase

3.4.1 Qualitative Approach

Qualitative research is a systematic, interactive and subjective approach used to investigate, explore, describe and understand life experiences, and give meaning to them in an in-depth and holistic fashion, through the collection of rich narrative materials (Creswell, 2009). According to Holloway and Wheeler (2010), in qualitative research, data have a primary status from which a theoretical framework is derived and is not pre-determined. Qualitative research is context bound and calls for researchers to be context-sensitive and immersed in the participants' natural setting in order to explore a less known phenomenon through observation, questioning and listening in order to obtain rich data.

The focus in qualitative research is on the views of people involved in the study and their perceptions, meanings and interpretation. For the purpose of this study, the researcher used exploratory as well as descriptive designs, and data were collected through in-depth, face-to-face individual interviews at regional hospitals and a tertiary hospital in Limpopo Province. The researcher analyzed and interpreted data beyond the participants' construction to obtain new insights concerning the phenomenon under study (Holloway and Wheeler, 2010; Mouton, 2010). The use of the selected approach was informed by objectives 1, 2 and 3 of the study as indicated in Table 3.2.

Table 3.2: Objectives to inform qualitative approach

Objective	Description
1	Explore and describe the experiences of newly graduated midwives regarding provision of midwifery services during their transition period
2	Describe the expectations of experienced midwives from newly graduated midwives during their first year of clinical practice
3	Explore the support provided by experienced midwives to newly graduated midwives during their first year of clinical practice

3.4.1.1 Exploratory Design

Exploratory design refers to an investigation of the phenomenon, its manifestations and factors related to it (Polit and Beck, 2012). It is a valuable approach to study an unknown or less known phenomenon, and it has the potential to produce new insights into a phenomenon (Babbie, 2016; De Vos, Strydom, Fouché and Delport, 2013). Burns and Grove (2009) highlighted that the purpose of an exploratory research design is to increase the knowledge of the field of study rather than to generalize the findings to the entire population. In this study, the researcher explored the newly graduated midwives' experiences regarding provision of midwifery services during their transition period. Support provided by experienced midwives to the newly graduated midwives during their first year of clinical practice in Limpopo Province was also explored.

3.4.1.2 Descriptive Design

Descriptive design refers to an accurate portrayal of the characteristics of persons, situations and phenomena as they naturally happen (Burns and Grove, 2009). Of critical importance, a descriptive research design also generates new knowledge about a phenomenon where there is limited or no research conducted in that regard (Burns and Grove, 2009). In this study, the researcher described the newly graduated midwives' experiences regarding provision of midwifery services during their transition period. Experienced midwives' expectations from newly graduated midwives during their first year of clinical practice in Limpopo Province, were also described.

3.5 Population

Population refers to the entire aggregation of individuals having some common characteristic that the researcher is interested in studying (Polit and Beck, 2012). In this study, the population was composed of two groups:

❖ **The First Group**

Comprised of all newly graduated midwives who have undergone a comprehensive nursing programme (R425 of 19 February 1985, as amended) and qualified as nurses (General, Psychiatric and Community) and Midwifery, from the universities and nursing colleges, and were working at the selected hospitals in Vhembe, Mopani, Capricorn, Waterberg and Greater Sekhukhune districts of Limpopo Province, South Africa.

❖ **The Second Group**

Comprised of all the professional nurses working at the selected hospitals in Vhembe, Mopani, Capricorn, Waterberg and Greater Sekhukhune districts of Limpopo Province, South Africa.

3.6 Sampling

Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit and Beck, 2012). Sampling of the hospitals as well as the participants was done.

3.6.1 Sampling of Hospitals

Purposive sampling, which is a subtype of non-probability sampling, was used in sampling of hospitals. Purposive sampling means that the researcher selects information-rich cases or those cases that can inform the researcher a great deal about the purpose of the study (Burns and Grove, 2009). In Limpopo Province, fifteen (15) hospitals are used as clinical training facilities for a comprehensive programme (R425 of 19 February 1985, as amended). Out of these fifteen (15) hospitals, eleven (11) are utilized as midwifery and general nursing clinical facilities, one (1) for general nursing without midwifery and three (3) are specialized institutions. Out of eleven

hospitals, a regional hospital from each district was purposively selected for the study; for Capricorn district, one tertiary hospital was randomnly selected as there is no regional hospital. The hospitals were selected by virtue of being referral hospitals, whereby many patients were admitted, high care services provided and a high number of newly graduated midwives placed for community service. Therefore, the hospitals that were selected were St Rita's Regional Hospital, Tshilidzini Regional Hospital, Letaba Regional Hospital, Mokopane Regional Hospital as well as Mankweng Tertiary Hospital, as displayed in Table 3.3.

Table 3.3: SANC approved hospitals as maternity clinical facilities

District	Hospital
Capricorn	Polokwane Tertiary Hospital
	Mankweng Tertiary Hospital
	Seshego District Hospital
Waterberg	**Mokopane Regional Hospital**
Greater Sekhukhune	**St Rita's Regional Hospital**
Vhembe	**Tshilidzini Regional Hospital**
	Donald Fraser District Hospital
	Siloam District Hospital
	Elim District Hospital
Mopani	**Letaba Regional Hospital**
	Nkhensani District Hospital

3.6.2 Sampling of Participants

Based on Polit and Beck (2012), the researcher selected information-rich cases or those cases that were informative about the purpose of the study. A non-probability, purposive sampling method was used for sampling of the newly graduated midwives as well as experienced midwives. Both groups were knowledgeable regarding the phenomenon under study.

3.6.3 Inclusion Criteria

According to Burns and Grove (2009) as well as Polit and Beck (2012), inclusion criteria are those characteristics that a subject or element must possess to be part of the target population—such criteria specify a population. In this study, newly graduated midwives who have undergone the R425 comprehensive nursing programme, from the universities and nursing college, as well as experienced midwives were selected as participants. Inclusion criteria were:

- Newly graduated midwives who have been working for a period less or equals to one year following their successful completion of training, and were working in maternity units of the selected hospitals.

- Professional nurses, qualified as midwives and have been working in maternity units of the selected hospitals for at least five years.

3.6.4 Sample

Sample refers to a subset of a population, selected by the researcher to participate in a research study (Polit and Beck, 2012). The sample of this study comprised of five (5) newly graduated midwives and five (5) experienced midwives from a maternity unit of each selected hospital, and who met the criteria for the study. Therefore, the sample size was fifty (50) of which twenty five (25) were newly graduated midwives and another twenty five (25) consisted of experienced midwives. Of the twenty five (25) experienced midwives, eleven (11) were operational managers.

3.7 Data Collection

An appointment was secured with participants and data collected at the selected hospitals during the convenient times of the participants, when the participants were not busy with provision of care. Data were collected from participants through in-depth

individual face-to-face interviews. The researcher engaged with the participants individually by posing questions in a neutral manner, listening attentively to their responses, and asking follow-up questions and probes based on those responses. Three phases were followed during data collection, namely, preparatory, interview and post-interview.

3.7.1 The Preparatory Phase

The preparatory phase refers to the planning for data collection, the conversation between the researcher and a participant before the actual phase of the interview is conducted (De Vos et al., 2013). Participants were recruited based on research objectives. After receiving approval for conduction of the study from the UVHDC and UVREC (Annexures A and B), permission to access facilities was sought from the DoH and relevant authorities (Annexures C, D, E, F, G, H and I). Appointments were secured with the participants.

3.7.2 The Interview Phase

The interview phase refers to the beginning of a conversation between the researcher and a participant with the specific objective of gathering information about a topic that is being researched (De Vos et al., 2013). Interviews were conducted in a side room at the selected hospitals, when the participants were not busy with provision of care. The researcher created an environment favourable for conversation by warmly welcoming and thanking the participant for his/her willingness to participate and implying that s/he was an expert in the topic of interest. English was used as a medium of instruction, as the participants were literate and have undergone their professional training in English. The researcher explained the purpose of the interview to the participant; and ensured that ethical measures such as informed consent, guarantee of beneficence and the participant's right to withdraw from research were applied.

Permission to use a voice recorder and to record field notes were sought from all participants and the interview sessions lasted on average for about an hour.

The following questions were posed to newly graduated midwives:

What are your experiences regarding provision of midwifery services during your transition period?

What support do experienced midwives offer to you as newly graduated midwives during your first year of clinical practice?

The following questions were posed to experienced midwives:

What support do you offer to the newly graduated midwives during their first year of clinical practice?

What are your expectations from newly graduated midwives during their first year of clinical practice?

The questions for both groups were followed by probing as a communication skill which ensured that more appropriate data were provided by the participants, as postulated by Polit and Beck (2012). Examples of probes were:

Do I understand you when you say….?

Could you explain further?

What do you mean by …?

The researcher showed the participant a pause button s/he could press if there was some sensitive information which should not be recorded. Field notes were taken by the researcher to serve as a backup—these were captured nonverbal information as well as confidential information when the participant has switched the voice recorder

off. Data were collected until theoretical saturation of each new category was reached (Burns and Grove, 2009).

3.7.3 The Post-Interview Phase

The post-interview phase refers to the time after the actual interview between the researcher and the participants (Rossouw, 2003). When the interviews were over, the researcher listened to the recorded information checking for audibility and completeness.

All the recorded interviews were audible and complete. If there were interviews which were inaudible or incomplete, the researcher would have expanded the notes immediately. All data files were automatically labelled with identification numbers and the date on which data were collected. All materials were assembled in one envelope.

3.8 Data Analysis

Data analysis refers to the systematic organization and synthesis of research data, conducted to reduce, organize and give meaning to the data (Burns and Grove, 2009; Polit and Beck, 2012). Transcribed interviews were analyzed by the researcher. Table 3.4 shows how qualitative data were coded by an independent coder, using the eight steps of Tesch's open-coding method by Creswell (2009).

3.9 Measures to Ensure Trustworthiness

Trustworthiness refers to the degree of confidence qualitative researchers have in their data. Data were assessed using criteria of credibility, dependability, conformability, transferability and authenticity (Polit and Beck, 2012).

In this study, trustworthiness of data were ensured by using the following criteria:

3.9.1 Credibility

Credibility refers to confidence in the truth of data and interpretation of such data (Polit and Beck, 2012). In this study, credibility was achieved by ensuring that the population was accurately identified based on their knowledge regarding the phenomenon under study. Credibility was also ensured through prolonged engagement, member checking as well as referral adequacy.

Table 3.4: Tesch's open-coding method of qualitative data analysis

Step	Method
1	The researcher read all the transcriptions carefully to get a sense of the whole, and wrote down some ideas as they came to mind.
2	The researcher picked one document (one interview) which was on top, went through it; not thinking about the substance of the information but its underlying meaning. The researcher wrote thoughts in the margin.
3	The researcher made a list of topics on completion of the task. The researcher clustered similar topics together and arranged topics into columns, as major topics, unique topics and leftovers.
4	The researcher took a list and compared with the data. Topics were abbreviated as codes and a code was written next to the appropriate segments of the text. The researcher tried the preliminary organizing scheme to see if new categories and codes emerged. Those words and sentences were sorted into categories and themes were identified.
5	The researcher found the most descriptive wording for the topics and turned them into major themes. The researcher looked for ways to reduce the total list of major themes by grouping topics that related to each other. Lines were drawn between the major themes to show interrelationships.
6	The researcher made a final decision on the abbreviation for each major theme and codes were alphabetized.
7	The researcher assembled data materials belonging to each category in one place and performed a preliminary analysis.
8	The researcher recorded the existing data. Direct quotations by the participants were used to support each major theme, theme and sub-theme.

3.9.1.1 Prolonged Engagement

Prolonged engagement refers to the investment of sufficient time during data collection in order to have an in-depth understanding of the group under study and it will enhance credibility (Polit and Beck, 2012). The researcher met with the

participants, introduced herself, explained the purpose and objectives of the study and secured an appointment for data collection. All these were done in order to establish rapport and build trust between the researcher and participants as that was needed in the gathering of rich data. Data were collected on the appointment dates, and the researcher stayed in the field interviewing participants until data saturation was reached. The researcher went back for validation of the developed programme.

3.9.1.2 Member Checking

Member checking means that the researcher provides feedback to study participants about emerging interpretations and their realities (Polit and Beck, 2012). In this study, member checking was done throughout the interview in an on-going manner as data were collected through deliberate probing. The emerging findings of the study were taken back to the participants in order for the interpretations of the data as well as the adequacy thereof to be discussed and confirmed. Participants were asked to read the transcripts of dialogues in which they participated, to ensure that their words as recorded by the voice recorder matched what they actually intended.

3.9.1.3 Referral Adequacy

Referral adequacy involves determining all materials that are available for documentation of the findings (Brink, van der Walt and van Rensburg, 2014). Voice recording of the interview was done and the participant was shown how to stop the recording in case s/he did not want some of the information to be recorded. Field notes were taken to serve as a backup and non-verbal cues were captured as well as confidential information when the participant had switched the voice recorder off.

3.9.2 Dependability

Dependability refers to stability (reliability) of data over time and over conditions, that

is, if the work was to be repeated, in the same context, with the same methods and with the same participants, similar results would be obtained (Polit and Beck, 2012). The processes within the study were reported in detail, reflecting in-depth coverage of the proper research practices followed that would enable readers of the research report to develop a thorough understanding of the methods and their effectiveness.

3.9.3 Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about data accuracy, relevancy or meaning (Brink, 2006). Confirmability was ensured by having an assistant to transcribe the same data and then comparisons were made to reach for an agreement. Transcribed interviews were analyzed by the researcher and data were coded by an independent coder.

3.9.4 Transferability

According to Polit and Beck (2012), transferability refers essentially to the generalizability of the data—this is the extent to which the findings can be transferred to or have applicability in other settings or groups. Provision of background data to establish the context of study and detailed description of phenomenon in question was done to allow comparisons to be made.

3.10 Phase 2: Programme Development

Phase two (2) comprised of concept analysis, programme development as well as programme validation, as informed by objectives 4 and 5. The objectives are summarized in Table 3.5:

3.10.1 Concept Analysis

Concept analysis refers to clarification and analysis of the lay concepts in the study

and to the way in which one`s research is integrated into the body of existing theory and research (Mouton, 2010). Concept analysis was used to clarify meaning and promote mutual understanding of the readers, with regard to the major concept that emerged from the findings of the study.

Table 3.5: Objectives to inform Phase 2 of the study

Objective	Description
4	Develop a transition support programme to enhance effective support of newly graduated midwives during their transition period.
5	Validate a developed transition support programme for effective support of newly graduated midwives during their transition period.

In this study, Walker and Avant's (2011) method was used for concept analysis; concepts were classified in different levels of abstractness as follows:

- **Primitive concepts**—those having common shared meaning among all individuals in a culture, concrete and abstract.

- **Concrete concepts**—those that can be defined by primitive concepts, but limited to time and space, and observable in reality.

- **Abstract concepts**—defined by primitive or concrete concepts, but independent to time and space.

The researcher was guided by the following steps as outlined by Walker and Avant (2011), during concept analysis:

- Selection of the concept

- Specification of the aims of analysis

- Identification of uses, characteristics or connotations of the concept
- Determination and definition of attributes
- Development of model cases which exemplify the analysis
- Identification of antecedents and consequences
- Definition of empirical referents

3.10.2 Programme Development

The findings of concept analysis led to the development of a transition support programme. Development of a transition support programme was based on: (1) Conceptual framework of ADDIE's model for training and instructional design, of which the steps are: **A**nalysis, **D**esign, **D**evelopment, **I**mplementation and **E**valuation (Cutler, Lee and McNair, 2012); and (2) Stages of transition theory by (Duchscher, 2009) namely, the stage of doing, stage of being and stage of knowing.

3.10.3 Validation of the Developed Programme

The developed programme was validated using quantitative approach in which exploratory and descriptive research designs were employed. The validation process was based on a framework for programme evaluation in public health by the Centers for Disease Control and Prevention (CDC) (1999).

3.11 Ethical Considerations

According to Schneider, Whitehead, Elliot, Lobiondo-Wood and Haber (2007), ethical principles in research are concerned with the protection of human participants for whom there are ethical codes and legal regulations to ensure the absence or

minimization of harm, trauma, anxiety or discomfort. Ethical principles serve as standards, and the basis upon which each researcher ought to evaluate his/her own conduct so as not to impose physical or psychological harm on the participants (Polit and Beck, 2012). In this study, the following six (6) ethical principles were used: permission to conduct the study, informed consent, beneficence, right to self-determination, confidentiality and anonymity.

3.11.1 Permission to Conduct the Study

The University of Venda Higher Degrees Committee (UVHDC) and University of Venda Research Ethics Committee (UVREC) granted permission to conduct the study (Annexures A and B). Ethical Clearance number: SHS/16/PDC/06/1304 (Annexure B). Permission to conduct a study was also sought and obtained from the following authorities:

- The Limpopo DoH Provincial Research Committee (Annexures C, D, F)
- Limpopo DoH District Offices (Annexures G, H and I)
- Selected hospitals in Limpopo Province (Annexure E)

3.11.2 Informed Consent

Informed consent refers to the act of giving the participant adequate information regarding the research. The participants are capable of comprehending the information and have the power of free choice, enabling them to consent or decline participation voluntarily (Speziale and Carpenter, 2007). Burns and Grove (2009) define informed consent as the prospective subjects' agreement to voluntarily participate in a study. This agreement was reached after assimilation of essential information about the study (Annexure J). In this study, participation was voluntary.

Participants were not coerced to participate in the study. The participants were asked to sign an informed consent form, which is a legal document proving that participation was voluntary (Annexure K).

3.11.3 Beneficence

The ethical principle of beneficence involves doing good, as well as preventing and removing any potential harm (Schneider et al., 2007). In this study, no psychological and physical harm was anticipated; should any harm occurred, the study would be discontinued.

3.11.4 The Right to Self-Determination

According to Burns and Grove (2009), the right to self-determination is based on the ethical principle of respect for persons and states that humans are capable of controlling their own destiny. Polit and Beck (2012) define the right to self-determination as the right of prospective participants to decide voluntarily whether to participate in the study or not without risking penalty or prejudicial treatment. Participants were given adequate information regarding the research study and participation in the study was voluntary (Annexure J). Participants were not coerced to participate in the study. The participants were allowed to ask questions, to withhold some of the information or to withdraw from the study at any time without any penalty. During the actual interview, participants were shown the stop button on the recorder which they could use if some of the information was sensitive and did not want the public to hear.

3.11.5 Confidentiality and Anonymity

Confidentiality implies that only the researcher and a few members who are assisting during the research process are aware of the identity of the participants. The

researcher made commitment to keep participants' information confidential (Polit and Beck, 2012). Anonymity means that no one, including the researcher, should be able to identify any subjects afterwards (Burns and Grove, 2009). The subjects and hospitals' identities were concealed using code numbers. Research information was kept safe until analysis was completed. Participants' identities were not reflected in the document analysis. Research documents will be destroyed after 5 years following publication of the results.

3.12 Summary

Chapter 3 described the background of research methodology, research design, research setting and the population of the study. Sampling, sample, data collection, data analysis, measures to ensure trustworthiness and ethical considerations were also discussed. An introductory layout on concept analysis, programme development and its validation was also provided. The next chapter describes the results of the study organized according to the major themes, themes and sub-themes; controlled by relevant literature.

CHAPTER 4

Presentation and Discussion of the Results

4.1 Introduction

In Chapter 3, the research design and methods of the study were discussed. This chapter presents the interpretation of the data collected from a sample of five (5) experienced midwives and five (5) newly graduated midwives from each of the four regional hospitals and one tertiary hospital in all the districts of Limpopo Province of South Africa. The following questions were posed to newly graduated midwives:

> *What are your experiences regarding provision of midwifery services during your transition period?*
>
> *What support do experienced midwives offer to you as newly graduated midwives during your first year of clinical practice?*

The following questions were posed to experienced midwives:

> *What support do you offer to the newly graduated midwives during their first year of clinical practice?*
>
> *What are your expectations from newly graduated midwives during their first year of clinical practice?*

Data were collected through in-depth individual face-to-face interviews and the discussion was controlled with literature. Qualitative data were analyzed after all interviews were completed.

The voice-recorded interviews were listened to repeatedly and compared to the transcripts. Key phrases were pointed out. The findings of this study presented the responses from experiences of newly graduated midwives regarding provision of midwifery services during their transition period, support provided by experienced midwives to newly graduated midwives during their first year of clinical practice and expectations of experienced midwives from newly graduated midwives during their first year of clinical practice. The responses expressed were noted and grouped into major themes, themes and sub-themes (Creswell, 2009).

4.2 Background Information for the Results

This study was conducted in two phases. The findings of Phase 1 are presented in this chapter; whereas the findings of Phase 2 (concept analysis, programme development and validation of a developed programme) are presented in Chapter 5. Data were collected from four regional hospitals and one tertiary hospital in all the districts of Limpopo Province. For the purpose of discussion of the results, identification of selected hospitals as well as participants' profile are displayed in Tables 4.1, 4.2 and 4.3.

Table 4.1: Identification of selected hospitals and participants

Hospital/ *Type*	**Acronym used for the purpose of the study**	**Number of participants (Newly graduated midwives)**	**Number of participants (Experienced midwives)**	**Identification of participants**	
				Newly graduated midwives	**Experienced midwives**
Mankweng *Provincial*	MP	5	5	NGM 1	EM 1
St Ritas *Regional*	SRR	5	5	NGM 2	EM 2
Mokopane *Regional*	MR	5	5	NGM 3	EM 3
Letaba *Regional*	LR	5	5	NGM 4	EM 4
Tshilidzini *Regional*	TR	5	5	NGM 5	EM 5
Total		**25**	**25**		

4.3 Presentation of the Findings

The analyzed data were grouped into five (5) major themes, ten (10) themes and twenty (20) sub-themes.

Table 4.2: Profile for Newly graduated midwifery participants

	Gender		Age (years)		Year of completion of training	Educational institution	
	Female	**Male**	**22-25**	**Above 25**	2016	**University**	**Nursing College**
	20	5	21	4	25	16	9
Total	**25**		**25**		**25**	**25**	

Table 4.3: Profile for Experienced midwifery participants

	Gender		Type of midwifery training		Years of experience as a RN			Years spent working in maternity		Years worked as operational manager	
	Female	**Male**	**R254**	**R425**	**5-10**	**11-15**	**16**	**5-10**	**11**	**3-5**	**>5**
	25	0	16	9	7	12	6	18	7	7	4
Total	**25**		**25**		**25**			**25**		**11***	
***Included in the total of 25**											

Each sub-theme was discussed with relevant quotations from the participants, and the relevant literature was also cited as control to the findings of this research. Direct quotations in italics represented the experiences of working as newly graduated midwives in the labour ward, support provided to newly graduated midwives by experienced midwives during transition, relationship between experienced and newly graduated midwives in the labour ward, expectations of experienced midwives from newly graduated midwives and the newly graduated midwives' views related to their placement in the labour ward. Verbatim transcripts were presented and coded to facilitate audit trailing. Table 4.4 presents findings of the interviews conducted from four (4) selected regional hospitals and one (1) tertiary hospital of Limpopo Province.

Table 4.4: Major themes, themes and sub-themes that emerged from the data analysis

Major Themes		Themes		Sub-Themes	
1.	**Experiences of being a newly graduated midwife in labour ward**	1.1	Physical strain	1.1.1	Labour ward viewed as a traumatic environment
				1.1.2	High level of responsibility and accountability accompanying the status of a registered midwife
		1.2	Psychological strain	1.2.1	Professional nurses status: an admirable status though stressful
		1.3	Emotional strain	1.3.1	Lack versus existence of formal delegation of duties leading to feelings of uncertainties
				1.3.2	Negative comments occurrences experienced from experienced midwives
		1.4	Theory practice gap	1.4.1	Difference between theory and practice experience occurred on different levels
		1.5	Reality practice	1.5.1	Reality shock
2.	**Support provided by experienced midwives**	2.1	Ineffective support	2.1.1	Lack versus existence of support from experienced midwives
				2.1.2	Lack versus existence of mentorship and supervision by experienced midwives
				2.1.3	Non-conducive learning environment

Continued/…

Table 4.4: Major themes, themes and sub-themes that emerged from the data analysis (continued)

Main Themes		Themes		Sub-Themes	
3.	**Relationship between experienced and newly graduated midwives in maternity ward**	3.1	Positive collegial relationship and willingness to help	3.1.1	Poor versus positive relationship experienced during execution of duties
				3.1.2	Existence versus lack of willingness by experienced midwives to assist newly graduated midwives
				3.1.3	Lack of orientation in labour ward resulting in strained relationship
				3.1.4	Duty scheduling fairly drawn resulting in improvement of supervision relationship
		3.2	Attitudes towards 4 year programme	3.2.1	Existence of hatred by experienced midwives to newly graduated midwives
4.	**Clinical expectations of experienced midwives from newly graduated midwives**	4.1	Ability to function as professionals	4.1.1	Sense of independence
				4.1.2	Reduction of workload
				4.1.3	Commitment to patient care
5.	**Clinical placement expectations of newly graduated midwives**	5.1	Period of placement	5.1.1	Prolonged placement in the labour ward
				5.1.2	Placement in maternity sub-units versus general wards

4.3.1 Major Theme 1: Experiences of Being a Newly Graduated Midwife in Labour Ward

Based on empirical findings, newly graduated midwives reported that being qualified as midwives was very frustrating and caused a lot of anxiety. That was because they were still new and disorientated in the role, yet they were faced with a lot of expectations from their colleagues, students as well as patients. Under this major theme, the following themes and sub-themes emerged, as displayed in Table 4.5.

Table 4.5: Themes and sub-themes for major theme 1

Themes		Sub-Themes	
1.1	**Existing physical strain outlined**	1.1.1	Labour ward viewed as a traumatic environment
		1.1.2	High level of responsibility and accountability accompanying the status of a registered midwife
1.2	**Evidence of psychological burden**	1.2.1	Professional nurses status: an admirable status though stressful
1.3	**Uncertainties causing burden on emotional being**	1.3.1	Lack versus existence of formal delegation of duties leading to feelings of uncertainties
		1.3.2	Negative comments occurrences experienced from experienced midwives
1.4	**Theory practice gap: A thorn in the flesh**	1.4.1	Difference between theory and practice experience occurred on different levels
1.5	**Reality clinical practice: A challenge to overcome**	1.5.1	Reality shock

4.3.1.1 Theme 1.1: Physical Strain Outlined

Empirical findings revealed that newly graduated midwives experienced a lot of physical exhaustion as the labour ward was very busy, and they also raised an issue of serious shortage of staff. This was consistent with what was reported by Fenwick et al. (2012) who asserted that graduates reported serious shortage of midwives in

the labour ward which resulted in physical exhaustion as the workload was too much for them.

4.3.1.1.1 Sub-Theme 1.1.1: Labour Ward Viewed As a Traumatic Environment

Empirical findings revealed that participants described labour ward as a very traumatic and stressful environment. Results further revealed that the business of the labour ward affected the level of care graduates provided to patients, especially because the support they got from the experienced midwives was not effective. In their study about 'newly graduated midwives' experiences,' Kensington et al. (2016) argued that the environment where newly qualified midwives first work is crucial to a smooth transition, yet the majority of newly qualified midwives experienced lack of support.

NGM 3 from LR hospital said:

> *The labour ward is abnormally busy, in such a way that sometimes you even feel like taking your shoes off and walk around with your bare feet. Oh! Working in labour ward is so tiring.*

NGM 1 from SRR hospital confirmed when she reported:

> *There are days that are so busy in such a way that we may end up delivering more than ten women; and that means provision of care to twenty patients or more in case of multiple births. The women expect special attention regardless of shortage of staff. We just don't have time to give that level of care, even though we'd like to. That is so demanding.*

In a study conducted by Hobbs (2012), participants hated that they had to 'spread themselves so thin' and regularly described their working day as 'chasing their own tails'. According to Lennox and Foureur's (2012) findings, working in extremely busy labour wards left newly qualified midwives suffering from fear, anxiety and diminished

confidence, which left them struggling to cope. The authors further reported that, at times, feelings such as these were accompanied by acute physical reactions which included palpitations, abdominal pains and diarrhoea.

NGM 5 from LR hospital reported:

> *Despite the fact that labour ward is busy, there is a very serious shortage of staff. Sometimes the experienced midwives fail to give us the support we need, not because they don't want but due to shortage of staff.*

This was supported by NGM 4 from MR hospital who stated that:

> *There is shortage of experienced midwives and it is very serious. This shortage also contributes to lack of support by experienced midwives. How will they assist us when there is such a shortage?*

Skirton, Stephen, Doris, Cooper, Avis and Fraser (2012) revealed that staff shortages were a major contributing factor to lack of support given to newly qualified midwives once in a post, rather than unwillingness from established members of staff. This should be a concern for ward managers who decide what constitutes adequate staffing levels, as this will directly affect the policy of a mandatory preceptorship programme. Fenwick et al. (2012) identified that due to pressures of a busy ward environment, newly qualified midwives said they were treated as part of the workforce and their learning needs were not a priority. These negative experiences exacerbated their feelings of stress and affected their perceptions of qualification. NGM 4 from MP hospital stated:

> *I am concerned about my level of knowledge and skills, but I also find the workplace challenging in terms of workload and staff shortage.*

In their study on 'graduates' experiences regarding transition, Bolden, Cuevas, Raia, Meredith and Prince (2011) revealed that participants reported a situation that was challenging to them in terms of lack of experience, heavy workload and staff shortages. Frustration was connected with feelings about being unable to give optimal midwifery care and the work focusing on high-risk situations, rather than normal midwifery. The reality of busy clinical areas where support was perceived as limited also left participants feeling frustrated and dissatisfied with the care they provided. Feeling 'pressured,' 'out of control' and 'panicked' were common concepts, referred to by participants (Banks, Roxburgh, Kane, Lauder, Jones, Kydd and Atkinson, 2011).

NGM 1 from TR hospital said:

> *The off duties we use here are very tiresome. Seven days in seven days out, they are too long you become exhausted, but there is no choice.*

In a study conducted by Bolden et al. (2011), participants reported that long shifts and long stretches of working consecutive days led to extreme tiredness leaving them in a situation whereby they did not want to continue working.

4.3.1.1.2 Sub-Theme 1.1.2: High Level of Responsibility and Accountability Accompanying the Status of a Registered Midwife

The findings of the study revealed that newly graduated midwives found it very hard to adjust themselves to the responsibilities of a professional midwife as they felt incapable of dealing with the challenges of a professional midwife's role. In an Irish study of newly qualified midwives, Van der Putten (2008) found that newly qualified midwives often struggled to adapt to their new role. These midwives explained that the increased responsibility and awareness of accountability, often led to feelings of fear and insecurity. Based on a study conducted by Hillman and Foster (2011), the increase

in newly qualified midwives' responsibility and accountability is a major stressor in the transition process.

NGM 4 from LR hospital stated:

> *One thing that makes me scared is the high level of responsibility and accountability accompanying this new role, whereby I am expected to make decisions regarding care of patients as well as management of the ward. I feel like I can run away.*

This is congruent with what was reported by Hillman and Foster (2011) as well as Fenwick et al. (2012) who asserted that transition from a student to a professional practitioner puts some burden on graduates as they are scared and anxious about their ability to cope with the demands of a new role. According to Delaney (2013), midwifery graduates experienced problems in adjusting themselves with the role of a professional midwife; as they were not certain whether they would be able to carry out the functions of a professional midwife.

NGM 1 from MP hospital confirmed when she stated:

> *I like being a professional nurse, but it's very stressful, everything just has to be perfect. What makes the situation worse is that you're also expected to be accountable for the actions of the subordinates. Oh! It's such a challenge. I really need strong supervision and support before I can manage that on my own.*

NGM 5 from SRR hospital made a confirmation when she said:

> *Maybe it would be better if we were given one responsibility at a time. Like for instance, if we were only responsible for patients' care, but it is not like that. They expect us to do everything including teaching and supervision of students, Oh! That's too much. How can I be*

expected to take care of students when I am still struggling like this?

In their study, Lennox and Foureur (2012) revealed that newly qualified midwives found it very difficult to take the responsibility of supervising the students, especially during their first months of employment as graduates because they also needed supervision from the experienced colleagues. Kumaran et al. (2014) echoed a similar view when they reported that newly graduated midwives experienced frustration when they were expected to carry out responsibilities for patients' care and students' learning. Chick and Meleis' (1986) transition theory cited in Kumaran et al. (2014) is also relevant in relation to midwifery graduates experiencing incongruence between former sets of expectations experienced during training; and those that prevail in the new situation as a midwifery graduate faced with a high level of responsibility and accountability as the cornerstone of midwifery practice.

4.3.1.2 Theme 1.2: Evidence of Psychological Burden

Based on the results, participants admired their achievement of being professional nurses, but raised a serious concern that a professional nurses' role is accompanied by increased level of stress. Barry et al. (2013) affirmed that graduates reported psychological exhaustion caused by increased demands that accompanied a role of a registered midwife.

4.3.1.2.1 Sub-Theme 1.2.1: Professional Nurses Status: An Admirable Status, Though Stressful

The findings of the study revealed that newly graduated midwives are happy that they have siuccessfully completed their training, but graduates are worried about changing of the roles. Participants somehow felt that the status of being students was better as compared to a new status with regard to security. Hillman and Foster (2011) also described transition of graduates as moving between two different worlds, suggesting

that of the student was sheltered, whereas the world of the newly qualified was exposed.

NGM 1 from LR hospital stated:

> *The fact that I am a professional nurse is good and makes me happy, but the fact that every junior member of staff looks up at me for solution is stressful and makes me wish somehow I were still in students' boots.*

NGM 4 from LR hospital stated said:

> *One thing that makes me scared is the reality that I have to stand as a professional nurse and make decisions regarding care of patients and management of the ward. At the same time the students want me to assist them and patients are also expecting quality care from me.*

NGM 1 from MP hospital confirmed when she stated:

> *I like being a professional nurse because it is good, but this causes a lot of stress. Why do I say that? Because everything you do must be perfect. How can I be perfect whe I have only passed now, and I don't have any experience?*

Lennox and Foureur (2012), found that the expectation to take responsibility for overseeing junior students while consolidating their own training was difficult, especially when it occurred within the first month of employment. Asking very newly qualified midwives to take on this responsibility led to increased anxiety and frustration, which undermined their time for their own preceptorship and support. Kensington et al. (2016) reflected a similar view when they reported that there is nothing frustrating for a newly graduated midwife than being responsible for patients'

care as well as students' learning at the same time.

NGM 4 from MR hospital stated:

> *When I wake up every morning and start to think that I am no longer a student and have to be a professional nurse who is responsible, I feel stressed. It is not that I don't want to be a professional nurse. I want to be a professional nurse but, that post needs somebody who is very prepared. Now, I don't feel prepared and ready, that is why I am stressed, especially because the experienced midwives do not want to help. Maybe if they were helpful I would be less stressed.*

NGM 2 from SRR hospital stated:

> *Besides conduction of delivery, another procedure that causes a lot of anxiety for me is to order the drugs and to keep the drug cupboard key. I am afraid of this procedure.*

Solowiej, Upton and Upton (2010), also reported drug administration by newly qualified professionals as a major cause of anxiety during the period of transition. Before qualifyin g, students had carried this procedure out only under rigorous supervision, but were expected to practise unsupervised following qualification **(**Solowiej et al., 2010**)**. Lennox and Foureur (2012) concurred when they noted inconsistencies in preparation for management, suggesting that while the theoretical context was adequate, the practical aspects, such as drug administration, prioritising, decision making and clinical skills were variable. Lennox and Foureur (2012) argued that this area of practice is not adequately addressed during the educational preparation of nurses and midwives.

NGM 4 from MP hospital said:

> *The big challenge that is facing us as newly qualied midwives is that*

> *things have changed. The patients and community members are now aware of their rights; if you do something wrong they will report you. They expect us to be perfect in everything we do.*

In a study conducted by Bolden et al. (2011), participants reported on their awareness of the depth of trust placed in them by the women they care for and the increased levels of expectations of women and their families today as being stressful.

NGM 4 from TR hospital stated*:*

> *Losing a status of being a student is good because it is part of growth. Learn to put everything you were taught in practice. Learn to be responsible and accountable, deliver patients. What is frustrating is that you learn to do all these things, at the same time you also learn to think creatively so that you make reasonable decisions because nobody is supervising you. At this stage I have no one to depend on, unlike previously where I used to depend on my lecturers. I feel stressed and anxious.*

NGM 4 from MR hospital said*:*

> *It's awful, it's a lot harder than I expected. I didn't know that becoming a registered midwife would be this difficult. May be it is because when we were students we were working under the prtotection of both our lecturers and the ward sisters, but now you are the one who is in charge and should also protect the students.*

Fenwick et al. (2012) suggested that despite an obvious lack of support, newly qualified nurses learnt to cope with the change in status from supernumerary student to independent practitioner as an aspect of their new role. The unfortunate part of it is that you master that alone with nobody giving you any support, as the world of the newly qualified is not sheltered but exposed.

NGM 2 from SRR hospital stated*:*

> *Experienced midwives also cause some confussion because when it comes to work like delivering of the patients, they say do it yourself, you are a midwife. When it comes to decision making it is different, if I make a certain decision regarding off duties or those of the subordinates, they say no you are still a comserve, you can't make decisions. They only acknowledge my status as a midwife and a professional when it suits them.*

This is congruent with the findings of Solowiej et al. (2010) which concluded that decision-making was seen to be controlled by the delivery suite coordinators and/or the obstetric team. Kensington et al. (2016) concurred when they reported that participants did not feel valued or trusted in decision-making and they perceived they were required to carry out preordained instructions for the clients who were in labour.

NGM 5 from TR hospital reported:

> *Being a professional nurse is so demanding; sometimes you just have to compromise your peace and try to impress the experienced midwives. This we are forced to do in order to buy favours from experienced midwives; especially because they don't accept us.*

In a study conducted by Bolden et al. (2011), participants reported their perceived need to impress their delivery suite senior colleagues, even when they had been unkind to them, in order to feel that they 'belonged' and were accepted. When they realized they were not able to impress them, they became stressed. Delaney (2013) concurred with Bolden et al. (2011) when reporting that the participants' working worlds often seemed to revolve around others' moods or their perceptions of their characters. If the delivery suite coordinator was nice, participants felt positive in their work and had an increased level of morale. They began to know who to ask if they were unsure about what to do and who to avoid.

4.3.1.3. Theme 1.3: Uncertainties Causing Burden on Emotional Being

Empirical findings revealed that negative attitudes of experienced midwives towards newly graduated midwives lead to feelings of uncertainty that negatively affected graduates' performance. Performance of newly qualified midwives is also determined by the type of relationship they have with their experienced colleagues (Fullerton, Thompson and Johnson, 2013).

4.3.1.3.1 Sub-Theme 1.3.1: Lack versus Existence of Formal Delegation of Duties Leading to Feelings of Uncertainties

Participants reported feelings of uncertainties resulting from the fact that they were not delegated, which made them lose interest in midwifery care.

NGM 2 from TR hospital said:

> *I would like it if they would delegate me, maybe like working in stage one for a day and the following day in the second stage. But in all cases I would like to be delegated with an experienced midwife. Unfortunately it is only a wish, there is no such delegation.*

NGM 1 from LR hospital also said:

> *They don't delegate us, and it is so frustrating because it makes you not be sure of what to do. When you ask them what you should do, they tell you that you should just see what to do. We end up lingering sometimes.*

In a study conducted by Davis et al. (2011), midwifery graduates demanded to be delegated because they felt that supervision would improve. Graduates also reported that proper delegation keep them posted, unlike when there is no delegation. Cummins, Denney-Wilson and Homer (2016) corroborated that graduates found themselves jobless in many instances which tempted them to absent themselves from

duty. In their study on 'support of newly qualified staff, Dixon et al. (2015) reported that graduates preferred to have individual mentors who would supervise and mentor them during performance of delegated tasks. Participants also reported that allocation of individual mentors would strengthen the relationship.

NGM 3 from MR hospital reflected a different view when she reported that:

> *Sometimes they delegate us alone, but sometimes they delegate us with an experienced midwife. But it is all the same because you end up working alone as she will also be doing something else, because of lack of staff.*

Delaney (2013) reported that newly graduated midwives need support in all spheres especially emotional, because; how do we expect them to provide holistic care to patients when they too are emotionally unstable?

4.3.1.3.2 Sub-Theme 1.3.2: Negative Comments Occurrences Experienced from Experienced Midwives

Based on the findings, experienced midwives often passed negative remarks towards newly graduated midwives, which negatively affected their performance. Lennox and Foureur (2012) reported that midwives used ineffective ways of communicating with the newly qualified midwives, which left them offended.

NGM 5 from TR hospital reported:

> *The relationship between us and some of the experienced midwives is good, but if you make a mistake you will know them better because they will shout at you.*

NGM 2 from MR hospital said:

> *Some of the experienced midwives are good but some are negative. Those who are negative are always ready to attack you with negative remarks every time you ask something, and it's so frustrating.*

A confirmation of what has been reported by NGM 2 from MR hospital was made by NGM 5 from LR hospital who reported:

> *I don't feel comfortable asking questions because there are those experienced midwives who always pass remarks such as 'you think you know much,' so, I feel if I ask questions they will think that I want to challenge them. One day my colleague asked a question, and was told to either consult her books or her colleagues.*

The study by Davis et al. (2011) is in line with what participants said when he reported that inability to feel comfortable to ask questions from experienced members was evident in a study conducted in Australia, about experiences of new graduates regarding working in clinical areas; as a result, new graduates presented with poor performance.

NGM 3 from LR hospital stated:

> *The body language' really tells that they don't want to entertain whatever you are asking. There are those who would roll their eyes. Some will just keep quiet and look at you. The way they look at you sends obvious messages that they are not willing to assist you.*

NGM 4 from SRR hospital said:

> *I asked if one of the experienced midwives would just come and be next to the delivery bed as I was assisting a woman to deliver. She did not.*

In a study conducted by Fenwick et al. (2012), newly qualified midwives experienced

a sense of being ignored and/or left to flounder when they were not attended to while asking for assistance. Participants also reported that the context of these behaviours was during a clinical task or skill and sometimes in front of the women which added to their distress. The authors further reported the most disturbing descriptions of passive aggressive behaviours revealed by participants, which they perceived to be 'bullying' behaviours. Such behaviours included belittlement, sighing, hesitation before helping or a slight delay and the tone of voice (Fenwick et al., 2012).

There was a general consensus that some midwives used their position in a negative manner. Perhaps, most striking were participants' descriptions of the communication patterns that sometimes subtly and sometimes quite overtly, engendered feelings of guilt, blame and exclusion (Lennox and Foureur, 2012). In a study conducted by Kensington et al. (2016), newly qualified midwives described feeling confused and upset at being treated badly by experienced midwives. Participants also reported that they needed experienced midwives to role model expected behaviours about what is appropriate in creating a trusting atmosphere full of respect within a professional relationship (Kensington et al., 2016).

NGM 2 from MP hospital reported:

> *One day I made a mistake of going for a tea break without having reported. I was scolded at and a lot of negative remarks were passed. I apologized and thought it was over. The next day when I reported before going, I was reminded of yesterday's incident and told not to report anything to anybody anymore because I was behaving like a boss. I was so confused and did not know what to do.*

According to Dixon et al. (2015), effective communication between experienced and newly graduated midwives is critical to the fundamental success of transition support.

Participants talked of growing more confident during the period of transition when they had good clinical support**.**

4.3.1.4 Theme 1.4: Theory Practice Gap

The results of the study revealed that newly graduated midwives marked a difference between the theoretical midwifery learnt in the classroom and the midwifery practiced in the clinical setting; resulting in frustration during their transition period. Fenwick et al. (2012) revealed that graduates reported frustration and anger that resulted from the discrepancies they experienced as they found themselves in two different worlds of midwifery practice.

4.3.1.4.1 Sub-Theme 1.4.1: Difference Between Theory and Practice Experience Occurred on Different Levels

Participants of the study reported that there is a great difference existing between the theoretical knowledge as well as the way they were trained on how to perform procedures and the way things are done in the wards.

NGM 4 from LR hospital said*:*

> *It is so frustrating, when you perform procedures; they expect you to do shortcuts. I don't want to do shortcuts, and when I do the correct things they say I am slow and they also pass such remarks like 'we are not in the classroom here, where you do things that are not real. Here we do real things because we are dealing with the patients.' That is what they say, and I feel confused.*

NGM 5 from LR hospital confirmed*:*

> *When we do procedures they want us to do them in their own way, not in the way we were taught at school. In the class we were taught that when we put up a drip we must also write in the fluid chart, when I do that they say, 'you are wasting time as long as the drip is running*

> *it is fine. After all, what we want to have is to give strength to the woman in labour and nothing else.' I feel confused because I don't know what is right anymore.*

Delaney (2013) revealed that newly graduated midwives identified a gap between what they have learned at university and what they witnessed in practice. This theory practice gap resulted in some experiencing a sense of dissonance as the values they had developed throughout their education were not supported in practice. The impact of this perceived 'theory-practice gap' on the new graduates cannot be underestimated as it may lead them to doubt and question their training and desire to remain in their chosen profession (Doody et al., 2012).

In a study conducted by Fenwick et al. (2012), participants described feeling frustrated, angry and emotionally distressed when they were unable to adapt to their new role due to apparent conflicting ideologies with which they came into contact when caring for women. This difficulty is illustrated by the discrepancy between what has been taught in the classroom and how care is given in practice. This was supported by McCusker (2013) who reported that the dissonance between woman-centred care and the management of care provided in the hospital setting confuses the newly qualified midwives and diminishes the midwifery role.

Fenwick et al. (2012) further reported that newly qualified midwives in the study they conducted also found it difficult to comprehend why they were educated to question and use their initiative, yet in practice were required to obey orders and conform. As a result, newly qualified midwives felt they were inadequately prepared for their roles in practice.

NGM 2 from MR hospital said:

> *Sometimes you are caught in the middle when you realize that what is being done in practice is completely different from what is in the books and what you have been taught in the classroom, especially if the outcome becomes positive in the sense that the patient recovers well and maybe even faster. Frustration comes when you realize that the short cuts they are taking are really working.*

At the point of registration, participants expressed the belief that their training and experiences of caseload held practice, community, birth centre and hospital focused care provision had prepared them well for their post as a qualified midwife (Pairman, Dixon, Tumilty, Gray, Campbell, Calvert and Kensington, 2015). However, as time since qualification elapsed, they became more sceptical about the preparation they have received. At 4 months post-registration the newly qualified midwives considered that their training had not fully equipped them for the real world of clinical practice (Pairman et al., 2015).

In a study conducted in Australia, McCusker (2013) reported that newly qualified midwives recommended that better preparation should be done during the educational programme so as to address the difference between theory and practice. Some of the issues to be taken note of during students' training are: prioritising and managing care in a busy postnatal unit, care of mothers with mental health problems, antenatal screening and care of a baby with congenital abnormalities (McCusker, 2013).

NGM 5 from MP hospital stated:

> *We were well prepared academically, but as students, we were supposed to have had more time in areas such as labour ward, perineal suturing and high risk areas like shoulder dystocia. That would have been much better from a learning point of view. I would have felt better prepared.*

According to Lennox, Jutel and Foureur's (2012) findings, newly qualified midwives' theoretical preparation was generally considered to be appropriate, although their clinical learning opportunities were constrained by the short duration of most clinical placements as students. The need to offer students longer practical placements to overcome this problem is an issue that has been reported in McCusker's (2013) study; although little empirical evidence exists to support this argument. Appropriate preparation in pre-registration education and supportive programmes for newly qualified midwives can help achieve effective role transition (Pairman et al., 2015).

In a study conducted on newly qualified midwives' experiences, McCusker (2013) reported that participants felt that they did have good knowledge base around complications and high risk maternity care, however this knowledge often came from university lectures or skills teaching and simulations, as they had not had to deal with these events in practice until they were qualified. Pairman et al. (2015) concurred when he reported that a participant stated that she thought she knew what to do during an emergency, but due to lack of experience, she was a bit slow. She said she felt so useless when the mentor came in and took over.

Kensington et al. (2016) supported what was reported by the previous sources when they reported that although induction of labour was taught during training, it was not easy for the new graduates to deal with the actual processes and timing of events during an induction of labour. Newly qualified midwives also expressed anxiety about preparing a woman for delivery by emergency caesarean section, even when this was mastered in the classroom (Kensington et al., 2016).

> *Experienced midwives expect us to work like them. They forget that the world we are living in now, is a completely different one; as we have just completed training, and have no experience.*

Bolden et al. (2011) implied a consonant view that the expectations of other midwives of the graduates' performance can also prove to be demanding. This is consistent with Hobbs' (2012) study which reported that the stress and difficulties experienced by newly qualified midwives is exacerbated by how other people perceive them. Davis et al. (2011) highlighted how ward managers' expectations of newly qualified midwives were unrealistic, suggesting that pressures of the ward environment, being able to adapt and integrate quickly, and the added responsibility of accountability were particularly overwhelming.

4.3.1.5 Theme 1.5: Reality of Clinical Practice: A Challenge to Overcome

The findings revealed that newly graduated midwives have mixed emotions. They are excited that they have successfully completed their training but on the other hand, afraid that they will not be able to cope with the reality of professional practice. In their study on 'graduates' experiences regarding transition,' Bolden et al. (2011) revealed that participants reported a situation that was full of challenges for them due to the following reasons: they were inexperienced, patients' demands for quality care were very high, students needed to be taught and supervised yet graduates also needed to be supervised; these made the graduates to be in a predicament. Fenwick et al. (2012) concurred, when they reported about the reality of busy clinical areas where graduates were expected to be responsible for management of the ward, patient care and supervision of subordinates including students; and all these left participants feeling frustrated.

4.3.1.5.1 Sub-Theme 1.5.1: Reality Shock

The findings revealed that newly graduated midwives are excited that they have successfully completed their training. On the other hand, shocked as they are faced with the reality that they are now expected to function as professional midwives who

should take decisions that determine patients' well-being. This is conversant with what has been reported by Duchscher (2009) when he revealed that newly-qualified midwives experienced mixed emotions of satisfaction and sense of achievement, nervousness and apprehension upon qualification. These emotions were also found by Kumaran et al. (2014) who reported that newly-qualified midwives approached their initial introduction to practice with exhilaration and eagerness, but experienced fear, anxiety, apprehension and intimidation when the reality of professional practice set in.

NGM 2 from TR hospital confirmed when she stated:

> *I am so happy to have completed the training. But the experience in a labour ward is such a big challenge. Everything is just upon your shoulders including the students. I am so shocked, I never xpected it to be like this.*

This was confirmed by NGM 4 from MR hospital who said:

> *The situation we are in is confusing; may be it is because we are still in a state of shock. I am happy that I have passed, but I am not sure if I will be able to deal with the challenges of being a professional nurse.*

Kramer (1974) described the period of excitement for completion of training as "the honeymoon phase", which was then replaced by "reality shock" and initial feelings of nervousness and vulnerability when starting with the new roles accompanying a new status. This is in line with the first and the second stages of Duchscher's (2009) transition theory, in which the graduates suffer from transition shock as well as transition crisis, which leave them with little strength to face and accommodate the responsibilities set before them. In a study conducted by Mason and Davies (2013), graduates reported experiencing the positive benefits of being qualified, but also had to deal with related negative impacts, such as, assimilation anxiety, responsibility and

accountability as a burden and a feeling of loss of sheltered academia.

NGM 3 from LR hospital said:

> *I am shocked as I am faced with reality that I have to stand on my own. Each one of us is alone and no longer addressed as a group of students. The other thing that makes me to be miserable is that I have lost the status of being a student. Instead, students are now looking at me for help; patients are demanding their care and other nurses expect me to work independently. This situation causes a lot of distress.*

In a study on 'graduates' expectations' by Lennox et al. (2012), newly qualified midwives experienced high levels of anxiety due to fear of making mistakes leading to litigations, lack of knowledge and experience, lack of organizational skills together with the accountability associated with the new role.

NGM 5 from SRR hospital said:

> *The other aspect that is really shocking and frustrating is the way the senior midwives behave and do things here in the ward. I never expected to see what is really happening here in the ward. I thought we will be treated they way we were treated during training, especially because we are still doing our community service. Oh! Things are so different.*

Chick and Meleis' (1986) transition theory is also relevant in relation to midwifery graduates experiencing incongruence between former sets of expectations experienced during training; and those that prevail in the new situation as a midwifery graduate faced with a high level of responsibility and accountability as the cornerstone of midwifery practice. Hobbs (2012) concurred that at the inception of their midwifery career, participants had an idealistic perception of the role of a midwife, the work that

they would be expected to do and the relationships that they would have with others. When reality of midwifery practice failed to measure up to their ideals and self-made expectations, anxiety, stress and frustration result. In effect, they experienced what Kumaran et al. (2014) described as theft by deceit or by false promises. In Pearce's (1953) work, the false promises were made by others; in this study, the false promises were self-inflicted by the participants as they constructed their imaginary expectations; their 'fairy tale of midwifery'. According to Kumaran et al. (2014), as newly qualified midwives began to practice, they experienced the reality of midwifery rather than their idealised fiction. Hence, reality shattered their fairy tale away resulting in reality shock.

4.3.2 Major Theme 2: Support Provided by Experienced Midwives

According to the results, newly graduated midwives expected some form of support from experienced midwives, yet, experienced midwives showed no interest in supporting them. Results also showed that, working environment was not conducive for newly graduated midwives to learn. Table 4.6 presents themes and sub-themes that emerged under major theme 2.

Table 4.6: Themes and sub-themes for major theme 2

Themes		Sub-Themes	
2.1	**Existence of ineffective support**	2.1.1	Lack versus existence of support from experienced midwives
		2.1.2	Lack versus existence of mentorship and supervision by experienced midwives
		2.1.3	Non-conducive learning environment

4.3.2.1 Theme 2.1: Existence of Ineffective Support

Empirical findings revealed that newly graduated midwives expressed feelings of fear and lack of confidence during provision of midwifery services as experienced

midwives were not supportive. In their study on 'the use of reflective practice in new graduate registered nurses' residency program,' Bolden et al. (2011) described negative behaviours exhibited by midwives as unsupportive, which left graduates struggling to work, learn and cope within the maternity environment.

4.3.2.1.1 Sub-Theme 2.1.1. Lack Versus Existence of Support from Experienced Midwives

Empirical findings revealed that newly graduated midwives did not get the necessary support they needed from the experienced midwives, resulting in poor performance of midwifery services which negatively affected the quality of care provision. On the contrary, Fenwick et al. (2012) reported that participants described the consequences of positive interactions with colleagues and a supportive environment as swimming in a pond. In essence, swimming was almost exclusively about building confidence. Feeling comfortable, supported and good about oneself. The environment enabled the new midwives to assess their own learning needs, therefore promoting professional development (Fenwick et al., 2012).

NGM 2 from TR hospital said:

> *Most of the experienced midwives don't give us the support we need. Of course, there are those who support us, but there are others who do not give us any support. It's like those who don't support us are suffering from inferiority complex; because they tell you that you have all the bars in the world. It is high time you have to stand on your own.*

NGM 1 from SRR hospital stated:

> *One day I remained with one of the experienced midwives who is not supportive, and we were going off at 19h00. A woman who was in labour started to scream and I went to check her and found that she*

> *was fully dilated. When I asked the experienced midwife to help me as I was delivering her, she told me to leave her alone and went out. I delivered that woman while the sister was just sitting outside talking with other nurses. She only came back when we were about to go off. Sometimes you even think that these experienced midwives want you to make a mistake so that you end up reported to the South African Nursing Council.*

NGM 4 from MP hospital reported:

> *When I came here, I thought that the enrolled nurses and enrolled nursing auxiliaries will not cooperate with me and that made me scared. I was wrong because they are the ones who are really supportive. Sometimes they even help me during delivery especially when the experienced midwives don't want to assist.*

Hobbs (2012) agreed that there is a statutory expectation that newly qualified midwives are able to provide midwifery care competently as soon as they have graduated. However, working on their own responsibility as registered midwives requires additional support. McCusker (2013) supported Hobbs (2012), when reporting that introduction of transition programmes has been an international response for provision of positive reinforcement to the heightened anxiety and stress experienced by newly graduated midwives.

EM 2 from LR hospital supported what was stated by graduate participants when she said:

> *Some of the experienced midwives leave the new graduates alone in the labour ward and go and sit outside gossiping. When they are asked why they are sitting outside they usually say, 'I am taking some fresh air.*

NGM 5 from MP hospital said:

> *The other day I was sent to theatre to receive a new-born baby born through caesarean section, I did not know how theatre in that hospital looked like as I never worked in that hospital during training. When I said I have never been in that theatre and wanted an experienced midwife to go with me, I was told that theatre is theatre just go there is nothing different. That simply means that they don't want to support us but they expect us to be competent and responsible professional nurses, how is that going to happen when we are not supported.*

NGM 2 from SRR hospital reported:

> *But it is not all experienced midwives who do not support, some are supportive and when you ask questions they guide you well. But, even though they are supportive, sometimes they fail to provide support due to shortage of staff. It makes a big difference to your learning if they're supportive. You feel confident in pushing yourself if you know that someone is there to catch you if you fall.*

According to Dixon et al. (2014), the ability of experienced midwives to demonstrate true regard for the newly qualified midwife's learning experience and their emotional well-being was central to participants' feelings of personal and professional development.

Pairman et al. (2015) concurred when they described the ability to actively engage in dialogue around care and ask questions without feeling judged or stupid as a major strategy that contributed to participants' sense of being supported and feeling safe.

NGM 2 from MR hospital expressed her positive learning experiences, when she reported:

> *I am paired with an experienced midwife who is so supportive, empathetic, very calm and peaceful. She encourages a labouring*

> *woman in order to let her body do what it needs to be doing. It is really great and also boosts my confidence.*

This was supported by what NGM 4 from the same hospital with the previous participant stated:

> *I worked with one experienced midwife who would just calmly directs you on what to do, especially during emergencies. She does not panic, she is so good in getting the situation under control. I learn when I work with her.*

Lennox and Foureur (2012) reported about experienced midwives' ability to be 'calm' and 'relaxed' in the clinical environment as facilitative and supportive actions. The findings of Fenwick et al. (2012) are consistent with Lennox and Foureur's (2012) when they reported that working in a situation where the midwives were supportive decreased fear, increased confidence and helped them to learn more.

According to Dixon et al. (2014), participants talked of growing more confidence during the period of time when they had good clinical support at ward level. Participants also revealed that they felt safe when working with experienced midwives because chances of missing any aspect of care were very limited.

In a study conducted by Pairman et al. (2015), structured programmes were used as a supportive measure to increase levels of confidence, consolidate knowledge and experience, support critical reflection as well as bridging the gap between being a student and being a practitioner.

On the contrary, Bolden et al. (2011) reported negative or inhibitory midwifery behaviours, which were in most cases, the reverse or opposite of those behaviours participants described as facilitatory and supportive.

4.3.2.1.2 Sub-Theme 2.1.2. Lack Versus Existence of Mentorship and Supervision by Experienced Midwives

According to the findings, newly graduated midwives expected that experienced midwives would mentor and supervise them as they would be providing care to patients. But to their surprise, neither mentoring nor supervision was provided resulting in despair, anxiety and frustration.

NGM 5 from TR hospital stated:

> *Mentoring and Supervision are not there; you have to open your eyes and deliver the baby and make sure everything is fine regarding the mother and the baby. There are a lot of questions and challenges I am faced with in the practical situation and there is no one to ask for clarity. I wish it was possible to go back to the classroom so that I could ask these questions from the lecturers in the classroom so that we hold discussions with other lecturers as well as my classmates.*

According to the findings of the study by Dixon et al. (2015), the new graduate midwives valued being allocated a mentor as they transit from student to an independent practitioner in midwifery continuity of care models. The authors further reported that being allocated a mentor is similar to the concept of preceptorship conducted over a specified timeframe based around clinical teaching and socialization into the organization.

The findings of Dixon et al. (2015) are consistent with Cummins et al. (2016) s' findings when they recommended that nursing must strengthen mentor connections at all levels and develop an everyday mind-set of the mentoring culture. Whether formal or informal, mentoring has been acknowledged as a mutual contract (Cummins et al., 2016). According to (Haggerty et al., 2012), effective communication and personal

commitment on the part of the mentee and mentor is critical to the fundamental success of the partnership.

NGM 3 from LR hospital stated:

> *Supervision they provide is not enough because they just come and observe, if you are doing something right they leave you, no praise. If what you are doing is wrong, some will just say 'do this and this'. Some say 'ask your colleagues to help you. This is bad because as a new graduate, I need somebody who will show me the way as my mentor.*

This was supported by NGM 2 from TR who stated:

> *I am surprised because it is like the main reason of community service is to expose us to maternity unit so that we work under supervision and mentoring. Unfortunately, we are just working like others without any supervision or mentoring. These midwives are so unfair to us. How do they expect us to cope in this situation?*

What participants reflected above is contrary to the findings of the study on 'the mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia' by Pairman et al. (2015) who revealed that a midwifery graduate reported that having a mentor meant a lot to her as she was working under some supervision. "I had a mentor in the first month and I appreciate the fact that I did everything with her". Cummins et al. (2016) supported Pairman et al. (2015), when they revealed that being allocated a mentor meant that a positive relationship developed between the new graduate and the more experienced midwife, described here 'I was allocated a mentor for a month and we still have good mentoring relationship going on.' In a study conducted by Feltham (2014), newly qualified midwives felt mentorship was important in aiding clinical skills enhancement as they

would be able to develop their skills with support and guidance from an experienced midwife rather than being left alone. This is supported by Willis (2015), who found that newly qualified midwives expressed concerns at lack of practice skills and feelings of 'not knowing enough' which affected their confidence. Therefore, there is a need for a robust mentorship programme to be available for all newly qualified midwives as well as the need for further work to be undertaken to ensure that perceived gaps in knowledge have been addressed prior to registration.

NGM 5 from LR hospital stated:

> *I was so frustrated the other day when I asked one of the experienced midwives to help me with vaginal examination because I was not sure of the findings. She never came, she only shouted from where she was saying, 'people come and be my witnesses. I am hearing miracles from this graduate. A graduate who was taught by professors says she is not sure of the findings.' I was so hurt and embarrassed at the same time, but I thank God because one of the midwives came to assist me after hearing that shout.*

Haggerty et al. (2012) reflected a completely different situation whereby the mentors always answered mentees who called them with queries. Mentees referred to their mentors as a "fountain and wealth of knowledge." Lewis and McGowan (2015) concurred with Haggerty et al. (2012) when reporting that the purpose of the mentoring relationship is to enhance the mentee's development by inspiring the mentee to a greater understanding of the role. Lewis and McGowan (2015) further indicated that the learning process is shared, in the sense that the mentee is learning about a role or increasing expertise whereas the mentor is learning about the process of stimulating developmental changes.

NGM 1 from TR hospital said:

> *Honestly speaking there is no supervision and mentoring. When a patient is in labour, I progress her and even deliver her alone without any supervision or assistance. It is really unfair.*

According to a study conducted by Van der Putten (2008) on 'the lived experiences of newly qualified midwives**',** participants identified the importance of good clinical support for newly qualified midwives; the need for a formal supervision and mentorship programme was acknowledged as being extremely important. Participants also felt that allocation of a named mentor or preceptor was very important. Procter et al. (2011) supported Van der Putten (2008) when they recommended that nursing must strengthen the support connections for the newly qualified at all levels and develop an everyday mindset of the mentoring culture.

Malouf and West (2011), reported that newly qualified midwives who received clinical support during their time of exposure, experienced the full range of midwifery skills resulting in a boost in their confidence. These findings are consistent with those of Sullivan et al. (2011), who reported that good clinical support must be accompanied by effective communication and personal commitment between the mentor and the mentee. This makes the partnership to be successful. Rush et al. (2014) reflected a similar view when they reported that support and mentorship offered to newly graduated midwives during their transition period influenced their professional development, leading to the development of professional identity as well as increased reflection on practice.

4.3.2.1.3 Sub-Theme 2.1.3. A Non-Conducive Learning Environment

According to Duchscher's (2009) transition theory, during the initial stages, newly graduated midwives are searching, doubting and questioning almost every aspect of care. Therefore, their queries can be addressed through exposure to conducive learning environment (Duchscher, 2009). Unfortunately, results revealed that the

environment in which newly graduated midwives are working, is not conducive for learning. As a result, their doubts and questions related to aspects of midwifery care are less likely to be attended to.

NGM 2 from MR hospital supported when she stated:

> *The environment is not conducive for learning because when you ask questions you are told that there is no time to attend to your questions as the ward is busy. It is not that they don't teach because the ward is busy, they just don't want to teach. The environment here is not conducive for learning at all. I don't know as to when was the teaching programme prepared, because it has even changed the colour. It is not renewed and not implemented. You even ask yourself as to why is it there because we are never taught.*

NGM 5 from LR hospital stated:

> *We don't learn much from the teaching program that is available because in most instances the program is ignored, and no teachings are done. In cases where the responsible person is reminded to give a lesson, excuses, are made. Example of excuses made include 'I am not prepared as I didn't know that I would be giving a lesson.' If forced, the information shared is very limited as there was no preparation made and lessons end up not helping much.*

A culture that promotes a supportive learning environment where skilled clinicians are able and willing to share their clinical knowledge and expertise is required to create confident practitioners who feel valued and able to start on their professional career (Lennox and Foureur, 2012; Mason and Davies, 2013; Tastan et al., 2013). Unfortunately, there is evidence that this is often not the case, with the new graduates repeatedly describing the workplace as a negative environment that is unhelpful, unsupportive, oppressively hierarchical and at times perceived as having a bullying

culture (Mason and Davies, 2013; Dixon et al., 2015; Kensington et al., 2016).

NGM 2 from MP hospital stated:

> *The environment is not conducive for learning, in most instances you have to learn through trial and error. I did not know how to resuscitate the new-born baby, until one day in which I had to practice it for the first time on the baby. To tell you the honest fact, it was just learning through trial and error. Fortunately the baby cried whilst I was still struggling with the tubing. We were well prepared academically, but you need to have more time in areas such as rescucitation of a newborn baby. We need more workshops and in-service training regarding some midwifery procedures before we can be left to be all by ourselves.*

According to Pairman et al. (2015), one of the strategies to better support midwives in their birth suite rotation was to offer study days that specifically focused on the knowledge and skills required for clinical practice in this setting, for example perineal repair and maternity emergencies. Given the level of anxiety that working in birth suite caused, it is not perhaps surprising that the provision of such study days was highly regarded (Pairman et al., 2015).

NGM 1 from MR hospital said:

> *Some experienced midwives do not say anything when you are doing a procedure. They just keep quiet. If you do something wrong it is then that they scold at you telling you that you think you know better. Some even go to an extent of threatening you, telling you that South African Nursing Council will charge you as if that is their wish. Such threats destroy the little confidence I have resulting in reluctance to perform procedures, because I don't want to be charged.*

In a study on perceived expectations of newly graduated midwives, Kensington et al. (2016), described the hostile learning environment as 'eroding' and 'undermining' graduates' confidence and exponentially increased their fear of 'doing something wrong'; and all these affected their level of performance.

4.3.3 Major Theme 3: Relationship Between Experienced and Newly Graduated Midwives in Maternity Ward

According to the findings, relationship between experienced midwives and newly graduated midwives was poor, resulting in feelings of negativity regarding performane of midwifery skills on the part of newly graduated midwives. Under this major theme, the following themes and sub-themes emerged, as presented in Table 4.7.

Table 4.7: Themes and sub-themes for major theme 3

Themes		Sub-Themes	
3.1	**Positive collegial relationship and willingness to help**	3.1.1	Poor versus positive relationship experienced during execution of duties
		3.1.2	Existence versus lack of willingness by experienced midwives to assist newly graduated midwives
		3.1.3	Lack of orientation in labour ward resulting in strained relationship
		3.1.4	Duty scheduling fairly drawn resulting in improvement of supervision relationship
3.2	**Existence of negative attitudes towards 4 year programme's graduates**	3.2.1	Existence of hatred by experienced midwives to newly graduated midwives

4.3.3.1 Theme 3.1 Positive Collegial Relationship and Willingness to Help

Based on the results of the study, unwillingness to help and negative relationship displayed by experienced midwives towards newly graduated midwives led to poor performance of newly graduated midwives. According to Gray, Leap, Sheehy and Homer (2012), positive relationship between experienced midwives and newly

qualified ones, forms the basis of support, resulting in production of competent and confident professionals.

4.3.3.1.1 Sub-Theme 3.1.1. Poor Versus Positive Relationship Experienced During Execution of Duties

According to Hobbs (2012), the type of relationships that newly qualified midwives had with their colleagues was an important and significant feature of their early experiences. Positive relationships with midwives provided a firm foundation of support on which participants grounded themselves. The results of Dixon et al. (2014) are in agreement with previous assertions when they argued that the individual actions and interactions of midwifery colleagues had a powerful effect on either facilitating or hindering the graduates' level of confidence, competence and sense of safety and engagement within the work environment.

NGM 4 from TR hospital stated:

> *The relationship I am having with some experienced midwives and other members of staff are very good. I respect them and they also treat me with respect. One advanced midwife always encourages me to ask questions where I don't understand, and she teaches me different conditions when the ward is not busy. But with others, they only show you how things are done if you ask, if you don't ask, they just leave you.*

NGM 2 from MR hospital supported NGM 4 from TR hospital when she said:

> *Some experienced midwives are very friendly and approachable; when you ask them to help you they are always there. I feel so safe and confident working in that situation.*

Bolden et al. (2011) and Hobbs (2012) displayed a great similarity between what

participants reported when they discussed about how positive and collegial relationship with the experienced midwives facilitated their ability to take up their role as newly qualified midwives within the context and culture of the maternity unit. Dixon et al. (2014) concurred when he revealed that participants described midwives who made a positive difference and helped them feel comfortable and confident to be 'nice people' that had 'positive attitudes' and demonstrated 'compassion' and 'empathy' to both themselves and women in labour. Based on Hillman and Foster's (2011) findings, the context of positive relationships enabled participants to openly question practice and extend themselves in an environment where someone would always be available to support them.

According to Dixon et al. (2015), evidence revealed that positive midwife–midwife interactions within supportive working environments reflected a sense of equality and restored participants' faith in self. This was supported by Kensington et al. (2016) who described the relationship between the experienced midwife and the newly qualified midwife as central to the learning process.

On the contrary, NGM 1 from LR hospital stated:

> *The relationship between us and some experienced midwives is very poor. When we ask questions, we are told that we are so impossible.*

This was supported by NGM 5 from TR hospital who stated:

> *Some of the experienced midwives don't like us, they even isolate us. If you decide to join them during meals, they openly tell you to wait for them to finish.*

In a study conducted by Pairman et al. (2015), newly qualified midwives reported that they experienced a sense of isolation and exclusion and worried about being labelled

a ‘troublemaker’ if they spoke out. This heightened their nervousness and anxiety. Perceptions of being ‘blamed’ and feeling ‘guilty’ over poor clinical outcomes were associated with an increasing sense of ‘incompetence’ and an inability to fulfil their ‘dream’ of being a midwife.

NGM 5 from LR hospital stated:

> *The relationship is so bad in such a way that when I think of coming on duty, I feel so bored; especially when I know I am in the same shift with those who are not friendly. There are those who even tell you that they don’t want newly graduated midwives in their shift. Such statements are so discouraging and destroy one’s confidence.*

Fenwick et al. (2012) revealed that participants described the consequence of poor relationships with individual midwives and a harsh working environment as sinking of the boat. According to Dixon et al. (2015), feeling ‘small’, ‘belittled’, ‘foolish’ and ‘intimidated’ were just a few of the words used to describe how participants responded to what they described as ‘humiliating’ interpersonal situations and negative interactions with colleagues.

4.3.3.1.2 Sub-theme 3.1.2. Existence Versus Lack of Willingness by Experienced Midwives to Assist Newly Graduated Midwives

The findings revealed that some of the experienced midwives are willing to help, but others are not.

This was reported by NGM 2 from SRR hospital who said:

> *There are those who are very helpful, and are always available whenever you ask for assistance during performance of procedures. If they are not sure of what you are asking, they tell you that they will first go and check you will get the answer tomorrow and indeed when*

they come the next day tomorrow, they will give you an answer.

Mason and Davies (2013) described experienced midwives who were willing to facilitate the sharing of knowledge and expertise and participated in assisting the newly qualified midwives, as crucial to learning and professional development of the newly qualified midwife.

According to Gray et al. (2012), midwives who were 'inclusive' and willingly shared their knowledge, skills and expertise were highly valued by newly qualified midwives. That really helped in building confidence and competence and enhancing one's ability to maintain a focus in the process of progressing a woman in labour. On the contrary, empirical findings also revealed that there are experienced midwives who are not willing to help newly qualified midwives.

NGM 3 from MR hospital said:

> *When you ask for help, some experienced midwives refuse to help saying that they are not going to waste their time teaching us because we used to dodge during our training. I was so bored when one of them answered in that manner because I never worked in that hospital during my training, so where did she see me dodging.*

This was supported by NGM 5 from MP hospital who stated:

> *Experienced midwives give excuses when you ask for help, and there are those who are so bold to openly say that they are not willing to help, others refer us to the colleagues.*

This is contrary to what was reported by Hillman and Foster (2011), who described the value of positivity and willingness of experienced midwives regarding provision of necessary support to the newly qualified midwives, as very important.

4.3.3.1.3 Sub-Theme 3.1.3. Lack of Orientation in Labour Ward Resulting in Strained Relationship

Empirical findings revealed that orientation is done but, not in detail resulting in them running around not knowing where to get some of the resources for use. According to Duchscher's transition theory, orientation forms the foundation of effective transition support (Duchscher, 2009). Kumaran et al. (2014) reported transition period as a difficult period filled with manifestations of reality shock such as fear and anxiety, therefore newly qualified need to be orientated as a way of familiarising them with a new clinical environment full of new responsibilities.

MG 2 from LR hospital supported:

> *It would be better if we were orientated when we first came in the ward. You find it very difficult to work in an unfamiliar situation, and when you ask some of the things, they look at you as if you are trying to be funny; or you are irresponsible.*

This was confirmed by MG 1 from MP hospital who said:

> *They orientated us but not in detail. They just said 'this is labour ward, first stage, second stage, post-natal etc'. They do not tell you the details of what is happening in each unit and where to get equipment, medicines etc. I did not know where to find important drugs such as syntometrine, konakion etc." That is why I said the orientation was not in detail.*

MG 4 from MR hospital said:

> *I felt so embarrassed one day when I was sent to collect adrenaline from an emergency trolley, I did not know where an emergency trolley was as it was not shown to me during orientation. As a result, the doctor had to leave the patient and went to the emergency trolley himself.*

In a study conducted by Schytt and Waldenström (2013), new graduates expressed concerns regarding their level of knowledge and skills, but also found the workplace challenging in terms of the workload and unfamiliarity of a new environment. The authors suggested that effective orientation programme be put in place so that they can be introduced to both the environment and the work routine (Schytt and Waldenström, 2013).

Mason and Davies (2013) reflected a similar version when they reported that orientation does not only familiarize graduates with a new environment, but also boosts graduates' confidence. Kumaran et al. (2014) concurred when they reported that orientation of newly qualified members will enable them to function effectively thereby improving their performance. One participant from a different hospital confirmed that the type of orientation that is done is not helpful, because it is only based on the physical layout of a maternity ward; we were never orientated to some of the important aspects such as the policies and guidelines that govern our practice as midwives.

MG 5 from MR hospital said:

> *When I arrived in the ward I was handed over to a professional nurse who delegated an enrolled nurse to orientate me. I was only orientated on the physical layout of the ward. Nothing was said regarding the policies and protocols. I asked her about a policy for management of post-partum haemorrhage, she said she doesn't know.*

Mason and Davis (2013) reported orientation as the foundation for support for graduates. Authors further reported that it is through orientation whereby graduates can be able to function effectively in a new environment. Dixon et al. (2014), reflected a similar version when they revealed that orientation of newly qualified midwives must

not only involve orientation to the surrounding, but must cover orientation to the policies, guidelines, rules as well as regulations.

Similarly, Schroeder et al. (2014) who interviewed ten newly qualified midwives in Connecticut USA, described new graduates' feelings of anxiety and insecurity as they took up their new role. The authors recommended that they be orientated not only to the new surroundings, but to the routine, policies, guidelines as well as the regulations that govern their practice; in order to facilitate their performance (Schroeder et al., 2014).

4.3.3.1.4 Sub-Theme 3.1.4: Duty Scheduling Fairly Drawn, Resulting in Improvement of Supervision Relationship

Regarding duty scheduling, newly graduated midwives expressed their satisfaction on the way they were drawn, as they were never left to manage the wards alone without a senior member of staff.

NGM 5 from TR hospital said:

> *The nurse managers don't want us to remain alone, being in charge of the ward. They say we must always be with an experienced midwife in each shift and I like that because I am still scared to remain alone with the juniors.*

NGM 2 from LR hospital stated:

> *I like the fact that I* am *always with an experienced midwife, in every shift, I am never left alone to run a shift. It is like a principle, when they prepare off duties, there is no time at which you are left alone as a professional nurse in charge of a shift.*

Contrary to what participants reported, Lennox and Foureur's (2012) findings revealed

that participants were expected, within the first few weeks of qualifying, to be the only qualified midwife in a busy high-risk ward area assuming responsibility for 25 to 30 women and their babies. The authors further reported that letting newly qualified midwives to run high risk wards had a dual effect. Firstly, it created a heightened level of anxiety; on the other hand, it was a steep learning curve (Lennox and Foureur, 2012).

In a study conducted by Dixon et al. (2014), newly qualified midwives were sometimes left managing a ward alone, as the only qualified midwife, at work. They found it hard to *switch off* from their work, often worrying that they had omitted something important or that they had done something wrong. Kensington et al., (2016) concurred when they reported that newly graduated midwives who were left running the ward with no experienced midwife, suffered increased levels of stress and anxiety.

4.3.3.2 Theme 3.2: Existence of Attitudes Towards 4-Year Programme's Graduates

Based on the study by Kensington et al. (2016), newly qualified midwives' performance was negatively affected, as midwives treated them negatively; therefore graduates felt they did not belong to a community of midwives. Cummins et al. (2016) concurred when they reported a close relationship between relationship and performance. Results revealed that experienced midwives had negative attitudes towards newly graduated midwives which really affected their performance.

4.3.3.2.1 Sub-Theme 3.2.1: Existence of Hatred by Experienced Midwives to Newly Graduated Midwives

Participants raised a concern that experienced midwives displayed hatred and unacceptance towards them. This was confirmed by what participants reported.

NGM 4 from SRR hospital stated:

> *There are those who accept and like us, but there are those who hate the graduates of a four year programme. One day I asked one of the experienced midwives to help me with a certain procedure; hey, the response was 'what were you doing at the university for all these four years. We thought you will be expert.' I thought she would help me after having said that unfortunately she did not.*

NGM 3 from TR hospital confirmed when he said:

> *Some experienced midwives do not like us. They are having a problem with our training because they always say that they are looking forward to see the specialised nursing skills learnt at the university. Such remarks make us feel that we are not welcomed. Some even say that products of a four year programme, think they know better, so, I feel if I ask questions they will think that I want to prove a point.*

Davis et al. (2011) reported negative attitude with which experienced staff members presented, resulting in graduates' poor performance as the environment was not conducive for learning. Coulm et al. (2012) concurred when they reported that negative attitude of professionals negatively affected the confidence of the graduates therefore leading to poor performance.

NGM 3 from MP hospital reported:

> *My experience is that some of the experienced midwives don't accept us, and you don't know what to do to make them happy. One day I made a mistake of going for tea without reporting, when I came back I was scolded at. What surprised me was, the following day I reported, instead of her applauding me for having repented, the following was said 'don't tempt me, why are you telling me. Isn't that*

> *you are a boss you just go as you please, don't try to be smart on me. I felt so confused, and I did not know what to do because I thought she was going to be happy and praise me because I changed my bad behavior. They are so frustrating, you don't know how to make them happy. You do this you are wrong, you do this you are also wrong. Really the relationship is not good.*

In a study on 'experiences of new graduates', Kensington et al. (2016) reported that newly graduated midwives felt unaccepted and unwelcomed in the labour ward. As a result, graduates developed negativity towards work which was evidenced by high absenteeism rate. Kensington et al. (2016) reported that there is a close relationship between acceptance in the workplace and level of performance.

4.3.4 Major Theme 4: Expectations of Experienced Midwives from Newly Graduated Midwives

Results of the study revealed that experienced midwives expected newly graduated midwives to function competently and confidently irrespective of their clinical experience. In Table 4.8, themes and sub-themes that emerged under this major theme are displayed.

Table 4.8: Themes and sub-themes for major theme 4

Themes	Sub-Themes	
4.1 Ability to function as professionals	4.1.1	Sense of independence
	4.1.2	Reduction of workload
	4.1.3	Commitment to patient care

4.3.4.1 Theme 4.1 Ability to Function as Professionals

The findings showed that experienced midwives had very high expectation from newly graduated midwives; which when unmet influenced the transition process negatively.

Cubit and Ryan (2011) reported that experienced midwives' expectations of the new graduates may impact on the opportunities and experiences available to them during their transition to practice. Furthermore, new graduates' perceptions of their own level of knowledge, skills and expertise on registration influence how they approach their transition to practice.

4.3.4.1.1 Sub-Theme 4.1.1. Sense of Independence

Results revealed that experienced midwives expect newly graduated midwives to be competent and behave like independent practitioners. When newly graduated midwives fail to behave likewise, experienced midwives become frustrated.

This was confirmed by what EM 3 from MR hospital reported:

> *I am so disappointed because I thought that the graduates will be able to function as independent professionals, instead they are not. When you are working with them it's the same as when working with students. They are not fit to work as professional nurses, you always need to be with them at all times and that's so frustrating.*

According to Ostini and Bonner (2012) as soon as graduates are placed in the units for provision of services, they should be able to correlate theory mastered in classrooms with the practical settings' requirements. Mason and Davis (2013) concurred that experienced midwives considered graduates to be competent regarding provision of normal midwifery services despite the fact that they lacked experience. On the other hand, Price (2014) advocated for the use of preceptors who would assist the graduates to promote effective correlation of theory and practice.

EM 1 from TR hospital said*:*

> *You expect extra hands, instead they need you wholly. There are*

> *those who need assistance in simple procedures such as admission of a woman in labour. You ask yourself if such graduates never went to the clinical area during their training. When they realize you are committed to help them, they will make a streamline following you; this makes you not to complete your job as you will be attending to them. In that situation, you feel it would be better if you were alone because they are just a burden to you.*

Based on Mason and Davies' (2013) study, graduates were considered to know everything; therefore they were expected to function in the same way experienced midwives did. Dixon et al. (2014) concurred when they reported about high and idealistic expectations experienced midwives had from graduates. These authors also stated that experienced midwives expected new graduates to be able to cope with high levels of responsibility and accountability of their new roles (Dixon et al. 2014).

EM 3 from MP hospital said*:*

> *These graduates don't want to remain in the unit alone and say if something happens they will be accountable. That is so frustrating because we are banking on them as they are no longer students. We end up changing our off duties in order to remain with them. Some don't want to go to theatre alone to receive new-born babies. They say they don't feel confident enough to that alone.*

This is confirmed by Feltham (2014), who reported that newly graduated midwives do not feel safe to remain with the ward alone. They need time to familiarize themselves with the new work situation and to develop the competence necessary to assume full responsibility (Feltham, 2014). Avis et al. (2012) revealed that on qualification participants realized that the protection and support offered by their preceptors during their training was abruptly withdrawn, and such withdrawal made them feel like they are abandoned resulting in clinging to the experienced midwives for support. This was supported by Jordan et al. (2013), who reported the assimilation anxiety experienced

by newly graduated midwives as they are suddenly expected to assume responsibility for their own patients, together with a loss of sheltered academia which made them feel vulnerable.

4.3.4.1.2 Sub-Theme 4.1.2. Reduction of Workload

Experienced midwives reported that availability of newly graduated midwives to the labour wards was expected to add extra manpower reducing the workloads. However, the newly graduated midwives could not meet these expectations. Managing the workload in any area of maternity care was a challenge all midwives face, whether they are newly qualified or not (Carter et al. 2013).

EM 1 from LR hospital said*:*

> *It's so frustrating because we thought our workload will be reduced as we are now having extra hands. Instead they become a problem because they can hardly perform any single procedure alone. You should always be there for assistance whenever they are performing duties.*

EM 3 from SRR hospital stated:

> *Sometimes you feel like it would be better if you were alone because you spend so much time guiding and supervising them as if you are working with a student. We thought our lives were going to be better as we though they would reduce the workload, instead they make the workload to be doubled.*

In their study of newly graduated midwives in New Zealand, McCarthy et al. (2013) found that graduates struggle to fit in and unable to develop the confidence and competence to positively contribute to the workload. This is because they may not have the required level of skills or expertise, leaving the experienced midwives

struggling with the workload (McCarthy et al., 2013).

EM 5 from SRR hospital stated:

> *We were so happy when we realized they were going to form part of our staff, because we are over-worked due to shortage of staff. But we are so disappoint because there is no reduction of workload at all. One day I delegated one to go to theatre to receive a new-born baby. The response I got was, 'I don't feel confident enough to go to theatre alone.*

This was confirmed by EM 4 from MR hospital *who* said:

> *We are short staffed to provide close supervision, and it's like these graduates do not take that seriously because they still demand your attention even if you are alone.*

In contrast, New Zealand authors Panzavecchia and Pearce (2014) asserted that it is unacceptable to expect undergraduate prepared midwives to have all the necessary skills on qualification because they do not have the additional nursing experience or knowledge. In their opinion piece they state that structured transition programs need to be on offer in order to support them safely and effectively into practice (Panzavecchia and Pearce, 2014).

4.3.4.1.3 Sub-Theme 4.1.3. Commitment to Patient Care

Experienced midwives reported that newly graduated midwives are not committed to provision of midwifery services. This is congruent with what was reported by Deasy, Doody and Tuohy (2011) that on qualification, graduates seem to be less committed to care provision because they are still confused about role changing.

EM 2 from TR hospital said:

> *Some of the new graduates are committed to provision of care to patients, the problem is that they are not competent. Some are competent but do not have confidence in what they do as a result, performance of procedures becomes very slow.*

In their study, Fenwick et al. (2012) reported that participants *"…are committed to provision of quality care, but the problem is that during transition they still feel incompetent and less confident; therefore they need support from the experienced professionals. Unfortunately, support is not there and that makes them resort to being mischievous as a way out."*

EM 1 from LR hospital said:

> *These graduates are not serious, neither are they committed. If a cell phone rings whilst attending to the patient, s/he stops everything and attends to a cell phone. They are not committed; you cannot even risk leaving them running a shift.*

This was supported by another participant who said:

> *We are so shocked because we thought they will be committed to render quality care to patients, but they are not. Some openly verbalize that they are not even interested in working in the labour ward they are just complying with the…*

Young (2012) revealed that newly graduated midwives find it difficult to make independent decisions, high levels of responsibility and accountability lead to anxiety; that negatively affect their commitment regarding performance of care to patients. Jordan et al. (2013) concurred when they reported that newly qualified midwives demonstrated a very low level of commitment to provision of care. This was due to increased level of anxiety resulting from fear of making mistakes, lack of knowledge and experience, lack of organizational skills together with the accountability associated with the new role (Jordan et al., 2013).

EM 4 from MP hospital said:

> *Some graduates first check the off duties. When they realize they are remaining with the supervisor they don't like, they absent themselves from duty, faking illness. They don't even hide it they tell their friends that I won't come tomorrow because I don't want to work with so and so.*

EM 3 from MR hospital stated*:*

> *Some absent themselves because the say that the type of duties in which you are on duty for 8 consecutive days are so strenuous. Therefore they either report sick a day or two before going for resting days or vice versa. Some report sick if their requisitions for special off duties have not been approved.*

Fenwick et.al (2012) indicated that experienced midwives rated some newly qualified midwives as competent regarding the necessary skills and knowledge to perform the roles expected of them, the only problem was lack of interest in midwifery field and this affected their commitment. This was confirmed by Crombag et al. (2013), who assessed newly qualified midwives, and concluded that they were fit for practice at the time of their professional registration; the only thing that could not be guaranteed was the level of commitment.

4.3.5 Major Theme 5: Clinical Placement Expectations of Newly Graduated Midwives

Results revealed that participants felt that the period of placement in maternity unit during transition period is short, and should therefore be extended to twelve months. Participants further claimed that extension of the placement period will help them gain competence as well as confidence. Under this major theme, a theme with two sub-themes emerged, as reflected in Table 4.9.

Table 4.9: Themes and sub-themes for major theme 5

Themes		Sub-Themes	
5.1	**Period of placement**	5.1.1	Prolonged placement in the labour ward
		5.1.2	Placement in maternity sub-units versus general wards

4.3.5.1 Theme 5.1: Period of Placement

Newly graduated midwives recommended that they would appreciate it if the period of placement in a maternity ward would be prolonged to a year instead of six months, so that they become confident regarding provision of quality midwifery services. Dixon et al. (2015) reported that the more newly qualified midwives are exposed to the clinical area, the more they become competent and confident in managing midwifery services.

4.3.5.1.1 Sub-Theme 5.1.1. Prolonged placement in the Labour Ward

Empirical findings revealed that participants recommended that they be placed in maternity ward for longer periods in order to gain more competence as well as confidence. With regard to the duration of placement in a labour unit, a number of authors debate if newly graduated midwives are confident enough in their knowledge and skills to practice autonomously after a three months placement period (Shibley, Amaral, Shank and Shibley, 2011; Fenwick et al., 2012; Dixon et al., 2014).

NGM 2 from TR hospital stated*:*

> *If I had the power, I would say that newly graduated midwives should be placed in labour ward for six-months continuously, whereby 4 months should be during the day and 2 months during the night. Maybe this would help us to improve our knowledge and skills, gain confidence and competence as well as becoming responsible and accountable.*

NGM 4 from SRR hospital stated:

> *I feel that six months placement in a maternity unit is not enough. I would recommend that newly graduated midwives be placed in a maternity unit for the whole year; in which one is placed in labour ward for six months and the rest of the time is allocated for other sections of maternity. The first two months in labour ward, must be spent working with a mentor on a fulltime basis.*

Participants expressed fear, anxiety and frustration when they were confronted with the difference between the ideal world and the real world in a labour unit; which led them to suggest that the period of placement in a labour unit be extended. Extension would help them familiarize themselves with labour ward routine (Hillman and Foster, 2011). Dixon et al. (2015) concurred when they asserted that placement of newly graduated midwives should be done in such a way that graduates obtain enough time for exposure to the routine, this would help them gain competence as well as confidence.

NGM 3 from LR hospital said:

> *I have completed my training and I know how to perform procedures, but I don't feel confident enough to manage the ward. I need more time to manage the labour ward.*

NGM 1 from MP supported what was said by the previous participant, when she said:

> *It is so unfair because experienced midwives expect us to work like them, and that is not possible because we are still not competent and confident to practice as professional nurses. They expect too much from us and they forget that they also started like us. We still need more time to gain experience which will enable us to manage the labour ward competently and confidently.*

In an Australian study of newly qualified midwives, (Davis et al., 2011) found that self-reported confidence to be able to practise, within the International Confederation of Midwives' definition and scope of practice of a midwife, was low for Australian graduates. Kumaran et al. (2014) concurred with what was reported by Davis et al. (2011) when they revealed that graduates required more time to become confident within the clinical setting of a labour unit and that a well-supported graduate nurse programme was needed.

4.3.5.1.2 Sub-Theme 5.1.2. Placement in Maternity Sub-Units Versus General Wards

Results revealed that graduates feel more competent and confident regarding placement in general wards than in maternity units, Hence, they recommended that placement in maternity unit be prolonged. Fullerton et al. (2013) asserted that graduates considered placement in maternity units as more complex than in any other unit in the hospital. Dixon et al. (2014) concurred when reporting that newly qualified midwives felt more confident regarding provision of care in the medical and surgical units than in maternity unit.

NGM 3 from MP hospital stated:

> *I don't have any problem with medical and surgical conditions, they are not as complex as maternity conditions. I feel confident in managing them easily, but with midwifery conditions I can't, and when I think about midwifery complications it's even worse.*

NGM 4 from LR hospital stated:

> *"I understand the fact that shortage is all over, but in general wards it is better because enrolled nurses and enrolled nursing auxiliaries are also involved in care provision; but in maternity wards midwives*

are the only ones involved in provision of care. Therefore, our prolonged period of placement in maternity unit will also help in solving the problem of shortage of staff. "

NGM 5 from SRR hospital stated:

*Graduates need more practice i**n** midwifery care, especially because midwifery training is less as compared to general nursing. Midwifery training starts during 3rd year and continue to 4th year but general nursing continues throughout a period of 4 years.*

Barry et al. (2013) emphasized that newly qualified midwives still need more supervised practice especially when dealing with midwifery high risk conditions. This is because they don't have enough experience regarding provision of midwifery services. Cummins et al. (2016) concurred when reporting that midwifery graduates revealed that their period of exposure to midwifery cases during training is limited as compared to general cases. The authors further reported that graduates felt less confident to manage midwifery cases; Hence, they needed prolonged exposure to midwifery world after completion of their training (Cummins et al., 2016).

4.4 Summary

This chapter focused on the interpretation of the data collected from a sample of five (5) experienced midwives and five (5) newly graduated midwives from each selected regional hospital and a tertiary hospital in all the districts of Limpopo Province. Collected data was based on the objectives. Labour ward was viewed as a traumatic environment, and graduates revealed that professional nurse's role was very demanding. Newly graduated midwives felt that the support they received from the experienced midwives was ineffective, as they were neither mentored nor properly supervised and the environment was not conducive for learning. Empirical findings revealed that graduates failed to meet experienced midwives' expectations as they

were unable to function independently. Effective transition support emerged as a core concept, and its analysis is discussed in the next chapter. Discussion on development as well as validation of a transition orientation programme is also covered in the next chapter.

CHAPTER 5

Concept Analysis, Programme Development and Validation

5.1 Introduction

The findings of phase 1 of the study were discussed in the previous chapter. This chapter focuses on phase two (2) of the study, which is comprised of concept analysis, programme development as well as its validation. Concept analysis was guided by the steps as outlined by Walker and Avant (2011). The findings of concept analysis led to development of a transition support programme, which was based on: (1) Conceptual framework of ADDIE's model for training and instructional design, of which the steps are: Analysis, Design, Development, Implementation and Evaluation (Cutler et al., 2012); and (2) Stages of transition theory by (Duchscher, 2009) as follows: the stage of doing, stage of being and stage of knowing. A quantitative approach was used to validate whether the developed transition support programme would be able to serve as an effective tool for supporting newly graduated midwives during their transition period. The validation process was based on a framework for programme evaluation in public health by CDC. This chapter is congruent to objectives 4 and 5, which state:

- To develop a transition support programme to enhance effective support of newly graduated midwives during their transition period

- To validate a developed transition support programme for effective support of newly graduated midwives during their transition period.

5.2 Concept Analysis

According to Mouton (2010), concept analysis refers to clarification and analysis of the lay concepts in the study in the way in which one's research is integrated into the body of existing theory and research. Walker and Avant (2011) defined concept analysis as an integrated part of terminology work, because concept is considered as a central element in terminological theory. Concept analysis was done based on Walker and Avant's (2011) method, in order to clarify meaning and promote mutual understanding of the readers, regarding the major concept '*effective transition support*' that emerged from the findings of the study. Analysis of the concept '*effective transition support*' was guided by the following steps as described by Walker and Avant (2011):

1. Select a concept
2. Aims of analysis
3. Identify uses, characteristics or connotations of the concept
4. Determine defining attributes
5. Construction of a model case
6. Identify antecedents and consequences
7. Define empirical referents

5.2.1 Select a Concept

Empirical findings revealed that newly graduated midwives viewed labour ward as a traumatic environment as it was very busy and with a serious shortage of staff. Graduates also expressed a professional nurse's role as stressful as it demands a high level of responsibility and accountability which they did not have, and

experienced midwives being so unsupportive. Newly graduated midwives felt that the support they received from experienced midwives was ineffective, as they were neither mentored nor properly supervised and the environment was not conducive for learning. Reality shock experienced by newly graduated midwives, coupled with poor relationship with experienced midwives and poor learning opportunities frustrated graduates and made them lose the little confidence they had. The findings also revealed that graduates failed to meet experienced midwives' expectations as they were unable to function independently, resulting in failure to reduce the workload.

Newly graduated midwives recommended that their placement in maternity ward be extended from a period of six months to a year in order for them to build confidence in midwifery practice. Based on the findings, ineffective transition support of newly graduated midwives during their transition period, was found to be the central idea or event and all other categories and attributes revolved around it. The identified transition support gaps then raised a question in the mind of the researcher as to "What then constitutes 'effective transition support'?" Hence, the researcher identified '*effective transition support*' as a core concept to be analysed. The section that follows aims at determining the aims or purposes of concept analysis.

5.2.2 Determine the Aims or Purposes of Analysis

In order to achieve the aims of analysis, a researcher conducted an extensive literature search. Based on Walker and Avant (2011), the main aim of concept analysis was to provide a definition and clarity to the meaning of 'effective transition support' that contributed to understanding its use within the context of provision of midwifery services by newly graduated midwives, during their transition period in Limpopo Province. Concept analysis was done in order to have a better understanding of how the term 'effective transition support' is perceived.

Definitions were sought from various sources, including English dictionaries; psychology; sociology and health sciences literature. As this is a three-word concept, the words '*effective transition support*' were explored independently. Based on Smeltzer (2008), the critical attributes of 'effective transition support' as both the process and product were identified and differences between 'connotation' and 'reference' distinguished. The analysis determined the meaning of the concept 'effective transition support' and its usefulness, applicability and effectiveness as key concepts for transition support. Moreover, concept analysis was used to define a term for subsequent research or to examine how a concept was used within the current literature or in actual clinical practice (Chinn and Kramer, 1999). Discussion about the uses as well as characteristics or connotations of the concept were analyzed in the next step.

5.2.3 Identify Uses, Characteristics or Connotations of the Concept

To identify and explore basic information about the concept "*effective transition support*", dictionaries, thesauruses and available literature were used. Extensive literature review was done and the ultimate choices of the defining attributes were based on such review of literature.

5.2.3.1 Definitions

5.2.3.1.1 Effective

Effective means producing the desired or intended results (Merriam Webster Dictionary, 1991). Barry et al. (2013) defined effective as an extent to which planned outcomes, goals, or objectives are achieved as a result of an activity, strategy, intervention or initiative intended to achieve the desired effect, under ordinary circumstances.

5.2.3.1.2 Transition

Transition is a process of changing from one state or condition to the other (Oxford dictionary, 2016). Merriam Webster Dictionary (1991) defined transition as movement, development, or evolution from one form, stage, or style to another. Based on Schlossberg's Transition Theory in sociology, Evans, Forney and Guido-DiBrito (1998) defined transition as any event, or non-event that results in changed relationships, routines, assumptions, and roles. The authors further highlighted that it is important to consider the type, context, and impact of the transition for a particular individual in order to understand the meaning of transition to that individual (Evans et al., 1998).

According to Duchscher's (2009) transition theory, transition is the process whereby neophytes of a profession progress through the stages starting from when they are excited and exhilarated; through a shocking assault on their professional values that leaves them disoriented and disillusioned; and to the recovery and resolution phases, marked by a return of a sense of balance.

In the health care context, transition refers to movement of patients between health care practitioners, settings, and home as their condition and care needs change. For example, a patient might receive care from a primary care physician or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility.

Finally, the patient might return home, where he or she may receive care from a visiting nurse or support from a family member or friend (JCC, 2010). In the psychological perspective, transition is defined as the process of change that people make from one place or phase of life to another over time (Fabian and Dunlop, 2006).

The authors reported that transition involves changes of relationship, teaching style, environment, space, time, contexts for learning, and learning itself, combine at moments of transition making intense and accelerated demands (Fabian and Dunlop, 2006).

According to the authors, transition can bring the excitement of new beginnings, the anticipation of meeting new people and making new friends, and the opportunity to learn new things. There can also be an element of apprehension of the unknown which can cause confusion and anxiety, leaving an impression that may still affect behaviour many years later (Fabian and Dunlop, 2006).

5.2.3.1.3 Support

Stoltz, Anderson and Wilma (2007) described support as provision of assistance, encouragement or approval to whatever one is doing. The authors further described support as a mechanism or arrangement that helps keep something else functioning, and such support ca be physical, emotional or life support (Stoltz et al., 2007). According to JCC (2010), support is a process to enable someone to last out, give strength to, encourage, give help and speak in favour of.

The Merriam Webster Dictionary (1991) reflected that support is about assisting a person by one's presence, giving moral and, or psychological support. In the health care context, support involves provision of services to human beings; in order to promote, improve, conserve, and or restore the mental, physical, emotional, spiritual as well as social well-being of human beings.

Services for support include among others; the management of health services resources, such as manpower, finances and facilities; preventive and curative health measures (Fabian and Dunlop, 2006). In the sociological concept, support is

described as an array of social exchanges which involves encountering support, recognizing support and feeling supported (Cora and Alwyn, 1997).

5.2.3.1.4 Effective Transition Support in Health

Effective transition support is the support that is given during the period of development from one stage to the other with an aim of producing desired results (Duchscher, 2009). The author further reported that for neophytes of the profession to effectively progress from the transition stages, experienced members of the profession should take them by a hand.

Hence, effective transition support in the health perspective involves two aspects. Firstly, structured support that should be provided to graduates by experienced members of the team and secondly, formal and structured support that should be provided to patients during their movement between health care practitioners, settings, and home as demanded by their care needs.

5.2.3.1.5 Effective Transition Support in Psychology

Support that is provided to an individual during the process of development of new and appropriate psychological and behavioural responses which gradually turn unfamiliar and stressful demands into routine stimuli (Sykes and Eden, 1985). According to Evans et al. (1998), for transition support to be effective, factors such as the situation, self, support, and strategies should be taken into consideration.

The situation or environment should be conducive for effective transition support. The self covers personal and demographic characteristics such as the way an individual views life, age and health status; whereas the psychological status includes the ego, outlook, commitment, values and the types of relationships that should be established in order to promote effective transition support. The strategies that are employed

should be conducive for promotion of effective support (Evans et al., 1998).

5.2.3.1.6 Effective Transition Support in Sociology

Transition involves the normative and non-normative changes that individuals experience over time (George, 1993). Stoltz et al. (2007) described effective transition support as an arrangement that covers social support, perceived social support and received social support; that helps keep something else functioning. Therefore, transition support is considered effective when all aspects of social support have been taken into consideration; resulting in identification of the mechanisms by which transitions affect outcomes. It is important to note that transition can only be described as effective by the individual experiencing it (George, 1993; Stoltz et al., 2007).

5.2.3.2 Types of Effective Transition Support

There is a general consensus that effective transition support moderates stress, frustration and anxiety. Individuals have needs that are supposed to be met through the interactions in a variety of relationships; and failure to meet such needs may lead to a certain degree of distress (Uprichard, 2008). Barry et al. (2013), supported what (Uprichard, 2008) revealed when they reported that every individual needs to have support because provision of such support results in satisfaction of interpersonal needs; on the other hand, inadequate provision of support leads to distress. Hereunder is a discussion of different types of transition support which are; emotional support, appraisal support, informational support and instrumental support.

5.2.3.2.1 Emotional Support

Yongmei, Jun and Weitz (2011) defined emotional support as the ability to show empathy, compassion and genuine concern for another person. Empirical findings revealed that newly graduated midwives experienced tension, anxiety, frustration and

stress resulting from a lot of contributory factors revolving around the responsibilities of a new role as well as the labour ward environment. Duchscher (2009) also reported that emotional support of newly graduated midwives is of vital importance especially during first and second stages of transition theory which are 'the stage of doing and the stage of being'. The author revealed that during these stages, new graduates suffer from transition shock as well as transition crisis, which leave them with little strength to face and accommodate the responsibilities set before them (Duchscher, 2009). It is therefore important that a system be put in place for newly graduated midwives to be supported regarding issues that affect their emotional state, and such may include provision of counselling services.

5.2.3.2.2 Appraisal Support

This form of support involves transmission of information in the form of workshops, in-service education as well as positive feedback (Uprichard, 2008). According to Kumaran et al. (2014), midwifery graduates perceived support to be particularly high, when the organization provided appropriate resources such as developmental opportunities and feedback.

Empirical findings revealed that newly graduated midwives needed to be commended for the effort they were putting regarding provision of midwifery services under stressful conditions such as busy labour ward, shortage of staff and ineffective support by the experienced midwives. The process of commending graduates should be done by their supervisors, managers and colleagues; and that they be provided with knowledge of how to provide quality midwifery care to patients under such stressful conditions.

Zagenczyk, Scott, Gibney, Murrell and Thatcher (2010), also reported that human resources practices such as rewards for good performance, developmental

experiences and promotions are an indication of the organization's respect for the performance of employees. Based on Duchscher's (2009) transition theory, new graduates experience consistent and rapid advancement in their thinking, knowledge level and skill competency; especially during the 'stage of being'. It is therefore necessary that the management team as well as experienced midwives be committed to provide appraisal support for the rapid advancement. It is important that praises and constructive criticism be given when due as a way of encouraging them to strive for the best Duchscher (2009).

5.2.3.2.3 Informational Support

According to Yongmei et al. (2011), information support includes advice, guidance, suggestions, directives or any useful information to assist the person to respond appropriately to personal or situational demands. Jacobson (1986), describes informational support as information and knowledge sharing and or advice giving that helps the individual to understand his or her world so that he adjusts to changes within it. According to Duchscher's (2009) transition theory, during the stage of being, graduates express a desire for clarification and confirmation of their own thoughts and actions. They feel confident when they realize that they could make decisions and implement actions that are not only appropriate but also safe (Duchscher, 2009).

Therefore, experienced midwives must keep newly graduated midwives informed about policies, guidelines and organizational norms regarding effective management of patients. Procedures as well as issues related to effective management of the unit should be made clear so as to foster positive self-regard, build trust as well as confidence in newly graduated midwives. Updated policies, directives as well as procedure manuals on how to manage different conditions in a maternity setting; should be made available to newly qualified midwives.

5.2.3.2.4 Instrumental Support -

The most concrete direct form of support that can be provided to new employees is in the form of human as well as material resources (Solowiej et al., 2010). Based on empirical findings, there is a very serious shortage of midwives in maternity ward; which make them work for long shifts. Shortage of equipment has also been reported as a challenge to provision of quality midwifery services. Newly graduated midwives need to be provided with more concrete forms of support which include enough human and material resources, conducive and flexible working shifts as well as conducive tea rooms in which they can rest in between the broken shifts.

The literature showed that there are other concepts that are closely related to the core concept but are not the same as the concept in question (Walker and Avant, 2011). In this study, the concepts that are closely related to effective transition support are professional support, clinical support and mentoring; and are discussed below.

5.2.3.3 Disambiguation of the Concept "Effective Transition Support"

Concepts of professional support, clinical support and mentoring are closely related to effective transition support. These concepts play a major role in the promotion of effective transition support, and hereunder follow a description of each:

5.2.3.3.1 Professional Support

According to Lennox et al. (2012), professional support is the kind of support that is given to a group of professionals by members of the same professional group, as a way of encouraging, updating and motivating one another regarding a particular profession. Lennox et al. (2012) reported that lack of support from professionals has been identified as a major barrier to professional development, especially among the new employees.

Professional support cuts across all professional members as it is believed that learning is continuous, and can be done through seminars, workshops, conferences. Professional support is different from effective transition support because the latter is geared at provision of support to graduates during their transition period; whereas the former is not necessarily aimed at new graduates at a prescribed period of time, but every professional and it happens continuously.

5.2.3.3.2 Clinical Support

Clinical support involves support provided to students during their placements in the clinical areas as well as support provided to workers in general during their employment in the clinical areas (Schytt and Waldenström, 2013). When students are placed at the clinical facilities, lecturers and preceptors from the educational institution responsible for their training follow them up in the clinical areas to ensure that they are able to correlate the theory they learnt in the classroom with the practice they are faced with in the clinical areas. It is through clinical support whereby learning becomes easy and practical. This kind of support should continue even during transition period, through supervision and mentoring by experienced midwives. Clinical support does not necessarily mean transition support as it is provided throughout; whereas transition support is provided during transition period.

5.2.3.3.3 Mentoring

Mentoring is a relationship between two individuals based on a mutual desire for development towards career goals and objectives (Kensington et al., 2016). According to Lennox and Foureur (2012), mentoring is a structured dialogue in which a mentor facilitates reflection and the relationship is based on trust, confidentiality, mutual respect and sensitivity. Mentoring is not transition support, but can rather be one of the strategies to enhance transition support. The main purpose of mentoring the newly

graduated midwives was to help increase the impact of continuing professional development. It was through mentoring whereby newly graduated midwives are socialized into the midwifery field. Mentoring makes the whole transition process to be smooth and effective as graduates do not travel this journey alone, but their hands are held by somebody full of knowledge and experience.

Not only does mentoring make transition smooth, but also helps graduates to become competent, confident, responsible and accountable thus preparing them to accomplish their independent role as professionals. After distinguishing effective transition support from other closely related concepts, its attributes were determined as positive collegial relationships, learning opportunities, supervision, mentoring, orientation and commitment; and their discussion was covered in the next step.

5.2.4 Determine the Defining Attributes

The attributes and essential characteristics of a concept are determined by the meaning of the identified concept. The components that constitute the concept should be applicable to any situation in which the concept is located. Walker and Avant (2011) consider determining the defining attributes as the 'heart of concept analysis. The purpose of this step was to identify all those characteristics without which effective transition support would not be possible. Defining attributes of the concept exist when the analyst has identified all the different usages on examining the different concept, taking into consideration the characteristics that appear over and over again (Walker and Avant, 2011).

Based on Walker and Avant's (2011) principle, any concept analysis should consist of more than one defining attribute; however, one needs to determine which attributes are appropriate for the purpose of exploration of the concept. Based on this principle, the critical defining attributes of the concept 'effective transition support' included:

positive collegial relationships, learning opportunities, supervision, mentoring, orientation and commitment, as presented in Figure 5.1. These attributes were identified as they formed the basis for the existence of effective transition support. There wouldn't be any effective transition support without the existence of positive collegial relationships, learning opportunities, supervision, mentoring, orientation as well as commitment; and the discussion of each was covered in this step.

Source: Walker and Avant (2011)

Figure 5.1: Defining attributes of effective transition support

5.2.4.1 Positive Collegial Relationships

The foundation for effective transition support of newly graduated midwives is establishment and maintenance of positive collegial relationships between experienced and newly graduated midwives. In other words, effective transition

support cannot be possible without the existence of positive collegial relationships between the two parties. It is important that establishment of positive collegial relationships starts right from the beginning of transition process, because during the first two stages of Duchscher's (2009) transition theory, that is 'the stage of doing, and the stage of being', graduates suffer from transition shock and transition crisis. Therefore, an environment conducive for positive collegial relationships should be established so that the graduates can have a shoulder to lean on.

Newly graduated midwives are so frustrated and anxious, and when the relationship is negative and unfriendly, frustration, anxiety as well as tension becomes worse for they don't have anybody to turn to for support. It is therefore important that they interact with individuals who are empathetic, caring and compassionate in order to assist them go through transition stages with positive minds.

Establishment of a firm foundation of good and positive supervisory relationship and support system enables newly qualified midwives to confidently embrace the challenges and never ending learning opportunities that the real world of midwifery practice presents (Fenwick et al., 2012). In a study conducted by Kensington et al. (2016), newly graduated midwives considered positive relationship with their experienced peers as very important and significant to their development, as it provided them with the opportunity for supervision, guidance, support and orientation. Not only do positive relationships benefit newly graduated midwives but the entire maternity unit including even patients (Kensington et al., 2016). Tastan et al. (2013) reported that in a study they conducted, newly qualified midwives expressed their desire to access supportive supervisors who are positive, approachable, trustworthy and have clinical credibility, rather than negative experiences that deeply affect their long-term expectations.

5.2.4.2 Learning Opportunities

Creation of an environment conducive for learning opportunities is also very important for effective support of newly graduated midwives during their transition period; because it is through learning opportunities whereby effective support is enhanced. Despite the fact that newly graduated midwives have successfully completed their training, they need guidance on how to effectively integrate the knowledge and skills gained during training with practice. This will enable them to provide quality midwifery services.

Based on Duchscher's (2009) transition theory, during the initial stages of transition, graduates are searching, doubting and questioning almost everything. It is therefore through positive learning opportunities whereby their questions and doubts can be addressed. Lennox and Foureur (2012) revealed that it is in a supportive learning environment whereby, skilled professionals are able to share their clinical knowledge and expertise to develop confident practitioners who feel valued and able to start on their professional career.

5.2.4.3 Mentoring

Mentoring is a strong and powerful tool for effective transition support, as it provides an opportunity for newly graduated midwives to learn and therefore effectively implement the knowledge and skills they have gained under the umbrella of an experienced midwife. This helps them to feel confident as they provide midwifery services to patients. It is through mentoring whereby effective communication skills between experienced and newly graduated midwives as well as with the patients are enhanced; resulting in graduates mastering effective communication skills through which they will effectively communicate with the patients. According to Feltham (2014), newly graduated midwives reported that they felt they were effectively

supported as experienced midwives walked with them through their transition journey teaching, guiding and showing them the way as their mentors. Literature also revealed the importance of mentoring when Haggerty et al. (2012) described mentoring as characterised by the mentee taking an active role in the relationship rather than the mentor so that “empowerment and personal accountability” are enhanced.

Lewis and McGowan (2015) concurred with Haggerty et al. (2012) when reporting that the purpose of mentoring is to enhance the mentee’s development by inspiring the mentee to a greater understanding of the role. Lewis and McGowan (2015) further indicated that the learning process is shared, in the sense that the mentee is learning about a role or increasing expertise whereas the mentor is learning about the process of stimulating developmental changes.

5.2.4.4 Supervision

For effective transition support to be possible, newly graduated midwives need to be supervised, as they are not yet fully competent and still lack the experience regarding provision of midwifery services. Therefore, for them to effectively transit from being students to becoming professionals, supervision is necessary so that they get an opportunity of learning to be competent and confident under close supervision of the experienced midwives.

Feltham (2014) revealed that graduates felt they were effectively supported, as they were closely supervised by the experienced midwives during performance of midwifery tasks. Kensington et al. (2016) concurred when reporting that newly qualified midwives never felt stranded during patient care because their senior colleagues provided them with the necessary supervision they needed, especially in the labour ward; which boosted their confidence.

5.2.4.5 Orientation

According to a transition theory by Duchscher (2009), orientation forms the foundation of effective transition process. Therefore, there is no way in which one can claim to effectively provide transition support when the process is not based on orientation as the foundation. The whole transition support has to start with orientation of the graduates. Graduates should be orientated to such aspects as the surrounding, routine, policies and guidelies regarding provision of quality midwifery services.

According to Lennox et al. (2012), orientation forms the basis of support for newly qualified staff members. The authors further reported that it is through orientation whereby newly qualified midwives can be able to function effectively in a familiar environment. Mason and Davies (2013) concurred when they reported that participants stated that they worked with confidence as they were well orientated. Participants further reported that even though they were new in the ward, they felt like they have been working there for months. For these reasons, orientation becomes one of the cornerstones for effective transition support of newly graduated midwives.

5.2.4.6 Commitment

For transition support to be effective, newly graduated midwives should be committed and ready for support, because no matter how effective transition support might be there is no way in which the objective can be met if the recipients who are graduates are not committed and ready for support. Not only should the newly graduated midwives be committed to effective support but should also be committed to provision of quality midwifery services to patients. Therefore, when the graduates are committed to their effective support during their transition period, they will gain knowledge and skills, develop competence and confidence and become responsible and accountable; which will therefore have a positive impact on their performance of midwifery services.

A discussion about the defining attributes was followed by the next step which covered construction of a model, borderline as well as contrary cases.

5.2.5 Construction of a Model Case

Walker and Avant (2011) emphasized that development of model and additional cases is important in clarifying abstract concepts. The following are the different kinds of cases; model, borderline, related, contrary, invented and illegitimate cases. However, only three cases are presented in this chapter to illustrate and clarify what effective transition support is; and such are model, borderline and contrary cases which were drawn from the findings and put in a real life context.

5.2.5.1 Model Case

A model case is a real life example of the use of the concept which includes all of the key characteristics of the concept, (defining criteria) and at least one of the antecedents and consequences (Walker and Avant, 2011). The model case should be a pure case of the concept, a paradigmatic example, or a pure exemplar (Walker and Avant, 2011). It is generally regarded that the author should be able to construct a model case which allows him/her to state ‘if this is not X, then nothing is.’

5.2.5.1.1 Example of a Model Case

Miss K is a 23 year old girl who is working in a labour ward serving a one year compulsory community service contract, following her graduation as a Bcur student. Her experience of working in a labour ward as a newly graduated midwife is bad as she claims she does not get enough support from the experienced midwives. She even shakes her head before explaining about her bad experience. In the first place, no orientation was done when she started working in this labour ward.

Experienced midwives don't supervise and help her, but expect her to be responsible and accountable. Sometimes she delivers patients alone without any assistance from the experienced midwives. Sometimes she is assisted by enrolled nurses when delivering patients. When she asks experienced midwives to help her, they tell her to deliver alone as she is also a professional nurse. During training, she used to deliver patients with the support of the professional nurses.

She still needs that support from the experienced midwives in order to gain the confidence, which will enable her to work independently. Unfortunately, the support is not there. Before coming here, she thought the relationship between her and the experienced midwives will be positive and collegial, but what is happening here is just an opposite. She even asks herself as to what the reason of bitterness might be.

Opportunities for learning are very poor, she was told the ward is busy when she was asking a questions. Some experienced midwives just come and observe when she is performing procedures, if she is doing something right they leave without having said anything. But if they find her doing something wrong, she is shouted at instead of being guided. She is surprised because when the nurse manager handed her over to the ward managers, they told them to be her mentors, but they are not mentoring her. Some experienced midwives say she is not committed, but that is not true. She is committed; the problem is that she is not getting any support.

5.2.5.1.2 Analysis of a Model Case

All the attributes of effective transition support are illustrated in this case. Miss K, showed her unpleasant and distressful experience through both verbal and behavioural responses; by shaking her head before explaining. Miss K expressed her frustration when she explained that she was never orientated when she started working in that labour ward. What made her situation more worse was that there was

neither supervision nor mentoring from the experienced midwives. The experienced midwives were so negative in such a way that lack of positive and collegial relationship between her and experienced midwives were so evident. The other thing that frustrated miss K is that there were no opportunities for learning. Miss K verbalised her strong sense of commitment to provision of quality midwifery services but experienced midwives always accused her of lack of commitment, and that really made her feel so bad.

5.2.5.1.3 Summary of a Model Case Analysis

Based on the model case, newly graduated midwives expressed a sense of misery and frustrations, about the way they were treated by experienced midwives during their transition period. Lack or ineffective orientation on their commencement of duties during transition, negatively affected their performance. Graduates also showed dissatisfaction about negative relationship they had with their experienced midwives, which also had an influence on effective supervision and mentoring. Despite their commitment, graduates considered themselves inadequate regarding provision and management of midwifery services; and therefore expected to be exposed to an environment conducive for learning. Unfortunately, such an environment was never established resulting in more frustrations.

5.2.5.2 Borderline Case

According to Walker and Avant (2011), a borderline case is the one which does not only demonstrates some of the attributes associated with the concept but also has some statistically significant differences. Below is an example of a borderline case.

5.2.5.2.1 Example of a Borderline Case

Miss G, a newly graduated midwife who has just completed her training from the

college frowns as she explains her experiences of working in labour ward as very bad. Supervision and mentoring is zero, experienced midwives have no time for graduates. They don't confirm their findings, but only intervene when the patients present with complications. Shortage of nurses is very serious, most of the times you find only three nurses in labour ward from morning until 19h00.

It will be an experienced midwife and two new graduates. It is really bad. The off duties used here are very tiresome. Midwives are on duty for seven days continuously without any rest. The working days are too long, you become exhausted but there is no choice. The other thing is about the relationship with experienced midwives, it is not good at all. They always say that 4 years candidates are playful, irresponsible and not committed. They always shout at them. The way they do it is like they are afraid that one day they are going to be their seniors, so they want to punish them now when they are still new and junior.

5.2.5.2.2 Analysis of a Borderline Case

Some of the attributes associated with effective transition support concept are demonstrated in a borderline case. Below is the analysis of a borderline case. Miss G, a newly graduated midwife verbalised her experiences of working in a labour ward as very traumatic because there is no supervision and mentoring from experienced midwives at all.

When graduates observe patients, experienced midwives don't even bother to confirm their findings. They only start to panic if patients complicate. The other thing that is a serious problem is shortage of staff. Miss G is also worried about the type of off duties, she said they are so tiresome and adds a burden on the busy labour ward. The relationship between experienced and newly graduated midwives is also very poor.

5.2.5.2.3 Summary of a Borderline Case Analysis

Lack of supervision and mentoring were described as problematic by newly graduated midwives. Experienced midwives never cared about the way graduates rendered care to patients, and left their care solely to the responsibility of graduates despite their lack of experience. They only started to act when they realized that patients were in danger. The relationship between the two parties was described as negative, unfortunately this also affected provision of care by newly graduated midwives.

Graduates also raised a concern regarding labour wards that are abnormally busy, with serious shortage of midwives, resulting in midwives engaging in working long shifts leaving them tired, therefore adding more burdens on the busy labour ward.

5.2.5.3 Contrary Case

A contrary case is a case in which there is an absence of the attributes (Walker and Avant, 2011). It is an example which does not represent the concept at all. People can easily recognize this concept as not the main concept (Walker and Avant, 2011).

5.2.5.3.1 Example of a Contrary Case

Mr M is a 24 year old young man who is working in a labour ward as a new graduate. He feels pity for women when they deliver. He reassures them and provides therapeutic counselling. One day he delivered a primigravida who was closing the legs when the baby was being delivered. He was so touched, and felt for her because he thought she did that because of pain. Fortunately he was with the doctor who explained to her that she was making it difficult for them to help her deliver, and that she will kill the baby. When she heard that she became cooperative. He doesn't regret being an accoucheur, he likes helping these women, but he won't work in maternity after the community service. He is only working because it is compulsory. The reason

being that there are a lot of complications that can make one go to court and even lose one's job as a professional nurse. He is not saying that because he is not competent, he feels competent and he even delivers women alone.

5.2.5.3.2 Analysis of a Contrary Case

There are no defining attributes of effective transition support in this case, Hence, a contrary case. Mr M is an accoucheur who demonstrated sympathy for labouring women. He wondered as to what labouring women feel during the process of labour and delivery. He expressed his confidence and competence in managing women in labour; but just feels pity for them. He was so frustrated the other day as he was assisting a primigravida who was uncooperative because of the labour pain; but ended up delivering normally.

An accoucheur is aiming at working in general wards after completion of compulsory placement in maternity, as he is scared of a lot of complications which may predispose one to disciplinary hearings by the employer.

5.2.5.3.3 Summary of a Contrary Case Analysis

A newly graduated accoucheur expressed his commitment to assist women in labour. A graduate also expressed his confidence and competence regarding provision and management of midwifery services, but verbalised his concern about the labour pain that seemed to be unbearable. He described himself as being empathetic about women in labour. The graduate also indicated that after completion of community placement, he intends to work in other wards except maternity, the reason being that there are a lot of complications which occur in maternity, which may even lead one to losing his job. Antecedents and consequences of effective transition support were discussed in the step that followed.

5.2.6 Identify Antecedents and Consequences

5.2.6.1 Antecedents

According to Walker and Avant (2011), antecedents are the events or incidents that happen before the existing concept. Antecedents are the determinants of the concept, things that precede or cause the concept or risk factors of the concept. Antecedents include personal and organizational factors that influence how the concept is enacted. Antecedents of the concept 'effective transition support' as determined from this analysis were: positive attitude, effective communication, existence of supportive relationships from the management, respect and team spirit.

The reason for identification of these antecedents was that before the existence of effective transition support of newly graduated midwives; positive attitude, effective communication, existence of supportive relationships from the management, respect and team spirit should be established, otherwise, the existence of effective transition support of newly graduated midwives would be in vain. The discussion below covered the antecedents of a concept 'effective transition support.'

5.2.6.1.1 Positive Attitude

For effective transition support to be possible, both experienced and newly graduated midwives should have positive attitudes towards each other and towards effective transition support process. They should establish and maintain harmonious relationships with each other.

Experienced midwives should be able to provide the necessary support and attend to newly graduated midwives' learning needs. They should attend to graduates' questions with pride and if they are not certain about the answers, they should be open about it and help them to get appropriate solutions to their problems. According

to Hobbs (2012), participants described the consequences of positive interactions with colleagues and a supportive environment as swimming in a pond; whereby swimming was almost exclusively about building confidence, feeling comfortable, supported and good about oneself. The environment enabled the new midwives to assess their own learning needs, therefore promoting professional development.

5.2.6.1.2 Effective Communication

Demonstration of good and effective communication skills by experienced midwives assist the newly graduated midwives to develop confidence, competence and above all, they also learn to communicate effectively with patients and family members irrespective of stressful situations they are faced with. Ability of both parties to use respectful words when communicating with one another formed the key for effective communication. Experienced midwives must avoid scolding at the newly graduated midwives, irrespective of the situation.

They should be calm and avoid screaming even when addressing frustrating situations. Avoid the use of unacceptable gestures such as rolling of eyes. Graduates must learn to report their movements to the experienced midwives, for an example, when going for meal breaks.

According to Dixon et al. (2015), effective communication between experienced and midwifery graduates is critical to the fundamental success of transition support. The authors also revealed that participants talked of growing more confident during the period of transition when they had good clinical support through effective communication (Dixon et al., 2015).

5.2.6.1.3 Existence of Supportive Relationships from the Management

It is important that managers create a supportive work environment that enables both

experienced and newly graduated midwives to accomplish their work in meaningful ways. Enough human resources should be made available in order to address shortage of staff described in the findings. Skirton et al. (2012) revealed that staff shortages were a major contributor to the lack of support given to newly qualified midwives, rather than unwillingness from established members of staff.

This should be a concern for ward managers who decide what constitutes adequate staffing levels, as this will directly affect the policy of a mandatory preceptorship programme. Fenwick et al. (2012) identified that due to pressures of a busy ward environment, newly qualified midwives said they were treated as part of the workforce and their learning needs were not a priority. These negative experiences exacerbated their feelings of stress and affected their perceptions of qualification.

5.2.6.1.4 Respect

The issue of respect is very much vital in preparation for a supportive environment. Both experienced and newly graduated midwives should respect each other. Respect demands that both parties are able to treat each other well despite the differences they have. They should respect each other irrespective of the age and the different types of training they have undergone. The use of appropriate words that demonstrate respect for one another should be practiced during communication.

Experienced midwives should accept that graduates deserve to be treated with respect irrespective of the fact that they are inexperienced and still need guidance and supervision. On the other hand, newly graduated midwives should respect experienced midwives as their mentors and role models in the midwifery field. When newly graduated midwives are used to a situation where respect for one another is the key, they will also learn to treat the patients with respect.

In a study conducted by Kensington et al. (2016), newly qualified midwives reported that they needed experienced midwives to role model expected behaviours about what is appropriate in creating a trusting atmosphere full of respect within a professional relationship. Participants further reported that respectful relationships with experienced midwives promote confidence building as well as their sense of belonging.

5.2.6.1.5 Team Spirit

Effective transition support demands that all parties involved in the process are motivated and willing to work collaboratively with one another to reach the set goals. When both experienced and newly graduated midwives are willing and committed to work jointly towards effective transition support process, they are more likely to rise above the challenges they face. According to Dixon et al. (2015), evidence revealed that positive midwife–midwife interactions within supportive working environments; whereby team work is encouraged, reflected a sense of equality and restored participants' faith in self. This was supported by Kensington et al. (2016) who described the relationship between the experienced midwife and the newly qualified midwife as central to the learning process. A discussion on the antecedents of a concept 'effective transition support', was followed by a discussion on the consequences.

5.2.6.2 Consequences

Consequences are the events or incidents that happen as results of the concept (Walker and Avant, 2011). Therefore, based on Walker and Avant's (2011) description of consequences, the consequences of "effective transition support" were identified as competence; confidence; responsibility and accountability, ability to function as an independent practitioner, quality midwifery services as well as reduced costs and law

suits; and are illustrated in Figure 5.2. The identified consequences were considered relevant because effective transition support of newly graduated midwives should result in improvement of their performance during provision of midwifery services, which should be demonstrated through; competence, confidence, responsibility and accountability, ability to function as independent practitioners, provision of quality midwifery services as well as reduced costs and law suits for the state. Hereunder, follows a description of each of the consequences

Source: Walker and Avant (2011)

Figure 5.2: Consequences of effective transition support

5.2.6.2.1 Competence

Competence is defined as being “properly qualified, capable, able, efficient, expert, good at, practical, proficient, resourceful, skilful, skilled, sure, fitting or sufficient for the purpose” (Macquarie, 2005). Effective transition support should result in production of a competent midwife who has the foresight and is able to respond appropriately to both planned and unanticipated situations in order to ensure safety of patients and clients.

A competent midwife is able to integrate the knowledge, skills, expertise, experience as well as personal attributes in the provision of care. In his study, Kensington et al. (2016) reported that new graduates should have access to the well-planned and organised support programmes to develop their level of competence; which will enable them to make positive contributions to the workload. Literature revealed that graduates who were supported and supervised demonstrated high levels of competence on completion of structured support programmes (Malouf and West, 2011).

5.2.6.2.2 Confidence

Results revealed that provision of effective support during transition period of newly graduated midwives results in production of confident midwifery professionals who are self-reliant, self-assured and believe in themselves. Effective transition support results in an increase in both familiarity and comfort in midwifery graduates' roles, making them to be confident in the provision of quality services. A confident midwife will be able to provide quality midwifery services as she will be certain regarding the knowledge and skills she will have acquired.

According to Hobbs (2012), structured programmes of support should be used to increase levels of confidence, consolidate knowledge and experience, support critical reflection as well as bridging the gap between being a student and being a practitioner. Mason and Davies (2013) concurred when they reported that good supervision and support provided to new graduates contributed to good learning environment, which led to renewed sense of confidence and increased level of assertiveness.

5.2.6.2.3 Responsibility and Accountability

A well supported newly graduated midwife develops into a midwife who is recognised

as a responsible and accountable professional, who works in partnership with women providing the necessary support, care and advice during pregnancy, labour and postpartum period; in a responsible and accountable manner. Following effective transition support, a responsible and accountable midwife should be able to rescue and save both the mother and the baby during provision of care.

In a study conducted by Dixon et al. (2015), newly graduated midwives reported stress resulting from high levels of responsibility and accountability accompanying the new role. Participants reported positive results of structured support programmes whereby they felt more confident to manage the units responsibly, without any fear of being responsible and accountable for both patient care as well as students' learning (Hobbs, 2012).

5.2.6.2.4 Ability to Function As An independent Practitioner

Provision of effective transition support to newly graduated midwives empowers them to develop sense of independence; therefore enabling them to unite with the larger midwifery community as professionals in their own right. Effective transition support should be able to produce a responsible and accountable midwife who is able to assess, diagnose, prescribe and implement the relevant midwifery regimen in order to meet needs of the mother, baby and family members.

Sense of independence was reported as one of the positive end results of structured transition programmes for supporting newly qualified midwives (Macquarie, 2005).

5.2.6.2.5 Quality Midwifery Services

Effective transition support of newly graduated midwives is the key to improvement of midwifery services. A well supported midwifery graduate will be competent, confident, responsible, accountable and having sense of independence. With all these qualities,

on completion of transition period, a professional midwife will be able to provide quality midwifery services. In a study on 'effectiveness of structured support programmes for graduates', Kensington et al. (2016) asserted that midwifery graduates should be effectively supported through the mentoring programme that should cover all the elements of the framework for quality maternal and new-born care, to ensure a balance between theory and practice (Kensington et al., 2016).

5.2.6.2.6 Reduced Costs and Law Suits

When the midwifery services provided to patients are of high quality, community members will be satisfied about provision of care to patients. Provision of quality services results in reduced periods of hospital stay, which contributes to reduction of cost for the hospital. When the community is satisfied about the level of care provided to patients, law suits will also be reduced. The final step of Walker and Avant (2011)'s method of concept analysis is to identify empirical referents as addressed hereunder.

5.2.7 Define Empirical Referents

According to Walker and Avant (2011), empirical referents are classes or categories of actual phenomena that by existence or presence demonstrate the occurrence of the concept itself. The authors further reported that, when a concept analysis is nearing completion and is highly abstract, the question arises, 'If we are to measure this concept or determine its existence in the real world, how do we do so?' The categories relate to critical attributes of the concept and in some cases, the empirical referents are the same as the critical attributes identified. Based on Walker and Avant's (2011) description of empirical referents, the following were identified as empirical referents for 'effective transition support', because through them, the occurrence of the effective transition support was demonstrated, as illustrated in Table 5.1 as: supportive and positive relationship during transition period, conducive

learning environment, conducive working environment in the labour ward, effective orientation in maternity unit, existence of effective supervision and mentoring.

Table 5.1: Empirical referents for effective transition support

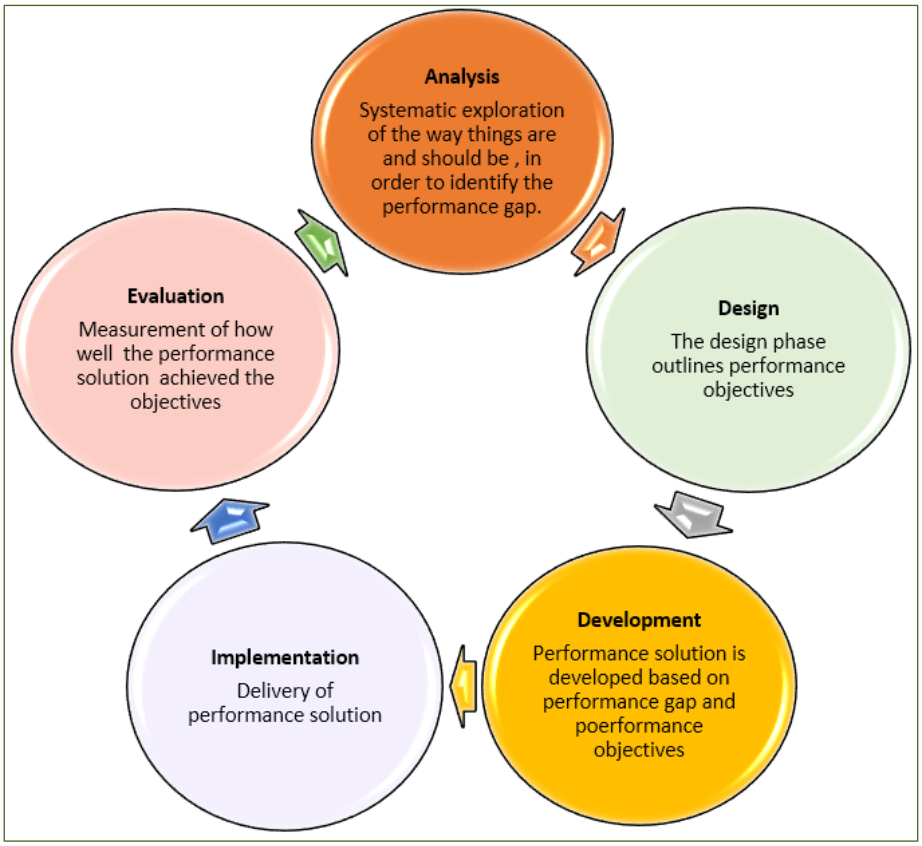
Empirical Referents	Indicators
Supportive and positive relationship during transition period	• Ability of experienced midwives to accept newly graduated midwives as neophytes who need guidance and supervision in the midwifery world • Ability of experienced midwives to treat newly graduated midwives as professionals who deserve to be respected. • Ability of experienced midwives to communicate effectively with newly graduated midwives without scolding and screaming at them.
Conducive learning environment	• Availability of a formal structured teaching programme for newly graduated midwives with documented proof of its implementation. • Evidence that questions of graduates regarding provision of care are well addressed. • Evidence that informal teaching such as teaching on the spot whereby teachable moments are utilised, is effectively carried out.
Conducive working environment	• Evidence that newly graduated midwives are provided with sufficient assistance from experienced midwives during conduction of deliveries. • Evidence that graduates' findings regarding patients' observations during the progress of labour are confirmed and necessary steps are taken immediately. • Availability of enough human resources to address a problem of staff shortage. • A record of conducive working shifts to avoid long working shifts that are tiring to staff members
Effective orientation	• Evidence that newly graduated midwives are able to function effectively in a familiar environment including theatre. • Ability of newly graduated midwives to function within the framework of prescribed policies and guidelines regarding provision of midwifery services. • Ability of newly graduated midwives to apply their knowledge and skills regarding effective utilization of emergency trolleys, eclamptic boxes as well as resuscitate.
Existence of effective mentorship and supervision	• Evidence that supervision, mentoring and any form of guidance is effectively carried out for the benefit of the graduates. • Evidence that newly graduated midwives are delegated to perform certain tasks whilst the experienced midwives takes overall supervisory role of the tasks performed by the graduates. • Evidence that mentors are assigned to individual newly graduated midwives as they perform their daily tasks.

5.3 Summary

Concept analysis was conducted to provide a better understanding of a concept 'effective transition support'; and was based on Walker and Avant (2011). Based on concept analysis, effective transition support should focus on positive collegial relationships, learning opportunities, commitment and readiness, orientation, supervision and mentoring. The consequences of "effective transition support" are related to the individual's performance in the work environment demonstrated through competence; confidence; responsibility and accountability, ability to function as an independent practitioner, quality midwifery services as well as reduced costs and law suits. Concept analysis provided a basis for the development of a transition support programme for newly graduated midwives, which is described in the next section of this chapter.

5.4 Programme Development

The findings of phase 1 as well as those of concept analysis, led to the development of a transition support programme in order to enhance effective support of newly graduated midwives during their transition period. Development of a transition support programme was based on: (1) Conceptual framework of ADDIE's model for training and instructional design (Figure 5.3), of which the steps are: **A**nalysis, **D**esign, **D**evelopment, **I**mplementation and **E**valuation (Cutler et al., 2012); and (2) Stages of transition theory by (Duchscher, 2009) as follows: the stage of doing, stage of being and stage of knowing. For the purpose of this study, the first three steps of ADDIE's model for training and instructional design, namely: analysis, design and develop were conducted. Implementation and evaluation fall beyond the scope of this study, and will therefore be carried out as a post-doctoral project. Underneath is a description of the development of a transition support programme according to the phases as described in ADDIE's model for training and instructional design (Cutler et al., 2012).



Source: Cutler et al. (2012)

Figure 5.3: Phases of ADDIE's model for training and instructional design

5.4.1 Phase 1: Analysis

Analysis is a systemic exploration of the way things are in comparison with the way things should be, resulting in the difference which is the performance gap (Cutler et al., 2012). The findings of the study revealed that newly graduated midwives were neither effectively orientated nor delegated. According to the findings, newly graduated midwives lacked supervision and mentoring during their transition period. Poor learning opportunities, theory practice gap and reality shock were also reported as serious challenges experienced by newly graduated midwives. Poor collegial relationships and negative attitudes displayed by experienced midwives resulted in newly graduated midwives failing to cope with high level of responsibility and accountability accompanying a new role, hence, their inability to function

independently. The next discussion focused on the following as identified during analysis of the findings: ineffective orientation, lack of delegation, lack of supervision and mentoring, poor learning opportunities, theory practice gap, reality shock, poor collegial relationships and negative attitudes, high level of responsibility and accountability accompanying a new role and inability to function independently.

5.4.1.1 Ineffective Orientation

Participants raised an issue regarding lack of orientation which did not only affect their performances negatively but also ruined their relationship with experienced midwives. There are participants who reported that they were scolded at when they took long to bring medications when sent, as they did not know where to get them as they were never orientated. Some participants were expected to receive babies born through caesarean section when they have never set a foot in a particular theatre. As they showed dissatisfaction about such delegation, they were labelled as being rude. According to McCarthy et al. (2013), orientation of newly qualified staff to everything including routine, the procedures and practices enables them to work confidently.

In a study conducted by McCusker (2013), participants stated that they worked with confidence as they were well orientated and everything explained to them including the routine, procedures and practices. Participants further reported that even though they were new in the ward, they felt like they have been working there for months.

5.4.1.2 Lack of Delegation

Based on the results, participants experienced uncertainties as tasks were not formally delegated to them, which made them lose interest in midwifery care. Participants also reported that they would feel better if they were delegated with an experienced midwife who would mentor and supervise them as they perform midwifery

services; this would also improve their relationship with their experienced midwifery colleagues. In a study conducted by Davis et al. (2011), midwifery graduates demanded to be delegated because they felt that supervision would improve. Graduates also reported that proper delegation keep them posted, unlike when there is no delegation.

Cummins et al. (2016) concurred when they stated that graduates found themselves jobless in many instances which tempted them to absent themselves from duty. In their study on 'support of newly qualified staff, Dixon et al. (2015) reported that graduates preferred to have individual mentors who would supervise and mentor them during performance of delegated tasks. Participants also reported that allocation of individual mentors would strengthen the relationship.

5.4.1.3 High Level of Responsibility and Accountability

Newly graduated midwives reported that they appreciate the fact that they have successfully completed their training; but the level of responsibility and accountability the position demands is too high especially because they don't have experience, resulting in stress. Graduates further indicated that when they were still students, their level of responsibility was very little as they relied on professional nurses. They feel overwhelmed by high levels of responsibility and accountability as they are now accountable for their own actions as well as the actions of their juniors.

Morgan et al. (2012) described an awareness of responsibility as a major difference between being a nursing student and a registered nurse. Similar findings of newly-qualified midwives struggling with their new responsibilities due to lack of experience and confidence to make decisions were reported in the study conducted by (Carter et al., 2012). Morgan et al. (2012),described the depth of trust and increased levels of expectations placed in newly graduated midwives by the women they care for and

their families, as stressful.

5.4.1.4 Theory Practice Gap

Empirical findings revealed that there is a great difference that exists between the theory newly graduated midwives learnt in the classroom and what is really happening in the ward. Participants indicated that they felt so frustrated because, when they perform procedures, they are expected to do shortcuts. They are told they are slow when they do the correct things and that leads to confusion.

In a study conducted by Fenwick et al. (2012), participants described feeling frustrated, angry and emotionally distressed when they were unable to adapt to their new role due to apparent conflicting ideologies with which they came into contact when caring for women. This difficulty is illustrated by the discrepancy between what has been taught in the classroom and how care is given in practice.

This was supported by McCusker (2013), who reported that the dissonance between woman-centred care and the management of care provided in the hospital setting confuses the newly graduated midwives and diminishes the midwifery role. Fenwick et al. (2012) also reported in the study they conducted that newly qualified midwives found it difficult to comprehend why they were educated to question and use their initiative and yet in practice were required to obey orders and conform. As a result, newly qualified midwives did not feel adequately prepared for their roles in practice.

5.4.1.5 Reality Shock

Participants reported that they feel scared to stand as professional midwives and make decisions regarding care of patients and management of the ward. The fact that students are also looking up at them for assistance and patients are expecting quality care makes them to be more anxious. Rush et al. (2014) reported that the new

graduate midwives experienced stress, particularly in the labour ward, which was seemingly linked to what participants described as “their new reality of being responsible for making decisions regarding a woman’s labour and birth care. The authors further reported that the midwives considered this to be a new experience because “as a student you never have to make a decision on your own”.

5.4.1.6 Lack of Supervision and Mentoring

Based on empirical findings, supervision and mentoring of newly graduated midwives is poor. Graduates reported that they progress and deliver patients alone without the supervision of experienced midwives. Participants expressed frustration and anger when they reported that there are experienced midwives who refuse to confirm their findings when progressing women in labour, which sometimes result in complications.

What participants reflected above is contrary to the findings of the study on the mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia by Cummins et al. (2016) who revealed that a midwifery graduate reported that having a mentor meant a lot to her as she was working under some supervision. “I had a mentor in the first month and I did everything with her”. Cummins et al. (2016) supported Sullivan et al. (2011), when they revealed that being allocated a mentor meant that a relationship developed between the new graduate and the more experienced midwife, “I was allocated a mentor for a month and we still have a bit of a mentoring relationship going on”.

Malouf and West (2011) reported that newly qualified midwives who received clinical support during their time of exposure, experienced the full range of midwifery skills resulting in a boost in their confidence. These findings are consistent with those of Sullivan et al. (2011), who reported that good clinical support must be accompanied by effective communication and personal commitment between the mentor and the

mentee. This makes the partnership to be successful. Rush et al. (2014) reflected a similar view when they reported that support and mentorship offered to newly graduated midwives during their transition period influenced their professional development, leading to the development of professional identity as well as increased reflection on practice.

5.4.1.7 Poor Collegial Relationships and Negative Attitudes

According to the empirical findings, the relationship between experienced and newly graduated midwives is not good. Graduates reported that poor relationship with experienced midwives affect their confidence negatively because there is no one to turn to when they need assistance. The findings also revealed that some experienced midwives are having negative attitude towards the newly graduated midwives, they just don't accept them.

Seibold et al. (2010) and Sullivan et al. (2011), displayed a great similarity between what participants reported when they discussed about how positive and collegial relationship with the experienced midwives facilitated graduates' ability to take up their role as newly qualified midwives within the context and culture of the maternity unit. Based on the findings of Sullivan et al. (2011), the context of positive relationships enabled participants to openly question practice and extend themselves in an environment where someone would always be available to support them, resulting in a boost of confidence.

5.4.1.8 Inability to Function Independently

Results revealed that experienced midwives expected newly graduated midwives to be competent and behave like independent practitioners. When newly graduated midwives fail to behave likewise, experienced midwives became frustrated.

Participants also expressed their disappointment as they expected them to be a pair of extra hands; instead they need complete support from experienced midwives. The findings also revealed that experienced midwives thought that the work load would be reduced as they would be working with the graduates; instead it's just an opposite. Feltham (2014) supported Schytt and Waldenström (2013) when he reported that due to pressures of a busy ward environment, newly qualified midwives reported that they were treated as independent practitioners, nobody bothered to guide them and that negatively affected their performance.

5.4.1.9 Poor Learning Opportunities

Results revealed that opportunities for learning are very poor. Participants reported very poor learning opportunities, because when they ask questions from experienced midwives they seldom get answers. In cases where answers are provided, no details are given and participants further reported that they are afraid of asking for details because they think experienced midwives will feel like their knowledge is being gauged. Participants acknowledged the fact that they were well prepared academically, but, they still need to have more time in areas such as labour ward, antenatal ward, perineal suturing and general management of the ward. They therefore recommended that they be exposed to more workshops and in-service training regarding midwifery procedures before they could be left to be all by themselves. During the transition period, new graduates expect support and supervision from experienced midwives as they are exposed to clinical areas in order to develop skills and confidence (Tingstig et al., 2012).

This is supported by McCarthy et al. (2013), who reported how the participants stressed how crucial it is for the beginning practitioner to work alongside experienced staff where they are able to watch, listen, learn and practice in an effort to make the

most of the learning opportunities available. This is consistent with Hughes and Fraser (2011), who revealed that newly graduated midwives expect to be supervised and supported by the experienced practitioner as they believe that their findings are not different from those of student midwives. Figure 5.4 represents results of the analysis phase of ADDIE's model for training and instructional design.

Source: Cutler et al. (2012)

Figure 5.4: Phase 1: Analysis phase of ADDIE's model for training and instructional design

The findings in the analysis phase revealed that newly graduated midwives were neither orientated nor delegated, which affected their performance. High level of responsibility and accountability was vested upon newly graduated midwives, resulting in frustration and anger as they were not competent and confident enough to function autonomously in managing the demands of a new role.

The relationship between experienced and newly graduated midwives was negative and therefore, newly graduated midwives were not effectively supported by the experienced midwives. The environment was not conducive for learning at all. All these were the performance gaps identified in the analysis phase. The step that followed was the design phase which addressed the identified performance gaps.

5.4.2 Phase 2: Design

The design is the phase in which the designer outlines the design or the plan of a programme (Cutler et al., 2012). The plan covers identification of objectives in order to address performance gaps identified during the analysis phase; the type of a programme needed as well as available resources for the implementation of a programme.

5.4.2.1 Identification of Objectives

Empirical findings revealed challenges experienced by both newly graduated as well as experienced midwives during transition period of newly graduated midwives; which were described in the analysis phase. Formulation of performance objectives was based on such challenges; aiming to address them through a transition support programme, in order to enhance effective support of newly graduated midwives during their transition period. Upon completion of community service placement, coupled with the implementation of a transition support programme, newly graduated midwives should be able to:

- Demonstrate their confidence during provision of care
- Demonstrate their competence in provision of care
- Verbalise and practice positive relationships with the experienced midwives

- Provide quality midwifery services as a result of effective supervision and mentoring
- Demonstrate their ability to function responsibly and accountably
- Demonstrate ability to function as independent practitioners
- Demonstrate their familiarity with the surrounding, policies and routine
- Demonstrate ability to correlate theory with practice

Phase 2 focused on formulation of objectives on which development of a transition support programme was based, as reflected in Figure 5.5. The phase that follows focuses on the development of a transition support programme in order to address the performance gaps identified during the analysis phase.

Source: Cutler et al. (2012)

Figure 5.5: Performance objectives to be addressed through a transition support programme

5.4.3 Phase 3: Development of a Transition Support Programme

A transition support programme was developed based on performance objectives formulated in the design phase, aiming at addressing the performance gaps identified during the analysis phase.

5.4.3.1 Transition Support Programme

The following are the key principles with which the stakeholders for a transition support programme should abide, for the programme to be effective.

5.4.3.1.1 Guidelines

- The nursing service manager should delegate either an area manager or an operational manager to be responsible for coordination of a transition support process.

- An experienced midwife who is willing and committed to take part as a mentor should be identified.

- A transition support programme should be made known and clear to all staff members.

- A transition support process should not be a one day thing, but has to be a process that should happen over a period of time.

- Commitment and readiness of newly graduated midwives to take part in transition support process is necessary.

- Each newly graduated midwife should have a copy of a transition support programme for reference.

- A newly graduated midwife should indicate by means of a tick on his/her copy if an activity has been achieved.

- All items that have not been achieved should be made known to the manager designated to coordinate the support process.

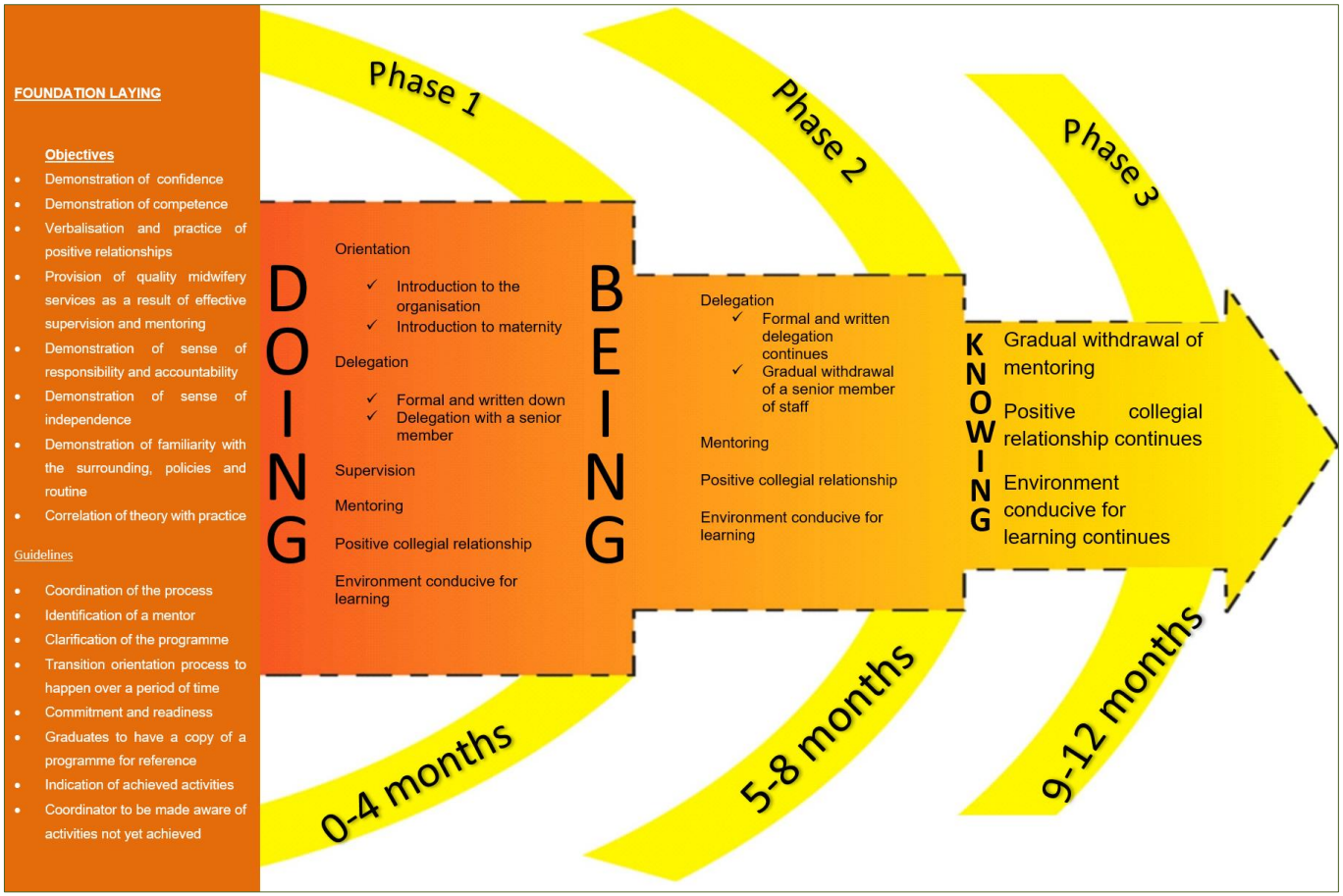
5.4.3.1.2 Phases in a Transition Support Programme

The development of a transition support programme was based on Duchscher's (2009) transition theory as well as ADDIE's model of training (Cutler et al., 2012). The programme was organised in three phases following the stages of Duchscher's (2009) transition theory, which are: the stage of doing, stage of being and stage of knowing.

Activities to be covered in all the phases were identified based on the performance gaps identified in the analysis phase, which is the first phase of ADDIE's framework; performance objectives were formulated during the second phase of ADDIE's framework; development of a programme was done during the third phase of ADDIE's framework. Implementation and evaluation of a developed transition support programme were not covered as they fall beyond the scope of this study.

Figure 5.6, is the schematic presentation of transition support programme based on Duchscher's (2009) transition theory as well as ADDIE's training model (Cutler et al., 2012).

To ensure effective implementation of the programme, a foundation should be laid in order to prepare both the newly graduated as well as the experienced midwives. Foundation laying covers clarification of objectives transition support programme aims to achieve; which were formulated during the design phase of ADDIE's framework.



Source: based on Duchscher's (2009) Transition Theory as well as ADDIE's Training Model (Cutler et al., 2012)

Figure 5.6: Transition support programme

Guidelines of the programme should also be made known to all members involved in the transition support process. Activities in the programme are addressing the performance gaps identified during the analysis phase. Development of a transion support programme was done in the third phase of ADDIE's training model, based on the stages of Duscher's (2009) transition theory.

❖ Phase 1: The Stage of Doing (0-4 Months)

During this stage, newly graduated midwives are expected to learn how to cope, adapt and adjust themselves to the new environment; whereby they are no longer students but professional midwives. Therefore, newly graduated midwives have to be orientated to the surrounding as well as the new role. They have little strength to face and accommodate the responsibilities set before them. This is because they experience transition shock and all the energy is being consumed as they anxiously try to perform in their new roles, without revealing how difficult this is for them.

Therefore, supervision and mentoring are necessary. It becomes more difficult for them to cope if their relationship with the senior members of staff is poor or if they feel unwelcomed. It is during this stage whereby newly graduated midwives require more prescriptive directives about what should be done in particular clinical situations, therefore they have to be delegated with a senior member of staff.

During the first phase of a transition support programme, orientation, supervision, mentoring, positive collegial relationship and delegation will be catered for.

❖ Orientation

Based on concept analysis, orientation of newly graduated midwives forms the foundation for effective transition support, and therefore acts as a baseline for an effective transition support programme. As it provides a foundation, orientation of

newly graduated midwives must be done during the first three to four months of transition, and should include the following:

❖ Introduction to the Organization

One of the responsibilities of newly graduated midwives is to effectively interact their midwifery services with the services provided by different sections within the hospital. Therefore, graduates must be introduced to different sections as soon after commencement of their transition period as possible. Introduction of graduates to the organization should be done as follows:

- Hospital tour should be conducted in order to familiarize newly graduated midwives with different sections in an organization (this should be done during the first week of arrival in an organization).

- Institutional policies should also be clarified to newly graduated midwives, so that they become conversant with effective functioning of the institution.

❖ Introduction to Maternity Unit

- For newly graduated midwives to function effectively, they must be orientated to the surroundings of a maternity unit including all the sub-units.

- A tour to Theatre should also be taken so that newly graduated midwives can familiarize themselves with a particular theatre in preparation for Caesarean births. Where possible, orientation should be done during the first week of arrival in an institution and should be done by a senior member of staff.

- For effective management of midwifery emergencies, newly graduated midwives should be orientated to important aspects of provision of care such

as, an emergency trolley, eclamptic box and a resuscitation unit. Graduates should be orientated to the routine of a maternity unit. This will facilitate effective provision and management of midwifery services.

- Policies, protocols, procedures and guidelines governing provision of midwifery services should be clarified to the graduates.

❖ Supervision

Supervision of newly graduated midwives should be done by all experienced midwives working with graduates during their transition period. As part of supervision, experienced midwives must confirm the findings made by newly graduated midwives regarding patients' observations, to ensure patients' safety. Newly graduated midwives must not perform procedures such as conduction of deliveries, suturing of episiotomies alone without any supervision by experienced midwives. Where necessary, supervision must be accompanied by teaching on the spot in order to address performance gaps.

❖ Mentoring

Formal mentoring process should be put in place with an aim of provision of effective support and development of newly graduated midwives. It is imperative that a mentor be assigned to each graduate; and such a mentor should be committed, passionate and having an interest in a role in order to facilitate mentoring process. A mentor should have an understanding of a role as support and guidance, enabling the new practitioner to adapt and grow into his/her professional role. Modelling, supporting best practice and provision of positive feedback should be the strong ingredients of a mentoring process. A mentee should be prepared and committed to the mentoring process to enhance development of knowledge and skills. Both a mentor and a

mentee should be responsible for establishment and maintenance of positive mentor-mentee relationship.

❖ Positive Collegial Relationship

There is no way in which effective transition support can be possible without establishment and maintenance of positive collegial relationship. Therapeutic sessions should be established and conducted on such days that are less busy and well-staffed, e.g. Wednesdays as the majority of personnel are on duty. It is in these sessions whereby discussions are held regarding effective transition support, and graduates are encouraged to air their views regarding the topic, such as: their views and feelings regarding transition, the kind of support they need and whether they are ready and committed to participate in their support process or not.

Effective communication is regarded as one of the pillars for positive collegial relationship, hence, discussions are held regarding promotion of effective communication amongst experienced as well as newly graduated midwives. Such discussions must cover issues as; what effective communication involves including the value thereof. One of the cornerstones of positive collegial relationship is respect for one another; therefore, both experienced as well as newly graduated midwives are encouraged to treat each other with respect.

❖ Delegation

Tasks should be delegated to graduates in order to prevent them from rooming around being jobless, as they are not yet used to activities that are carried out by professional practitioners. Delegation should be formal and should be written down, and the delegated graduates should sign for acceptance of the delegated tasks. It is mandatory that graduates are delegated with a senior member of staff to assist and

oversee the performance of delegated tasks; particularly in tasks that demand high levels of responsibility and accountability such as; management of highly scheduled drugs, management of a woman in labour, management of caesarean births in theatre and resuscitation of a newborn baby. Consideration of orientation, supervision, mentoring, positive collegial relationship and delegation may have a positive impact in graduates' performance during the first phase of transition support programme.

The next phase covers the discussion of the second stage of a transition support programme, which is the stage of being.

❖ Phase 2: The Stage of Being (5-8 Months)

During the stage of being, newly graduated midwives are confronted with inconsistencies and inadequacies within the health care system that serve to challenge their somewhat idealistic pre-graduate notions of the profession. They begin to get used to their professional roles and responsibilities; even though they are still faced with challenges regarding a lot of uncertainties within the health care system.

They ask themselves a lot of questions as they try to correlate their roles and express a strong desire for clarification and confirmation of their own thoughts and actions. Newly graduated midwives try to integrate their professional nurses' role with the roles of other professionals within the institution. They feel confident as they realize that they could make decisions and implement midwifery actions that are not only appropriate but also safe; as a result, mentoring should continue but should be minimised.

❖ Delegation

Newly graduated midwives are beginning to get used to their professional roles and responsibilities but are still not certain regarding some issues related to provision of

care; therefore delegation of tasks should still continue. Delegation should continue to be done formally and should be written down, but a senior member of staff should be gradually withdrawn.

❖ Environment Conducive for Learning

Formal teaching should be done especially during less busy and well-staffed days, such as on Wednesdays as the majority of nursing personnel are on duty. For facilitation of effective teaching and learning, a teaching programme should be prepared based on graduates' learning needs. Graduates should also participate in peer teaching, but should be allowed to choose the topics of interest in which they feel competent to teach, in order to boost their confidence.

Reflection should also be practised whereby graduates are given the opportunity to explore the situations they have been faced with including actions taken to manage such situations. Based on these reflections, identification of potential areas for personal development should be done. Graduates should be empowered so that they are able to provide high level of care and manage emergency situations that demand expertise on the use of:

- An emergency trolley
- An eclamptic box
- A resuscitation unit

❖ Phase 3: The Stage of Knowing (9-12 Months)

Newly graduated midwives are more familiar and comfortable with their professional positions; and their relationship with the colleagues is improved. These enable them

to explore their professional environment with a critical eye. They also begin taking notice of the more troubling aspects of their socio-cultural and political environments. It is during this time whereby everybody starts feeling their impossible way of thinking and doing things as it is the way they have been socialized. Mentoring should be withdrawn gradually but positive collegial relationship continued as a lifelong commitment. Environment conducive for learning should continue to be maintained but newly graduated midwives should be mostly involved in teaching. Table 5.2, presents a developed transition support programme.

5.4.4 Summary

The above discussion covered the details of the developed transition support programme based on Duchscher's transition theory as well as ADDIE's training model. Activities to be carried out to promote effective support of newly graduated midwives during their transition period, were highlighted. Implementation and evaluation phases of the developed programme fall beyond this study, and therefore were not covered. The section that follows focuses on a description of validation process of a developed transition support programme.

Table 5.2: A developed transition support programme

Phase and stage	Period	Objectives	Integrative Activities	Outcome	Responsible person
1. Phase 1 **The stage of doing**	0-4 months	• Demonstrate familiarity with the surrounding, policies, and routine. • Verbalise and practice positivecollegial relationships with the experienced midwives. • Demonstrate confidence during provision of care	**1.1 Orientation** • Introduce graduates to the organization through: ✓ Conduction of a hospital tour ✓ Introduction of graduates to organizational policies • Introduce graduates to maternity sub-units: Antenatal, Labour, Nursery and Postnatal. • Introduce graduates to theatre • Orientate graduates regarding routine, policies, protocols, procedures and guidelines. • Orientate graduates on the use of: An emergency trolley, eclamptic box and resuscitation unit. **1.2 Supervision** • Supervise graduates as they provide care to patients	Familiarity with the surrounding, policies and routine. Positive collegial relationships	Experienced midwives Mentor Newly graduated midwives

		• Provide quality midwifery services resulting from effective supervision and mentoring.	• Confirm graduates' findings at all times • Supervise graduates closely during performance of procedures such as: conduction of second stage of labour; suturing of episiotomies, resuscitation of a newborn baby. **1.3 Mentoring** • A committed and passionate mentor should be assigned • Mentees should be committed and prepared for the process • Modelling of best practice should be done • Positive feedback should be provided **1.4 Positive collegial relationship** • Therapeutic sessions should be established • Effective communication should be promoted • Members should treat each other with respect **1.5 Delegation** • Graduates should be delegated formally and the delegation should be written down • Graduates should be delegated with a senior member	Confidence in provision of quality midwifery services. Competence in rendering quality midwifery services	

2. Phase 2 **The stage of being**	5-8 months	Demonstrate competence in provision of care Demonstrate ability to function responsibly and accountably Correlate theory with practice	**2.1 Delegation** • Formal and written delegation continues • A senior member of staff should be withdrawn gradually **2.2 Environment conducive for learning** • Graduates' learning needs should be identified • Formal teaching sessions should be conducted during less busy days • Graduates should participate in peer teaching • Sessions for reflection about graduates' experiences, should be conducted • Graduates should be empowered on the use of: ✓ An emergency trolley ✓ Eclamptic box ✓ Resuscitation unit. • Teaching on the spot should be exercised	Competence Sense of responsibility and accountability Ability to correlate theory with practice	Experienced midwives Mentor Newly graduated midwives

3. Phase 3 **The stage of knowing**	9-12 months	Function as an independent practitioner	**3.1 Gradual withdrawal of mentoring but continuation positive collegial relationship** • Mentoring process should be withdrawn gradually, but maintenance of positive collegial relationship should continue **3.2 Environment conducive for learning continues, but newly graduated midwives mostly involved in teaching**	Sense of independence	Experienced midwives Mentor Newly graduated midwives

5.5 Programme Validation

The main focus of this section of the study was to validate for effectiveness and applicability of a developed transition support programme for enhancing effective support of newly graduated midwives during their transition period, in Limpopo Province of South Africa. Healy and Howe (2014) defined validation as a systematic, rigorous, and meticulous application of scientific methods to assess the design, implementation, improvement, or outcomes of a programme. According to Hurteau, Houle and Mongiat (2009), the main purpose of programme validation can be to determine the quality of a programme by formulating a judgment.

In this study, the purpose was to validate whether the developed programme will be able to serve as an effective tool for enhancing effective support of newly graduated midwives during their transition period. The process of programme validation was based on CDC (1999)'s framework for programme evaluation in public health, as discussed in the next section.

5.5.1 Framework for Programme Validation

According to CDC (1999), validation of a programme offers a way to understand and improve practice using methods that are useful, feasible, proper and accurate. The framework composed of two main dimensions on which programme validation was based. These dimensions were steps in evaluation as well as standards for good evaluation, as reflected in Figure 5.7. There are six connected steps of framework which served as a starting point around which effective transition support of newly graduated midwives tailored the validation process, to best meet their needs. The steps involved engagement of stakeholders, description of a programme, focusing the evaluation design, gathering credible evidence, justification of conclusions as well as ensuring use and sharing lessons learned.

Source: Centers for Disease Control (CDC, 1999)

Figure 5.7: A framework for programme evaluation in public health

According to CDC (1999), stakeholders are people or organizations that have something to gain or lose from what will be learned from an evaluation, and also in what will be done with that knowledge. CDC (1999) argued that for programme validation to be effective, different values held by stakeholders must be considered to ensure that their unique perspectives are understood. When stakeholders are not appropriately involved, evaluation findings are likely to be ignored, criticized, or resisted.

However, when they are part of the process, they experience sense of ownership for the evaluation process and results; therefore they will want to develop it, defend it, and make sure that the evaluation really works (CDC, 1999). That's why the evaluation

cycle begins by engaging the stakeholders, once involved; it would be possible to carry out the steps that followed. The step that followed was programme description, defined as a summary of the intervention being evaluated, which should illustrate the programme's core components and elements, as well as its ability to make changes (CDC, 1999). The authors further asserted that the way a programme is described sets the frame of reference for all future decisions about its evaluation; therefore, a programme which is not fully described, may lead to a situation whereby stakeholders may have different ideas about what the programme is supposed to achieve and why. Hence, it is important that the programme be described to enable all stakeholders to depart from the same ground (CDC, 1999).

Focusing the evaluation design, covered advance planning on how the validation process took place in terms of the method that worked better, questions that were asked to safeguard against ineffective use of time and resources. In order for the researcher to gather credible evidence, the type of questions asked enabled the stakeholders to provide relevant and useful information that enhanced effective validation process. Justification of conclusions involved analysis of information provided by the stakeholders, in order to draw conclusions. After justification of conclusions, deliberations were made and validation findings used appropriately.

5.5.2 Methodology

5.5.2.1 Validation Design

The validation process was conducted through the use of quantitative approach, wherein the exploratory and descriptive designs were used. Validation of the developed transition support programme was conducted in maternity units of the selected hospitals in Vhembe, Mopani, Capricorn, Greater Sekhukhune and Waterberg districts of Limpopo Province of South Africa. The setting in which the study

was conducted was natural as there was no manipulation of the environment; no changes were made to the unit and no special treatment were given to the respondents which could have affected the results.

5.5.2.2 Population for Validation

The population as stakeholders responsible for validation of the developed transition support programme composed of two groups:

- The first group comprised of all newly graduated midwives who have undergone a comprehensive nursing programme (R425 of 19 February 1985, as amended) and qualified as nurses (General, Psychiatric and Community) and Midwifery, both from the universities and nursing colleges and were working at the selected hospitals in Vhembe, Mopani, Capricorn, Waterberg and Greater Sekhukhune districts of Limpopo Province, South Africa.

- The second group comprised of all the professional nurses working at the selected hospitals in Vhembe, Mopani, Capricorn, Waterberg and Greater Sekhukhune districts of Limpopo Province, South Africa.

Therefore, the stakeholders who will be actively involved in the transition process were the ones engaged in the validation process, as they formed the population from which the sample of the validation process was drawn.

5.5.2.3 Sampling Procedure and Sample

A purposive sampling technique was used to select a sample of participants who met the following inclusion criteria:

- Newly graduated midwives who have been working for a period less or equals to one year following their successful completion of training, and were working in maternity units at the selected hospitals.
- Professional nurses, qualified as midwives and have been working in a maternity unit for at least five years.

A sample of 12 newly graduated midwives and 38 experienced midwives, of which 13 were operational managers working in maternity units of selected hospitals at the time of data collection and met selection criteria were selected.

Participants were selected as they were the ones who were actively involved in the transition process of newly graduated midwives and will be highly affected by the outcome of the study.

5.5.2.4 Development of an Instrument for Validation of a Developed Transition Support Programme

As a way of ensuring a planned validation process as well as safeguarding efficient use of time and resources, the researcher developed a questionnaire (Annexure N). Development of a questionnaire focused on the contents of a developed transition support programme aimed at enhancing effective support of newly graduated midwives during their transition period.

A transition support programme was organised according to the stages of transition theory as described by Duchscher (2009), which are; the stages of doing, being and knowing. Therefore, the stages of transition theory were also used as sub-headings of the questionnaire. The literature relevant, as well as guidance from other questionnaires used in similar studies were also considered in order to provide valuable insight. This was done to ensure that the validation design focused on the developed programme.

Development of an instrument (Annexure N), was done in consultation with the supervisors as well as a statistician who critically reviewed and verified the interpretations of the questions, before it was finalized and accepted in terms of face and content validity. Questions were formulated as simple as possible to reduce any ambiguities and the instructions were as clear as possible. The standards for good evaluation (Figure 5.7) were also considered during development of an instrument, and such were utility, feasibility, propriety and accuracy.

The questionnaire (Annexure N) comprised of five sections, namely:

1. **Section A:** Demographic Information
2. **Section B:** Standard of a Transition Support Programme
3. **Section C:** The Stage of Doing
4. **Section D:** The Stage of Being
5. **Section E:** The Stage of Knowing

Development of an instrument for validation of a developed programme was done in such a way that the researcher was able to gather credible evidence as one of the steps to be considered in the evaluation process by CDC (CDC, 1999).

5.5.2.5 Measures to Ensure Reliability and Validity of the Instrument

Development of an instrument (Annexure N), was done in consultation with the supervisors; the contents were based on the findings of phase 1 of this study, findings of concept analysis as well as a developed transition support programme. A statistician critically reviewed and verified the interpretations of the questions, before

an instrument was finalized and accepted in terms of face validity. Pre-testing of an instrument was done in order to determine the clarity of questions, effectiveness of instructions and consistency of the responses. Eight participants from one of the selected hospitals participated in a pre-test. Of the eight participants, three were newly graduated midwives, five experienced midwives of which two were operational managers. Participants had similar characteristics as the participants of the main study, and did not form part of the main validation process.

5.5.2.6 Ethical Principles

Following the description of a transition support programme, stakeholders were asked to give written informed consent; completed consent forms were collected and put in a separate envelope by the researcher before administration of questionnaires.

5.5.2.7 Data Collection

In this study, a brief description of the summary of findings of phase one was given to the stakeholders before data collection, in order to lay a foundation on why a particular transition support programme was developed. It was made clear to the stakeholders that a developed transition support programme was based on the findings of phase one of the study. Each member of the stakeholders was given a copy of a developed transition support programme as a frame of reference.

Thereafter, the contents of a transition support programme were discussed with the stakeholders, to give them the basis on which they completed the questionnaire. Description was based on the programme's intended results, programme activities according to the phases as well as responsible people for carrying out the activities. Questions were invited from the stakeholders, and were answered to their satisfaction. The researcher administered self-developed questionnaires and each participant

completed a questionnaire individually. When participants have finished completing questionnaires, the researcher collected them and put them in an envelope, separate from the one with signed consent forms. All the questionnaires were returned. The data collection process covered description of the programme as one of the steps in the evaluation process, as described in the framework by CDC (CDC, 1999).

5.5.2.8 Data Analysis

Data analysis was done with the assistance of a statistical consultant. Descriptive and inferential statistics were used. Figures were done using the Statistical Package for the Social Sciences (SPSS) version 24. Justification of conclusions involved analysis of information provided by participants, in order to draw conclusions.

5.5.3 Presentation of Results of the Validation Process

Evidence provided by stakeholders formed the basis on which conclusions were drawn, to ensure appropriate use of the findings. Results were presented according to the sections of a questionnaire as described in the next section.

5.5.3.1 Demographic Information

The total number of participants who completed questionnaires was 50 (100%) from all selected hospitals. Of the total participants, 24% (n=12) were newly graduated midwives; 76% (n=38) were experienced midwives of which 34% (n=13) were operational managers (Figure 5.8). The reason for including this question was to obtain relevant information from the relevant stakeholders who will be implementing the developed programme. Out of the newly graduated midwife participants (n=12), 58.3% (n=7) did their training in a university whereas 41.7% (n=5) did theirs in a college of nursing (Figure 5.9). All (100%) newly graduated midwives who participated in the validation process were on community service programme.

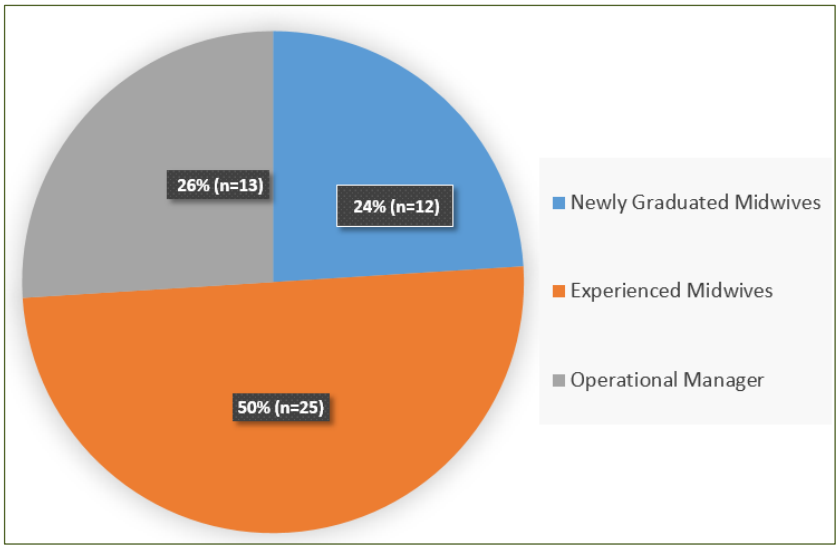


Figure 5.8: Participants who completed questionnaires

Results revealed that majority (98%, n=49) of the participants considered themselves relevant stake holders to validate the programme, whereas only a small minority (2%, n=1) thought otherwise. Of the participants who gave a positive response, 24% (n=12) were newly graduated midwives.

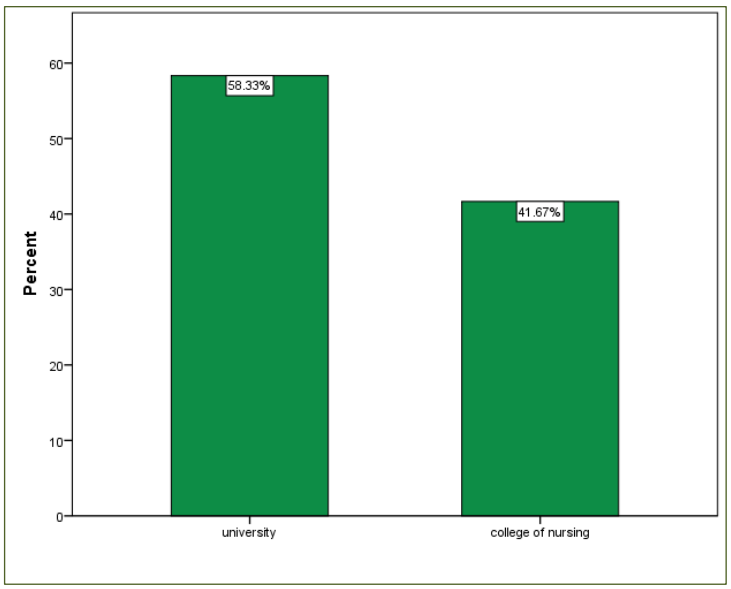


Figure 5.9: Educational institutions in which participants undertook training

5.5.3.2 The Stage of Doing

The stage of doing is the very first stage which lasts for the first four months of transition. According to the results, all participants (100%) agreed that orientation of newly graduated midwives to the hospital's surrounding will help in transition support process of newly graduated midwives. The fact that orientation of newly graduated midwives to all maternity sub-units forms part of effective transition support, was supported by all participants. All participants (100%) agreed that orientation of newly graduated midwives regarding theatre, forms part of orientation in maternity surrounding which forms the foundation for effective transition support.

All participants (100%) supported the fact that orientation of newly graduated midwives to the surrounding of the hospital should be done during the first week of their commencement in a clinical facility, as this forms the foundation for effective support during transition. The majority of participants (94%, n=47) reported that orientation to maternity surrounding will be more effective if done by a senior member of staff, whereas only 6% (n=3) reported that orientation can be done by any member of staff not necessarily a senior member. All participants (100%) agreed with the fact that orientation of newly graduated midwives on routine, policies, protocols, procedures and guidelines governing provision of midwifery services will provide a strong form of support for newly graduated midwives.

The results further showed that participants (100%) gave a positive response to the fact that senior midwifery colleagues must confirm graduates' findings during provision of midwifery services, as this will serve as a good pillar of support. The fact that supervision of newly graduated midwives during performance of procedures such as conduction of deliveries, suturing of episiotomies; will form a basis for effective transition support, was supported by all participants.

According to the results, 81.6% (n=31) of participants reported that it is possible to assign a mentor for each graduate; whereas a minority group of experienced midwives (18.4%, n= 7) reported the impossibility. All participants (100%) gave a positive response to support that allocation of a mentor for each graduate will assist in effective transition support of newly graduated midwives; and active participation of both a mentor and a mentee was supported to be an agent of promotion of positive mentoring process which will facilitate effective support during transition period.

Results also showed that all participants (100%) agreed that delegation is one of the strategies for effective transition support of newly graduated midwives. Based on the results, all participants (100%) supported the fact that in order for effective transition support to be possible, delegation of newly graduated midwives should be formal and written down. Results also showed that all participants (100%) gave a positive response in support of the fact that delegation of newly graduated midwives with a senior member in skills such as management of highly scheduled drugs, management of a woman in labour and management of caesarean births, will do justice in effective transition support of newly graduated midwives.

All participants (100%) reported that therapeutic sessions can be very helpful in the promotion of effective transition support of newly graduated midwives; effective communication and respect for one another were supported to form the ground rules during therapeutic sessions in order to aid effective support of graduates.

5.5.3.3 Stage of Being

Withdrawal of a senior member whilst delegating duties to newly graduated midwives during the stage of being was considered important, by the majority of participants (96%, n=48) indicating that it was very important for effective support; whereas the minority (4%, n=2) gave a negative response. All participants (100%) agreed that

teaching of graduates according to their learning needs will form part of their effective support during transition; and that participation of newly graduated midwives in peer teaching will assist in their transition support. The majority of the participants (98%, n=49) reported that reflection by newly graduated midwives regarding their ward experiences will have a positive impact on their effective transition support. Results also showed that all participants (100%) agreed that empowerment of newly graduated midwives regarding the use of an emergency trolley, eclamptic box as well as a resuscitation unit forms part of their effective support.

5.5.3.4 Stage of Knowing

Results showed that majority of participants (96%, n=48) reported that gradual withdrawal of mentoring at this stage will be good for graduates' support. All participants (100%) supported that continuation of positive collegial relationship will have a positive impact on support of newly graduated midwives. Results further showed that all participants (100%) gave a positive response in support of the fact that active participation of midwifery graduates in teaching during this stage, will help them become confident and competent; therefore becomes a strong pillar of support during their transition period.

5.5.3.5 Standard of a Transition Support Programme

Majority of operational managers (98%, n=12) reported that implementation of a developed transition support programme is not expensive in terms of costs; whereas only 2% (n=1) of operational managers reported that its implementation will be costly. All participants (100%) reported that a developed transition support programme can easily be implemented. The majority of the participants (96%, n=48) reported that all items in the programme are clear, whereas only 4% (n=2) of the participants reported that there are items which are not clear.

According to the results, the objectives of a transition support programme were clearly spelt out, as reflected by all participants (100%). All participants (100%) agreed that implementation of a developed transition support programme will assist in the promotion of provision of quality midwifery care. The next section focuses on the discussion of findings.

5.5.4 Discussion of the Findings

Based on the evaluation steps by CDC, discussion of findings of the validation process continued to address the last step in the evaluation process which covered; ensuring use and sharing lessons learned. Deliberations were made, through literature control in order to ensure that validation findings are used appropriately. Results revealed that majority of newly graduated midwives did their training in the universities as compared to those who trained in the colleges of nursing. According to Pairman et al. (2015), graduates who did their training at the universities proved to be more competent and committed to provision of quality patients' care as compared to those who did their training at the colleges; despite the fact that they were both trained for a period of four years.

In a study conducted by Healy and Howe (2014), participants reported that they valued inclusion of structured ward orientation in the transition support programme, because it formed a very strong foundation for their support during their transition period. Kensington et al. (2016) concurred when they reported that support programmes play a very important role in effective support of newly qualified staff as they foster a supportive working environment. Based on Healy and Howe's (2014) findings, participants supported that mentoring be included in graduates' support programmes to protect them from performing the roles that are supposed to be performed by the professionals in charge, which are outside of the scope of practice of a beginning

practitioner. Newly qualified midwives appreciated the fact that they were provided with individual preceptors who were mentoring them as part of the orientation programme. The reason why the provision was appreciated was because they needed someone close so that they could safely reveal their insecurities and uncertainties (Dixon et al., 2014). Pairman et al. (2015) concurred when reporting that graduates acknowledged that transition programme catered for availability of mentors for them as they felt vulnerable, as a result they felt safe and confident.

Healy and Howe (2014) reported that utilization of transition support programmes for newly qualified nurses and midwives, resulted in production of a sustainable and well prepared nursing and midwifery workforce capable of provision of high quality and safe nursing and midwifery care to patients. Pairman et al. (2015) concurred when they revealed that graduates reported that their performance of midwifery procedures improved after being exposed to transition support programmes. Participants supported the fact that a transition support programme advocated for formal and informal teaching of newly graduated midwives, based on their learning needs.

According to Charleston, Hayman-White, Ryan and Happell (2006), development and implementation of orientation programmes should be based on educational needs of the graduates to ensure success of recruitment and retention of graduates. This is in line with what was reported by Mason and Davies (2013), when they asserted that the challenge for the midwifery profession has been to develop and provide a transition programme that meets the individual needs of graduate midwives within the context of maternity care. In their studies, the authors reflected a similar version when they reported on the evaluations they made regarding graduates' support programmes that the elements of the programme were flexible and met the needs of the graduates, wherever they worked; which in their view was a strong supportive element for the graduates (Dixon et al., 2014; Dixon et al., 2015; Pairman et al., 2015).

In a study conducted by Healy and Howe (2014), graduates were so impressed by the provision support programmes made regarding structured opportunity for facilitated reflection, which had positive outcomes for their support. Graduates further acknowledged that the programmes created sessions for formal and informal constructive feedback, which played a very important role in their support process Healy and Howe (2014). Pairman et al. (2015) asserted that positive and collegial relationship between newly qualified midwives and their senior colleagues has to be a continuous process to promote provision of quality midwifery services.

Kensington et al. (2016) supported when reporting that graduates reported that they benefited from positive relations they had with experienced midwives, and hoped the relations would just continue for the sake of quality midwifery services. Not only is the evaluation process of a transition programme based on the steps in evaluation practice, but standards of good evaluation as well and such standards are described in the next section.

5.5.5 Validation Against the Standard for Good Evaluation

Based on the results, a developed transition support programme met the following standards for good validation: utility, propriety, feasibility, and accuracy. **Utility** is the state of being useful, profitable, or beneficial. Based on the findings, the programme met the utility standard as all participants (100%) reported that the programme will meet the needs of all relevant stakeholders including even, promotion of provision of quality patients' care.

Propriety is the condition of being right, appropriate or fitting. Results showed that a developed transition support programme met propriety standard, as majority of the participants (98%, n=49) considered themselves relevant stake holders to validate the programme. Results also showed that promotion of respect for human dignity and

interactions was well presented in a developed transition support programme; which demonstrates appropriateness of a programme.

Feasibility is the state or degree of being easily or conveniently done. The feasibility of a programme was evidenced by participants' reports which reflected that majority of operational managers (98%, n=12) reported that implementation of a developed transition support programme is not expensive in terms of costs; whereas only 2% (n=1) of the operational managers reported that its implementation will be costly. The fact that all participants (100%) reported that a developed transition support programme can easily be implemented, served as evidence that a programme met a feasibility standard.

Accuracy is the quality or state of being correct or precise. The accuracy of the programme was measured and demonstrated by positive results which reported that majority of the participants (96%, n=48) reported that all items in the programme are clear, whereas only 4% (n=2) of the participants reported that there are items which are not clear. Results further revealed that the objectives of a support programme were clearly spelt out, as reflected by all participants (100%).

5.5.6 Summary

The chapter focused on concept analysis whereby the core concept "effective transition support" was analyzed; leading to the development of a transition support programme which will be used for enhancement of support of newly graduated midwives during their transition period. The programme was validated. Results of the validation process were analyzed using SPSS version 24, and the findings were also discussed. The chapter that follows focuses on recommendations of the study based on the findings.

CHAPTER 6

Summary, Recommendations, Limitations and Conclusion

6.1 Introduction

The interpretation and discussion of the findings of Phase 1 were covered in Chapter 4. In Chapter 5, the concept '*effective transition support*' was analyzed. Results of Phase 1 as well as concept analysis guided the development of a transition support programme based on a conceptual framework of ADDIE's (Cutler et al., 2012) model for training and instructional design as well as Duchscher's (2009) transition theory. Following the development of a transition support programme, validation of a developed transition support programme was done using a quantitative approach in which the exploratory and descriptive designs were used.

The purpose of this chapter is to present a summary of the findings, recommendations, limitations as well as conclusion of the study. Phase 1 of the study focused on experiences of newly graduated midwives regarding provision of midwifery services during their transition period; expectations of experienced midwives from newly graduated midwives during their first year of clinical practice as well as the support provided by experienced midwives to newly graduated midwives during their first year of clinical practice. Concept analysis was done based on the findings of Phase 1 of the study. Transition support programme was developed, based on the findings of Phase 1 as well as those of the concept analysis; for the purpose of enhancing effective support of newly graduated midwives during their transition period.

The recommendations and conclusions established were in line with the problem statement, objectives of the study and were based on the research results.

6.2 Summary of the Major Findings

The study was completed in two phases. The qualitative research in Phase 1 focused on the following study objectives:

- Explore and describe the experiences of newly graduated midwives regarding provision of midwifery services during their transition period;
- Describe the expectations of experienced midwives from newly graduated midwives during their first year of clinical practice; and
- Explore the support provided by experienced midwives to newly graduated midwives during their first year of clinical practice.

The following were the objectives on which Phase 2 of the study was based:

- Develop a transition support programme to enhance effective support of newly graduated midwives during their transition period; and
- Validate a developed transition support programme for effective support of newly graduated midwives during their transition period.

6.3 Summary of Findings Based on Objectives

❖ **Objective 1: Explore and describe the experiences of newly graduated midwives regarding provision of midwifery services during their transition period**

Empirical findings revealed that newly graduated midwives experienced a lot of physical exhaustion as the labour ward was very busy with serious shortage of staff. According to the results, shortage of staff is one of the contributory factors of

ineffective support of newly graduated midwives by experienced midwives during the transition period. Results also showed that due to shortage of staff, midwives resort to working long shifts which further adds burden on physical, emotional and psychological health.

Participants admired their achievement of being professional nurses, but raised a concern of increased level of responsibility and accountability accompanying the position; which leads to stress. Results of the study revealed that newly graduated midwives found it very hard to adjust themselves with the responsibilities of a professional midwife; as they felt incapable of dealing with the challenges of a professional midwife's role. Graduates also expressed shock as they are faced with the reality that they are now expected to function as professional midwives who should take decisions that determine patients' well-being.

Results also showed that newly graduated midwives marked a difference between the midwifery learnt during training and the midwifery practiced in the clinical setting; resulting in frustration and anger as the values they had developed throughout their training were not supported in practice. Graduates also reported confusion as the discrepancies they experienced made them to find themselves in two different worlds of midwifery practice; which complicated the whole transition process.

The study also revealed that negative attitudes of experienced midwives towards newly graduated midwives led to feelings of uncertainties which negatively affected graduates' performance. Participants reported feelings of uncertainties resulting from the fact that they were not delegated, which made them to room around joblessly sometimes, resulting in loss of interest in midwifery care. Based on the findings of the study, experienced midwives often passed negative remarks towards newly graduated midwives, which negatively affected their performance. The study also

revealed that newly graduated midwives did not feel comfortable to ask questions from experienced midwives. It was also evident from the study that newly graduated midwives described feeling confused and upset at being treated badly by experienced midwives.

- **Objective 2: Describe the expectations of experienced midwives from newly graduated midwives during their first year of clinical practice**

Results of the study revealed that experienced midwives expected newly graduated midwives to function competently and confidently irrespective of their minimal clinical experience; unfortunately they did not, resulting in misery on both parties. According to the study results, experienced midwives were so disappointed and frustrated when newly graduated midwives failed to behave like responsible independent practitioners. The findings of the study also revealed that it was one of the expectations of experienced midwives that the presence of newly graduated midwives in maternity units will have a positive impact on the reduction of midwifery workload, unfortunately their expectation was unmet, resulting in their disappointment.

The findings also revealed that experienced midwives felt that working with newly graduated midwives was even worse than working in maternity unit alone; this was because they expected newly graduated midwives to add pairs of extra hands in provision of midwifery services; which newly graduated midwives could not as they still needed to be supervised and mentored. According to the results, experienced midwives felt that newly graduated midwives were committed to provision of midwifery services; but they still found it difficult to make independent decisions, and high levels of responsibility and accountability which led to anxiety; and all these negatively affected their commitment regarding performance of midwifery services to patients.

- **Objective 3: Explore the support provided by experienced midwives to newly graduated midwives during their first year of clinical practice**

The study revealed that newly graduated midwives expected some form of support from experienced midwives, yet, most of the experienced midwives showed no interest in supporting them. Ineffective support of newly graduated midwives by experienced midwives negatively affected graduates' performance of midwifery services. Results also showed that newly graduated midwives expressed feelings of fear and lack of confidence during provision of midwifery services; as experienced midwives displayed behaviours of being unsupportive which left graduates struggling to cope.

Empirical findings revealed that newly graduated midwives were not supervised nor mentored; as participants reported that they progressed patients in labour alone and even conducted deliveries alone, without any supervision or assistance. Based on the results of the study, negative relationship between experienced and newly graduated midwives was reported; leading to poor performance of newly graduated midwives. Results also showed that there were experienced midwives who even verbalized that they did not want newly graduated midwives in their shifts.

According to the results, the working environment in maternity units was not conducive for newly graduated midwives to learn. As a result, their doubts and questions related to aspects of midwifery care were less likely to be attended to. The study showed that the type of orientation done was ineffective, resulting in newly graduated midwives running around not knowing where to get some of the resources for use, which really affected their performance and their confidence. Regarding duty scheduling, the study revealed that newly graduated midwives expressed their satisfaction on the way they were drawn, as they were never left to manage the wards alone without a senior

member of staff.

- **Objective 4: Develop a transition support programme to enhance effective support of newly graduated midwives during their transition period**

Results of phase one of the study as well as those of concept analysis guided the development of a transition support programme. The process of programme development was based on a conceptual framework of ADDIE's model for training and instructional design, of which the steps are: analysis, design, development, implementation and evaluation (Cutler et al., 2012). The developed transition support programme was structured according to the stages of transition theory by Duchscher (2009) as follows: the stage of doing, stage of being and stage of knowing.

In the stage of doing, a transition support programme focused on orientation, supervision, mentoring, positive collegial relationship as well as delegation. According to the transition support programme, orientation of newly graduated midwives must be done during the first three to four months of transition. Hospital tour should be conducted in order for newly graduated midwives to familiarize themselves with different sections in an organization; and should be done during the first week of arrival in an organization. Institutional policies should also be clarified to the graduates, so that they become conversant with effective functioning of the institution.

For effective management of midwifery emergencies, newly graduated midwives should be orientated to important aspects of provision of care such as, an emergency trolley, eclamptic box and a resuscitation unit. Graduates should be orientated to the routine of a maternity unit. This will facilitate effective provision and management of midwifery services. Policies, protocols, procedures and guidelines governing provision of midwifery services should be clarified to the graduates.

Based on the programme, supervision of newly graduated midwives should be done by all experienced midwives working with graduates during their transition period. Experienced midwives must confirm the findings made by graduates regarding patients' observations to ensure patients' safety. Graduates must not perform procedures such as conduction of deliveries, suturing of episiotomies alone without any supervision by experienced midwives. Where necessary, supervision must be accompanied by teaching on the spot in order to address performance gaps.

A developed transition support programme also addressed an issue of mentoring with an aim of provision of support and development of the graduates. According to a transition support programme, each newly graduated midwife should have an individual mentor who considers modelling, supporting best practice and provision of positive feedback as strong ingredients of a mentoring process. Establishment and maintenance of positive collegial relationship was also emphasized in the transition support programme. The importance of therapeutic sessions, effective communication and maintenance of respect for one another were also addressed as important issues to be incorporated in the positive collegial relationship.

Delegation of the newly graduated midwives was also included in the doing stage of a developed transition support programme. According to a developed programme, it is mandatory that graduates are delegated with a senior member of staff to assist and oversee the performance of delegated tasks; particularly in tasks that demand high levels of responsibility and accountability such as; management of highly scheduled drugs, management of a woman in labour, management of caesarean births in theatre, resuscitation of a newborn baby.

In the stage of being, delegation of newly graduated midwives continues, but a senior member of staff should be gradually withdrawn, as newly graduated midwives at this

stage are beginning to get used to their professional roles and responsibilities. Formal teaching is considered important and graduates should also participate in peer teaching. Reflection should also be practiced whereby graduates are given the opportunity to explore the situations they have been faced with including actions taken to manage such situations.

Newly graduated midwives are more familiar and comfortable with their professional positions; and their relationship with the colleagues is improved to an extent that they are able to explore their professional environment with a critical eye. During the stage of knowing, the transition support programme dictates that mentoring should be withdrawn gradually but positive collegial relationship continues as a lifelong commitment. Environment conducive for learning should also continue to be maintained but newly graduated midwives should be the ones who should be mostly involved in teaching.

- **Objective 5: Validate a developed transition support programme for effective support of newly graduated midwives during their transition period.**

The validation of the developed transition support programme was done using quantitative approach in which the exploratory and descriptive designs were used. The similar setting with the participants who met the similar criteria as in Phase 1, validated the developed programme; as they were the ones who will be mostly affected in its implementation and will also benefit most from the results.

The whole process of programme validation was based on the framework for programme evaluation in public health (CDC, 1999), which is composed of two main dimensions on which programme validation was based, and such were steps in evaluation practice and standards for good evaluation. Based on validation results,

majority of participants (98%) reported that a developed transition support programme met the following standards; utility, propriety, feasibility, and accuracy. Results also showed that all participants (100%) agreed that orientation of newly graduated midwives to the hospital's surrounding, routine, policies, protocols, procedures and guidelines governing provision of midwifery services will provide a strong form of support for newly graduated midwives.

The majority of participants (94%) reported that orientation to maternity surrounding will be more effective if done by a senior member of staff. According to the results, all the participants (100%) gave a positive response to the fact that supervision of newly graduated midwives during performance of procedures such as conduction of deliveries, suturing of episiotomies; will form a basis for effective transition support.

All participants (100%) agreed that teaching of graduates according to their learning needs will form part of their effective support during transition; and that active participation of newly graduated midwives in peer teaching will be a strong booster in their competence and confidence level. Results also showed that all participants (100%) agreed that empowerment of newly graduated midwives regarding the use of an emergency trolley, eclamptic box as well as a resuscitation unit forms part of their effective support.

According to the results, majority of the participants (98%) reported that reflection by newly graduated midwives regarding their ward experiences will have a positive impact on their effective transition support. Withdrawal of a senior member whilst delegating duties to newly graduated midwives during the stage of being was considered important, by the majority (96%) of participants. Results also revealed that majority of participants (96%) reported that gradual withdrawal of mentoring at this stage will be good for graduates' support. All participants (100%) supported that

continuation of positive collegial relationship forms a strong pillar of support, resultin in newly graduated midwives becoming more competent and confident.

6.4 Recommendations

Based on the findings of the study, ineffective support of newly graduated midwives during their first year of clinical practice emerged as a central theme. The developed transition support programme addressed the major challenges identified in the findings of the main study. Only aspects of the results which were not addressed by the developed transition support programme were covered in the recommendations.

6.4.1 Recommendations for Nursing Education

- Universities and colleges should ensure that students' training should prepare graduates to be responsible and accountable so that they are able to manage the units independently; instead of depending on experienced midwives for assistance.

- Training of students at the universities and colleges should be such that on completion of training, graduates should effectively render midwifery services so that experienced midwives can feel that there are extra hands assisting regarding the workload.

- Universities and colleges should ensure that the type of training they offer to students should enable them to be competent, confident and committed professionals regarding provision of midwifery services.

- Midwifery training programmes should include opportunities for discussion of the transition process.

- Midwifery training should be such that prepares graduates to be able to

manage midwifery issues in a real practical situation.

- Clinical placement of students during training should be done in such a way that promotes correlation of theory with practice.

- More hours should be allocated for clinical learning rather that theoretical learning.

- Number of deliveries and vaginal examinations to be conducted by midwifery students should be increased from fifteen to thirty.

- Midwifery training should be such that prepares graduates for peer teaching, report giving as well as report taking.

6.4.2 Recommendations for Nursing Practice

- Experienced midwives should treat newly graduated midwives as neophytes in the professional world, and should therefore orientate, supervise and mentor them before expecting them to function as independent practitioners.

- Experienced midwives should not have unrealistic expectations from newly graduated midwives, expecting them to behave like experienced professionals.

- Experienced midwives should do away with the assumption that the fact that newly graduated midwives have undergone their training at the college or university does not mean that they are “all knowledgeable.

- Nursing service managers should motivate for more posts for midwives in order to address the problem of serious shortage.

- Nursing service managers should attend to the type of duty schedules in practice as they expose the staff members to tiredness due to long shifts.

- Period of placement of newly graduated midwives in maternity unit should be prolonged to twelve months, of which six months should be for labour ward and the remaining six months should be spread in ante-natal, post-natal as well as neonatal units respectively.

6.4.3 Recommendations for Future Research

- Future research should be conducted for the purpose of evaluation of the outcomes of a developed transition support programme.

- Research should be carried out to explore newly graduated midwives' views regarding the use of a developed transition support programme during their transition period.

- Research studies should be repeated after five years using the same participants in order to determine their relationship with experienced midwives during subsequent years following transition period.

6.5 Limitations of the Study

Development of a transition support programme was based on a conceptual framework of ADDIE's model for training and instructional design as well as Duchscher's transition theory. ADDIE's model for training and instructional design is composed of five steps which are: Analysis, Design, Development, Implementation and Evaluation. However, the study only covered the first three steps as the last two fall beyond its scope and will therefore be addressed as a post-doctoral project.

6.6 Conclusion

The study plan entailed the background, problem statement, purpose, objectives, research design and methods, trustworthiness and ethical considerations of the study.

Relevant literature was reviewed based on the objectives of the study. Data was collected and analysed qualitatively, and major themes, themes and sub-themes emerged. The concept effective transition support also emerged during data analysis and was analysed based on Walker and Avant's steps of concept analysis.

Results of phase 1 of the study as well as those of concept analysis formed the basis for development of a transition support programme aiming at enhancement of effective support of newly graduated midwives during their transition period. Quantitative approach was implied to validate a developed programme. Recommendations were made based on the findings, and the limitations of the study were also highlighted.

REFERENCES

Adegoke, A.A., Atiyaye, F.B., Abubakar, A.S., Auta, A. and Aboda, A. (2015). Job satisfaction and retention of midwives in rural Nigeria. *Midwifery*, 31(4), 946–956.

Avis, M., Mallik, M. and Fraser, D.M. (2012). 'Practising under your own Pin'–a description of the transition experiences of newly qualified midwives. *Journal of Nursing Management*, 21(8), 1061-1071.

Babbie, E. (2016). The practice of social research. 14th. Edition. Boston: Cengage.

Bacon, L. (2010). Involving supervisors of midwives in student education. *British Journal of Midwifery,* 18(5), 308–316.

Banks, P., Roxburgh, M., Kane, H., Lauder, W., Jones, M., Kydd, A. and Atkinson, J. (2011). Flying Start NHS: easing the transition from student to registered health professional. *Journal of Clinical Nursing,* 20(8), 3567-3576.

Barry, M., Hauck, Y., O'Donoghue, T. and Clarke, S. (2013). Newly-graduated midwives transcending barriers: A grounded theory study. *Midwifery*, 29(6), 1352–1357.

Bernitz, S., Øian, P., Rolland, R., Sandvik, L. and Blix, E. (2014). Oxytocin and dystocia as risk factors for adverse birth outcomes: A cohort of low-risk nulliparous women. *Midwifery*, 30(3), 364-370.

Bolden, L., Cuevas, N., Raia, L., Meredith, E. and Prince, T. (2011). The use of reflective practice in new graduate registered nurses' residency program. *Nursing Administration Quarterly, 35*(2),134-139.

Brink, H. (2006). Fundamentals of research methodology for health-care professionals. CapeTown: Juta and Co.

Brink, H., van der Walt, C. and van Rensburg, G. (2014). Fundamentals of researchmethodology for health care professionals, 3rd edn. Juta.

Burns, N. and Grove, S.K. (2009). The Practice of Nursing Research, Appraisal, Synthesis, And Generation of Evidence, 6th edn. Saunders.

Carter, A.G., Sidebotham, M., Creedy, D.K. Fenwick, J. and Gamble, J. (2013). Using root cause analysis to promote critical thinking in final year Bachelor of Midwifery students. *Nurse Education Today,* 34(6), 1018–1023.

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *MMWR* . 48 (No. RR-11), 1-42.

Charleston, R., Hayman‐White, K; Ryan, R. and Happell, B. (2006). Understanding the importance of effective orientation: what does this mean in psychiatric graduate nurse programs? *Australian Journal of Advanced Nursing*, 25(1), 24-30.

Chick, N. and Meleis, A.I. (1986). Transitions: a nursing concern. In: Chinn, P.L. (Ed.), Nursing Research Methodology. Aspen Publication, Boulder, CO, pp. 237-257.

Chinn, P.L. and Kramer, M.K. (1999). Theory and Nursing: A systematic Approach, (5th ed.).St Louis: Mosby.

Cho, S.H., Lee, J.Y., Mark, B.A. and Yun, S.C. (2012). Turnover of new graduate nurses in their first job using survival analysis. *Journal of Nursing Scholarship*, 44 (1), 63–70.

Clements, V. (2012). New graduate midwives' experiences of their transition support programs. Sydney, Australia: University of Technology, Sydney.

Cora, H. and Alwyn, M. 1997. Support as experienced by patients with cancer during radiotherapy treatment. *Journal of Advanced Nursing*, 26(2), 226-430.

Coulm, B., Le Ray, C., Lelong, N., Drewniah, N., Zeitlin, J. and Blondel, B. (2012). Obstetric interventions for low-risk pregnant women in France: Do maternity unit characteristics make a difference? *Birth*, 39(8), 183–191.

Creswell, J.W. (2009). Research design. Qualitative, quantitative and mixed methods approaches. Sage Publications Ltd, Thousand Oaks.

Crombag, N.M., Bensing, J.M., Iedema-Kuiper, R., Schielen, P.C. and Visser, G.H. (2013). Determinants affecting pregnant women's utilization of prenatal screening for Down syndrome: A review of the literature. *Journal of Maternal-Fetal and Neonatal Medicine*, 26(17), 1676-1681.

Cubit, K. A. and Ryan, B. (2011). Tailoring a graduate nurse program to meet the needs of our next generation nurses. *Nurse Education Today,* 31(1), 65-71.

Cummins, A.M., Denney-Wilson, E. and Homer, C.S.E. (2016). The mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia. *Nurse Education in Practice*, 12(2), 1-6.

Cutler, S., Lee, W.C. and McNair, M. (2012). Easing into Engineering Education: An orientation Program for Graduate Students. *American Society for Engineering Education*, 11(2), 1-16.

Davis, D., Foureur, M., Clements, V., Brodie, P. and Herbison, P. (2011). 'The self-reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia', *Women and Birth*, 35(7), 485-494.

Deasy, C., Doody, O. and Tuohy, D. (2011). "An exploratory study of role transition from student to registered nurse (general, mental health and intellectual disability) in Ireland". *Nurse Education in Practice*, 11(2), 109-113

Delaney, C. (2013). Walking a fine line: graduate nurses' transition experiences during orientation. *Journal of Nursing Education,* 42(10), 437-443.

Department of Health. (2016). *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals.* London: DH. tinyurl.com/preceptorship-framework

De Vos, A.S., Strydom, H., Fouche,C.B. and Delport, C.S.L. (2013). Research at Grass Roots.For the social sciences and human service professions. Pretoria: Van Schaik.

Dixon, L., Tumilty, E., Kensington, M., Campbell, N., Lennox, S., Calvert, S. and Pairman, S. (2014). Stepping forward into life as a midwife in New Zealand/Aotearoa: An analysis of the Midwifery First Year of Practice programme 2007 to 2010. *Midwifery,* 22(9), 1123-1136.

Dixon, L., Calvert, S., Tumilty, E., Kensington, M., Gray, E., Campbell, N. and Pairman, S. (2015). Supporting New Zealand graduate midwives to stay in the profession: An evaluation of the Midwifery First Year of Practice programme. *Midwifery,* 12(4), 102-114.

Dlamini, C.M., Mtshali, N.G., Dlamini, C.H., Mahanya, S., Shabangu, T. and Tsabedze, Z. (2014). New graduates' readiness for practice in Swaziland: An exploration of stakeholders' perspectives. *Journal of Nursing Education and Practice*, 21(4), 39-45.

Doody, O., Tuohy, D. and Deasy, C. (2012). Final-year student nurses' perceptions of role transition. *British Journal of Nurses,* 21(11), 684–688.

Duchscher, J.E.B. (2008). A Process of Becoming: The Stages of New Nursing Graduate Professional Role Transition. *The Journal of Continuing Education in Nursing, 39*(10), 441-450.

Duchscher, J.E.B. (2009). Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing*, 65(5), 1103–1113.

Dyess, S.M. and Sherman, R.O. (2009). The first year of practice: New graduate nurses transition and learning needs. *Journal of Continuing Education in Nursing*, 40(9), 403–410.

Evans, P., Forney, V.C. and Guido-DiBrito, B.A. (1998). *Student Development in College: Theory, Research, and Practice.* Jossey-Bass: San Francisco, CA.

Fabian, H and Dunlop, A.W. (2006). *Strong foundations: early childhood care and education.* Outcomes of good practice in transition processes for children entering primary school.. *Education for All Global Monitoring Report.*

Feltham C. (2014). The value of preceptorship for newly qualified midwives. *British Journal of Midwifery*, 22(6), 427- 431.

Fenwick, J., Hammond, A., Raymond, J., Smith, R., Gray, J., Foureur, M., Home, K. and Symon, A. (2012). Surviving, not thriving: A qualitative study of newly qualified midwives' experience of their transition to practice. *The Journal of Continuing Education in Nursing,* 41(12), 2054-2063.

Fraser, D.M. and Hughes, A.J. (2010). Midwifery Mentorship and Preceptorship Pilot Project Evaluation. *Final Report to NHS East Midlands*.

Fraser, D.M. and Avis, M. (2011). End RandD madness. *Health Service Journal,* 121(16), 624-635.

Fullerton, J.T., Thompson, J.B. and Johnson, P. (2013). Competency-based education: The essential basis of pre-service education for the professional midwifery workforce. *Midwifery,* 29(10), 1129–1136.

George, L.K. (1993). Sociological Perspectives on life Transitions. Departments of Sociology and Psychiatry, and Center for the Study of Aging, Duke University, Durham, North Carolina.

Gray, J.E., Leap, N., Sheehy, A. and Homer, C.S.E. (2012). The 'follow-through' experience in three-year Bachelor of Midwifery programs in Australia: a survey of students. *Nurse Education in Practice,* 12 (5), 258-263.

Green, S. (2014). Competence and the Nurse New to General Practice. *Practice Nursing*, 26(1), 42-45.

Haggerty, C., Holloway, K., Wilson, D. (2012) Entry to nursing practice preceptor education and support: Could we do it better? *Nursing Praxis in New Zealand,* **28**(1) 30-39.

Hammond, A., Gray, J., Smith, R.M., Fenwick, J. and Homer, C.S.E. (2011). Same, same but different: Expectations of graduates from two midwifery education courses in Australia. *Journal of Clinical Nursing*, 20(6), 2315–2324.

Handley, R. and Dodge, N. (2013). Can Simulated Practice Learning Improve Clinical Competence? *British Journal of Nursing*, 22(9), 529 – 535.

Healy, M. and Howe, V. (2014) Monitoring and Evaluation Framework for Victorian Graduate Programs for Nurses and Midwives. Final Monitoring and Evaluation Framework. Prepared by TNS for Nursing and Midwifery Workforce Well-being, Integrated Care and Ageing Department of Health. Retrieved 5/8/14 from http://www.health.vic.gov.au/__data/assets/pdf_file/0005/859604/FinalME-Framework_270314.pdf

Hillman, L. and Foster, R. R. (2011). The impact of a nursing transitions programme on retention and cost savings. *Journal of Nursing Management, 19(7)*, 50-56.

Hobbs, J.A. (2012). Newly qualified midwives' transition to qualified status and role: Assimilating the 'habitus' or reshaping it? *Midwifery,* 28(4), 391–399.

Holland, K., Roxburgh, M., Johnson, M., Topping, K., Watson, R., Lauder, W. and Porter, M. (2010). Fitness for practice in nursing and midwifery education in Scotland, United Kingdom. *Journal of Clinical Nursing,* 19(3–4), 461–469.

Holloway, I. and Wheeler, S. (2010). Qualitative research in nursing and health care. 3rd edition. United Kingdom:John Wiley and Sons.

Hood, L., Fenwick, J. and Butt, J. (2010). A story of scrutiny and fear: Australian midwives' experiences of an external review of obstetric services, being involved with litigation and the impact on clinical practice. *Midwifery*, 26(3), 268–285.

Hughes, A.J. and Fraser, D.M. (2011). ''SINK or SWIM'': The experiences of newly qualified midwives in England'. *Midwifery*, 43(6), 1010-1016.

Hurteau, M., Houle, S. and Mongiat, S. (2009). "How Legitimate and Justified are Judgments in Program Evaluation?"*. Evaluation, 15 (3), 307–319.*

Hyrkas, E.K, Linscott, D.A. and Rhudy, J.P. (2014). Evaluating preceptors and preceptees satisfaction concerning preceptorship and the preceptor-preceptee relationship. *Journal of Nursing Education and Practice,* 4(4), 120-133.

Jacobson, D.E. (1986). Types and timing of social support. *Journal of Health and Social Behaviour*, 27(3), 250-264.

James, L. (2013). Nurturing the next generation: Midwives' experiences when working with third year midwifery students in New Zealand. *New Zealand College of Midwives Journal,* 47(8), 14 -17.

Joint Commission Center for Hot Topics in Health Care, Transitions of care: the need for collaboration across entire care continuum. http://www.centerforhottopicsin health care.org/assets/4/6/CHTH_Transitions of care _set_final_2010.pdf (accessed April 11, 2012)

Jordan, K., Fenwick, J., Slavin, V., Sidebotham, M. and Gamble, J. (2013). Level of burnout in a small population of Australian midwives. *Women Birth*, 49(7), 1010- 1021.

Kensington, M., Campbell, N., Gray, E., Dixon, L., Tumilty, E., Pairman, S., Calvert, S., Lennox, S., (2016). New Zealand's Midwifery Profession: Embracing graduate midwives' transition to practice. *New Zealand College of Midwives Journal, 52*, 20-25.

Kramer, M. (1974). Reality Shock: Why nurses leave nursing. St. Louis: Mosby Company.

Kumaran, S., Suji, K. and Carney, M. (2014). Role transition from student nurse to staff nurse: Facilitating the transition period. *Nurse Education in Practice,* 14(3), 605-611.

Lennox, S. and Foureur, M. (2012). Developmental mentoring: New graduates' confidence grows when their needs shape the relationship. *New Zealand College of Midwives Journal, 46(11)*, 26-31.

Lennox, S., Jutel, A. and Foureur, M. (2012). The Concerns of Competent Novices during a Mentoring Year. *Nursing Research and Practice, 49(13),* 109-120.

Lewis, S. and McGowan B. (2015). Newly qualified nurse's experiences of preceptorship. *British Journal of Nurses,* 24(1), 40-43.

Macquarie, S. (2005). Macquarie Australia's National Dictionary: Budget Dictionary with Synonyms. The Macquarie Library Pty Ltd: Sydney.

Magnusson, C., Westwood, S., Ball, E., Curtis, K., Evans, K., Horton, K., Johnson, M. and Allan, H.T. (2014). An Investigation into Newly Qualified Nurses' Ability to Re-contextualise Knowledge to Allow them to Delegate and Supervise Care. [Online] Availablefrom:http://www.surrey.ac.uk/fhms/research/centres/crnme/currentactivity/AaRK%20project/aark-summary-report.pdf. [Date Accessed: 25/02/15].

Malouf, N. and West, S. (2011). Fitting in: A pervasive new graduate nurse need. *Nurse Education Today*, 1(5), 488–493.

Marquis, B.L. and Huston, C.J. (2009). *Leadership Roles and Management Functions in Nursing. Theory and Application*. 6th edn. China: Wolters Kluwer/Lippincott Williams and Wilkins.

Mason, J. and Davies, S. (2013). A qualitative evaluation of a preceptorship programme to support newly qualified midwives. J*ournal of the Royal College of Midwives, 11*(3), 94-98.

McCarthy, B. and Murphy, S. (2010). Preceptors' experiences of clinically educating and assessing undergraduate nursing students: An Irish context. *Journal of Nursing Management,* 18(5), 234–244.

McCarthy, C.F., Voss, J., Verani, A.R., Vidot, P., Salmon, M.E. and Riley, P. (2013). Nursing and midwifery regulation and HIV scale-up: Establishing a baseline in East, Central and Southern Africa. *Journal of International AIDS Society*, 16(7), 180- 192.

McCusker, C. (2013). Preceptorship: professional development and support for newly registered practitioners. *Journal of Perioperative Practice, 23*(12), 283-287.

Merriam-Webster's Fifth New Internationa Dictionary. 1991. Volume 3. A-G. Encyclopaedia, inc. Chicago.

Mollart, L., Skinner, V.M., Newing, C. and Foureur, M. (2011). Factors that may influence midwives work-related stress and burnout. *Women Birth*, 44(8), 1010- 1016.

Mooney M. (2007). Professional socialization: The key to survival as a newly qualified nurse. *International Journal of Nurse Practitioners*, 13(8), 75-80.

Morgan, A., Mattison, J., Stephens, M. and Meadows, S. (2012). Implementing structured preceptorship in an acute hospital. *Nursing Standards,* 26(28), 35-39.

Morrow, S. (2009). New graduate transitions: Leaving the nest, joining the flight. *Journal of Nursing Management,* 17(3), 278-287.

Motlolometsi, M.W.A. and Schoon, M.G. (2012). Poor maternal outcomes: A factor of poor professional systems design. *South African Medical Journal, 102*(10), 784-786.

Mouton, J. (2010). Basic Concept in Methodology of the Social Science. Pretoria: HSRC Publisher.

Ndaba, B.J. (2013). Lived experiences of newly qualified Professional nurses doing community service in midwifery section in one Gauteng hospital**.** *Curationis*, 23(5), 15-22.

Odland, L.H., Sneltvedt, T. and Sörlie, V. (2014). Responsible but unprepared: Experiences of newly educated nurses in hospital care. *Nurse Education Practice,* 14(5), 538-543.

Omansky, G.L. (2010). Staff nurses' experiences as preceptors and mentors: An integrative review. *Journal of Nursing Management*, 18(7), 697–703.

Oosthuizen, M.J. and Phil, D. (2012). The portrayal of nursing in South African newspapers: A qualitative content analysis. *African Journal of Nursing and Midwifery,* 14(1), 49-62.

O"Shea, M. and Kelly, B. (2007). The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland. *Journal of Clinical Nursing,* 16(3), 1534-1542.

Ostini, F. and Bonner, A. (2012). Australian new graduate experiences during their transition program in a rural regional acute care setting. *Contemporary Nurse,* 41 (2), 242-252.

Oxford dictionaries online. Confidence. 2016. Retrieved February 16, 2016 from http://www.oxforddictionaries.com/definition/english/confidence. 10.

Pairman, S., Dixon, L., Tumilty, E., Gray, E., Campbell, N., Calvert, S., and Kensington, M. (2015). The Midwifery First Year of Practice programme supporting New Zealand midwifery graduates in their transition to practice. Midwifery, 15(4), 122-134.

Panzavecchia, L. and Pearce, R. (2014). Are preceptors adequately prepared for their role in supporting newly qualified staff? Nurse Education Today, 34(7), 1119-1124.

Pearce, A.R. (1953). Theft by false promises. University of Pennsylvania Law Review 101(7): 967–1011.

Polit, D.F. and Beck, C.T. (2012). Nursing research: Generating and assessing evidence for nursing practice. 9th edn. Philadelphia: Lippincott.

Procter, N., Beutel, J., Deuter, K., Curren, D., de Crespigny, C. and Simon, M. (2011). The developing role of transition to practice programs for newly graduated mental health nurses. International Journal of Nursing Practice, 17(4), 254-261.

Price, B. (2014). Preceptorship of nurses in the community. *Primary Health Care,* 24 (4), 36 - 41.

Pugh, J.D., Twigg, D.E., Martin, T.L. and Rai, T. (2013). Western Australia facing critical losses in its midwifery workforce: A survey of midwives' intentions. *Midwifery*, 29(8), 497–505.

Rawson, S. (2010). A qualitative study exploring student midwives' experiences of carrying a caseload as part of their midwifery education in England. *Midwifery*, 27(6), 786-797.

Reynolds, E.K., Cluett, E. and Le-May, A. (2014). Fairy tale, midwifery fact or fiction: The lived experiences of newly qualified midwives. *British Journal of Midwifery*, 22(9), 660- 668.

Roxburgh, M., Lauder, W., Topping, K., Holland, K., Johnson, M. and Watson, R. (2010). Early findings from an evaluation of a post-registration staff development programme: The Flying Start NHS initiative in Scotland, UK. *Nurse Education in Practice*, 43(10), 76–81.

Roziers, R.L., Kyriacos, U. and Ramugondo, E.L. *(*2014). Newly Qualified South African Nurses' Lived Experience of the Transition from Student to Community Service Nurse: A Phenomenological Study. *The Journal of Continuing Education in Nursing*, 45(2), 45-51.

Rush, K.L., Adamack, M., Gordon, J. and Janke, R. (2014). New graduate nurse transition programs: Relationship with bullying and access to support. *Contemporary Nurse*, 48(2), 219-228.

Schneider, Z., Whitehead, D., Elliot, B., Lobiondo-Wood, G. and Haber, J. (2007). Nursing and Midwifery Research Methods and Appraisal for Evidence-Based Practice. 3rd edn. Mosby; Elsevier.

Schroeder, E., Petrou, S., Hollowell, J., Redshaw, M. and Brockelhurst, P. (2014). Birthplace cost-effectiveness analysis of planned place of birth: Decision analytic model*. Birth,* 24(8), 1604 – 1614.

Schytt, E. and Waldenström, U. (2013). How well does midwifery education prepare for clinical practice? Exploring the views of Swedish students, midwives and obstetricians. *Midwifery, 29*(2), 102–109.

Seibold, C., Licqurish, S., Rolls, C. and Hopkins, F. (2010). 'Lending the space': midwives perceptions of birth space and clinical risk management. *Midwifery,* 26(8), 526– 531.

Shibley, K. E., Amaral, J. D., Shank, B. and Shibley, L. R. (2011). Factors affecting transition roles to professional roles. *Journal of College Science Teaching*, 40(6), 68-80.

Skirton, H., Stephen, N., Doris, F., Cooper, M., Avis, M. and Fraser, D.M. (2012). Preparedness of newly qualified midwives to deliver clinical care: An evaluation of pre-registration midwifery education through analysis of key events. *Midwifery,* 28(5), 660-666.

Snow, T. (2013). Call for mandatory preceptorship programme for all new nurses. *Nursing Standards,* 27(19), 12-13.

Solowiej, K., Upton, P. and Upton, D. (2010). Supporting the transition from student to practitioner: a scheme to support the development of newly qualified practitioners. *International Journal of Therapy and Rehabilitation, 17*(9), 494-504.

South Africa. 2005. *Nursing Act (no 33 of 2005, as amended).*Pretoria: Government Printer.

South African Nursing Council.1992. Regulations Relating to the Approval of and the Minimum Requirements for the Education and Training of a Nurse (General, Psychiatric and Community) and Midwife leading to Registration. (R425 of February 1985) Pretoria: Government Printer.

South African Nursing Council.1992b. Philosophy and policy of the South African Nursing Council with regard to professional nursing education and training. Pretoria: Government Printer.

Speziale, H.J.S. and Carpenter, D.R. 2007. Qualitative Research in Nursing, Advancing the Humanistic Imperative. 4th edn. Philadelphia: Lippincott Williams and Wilkins.

Stacey, G. and Hardy, P. (2011). Challenging the shock of reality through digital storytelling. *Nurse Education in Practice*, *11*(2), 159-164.

Stoltz, P., Anderson, E.P. and Wilma, A. (2007). Support in nursing: An evolutionary concept analysis. *International Journal of Nursing Studies,* 44(8), 1478-1489.

Sullivan, K., Lock, L. and Homer, C.S. (2011). Factors that contribute to midwives staying in midwifery: A study in one area health service in New South Wales, Australia. *Midwifery*, *27*(3), 331-335.

Sykes, I.J. and Eden, D. (1985). Transitional stress, social support, and psychological strain. *Journal of Organizational Behavior*, 6(4), 293–298.

Tastan, S., Unver, V. and Hatipoglu, S. (2013). An analysis of the factors affecting the transition period to professional roles for newly graduated nurses in Turkey. *International Nursing Review*, *60*(3), 405-412.

Teoh, Y.T.E., Pua, L.H. and Chan, M.F. (2013). Lost in transition: A review of qualitative literature of newly qualified Registered Nurses' experiences in their transition to practice journey. *Nurse Education Today*, *33*(2), 143-147.

Tingstig, C., Gottvall, K., Grunewald, C. and Waldenström, U. (2012). Satisfaction with a Modified Form of In-Hospital Birth Center Care Compared with Standard Maternity Care. *Birth*, *39*(2), 106-114.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. 1990. The Report of the Post-registration Education and Practice Project. UKCC, London. PP.111-125

Uprichard, E. (2008). 'Children as 'Being and Becomings': Children, Childhood and Temporality'. *Children and Society,* 22(2), 4-12.

Van der Putten, D. (2008), 'The lived experience of newly qualified midwives: A qualitative study'. *British Journal of Midwifery*, 16(6), 348-359.

Walker, L.O. and Avant, K.C. 2011. Strategies for theory construction in nursing (5 ed). Upper Saddle River, NJ Prentice Hall.

Willis, G. (2015). Raising the Bar. Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants. http://tinyurl.com/q8wrttv (accessed 27 October 2015)

World Health Organization. (2003). *Pregnancy, Childbirth, Postpartum and Newborn Care. A Guide for essential practice*. Geneva, Switzerland: WHO.

Yanhua, C. and Watson, R. (2011). A review of clinical competence assessment in nursing. *Nurse Education Today*, *31*(8), 832-836.

Yongmei, L.I.U., Jun, X.U. and Weitz, B.A. (2011). 'The Role of Emotional Expression and Mentoring in Internship Learning'. *Academy of Management Learning and Education*,10(1), 94-110.

Young, N. (2012). An exploration of clinical decision-making among students and newly qualified midwives. *Midwifery,* 28(4), 824–830.

Zagenczyk, T.J., Scott, K.D., Gibney, R., Murell, A.J. and Thatcher, J.B. (2010). Social influence and perceived organizational support: A social networks analysis. *Journal of Organizational Behaviour and Human Decision Process,* 21(9), 127-138.

ANNEXURE A

APPROVAL OF RESEARCH PROPOSAL BY UNIVERSITY OF VENDA HIGHER DEGREES COMMITTEE

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS KG NETSHISAULU

SCHOOL OF HEALTH SCIENCE

FROM: PROF J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 26 FEBRUARY 2016

DECISIONS TAKEN BY UHDC OF 26TH FEBRUARY 2016

Application for approval of Thesis research proposal in Health Sciences: **KG Netshisaulu (11585560)**

Topic: "Transition support programme for newly graduated midwives in Limpopo Province, South Africa."

Promoter:	UNIVEN	Prof. M.S Maputla
Co-promoters:	UNIVEN	Prof. M.L Netshikweta
		Dr. N.H Shilubane

UHDC approved Thesis proposal

Prof J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

ANNEXURE B

ETHICS CLEARANCE CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms KG Netshisaulu
Student No:
11585560

PROJECT TITLE: **Transition Support Programme for Newly Graduated Midwives in Limpopo Province, South Africa.**

PROJECT NO: SHS/16/PDC/06/1304

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof MS Maputle	University of Venda	Supervisor
Prof ML Netshikweta	University of Venda	Co-Supervisor
Dr NH Shilubane	University of Venda	Co-Supervisor
Ms KG Netshisaulu	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2016
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2016 -04- 13
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXURE C

REQUEST TO LIMPOPO PROVINCE, DEPARTMENT OF HEALTH ETHICS COMMITTEE TO CONDUCT THE STUDY

P.O.Box 1636
Thohoyandou
0950

The Research Ethics Committee
Limpopo Province Department of Health
Private Bag X9302
Polokwane
0700

Dear Sir/Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY

This letter serves to request for permission to conduct a research study. I am currently a student registered for a Doctor of Philosophy (PhD) in Nursing at the University of Venda (UNIVEN). The research will be conducted to fulfil the requirements of the degree. The topic of my research study is: "Transition support programme for newly graduated midwives in Limpopo Province, South Africa."

The purpose of the study is to develop a programme that will enhance the transition support of newly graduated midwives during their first year of practice. The participants in the study will be experienced as well as newly graduated midwives working in selected hospitals.

It is envisaged that the study may assist newly graduated midwives in South Africa and globally to be more confident and competent when providing midwifery services to patients and clients during the first twelve months following completion of their training.

It is also assumed that patients and clients may benefit from the study as they will receive quality midwifery services provided by competent newly graduated midwives. The institution may also benefit from provision of quality care to patients which will promote hospitals' utilization rate Hence, reducing period of hospital stay. Good interpersonal relationship between experienced midwives and newly graduated midwives will also result in smooth running of services within the organization. The findings of the study may assist researchers to develop a programme which will enhance support of newly graduated midwives during their first twelve months of transition period. Implementation of the programme developed In this study, will assist in provision of quality midwifery care which may assist in the

achievement of Millennium Developmental Goals (MDGs) 4 and 5.

The government may also benefit from this study as competent registered midwives will provide quality midwifery services to patients, therefore reducing maternal as well as neonatal complications including deaths. This will also assist in the achievement of Millennium Developmental Goals (MDGs) 4 and 5.

I hereby pledge to adhere to all ethical principles for conducting a study.

Below are the contact details, should you have issues for further clarification or discussion:

Researcher: Mrs K.G. Netshisaulu (015 962 8000)

Promoter: Professor M.S. Maputle (015 962 8000)

Looking forward to your favourable response at your earliest convenience

Yours sincerely

……

K.G. Netshisaulu

ANNEXURE D

REQUEST TO LIMPOPO PROVINCE, DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

P.O.Box 1636
Thohoyandou
0950

The Provincial Manager
Limpopo Province Department of Health
Private Bag X9302
Polokwane
0700

Dear Sir/Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY

This letter serves to request for permission to conduct a research study. I am currently a student registered for a Doctor of Philosophy (PhD) in Nursing at the University of Venda (UNIVEN). The research will be conducted to fulfil the requirements of the degree. The topic of my research study is: "Transition support programme for newly graduated midwives in Limpopo Province, South Africa." The purpose of the study is to develop a programme that will enhance the transition support of newly graduated midwives during their first year of practice. The participants in the study will be experienced as well as newly graduated midwives working in selected hospitals.

It is envisaged that the study may assist newly graduated midwives in South Africa and globally to be more confident and competent when providing midwifery services to patients and clients during the first twelve months following completion of their training.

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developed In this study, will assist in provision of quality midwifery care which may assist in the achievement of Millennium Developmental Goals (MDGs) 4 and 5.

The government may also benefit from this study as competent registered midwives will provide quality midwifery services to patients, therefore reducing maternal as well as neonatal complications including deaths. This will also assist in the achievement of Millennium Developmental Goals (MDGs) 4 and 5.

I hereby pledge to adhere to all ethical principles for conducting a study.

Below are the contact details, should you have issues for further clarification or discussion:

Researcher: Mrs K.G. Netshisaulu (015 962 8000)

Promoter: Professor M.S. Maputle (015 962 8000)

Looking forward to your favourable response at your earliest convenience

Yours sincerely

……

K.G. Netshisaulu

ANNEXURE E

REQUEST TO SELECTED HOSPITALS IN LIMPOPO PROVINCE TO CONDUCT THE STUDY

P.O.Box 1636
Thohoyandou
0950

The Chief Executive Officer (CEO)
Tshilidzini / Letaba/ St Ritas/ Mokopane Regional Hospitals/ Mankweng Tertiary Hospital

Dear Sir/Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY

This letter serves to request for permission to conduct a research study. I am currently a student registered for a Doctor of Philosophy (PhD) in Nursing at the University of Venda (UNIVEN). The research will be conducted to fulfil the requirements of the degree. The topic of my research study is: “Transition support programme for newly graduated midwives in Limpopo Province, South Africa.”

The purpose of the study is to develop a programme that will enhance the transition support of newly graduated midwives during their first year of practice. The participants in the study will be experienced as well as newly graduated midwives working in selected hospitals.

It is envisaged that the study may assist newly graduated midwives in South Africa and globally to be more confident and competent when providing midwifery services to patients and clients during the first twelve months following completion of their training.

It is also assumed that patients and clients may benefit from the study as they will receive quality midwifery services provided by competent newly graduated midwives. The institution may also benefit from provision of quality care to patients which will promote hospitals’ utilization rate Hence, reducing period of hospital stay. Good interpersonal relationship between experienced midwives and newly graduated midwives will also result in smooth running of services within the organization. The findings of the study may assist researchers to develop a programme which will enhance support of newly graduated midwives during their first twelve months of transition period. Implementation of the programme developed In this study, will assist in provision of quality midwifery care which may assist in the

achievement of Millennium Developmental Goals (MDGs) 4 and 5.

The government may also benefit from this study as competent registered midwives will provide quality midwifery services to patients, therefore reducing maternal as well as neonatal complications including deaths. This will also assist in the achievement of Millennium Developmental Goals (MDGs) 4 and 5.

I hereby pledge to adhere to all ethical principles for conducting a study.

Below are the contact details, should you have issues for further clarification or discussion:

Researcher: Mrs K.G. Netshisaulu (015 962 8000)

Promoter: Professor M.S. Maputle (015 962 8000)

Looking forward to your favourable response at your earliest convenience

Yours sincerely

……

K.G. Netshisaulu

ANNEXURE F

PERMISSION FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650) Ref:4/2/2

Netshisaulu KG
University of Venda
Private Bag X5050
Thohoyandou
0950

Greetings,

RE: Transition support programme for newly graduated midwives in Limpopo Province, South Africa.

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

15/06/2016
Date

18 College Street, Polokwane, 0700. Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

The heartland of Southern Africa – *development is about people*

ANNEXURE G

PERMISSION FROM DEPARTMENT OF HEALTH, WATERBERG DISTRICT, TO CONDUCT THE STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
WATERBERG DISTRICT

REF: 4/3/3
ENQ: NKGODI D.R (PA TO THE DISTRICT EXECUTIVE MANAGER)
CELL NO: 082 344 0227.
DATE: 01/07/2016

TO: NETSHISAULU K.G.

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

The above bear's reference:-

1. The office of the Acting District Executive Manager, hereby confirms receipt of your request to conduct a research on transition support programme for newly graduated midwives in Limpopo Province, South Africa.
2. Permission is hereby grated as per approval by the HOD.
3. You are further requested to notify this office on when you are going to start with the research and make sure that there is no action that disturbs service delivery.

Your support and cooperation in terms of the above will be highly appreciated.

==========
ACTING DISTRICT EXECUTIVE MANAGER
WATERBERG DISTRICT

5/7/2016
==========
DATE

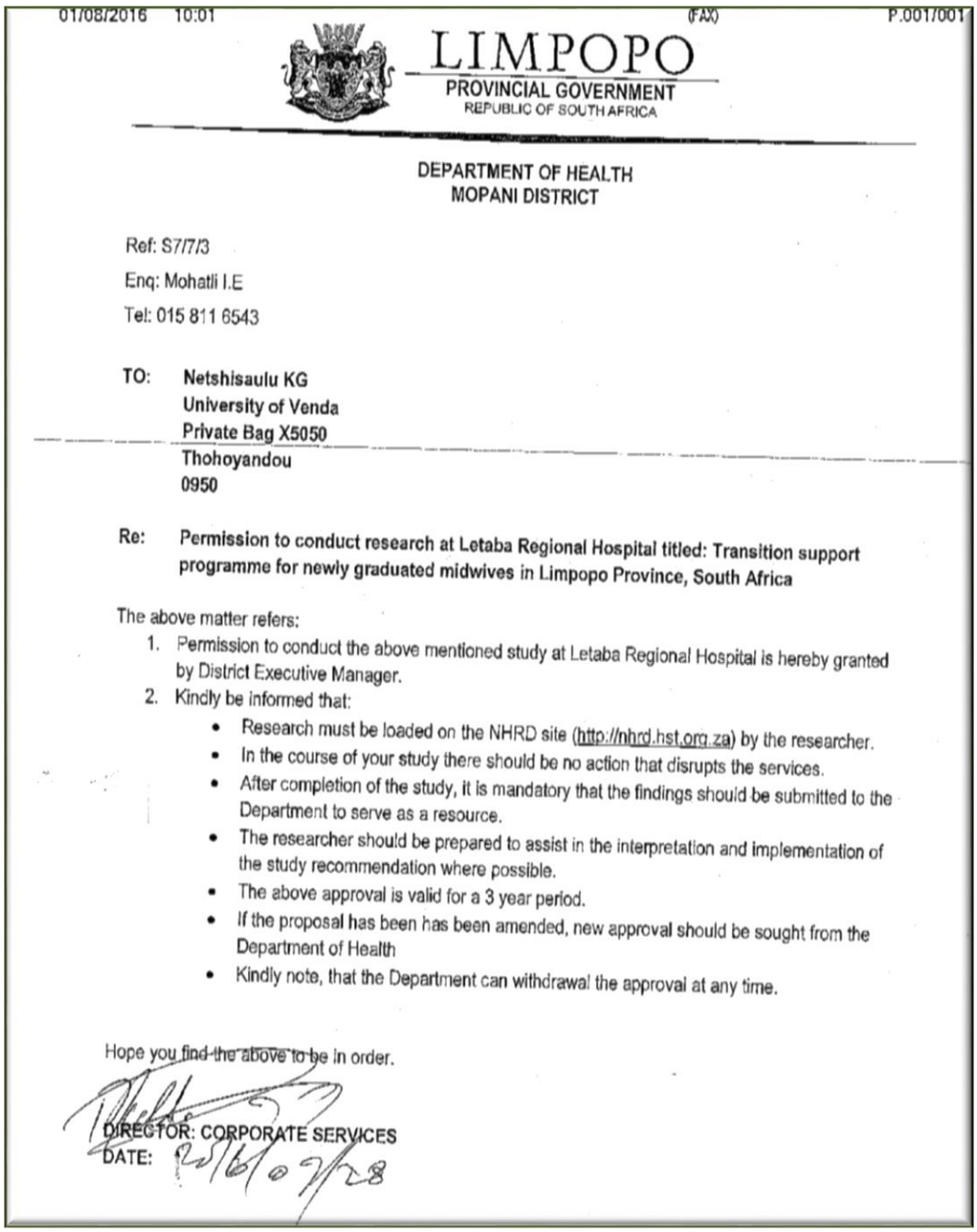
Waterberg District Office Private Bag X 1026 Modimolle,
0510 Tel (014) 718 0600 Fax (014) 718 0675

The heartland of Southern Africa – development is about people!

BATHO PELE

ANNEXURE H

PERMISSION FROM DEPARTMENT OF HEALTH, MOPANI DISTRICT, TO CONDUCT THE STUDY



01/08/2016 10:01 (FAX) P.001/001

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
MOPANI DISTRICT

Ref: S7/7/3
Enq: Mohatli I.E
Tel: 015 811 6543

TO: Netshisaulu KG
University of Venda
Private Bag X5050
Thohoyandou
0950

Re: Permission to conduct research at Letaba Regional Hospital titled: Transition support programme for newly graduated midwives in Limpopo Province, South Africa

The above matter refers:

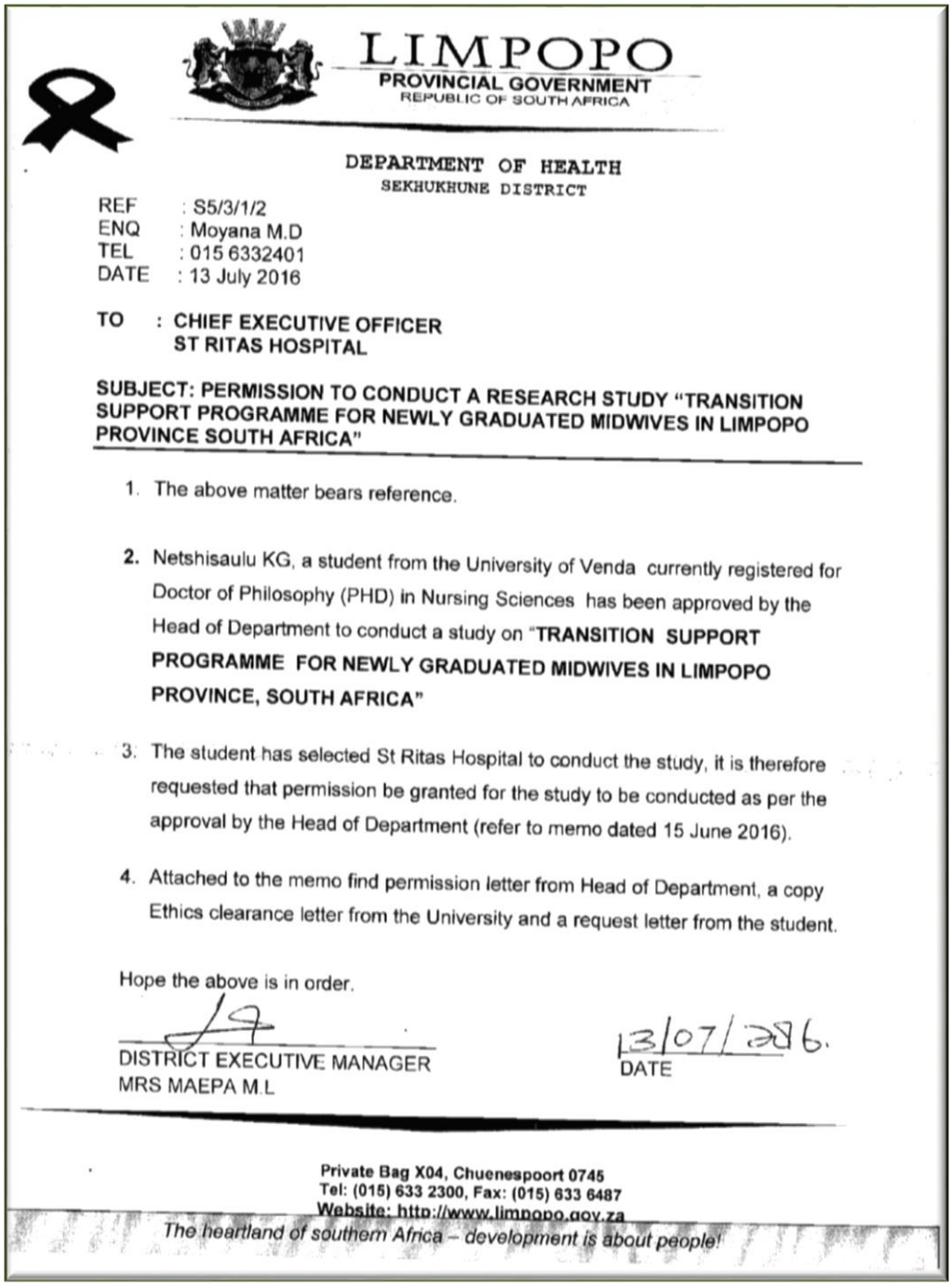
1. Permission to conduct the above mentioned study at Letaba Regional Hospital is hereby granted by District Executive Manager.
2. Kindly be informed that:
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been has been amended, new approval should be sought from the Department of Health
   - Kindly note, that the Department can withdrawal the approval at any time.

Hope you find the above to be in order.

DIRECTOR: CORPORATE SERVICES
DATE: 27/07/2016

ANNEXURE I

PERMISSION FROM DEPARTMENT OF HEALTH, GREATER SEKHUKHUNE DISTRICT, TO CONDUCT THE STUDY



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT

REF : S5/3/1/2
ENQ : Moyana M.D
TEL : 015 6332401
DATE : 13 July 2016

TO : CHIEF EXECUTIVE OFFICER
ST RITAS HOSPITAL

SUBJECT: PERMISSION TO CONDUCT A RESEARCH STUDY "TRANSITION SUPPORT PROGRAMME FOR NEWLY GRADUATED MIDWIVES IN LIMPOPO PROVINCE SOUTH AFRICA"

1. The above matter bears reference.

2. Netshisaulu KG, a student from the University of Venda currently registered for Doctor of Philosophy (PHD) in Nursing Sciences has been approved by the Head of Department to conduct a study on "**TRANSITION SUPPORT PROGRAMME FOR NEWLY GRADUATED MIDWIVES IN LIMPOPO PROVINCE, SOUTH AFRICA"**

3. The student has selected St Ritas Hospital to conduct the study, it is therefore requested that permission be granted for the study to be conducted as per the approval by the Head of Department (refer to memo dated 15 June 2016).

4. Attached to the memo find permission letter from Head of Department, a copy Ethics clearance letter from the University and a request letter from the student.

Hope the above is in order.

DISTRICT EXECUTIVE MANAGER
MRS MAEPA M.L

13/07/2016.
DATE

Private Bag X04, Chuenespoort 0745
Tel: (015) 633 2300, Fax: (015) 633 6487
Website: http://www.limpopo.gov.za

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ANNEXURE J

INFORMATION SHEET

Introduction and background

Good Day

My name is Netshisaulu Khathutshelo Grace. I am a PhD student at the University of Venda, conducting a study on “Transition support programme for newly graduated midwives in Limpopo Province, South Africa”, in fulfilment of the requirements for my doctoral study.

The main aim of this study is to develop a programme to support newly graduated midwives during their transition period in Limpopo Province, South Africa. I am inviting you to participate in the study.

The interview will last for about an hour. If you agree to take part, I will ask you a few questions in relation to transition support of newly graduated midwives in Limpopo Province. As a researcher, my role is to listen to and understand your point of view, and not to pass any judgement. If you feel uncomfortable with answering some of the questions, feel free to express your discomfort; you will not be penalised.

Confidentiality

The information that you give will be kept confidential. No names will be used when transcribing the interviews. I undertake that all information provided by you will be used only for the purpose of the study. Everything that you will say will be treated as private and confidential and no-one will know you answered the question apart from the researcher. The answers given by participants will be combined and analyzed according to common themes and categories and the combined information will be in the form of a report.

Consent

Ethical clearance has been obtained from the School of Health Sciences Higher Degrees Committee, University of Venda Higher Degrees Committee, and University of Venda Ethics Committee. Permission to conduct the study was sought from the Limpopo Provincial Department of Health, as well as the Hospital management. You will be requested to give a written consent to participate in the study, and that the interview will be recorded. The researcher will appreciate your willingness to give consent and

participate in sharing the information.

Benefits and Risks of Participation

Please note that participation In this study, is voluntary and there will be no direct benefits to anyone who participates. You are free to either withdraw from the study at any point, or refrain from answering questions which you feel are violating your rights; and no penalty will be imposed. However, I would really appreciate it if you share your thoughts and feelings in relation to the questions asked.

Recording the interview

I would like to ask permission to audio record the interview because it is not possible to write down all your answers quickly enough to capture all the important information. I might misrepresent your responses to some of the questions that you will be asked if recording is not done. It is important for you to know that the digital voice data and notes will remain confidential and your identity will not be disclosed. I am only interested in your honest responses to the questions.

Recordings and digital data of the interview will be listened to only by the researcher and the co-coder and will bear no names of the interviewees. The information will be analyzed and organised into a report according to themes. The recordings and digital data files will be kept in a locked safe. In accordance with the national requirements the voice recordings and digital data will be destroyed two years after the publication of the research findings.

Contact Details

I will be happy to answer any question or to offer clarity about any issues you may have regarding the study. This study has been approved by the Research Ethics Committee of the University of Venda. Should you have any question regarding the study, please contact the researcher.

Researcher: Mrs K.G. Netshisaulu (015 962 8000)

Promoter: Professor M.S. Maputle (015 962 8000)

ANNEXURE K

INFORMED CONSENT FORM

I……consent to participate in the research study on "Transition support programme for newly graduated midwives in Limpopo Province, South Africa". The full explanation about the research was given to me, including the benefits of the study. I understand that my confidentiality and privacy will be taken care of by the researcher. I also understand that the information collected from me will only be shared among people concerned with the study. It was made clear to me that I can terminate my participation in the study at any time without any intimidation. I also understand that there is no personal gain or reward that will be given to me by the researcher for participating in the study. I confirm that I was not forced or coerced into participating in the study, but doing it on my own free will.

Signature…… (Participant)

Date……..

Signature of researcher……

Date……

ANNEXURE L

INTERVIEW GUIDE FOR NEWLY GRADUATED MIDWIVES

TOPIC: TRANSITION SUPPORT PROGRAMME FOR NEWLY GRADUATED MIDWIVES IN LIMPOPO PROVINCE, SOUTH AFRICA.

- What are your experiences regarding provision of midwifery services during your transition period?
- What support do experienced midwives offer to you as newly graduated midwives during your first year of clinical practice?

The following are the examples of probes that will be used:

Do I understand you when you say….?

Could you explain further?

What do you mean by …?

ANNEXURE M

INTERVIEW GUIDE FOR EXPERIENCED MIDWIVES

TOPIC: TRANSITION SUPPORT PROGRAMME FOR NEWLY GRADUATED MIDWIVES IN LIMPOPO PROVINCE, SOUTH AFRICA.

What support do you offer to the newly graduated midwives during their first year of clinical practice?

What are your expectations from newly graduated midwives during their first year of clinical practice?

The following are the examples of probes that will be used:

Do I understand you when you say….?

Could you explain further?

What do you mean by …?

ANNEXURE N

QUESTIONNAIRE

TOPIC: TRANSITION SUPPORT PROGRAMME FOR NEWLY GRADUATED MIDWIVES IN LIMPOPO PROVINCE, SOUTH AFRICA.

Answer each question by making a cross in the appropriate box or write down your response in the space provided.

SECTION A : DEMOGRAPHIC INFORMATION				
				Official use
1.	**In which category do you belong?**		Newly qualified midwife	
			Experienced midwife	
			Operational Manager	
			Other :	
			Specify……..	
2.	**Where did you under your training? (For Graduates only)**		University	
			College of Nursing	
			Other:	
			Specify……..	
3.	**Are you on Community Service Programme? (For Graduates only)**		Yes	
			No	
			Comment:……	
4.	**Do you think you are a relevant stake holder to evaluate the program?**		Yes	
			No	
			Comment:……	

Continued/…

SECTION B: STANDARD OF A TRANSITION SUPPORT PROGRAMME				
				Official use
5.	**Is implementation of a programme expensive in terms of costs? (Experienced midwives only)**		Yes	
			No	
			Comment:……	
6.	**Can the program be easily implemented in terms of human resources and time? (Experienced midwives only)**		Yes	
			No	
			Comment:……	
7.	**Are there items in the programme which are not clear?**		Yes	
			No	
			Comment:……	
8.	**Are the objectives of orientation clearly spelt out?**		Yes	
			No	
			Comment:……	
9.	**Will the programme assist in the promotion of provision of quality patients' care?**		Yes	
			No	
			Comment:……	
SECTION C: THE STAGE OF DOING				
				Official use
10.	**Do you think orientation of newly graduated midwives to the hospital's surrounding will help in supporting the graduates?**		Yes	
			No	
			Comment:……	
11.	**Will orientation of newly graduated midwives to all the sub-units in maternity be helpful in supporting them during their transition period?**		Yes	
			No	
			Comment:……	
12.	**Orientation of newly graduated midwives regarding theatre, forms part of orientation in maternity surrounding, which forms the foundation for effective transition support.**		Yes	
			No	
			Comment:……	

13.	**Do you think it will be helpful to orientate graduates to hospital's surrounding during the first week of their commencement in a clinical facility?**		Yes	
			No	
			Comment:……	
14.	**Will it be helpful if orientation to maternity surrounding is done by a senior member of staff?**		Yes	
			No	
			Comment:……	
15.	**Policies, protocols, procedures and guidelines governing provision of midwifery services, will provide a strong form of support.**		Yes	
			No	
			Comment:……	
16.	**Confirmation of graduates' findings by senior colleagues during provision of midwifery services is a good pillar of support.**		Yes	
			No	
			Comment:……	
17.	**Supervision of newly graduated midwives by experienced midwives during performance of procedures such as conduction of deliveries, suturing of episiotomies etc., will form a basis for effective transition support.**		Yes	
			No	
			Comment:……	
18.	**Is it possible to assign a mentor for each graduate? (For experienced midwives only)**		Yes	
			No	
			Comment:……	
19.	**Will allocation of a mentor for each graduate assist in effective transition support of graduates?**		Yes	
			No	
			Comment:……	
20.	**Active participation of a mentor and a mentee promotes positive mentoring process which facilitates effective support during transition period.**		Yes	
			No	
			Comment:……	
21.	**Do you think delegation is one of the strategies for effective transition support of newly graduated midwives?**		Yes	
			No	
			Comment:……	

22.	**Delegation should be formal and written down, for effective transition support to be possible.**		Yes	
			No	
			Comment:……	
23.	**Delegation of newly graduated midwives with a senior member, especially in skills such as management of highly scheduled drugs, management of a woman in labour and management of caesarian births, will do justice in effective support during transition.**		Yes	
			No	
			Comment:……	
24.	**Do you think therapeutic sessions can be helpful in establishment of positive collegial relationships?**		Yes	
			No	
			Comment:……	
25.	**Do you think it will be supportive for graduates to discuss about effective communication and respect for one another during therapeutic sessions?**		Yes	
			No	
			Comment:……	
SECTION D: THE STAGE OF BEING				
				Official use
26.	**Is withdrawal of a senior member during delegation of newly graduated midwives during the stage of being, going to help in supporting graduates?**		Yes	
			No	
			Comment:……	
27.	**Will teaching of the graduates according to their needs form part of their effective support during transition?**		Yes	
			No	
			Comment:……	
28.	**Will participation of newly graduated midwives in peer teaching assist in their transition support?**		Yes	
			No	
			Comment:……	
29.	**Will reflection by newly graduated midwives regarding their ward experiences have any impact on their effective transition support?**		Yes	
			No	
			Comment:……	

Continued/…

30.	**Will empowerment of graduates regarding the use of the following assist in their effective support?** • **An emergency trolley** • **An eclamptic box** • **A resuscitation unit**		Yes	
			No	
			Comment:……	
SECTION E: THE STAGE OF KNOWING				
				Official use
31.	**Is withdrawal of mentoring at this stage good for graduates' support?**		Yes	
			No	
			Comment:……	
32.	**Continuation of positive collegial relationship will have positive impact regarding support of newly graduated midwives.**		Yes	
			No	
			Comment:……	
33.	**Active participation of graduates in teaching during this stage, helps them become confident and competent, therefore becomes a strong pillar of support during their transition period.**		Yes	
			No	
			Comment:……	

ANNEXURE O

TRANSCRIPT FOR NEWLY GRADUATED MIDWIVES

Archival #: Newly Graduated Midwife 1

Data collector: Netshisaulu K

Date of data collection: 2016. 08. 10

Data collection method: in-depth individual face-to-face interviews

Transcriber: Netshisaulu K

Typist: Netshisaulu K

Researcher: Good morning

Participant: Good morning

Researcher: How are you?

Participant: I am fine thank you, and how are you?

Researcher: I am fine thank you. I am a student who is conducting research, aiming at development of a transition support programme for effective support of newly graduated midwives during transition paeriod. May you kindly share your experiences with me regarding provision of midwifery services during your transition period?

Participant: The experiences I have regarding working in labour ward as a newly graduated midwife are bad.

Researcher: What do you mean, when you say your experiences are bad?

Participant: The experiences are bad because experienced midwives do not give me enough support. Sometimes I deliver patients alone without any assistance from the experienced midwives. Sometimes I am assisted by enrolled nurses when delivering patients. But there is a problem because sometimes I deliver patients alone while the experienced midwives are not busy. They just sit down and other professional midwives may just go out of the labour ward when you are about to deliver a patient. When you ask for their assistance, some tell you that you must deliver the patient alone as you are no longer a student but a sister. Some just say 'it is your turn get down and work', and once they say that they will never assist you.

Researcher: Is that the only thing that makes you say the experience is bad?

Participant: The other thing that is really frustrating me is the difference that exists between the theory I learnt in the classroom and what is really happening here in the ward. There is a great difference, when you do procedures they expect you to do shortcuts. I don't want to do shortcuts, and when I do the correct things they say I am slow and they also say 'we are not in the classroom here, where you do things that are not real. Here we do real things because we are dealing with the patients.' That is what they say, and I feel confused. When I was working in nursery, I was always delegated with an experienced midwife, except here in the labour ward where there is no delegation. I would like it if they would delegate me,

maybe like working in stage one for a day and the following day in stage. But in all cases I would like to be delegated with an experienced midwife.

Researcher: How do you feel about being a newly graduated midwife?

Participant: I am so happy to have completed the training. But it is really challenging and scaring especially working in the labour ward, because it demands a lot of responsibility and accountability. I am terrified in case I miss something. It's unlike when I was a student. Being a student is really safe. The other thing that is also a problem is shortage of experienced midwives, if they were many they were going to supervise and support us well. They are so few sometimes you even feel for them. The fact that I am a professional nurse is good and makes me happy, but the fact that every junior member of staff looks up at me for solution is stressful and makes me wish somehow I were still in students' boots. When I wake up every morning and start to think that I am no longer a student and have to be a professional nurse who is responsible I feel stressed. It is not that I don't want to be a professional nurse. I want to be a professional nurse but, that post needs somebody who is very responsible. At this stage, I don't feel responsible for that, that is why I am stressed. Especially because the experienced midwives do not want to help me. Maybe if they were helpful I would be less stressed.

The other thing that I want to talk about is the relationship between the experienced midwives and us the graduates. The relationship is not that good, of course there are those who accept and like us, but there are those who hate the graduates of a four year programme. Those are the ones who do not accept us. One day I asked one of the experienced midwives to help me with a certain procedure; hey, the response was 'what were you doing at the university for all these four years.' I thought she would help me after having said that unfortunately she never assisted me. When you ask for help, there are those who are willing to help, but some say 'I am not going to waste my time teaching you because you used to dodge during your training.' I was so bored when she answered in that manner because I never worked in that hospital during my training, so where did she see me dodging. I never dodged. But, there are some who are very helpful, when they are not sure of what you are asking, they tell you that they will first go and check you will get the answer tomorrow and indeed when they come tomorrow, they will give you an answer.

The other thing that is a problem is that the supervision they provide is not enough because they just come and observe, if you are doing something right they leave you, no praise. If what you are doing is wrong, some will just say 'do this and this'. Some say 'ask your colleague to help you. I was so frustrated the other day when I asked one of the experienced midwives to help me with vaginal examination because I was not sure of the findings. She never came, she only shouted from where she was saying, 'people come and be my witnesses….. I am hearing miracles from this graduate. A graduate who was taught by professors says she is not sure of the findings.' I was so hurt and embarrassed at the same time, but I thank God because one of the midwives came to assist me after hearing that shout.

I don't feel comfortable asking questions because there are those experienced midwives who always pass remarks such as 'you think you know much,' so, I feel if I ask questions they will think that I want to challenge them. One day my colleague who is also serving community service asked a question, and was told to either consult her books or her colleagues. When you look at me do you think I am still able to read a book? Some of the experienced midwives are good but some are negative. Those who are negative are always ready to attack you with negative remarks every time you ask something.

Researcher: How is your relationship with other members of the team?

Participant: The doctors are very good. They don't have problems with teaching, they explain, they also consider my views regarding patients' care. One day I told a doctor about a woman who was in labour but she was very short. I suggested caesarean section, but the doctor explained very well to me that it is not just about looking at the height only, they consider a lot of things like size of the baby, the mother's pelvis etc. He assured me that the woman will deliver normally as the baby was small, and the woman ended up delivering normal. The Apgar score was also 10/10 in a minute. I am saying this to show that the doctor never harassed me, but explained well to me and in a friendly way.

Researcher: Is there anything else you will like me to know regarding your experiences?

Participant: The other day I was sent to look for some medications, I took a long time to come back because I didn't know where that medication was as I was never orientated in that ward. The professional nurse who sent me scolded at me asking me as to why did I take long. But she forgot that I don't know the surrounding as I was never orientated. I just came and started working, no orientation was done. But, when you fail to get things fast they scold at you.

But one thing I like in this ward is that when they prepare off duties, they are very careful. They never leave us community service nurses alone as professional nurses in charge of a shift. We are always with an experienced midwife in all the shifts. I don't know what I would do if they were leaving me alone in charge of a ward.

I feel that six months placement in a maternity unit is not enough? If I had the power, I would recommend that newly graduated midwives be placed in a maternity unit for the whole year; in which one is placed in labour ward for six months and the rest of the time is allocated for other sections of maternity. The first two months in labour ward, must be spent working with a mentor on a fulltime basis. . Maybe this would help us to improve our knowledge and skills, gain confidence and competence as well as becoming responsible and accountable.

Participant: One thing that makes me scared is the reality that I have to stand as a professional nurse and make decisions regarding care of patients and management otf the ward. At the same time the students are now looking up at me for assistance and patients are expecting quality care from me. I feel like I can run away.

Being a professional nurse is so demanding, and that makes me scared and frustrated. Of course I am glad that I have completed the training, I am no longer a student but sometimes I regret that I wasted a lot of time as student. I was supposed to have been serious maybe by now I would be confident and responsible.

Researcher: Is there anything else you want to discuss with me or to let me know?

Participant: No, that is all I can say.

Researcher: Thank you very much for your time and for sharing this valuable information with me. Enjoy the rest of your day.

Participant: You are welcome.

ANNEXURE P

TRANSCRIPT FOR EXPERIENCED MIDWIVES

Archival #: Experienced Midwife

Data collector(s): Netshisaulu K

Date of data collection: 2016.10.20

Data collection method: in-depth individual face-to-face interviews

Transcriber: Netshisaulu K

Typist: Netshisaulu K

Researcher: Good morning

Participant: Good morning

Researcher: How are you?

Participant: I am fine thank you, and how are you?

Researcher: I am fine thank you. I am a student who is conducting research, aiming at development of a transition support programme for effective support of newly graduated midwives during transition paeriod.. Please share with me, "What are your experiences regarding working with newly graduated midwives?"

Participant: My experience of working with the newly graduated midwives is that some are committed to provision of quality care to patients. Some are not, we even see these things during delivery. One day a graduate was about to deliver a patient who was in the second stage of labour. As usual, the woman passed stools and the midwife did not want to clean the woman in preparation for the coming head. You know she was so mixed up, as if she could also discontinue with conduction of labour. When you are a trained midwife you understand why this happens and you cannot even think of abandoning the patient for that. That is why I say some are not committed.

Most of the times patients are transferred from the clinics. What they usually do is that if we receive a call saying that an ambulance is bringing a patient with pre-eclampsia, they usually run away. One day I asked one who was involved in that and she said she ran away because she knew she was going to be the one to attend to that patient, so she didn't want to be embarrassed and frustrated as she will be shouted at when asking what to do in order to manage the emergency situation effectively. Some of these graduates are very committed and they like their work the problem is that they don't have experience and they also do not have the confidence to work in the labour ward alone. They still need us to support and guide them but we are not prepared, we are tired of everything. When they ask anything we feel irritated that is why we just shout at them. It is just like when you are at home, if you have problems or you are tired from work when children say or ask things you feel they are irritating you and you just shout.

Researcher: Do you think the support you are giving to newly graduated midwives is enough?

Participant: No, the support we give is not enough, because there are those who abandon the new graduates alone in the labour ward and go and sit outside gossiping. When they are asked why they are sitting outside they usually say, 'I am taking some fresh air.' These graduates don't cope with labour ward situation, one day on a Friday all experienced midwives in labour ward were booked off sick. New graduates remained alone and they did not have pins for phoning, because they are only given to experienced midwives not the new graduates. They did not know how to report to the doctors, until they decided to report to the supervisor who was on call. The supervisor had to come down here to the labour ward for the calls. Messages lost while reporting as she is not in the situation. They were angry on Monday reporting the whole situation of what happened the previous day. You can ask yourself as to whether the whole team of the experienced midwives was really sick on the very same day. Sometimes when these graduates misbehave they copy from us.

In summary I can say that there is no supervision here, we just work with them expecting them to work as if they are experienced like us. We know that they are from the school but we don't care about that what we want is that they should come and relieve us from the stress of labour ward. It is long that we have been working with this shortage, so when they come we feel happy thinking that they will work and we shall take some fresh air.

To tell you the honest fact, I am personally disappointed because I thought that the graduates will be able to function as independent professionals, instead they are not. When you are working with them it's the same as when working with students. They are not fit to work as professional nurses, you always need to be with them at all times and that's so frustrating.

It is not that we don't know that they need our support and guidance, no we are the ones who do not accept these children. We know that they need to be assisted, because even when the nurse managers hand them over to us; they tell us to teach them so that they become experienced like you, but we are not doing that. We know we are supposed to teach and support them but we don't do that due to a lot of reasons. Some don't have interest to help them, some are jealous, some are threatened and some don't feel confident to teach. But in other situations you find that some may be having interest, but there is this shortage of staff that is killing us. We are also tired and stressed. If we were many we were going to have enough time to supervise and teach them.

Researcher: Can you please tell me more regarding their performance?

Participant: We don't expect them to know everything, but at least she must be able to start something so that I help her with something, but hey most of them are helpless. At least she have some graduates who are so incompetent in such a way that they don't even know how to start. They expect you to be teaching every little thing. Sometimes I even ask myself if these graduates were ever placed in a clinical situation. One day one graduate wanted me to assist her with a simple admission of a woman in labour.

In that case I feel it would be better if I were alone , but I just tolerate them, because some of them are committed to learn and even when lose you temper with them and scold at them they don't feel bad they still come to you for assistance. As a result, you will feel pity for them and help them. Some look at you as if they are saying please have mercy on me. Some even go to an extent of following you. If you are short tempered you won't tolerate.

They make a streamline following those who accommodate and tolerate them. They don't feel free when they are with those who don't support them.

It seems like they only start to realize that they have to be responsible, when they were students they used to dodge. Now it is late because we are looking at them and we expect some knowledge and you find that there is nothing at all. Practically there is nothing they know. Of course they are not the same. When we delegate them to perform tasks some perform them well but others fail. Even when it comes to teaching, they are those grasp easily but there are also those who take time. Some are stubborn some are fine.

Researcher: How committed are these newly graduated midwives?

Participant: My observation is that boys are more committed than girls. Like for an example, now I am working with a male graduate and a female one. If you leave him alone he doesn't have

problems, but if you leave the female, some of the activities will be left undone. He voluntarily wants to deliver as many patients as he can, but with the girl it's different.

I think we the experienced midwives also contribute to lack of committed. There are those who when allocated with them, leave them to work by themselves and they usually say, 'let them work its long that we have been working.' One graduate once delivered a fresh stillborn baby alone when the experienced midwife was seated outside refusing to help her, saying that she is also a midwife let her manage the situation.

Such statements demoralise them. If you are close they feel secured and supported and that builds their confidence for they know somebody is readily available for them.

Some just go out of the ward and disappear and return when they are about to go off, especially during the shift that goes off at 19h00. When you ask the reason for their behaviour they say, 'she is a midwife, she will see how to come out.'

Some graduates develop negative attitude towards some of the experienced midwives. Some will even tell you that 'I don't want to work with sister so and so because she does this and this.' From there she starts to be delinquent but when she works with the one who understands her, she behaves well and work hard because she respects the fact that sister works well with her. That is why I say sometimes we also contribute to their negative behaviour.

There are new graduates who are not interested in nursing. When they do procedures they are very slow, some don't even know how to do some simple procedures. Sometimes you even wonder as to how they passed because they don't know anything. But I am repeating we are also to be blamed in this whole problem, we also contribute.

Researcher: Is there anything else you want to discuss with me or to let me know?

Participant: No, that is all I can say.

Researcher: Thank you very much for your time and for sharing this valuable information with me. Enjoy the rest of your day.

Participant: You are welcome.

ANNEXURE Q

CONFIRMATION BY INDEPENDENT CODER

Qualitative data analysis

For a Doctor of Philosophy Candidate:

KHATHUTSHELO NETSHISAULU

THIS IS TO CERTIFY THAT:

Prof. Tebogo Maria Mothiba has co-coded the following qualitative data for:

One-to-one unstructured interviews

For the study:

DEVELOPMENT OF TRANSITION SUPPORT PROGRAMME FOR NEWLY GRADUATED MIDWIVES IN LIMPOPO PROVINCE, RSA

I declare that the candidate and I have reached consensus on the major themes, themes and sub-themes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Prof TM Mothiba

ANNEXURE R

CONFIRMATION BY LANGUAGE EDITOR

Prof Donavon C. Hiss

Cell: 072 200 1086

E-mail: hiss@gmx.us or

dhiss@outlook.com

9 January 2018

To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the PhD thesis by **Khathutshelo Grace Simane-Netshisaulu**, titled: **"Transition Support Programme for Newly Graduated Midwives in Limpopo Province, South Africa."** The manuscript was also professionally typeset by me.

Sincerely Yours

Cert. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD