Newly Qualified Midwives' Lived Experiences of Caring for Women During Labour and Birth

by

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Abstract

Once student midwives successfully complete their midwifery training, they become newly qualified midwives [NQMs] and their professional midwifery career commences. As they embark on this journey, one of the maternity settings where they get to provide midwifery care is the birthing unit. This study focuses on the lived experiences of NQMs while working at the birthing unit.

The study addressed this scenario and aimed to elicit and understand the meaning of NQMs' lived experiences of caring for women during labour and birth. The objectives of this study revolved around capturing NQMs' experiences of caring for women during labour and birth, uncovering the meaning of these experiences and elicit any supportive measures which NQMs identify as helpful when caring for women during labour and birth in such initial phase of their career.

A Heideggerian hermeneutic phenomenological research approach was adopted and a purposive sampling technique was used to recruit ten participants. One-time, one-to-one, semi-structured, in-depth interviews were conducted with each of the ten participants in this study. These included NQMs employed at the main local hospital who had worked at the Central Delivery Suite [CDS] as part of their rotation period in the last two years post qualification. The research process and analysis of the data were guided by van Manen's (1990) six-step approach. Hermeneutic philosophical notions and the William Bridges transition theory (1991) guided the study and the interpretation of the findings.

Two themes and their corresponding subthemes emerged from the data. The theme *Baptism of Fire* captures all the challenges, hurdles and impediments that NQMs faced once they started their placement at the CDS. In the theme *Containing the Fire*, findings revealed that after some time, things started to fall into place and NQMs started to better cope with challenges and address obstacles they faced. The main outcome of this study reveals that NQMs' experiences at the CDS were impacted by the outcome of their placement at the birthing unit when they were still student midwives, as well as the support and guidance they found from their colleagues once they started their rotation period and became part of the team as qualified midwives. Findings were congruent with the current literature however, there were a number of unique findings that emerged from this study. These include that working at the CDS and assisting a woman in labour and birth gives NQMs a sense of fulfilment. Moreover, they viewed their experience at the CDS as the essence of midwifery and a steppingstone in the growth of their career, as they felt that they had become true midwives.

Based on the findings of this study, several recommendations were highlighted, mainly for further research and implications for practice, policy and education to better assist NQMs as they embark on their journey of caring for women during labour and birth. The main recommendation, based on the participants' narratives, is for NQMs to be assigned to a senior midwife when on the birthing unit, so they have someone to refer to for guidance and support.

To

My dear husband

George

And our two amazing children

Elena Marie and Nathan Paul.

Also,

To all newly qualified midwives who aspire to be the best midwives they can be.

Remember,

"Speak tenderly; let there be kindness in your face, in your eyes, in your smile, in the warmth of your greeting. Always have a cheerful smile. Don't only give your care, but give your heart as well." ~ Mother Teresa

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Abbreviations and Acronyms

CASP	The Critical Appraisal Programme
CDS	Central Delivery Suite
CEBMa	Critical Appraisal of a Cross-sectional Study (Survey) from the Centre for Evidence-Based Management
CNM	Council for Nurses and Midwives
CTG	Cardiotocography
EUSNM	European Union Standards for Nurses and Midwives
FREC	Faculty of Health Sciences Research Ethics Committee
GDPR	General Data Protection Regulation
ICM	International Confederation of Midwives
IR	Integrative Review
ITU	Intensive Therapy Unit
JD-R	Job Demands-Resources
MDH	Mater Dei Hospital
MeSH	Medical Subject Heading
MINT	Midwives in Teaching Induction Programme
MMAT	Mixed Methods Appraisal Tool
NOIS	National Obstetric Information System
NPICU	Neonatal Paediatric Intensive Care Unit
NQMs	Newly Qualified Midwives
OAR@UM	Open Access Research at the University of Malta
PICO	Patient/Population, Intervention, Comparison and Outcomes
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses

SIGLE	System for Information on Grey Literature in Europe
SPIDER	Sample, Population of Interest, Design, Evaluation and Research type
UOM	University of Malta
VEs	Vaginal Examinations
WHO	World Health Organisation

Definitions of Key Concepts

Rotation	refers to the two-year programme offered to all newly qualified midwives as they enrol at Mater Dei Hospital.
Rotation period	refers to the length of placement. In this study, it refers to the six-month placement at the Central Delivery Suite.
Rotation placement	refers to the maternity setting where newly qualified midwives are assigned to during their rotation period. In this study the rotation placement referred to is the Central Delivery Suite of the main local hospital.

Chapter 1: Introduction

1.1 Background to the Study

1.1.1 The History and Role of a Midwife

The role of the midwife is as old as childbearing itself (Connerton, 2012) and has been practised around the globe for centuries (International Confederation of Midwives [ICM], 2014). Back in time, most of the women who practised this role were knowledgeable in healing with natural remedies and were mothers themselves who had been given the title of a midwife once they attended one of their neighbours' or family's births (Connerton, 2012). According to Sweet and Tiran (2000), the word midwife means "with women" (p. 3). Along the years, midwifery has developed according to one's social traditions, regional or local cultures and knowledge (ICM, 2014) with one global goal of caring for mothers, their babies and families throughout pregnancy, childbirth and the postpartum period (Patterson, 2018, as cited in Edwards et al., 2018).

1.1.2 Becoming a Midwife in Today's World

To qualify as a midwife, one must undergo a midwifery education programme that fulfils the academic recognition stipulated by their country, whereby most midwifery courses can be completed within three to four years to attain a diploma or degree in midwifery studies (Donovan, 2008; Sheehy, 2021). After the completion of the relevant academic midwifery studies, a newly qualified midwife [NQM] should possess the necessary knowledge and skills to care for women during normal pregnancies and assist them in labour. Moreover, a NQM is also expected to have the ability to detect complications in both the mother and infant, perform preventative measures to avoid

these complications from happening and carry out emergency measures for complications that may arise during pregnancy, childbirth and the postpartum period (ICM, 2017). A NQM should also have acquired the general knowledge and skills to provide counselling and education on women's reproductive and sexual health and childcare to women and their families (ICM, 2017). To summarise, the international definition of a qualified midwife as stated by the ICM (2017) is as follows:

> A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery. (ICM, 2017, p. 1)

To be with women during labour and birth, the European Union Standards for Nurses and Midwives [EUSNM] (2009) stipulates that midwives should be capable of assisting and caring for the mother during labour, have the knowledge to monitor the foetus in utero by using the appropriate equipment and be competent in aiding spontaneous deliveries and in emergency breech deliveries. Midwives should also be capable of performing episiotomies when needed, be able to detect any signs of abnormality in both the infant and the mother and refer to doctors when needed, help with emergencies such as manual removal of placenta in the doctors' absence, examining and caring for the newborn and perform resuscitation as needed (EUSNM, 2009).

1.1.3 Becoming a Midwife in Malta

In Malta, the undergraduate midwifery programme is offered by the University of Malta [UOM] within the Department of Midwifery at the Faculty of Health Sciences. The main aim of this course is to prepare students to achieve "the competencies needed to fulfil the requirements of a midwife as laid down in the definition of the midwife by ICM (2017) and also fulfil the European Union Midwives Directive 80/154/EEC Article 4, Directive 2005/36/EC Article 42 amended by Directive 2013/55/EU and with the Health Care Professional Act [cao.464, p4, art IV,23(5)]" (UOM, 2022). The course includes theoretical and clinical teaching together with clinical practice placements. Most of the local students' clinical placements are carried out at Mater Dei Hospital [MDH], which is the main local hospital in Malta.

Once students achieve their midwifery qualification and obtain their midwifery registration with the Council for Nurses and Midwives [CNM], they can apply for a midwifery post with the public health sector. The majority of NQMs apply to work at MDH once there is a call for applications for the post of a midwife. If these NQMs are recruited by the main local hospital, they embark on a two-year rotation programme, as stipulated by the policy of the maternity department at MDH. Such NQMs are assigned to work in different maternity settings throughout the midwifery department for a specific rotation period. One of these rotation placements is at the obstetric-led birthing unit known as the Central Delivery Suite [CDS], where NQMs are placed for a six-month rotation period.

Throughout the Maltese Islands, there are three birthing units with the main one located at MDH where the majority of the local births occur. A total of 4548 births were

registered in 2020 in Malta and Gozo. Four thousand two hundred and eighteen (4218) births took place in Malta, of which 4153 occurred at MDH, whilst 330 births occurred on the sister island, Gozo. Out of the total number of births, ten of these took place in a home environment, two deliveries occurred at another location and were later transferred to a hospital (National Obstetric Information System [NOIS] Report, 2020). These statistics are from the latest annual report available and show a good representation of the birthing exposure that NQMs have at MDH's CDS (NOIS, 2020).

1.2 The Newly Qualified Midwife, Labour and Birth

NQMs are valuable individuals as they represent the progression of midwifery (Barry et al., 2014). Hence, the ability of these NQMs to effectively make the transition from a student midwife to a registered midwife affects both the midwifery profession and maternity health services (Clements et al., 2013). A smooth transition is a key aspect of job retainment, especially since many countries worldwide fear an inadequate number of midwives for future staffing requirements (World Health Organisation [WHO], 2016). In the existing literature, NQMs describe their transition from student midwives to qualified midwives as a "reality shock" (Kramer 1974, as cited in Wain, 2017, p. 452) in view of the increased responsibilities encountered (Clements et al., 2013; van der Putten, 2008). Rahmadhena et al. (2017) believe that NQMs' transition must be a time that helps to develop their confidence and competence.

Midwives are known for their role as the advocate of normal birth (Carolan-Olah et al., 2014). The experience of childbirth is a very important and emotional event in a woman's life; it will forever affect how she sees herself as a woman, and her relationship with her partner and other family members (Humenick, 2006). When the mother feels

that it is a positive childbirth experience, this provides numerous psychological benefits for both her and her infant (Davis et al., 2012). This proves the importance of having NQMs who feel confident and competent while caring for women during labour and birth to promote a positive childbirth experience. Literature highlights that a midwife's well-being has a direct impact on the care provided to a woman in labour and the newborn's outcomes (Beaumont et al., 2016).

1.3 Rationale for the Study

As a midwife and mentor working at the CDS, I come into contact with numerous NQMs as they are allocated at the CDS for their rotation placement. I have also crossed the same bridge, having once been a NQM myself journeying through the transition process. Looking at the NQMs assigned to my shifts, as they embarked on their journey of assisting mothers during labour and birth and having my own preunderstandings of this scenario, piqued my interest to look in-depth into NQMs' experiences. As I carried out a scoping literature search on NQMs' experiences in birthing units, I found that most of the literature focused mainly on the transition of student midwives to qualified midwives during the early days of their employment. A gap in the literature was noted as I hardly found any studies that focused specifically on the lived experiences of NQMs during their placement at the birthing units. Yet, it has been highlighted in the literature that the birthing unit was the most challenging out of all other maternity settings for NQMs. This, therefore, intrigued me to carry out my study on the lived experiences of NQMs in a local setting, as they cared for women during labour and birth during their rotation placement, specifically at the CDS. This study extends the available body of knowledge, as it reveals the meaning of the feelings and experiences of NQMs as they assist women during labour and birth, rather than focusing only on the transition from a student midwife to an

employed midwife as found in the literature to date. This study also focuses on how NQMs deal with normal physiological labour and birth but more importantly when facing obstetric emergencies in Malta, which aims to address the needs of NQMs while working in this unit.

1.4 Research Question, Aim and Objectives of the Study

After considering the literature available and my own perspective on this research subject, the following research question was developed to guide the study: *What are the lived experiences of newly qualified midwives when caring for women during labour and birth?*

Consequently, the following aim and objectives were formulated.

Aim:

- To elicit and understand the meaning of newly qualified midwives' lived experiences of caring for women during labour and birth.

Objectives:

- To capture newly qualified midwives' lived experiences of caring for women during labour and birth.
- To uncover the meaning of caring for women during labour and birth amongst newly qualified midwives.
- To elicit any supportive measures which newly qualified midwives identify as helpful when caring for women during labour and birth in this initial stage of their career.

1.5 Overview of the Chapters

This dissertation is divided into six chapters. Chapter 1 gives an introduction to this study including a background on the topic chosen. This is followed by the literature review which includes the processes undertaken in reviewing the relevant literature,

including a critical analysis and discussion of the findings of the included research studies and reports. Chapter 3 gives a detailed description of the methodology used to carry out this study. It explains the philosophical underpinnings and theoretical framework used to guide this study and gives a full explanation of participants' recruitment, the method of data collection and how this data was then transcribed and analysed. Chapter 4 presents the participants' experiences as narrated by the participants themselves, obtained from the data collection during the one-to-one interviews carried out. Chapter 5 discusses the findings presented in the previous chapter, correlating them to the reviewed literature, the chosen Bridges transition theoretical framework (1991) and pertinent hermeneutic philosophical notions. Chapter 6 concludes the study by summarising and drawing all the relevant conclusions based on the evidence obtained from this research and proposes recommendations for practice, management, education and further research.

Chapter 2: Literature Review

2.1 Introduction

This chapter discusses in detail the methods and findings of the integrative review carried out for this study. This is carried out by explaining the aim of this review, justifying why the chosen review method was used, how it was accomplished and finally by providing critical analysis and discussion of the findings for the research studies and reports included in this review.

2.1.1 Choosing a Literature Review Method

In hermeneutic phenomenological research, the literature review is not the same as that of a quantitative or qualitative study. The nature of a hermeneutic review is based on exploring all potential sources to enhance the literature search (Dibley et al., 2020). Therefore, for a more holistic understanding of this specific phenomenon, an integrative review [IR] method was chosen. IR was seen as the most fitting method since, like hermeneutic phenomenology, it combines research and draws inferences from various sources on a topic, by looking and taking into consideration all literature present during the search, being empirical, methodological, and theoretical (Whittemore et al., 2014; Soares et al., 2014, as cited in Toronto & Remington, 2020). As Toronto and Remington (2020) suggest, for both transparency and rigorousness, this review was based on a systematic approach using Cooper's (1984) framework which consists of a six-step process that was implemented as guidance. These six-steps included: formulating the purpose for the review and formulating a review question, executing a systematic search and selecting appropriate literature, performing a quality appraisal of the literature chosen, carrying out analysis and synthesis of the studies, followed by the discussion,

conclusion and dissemination of these findings (Cooper, 1984, as cited in Toronto and Remington, 2020).

2.2 The Integrative Review [IR] Method

2.2.1 Formulating the Review Question

Since the research study, which is reported in the following chapters, adopted a qualitative approach with a hermeneutic phenomenological design, the SPIDER method was implemented as opposed to the PICO tool, which is more commonly used in quantitative studies (Cooke et al., 2012). This acronym which represents Sample, Population of Interest, Design, Evaluation and Research type helped to develop the review question, create keywords, assist in listing both the inclusion and exclusion criteria and guide the literature search (Dibley et al., 2020). Keywords were sought with the help of the Medical Subject Heading [MeSH] database. Table 2.1 represents the SPIDER method.

With the help of this method the following three review questions were formulated to help guide the literature search: *What are the experiences and feelings of NQMs when caring for women in the maternity setting? What may influence the NQM experiences on the job? What strategies may enhance the NQM in her new role?*

Before commencing the literature search, the keywords were combined with Boolean operators: AND and OR. An asterisk * was also placed at the end of certain words to search for all the possible terms which are known as truncate words, and the

question mark ? known as a wild card, was used to replace or represent more than one letter (Ecker & Skelly, 2010).

Table 2.1

SPIDER Method for Developing Keywords

Component	Explanation	Term
Sample	Type of participants	Newly qualified midwives, Newly graduate midwives, Junior midwives, Midwives on rotation, Novice midwives, Beginner midwives, Trainee midwives, Newcomer midwives, Apprentice midwives, Learner midwives, Amateur midwives, Newly practising midwives, Newly registered midwives.
Phenomenon of Interest	Area of focus	Labour, Birth, Intrapartum, Parturition, Childbirth, Different stages of labour, Obstetric emergencies, Normal vaginal delivery, NVD, Confinement, Operative birth.
Design	Methods of data collection	Interviews: Structured interview, Unstructured interview, Semi-structured, Open-ended interview, Face-to-face interview, Telephone interview, Focus group, Survey, Observation, Audio recording, Field notes, Personal diary, Tape-recorded.
Evaluation	Analysis of Experience	Meaning, Understanding, Lived experiences, Views, Attitudes, Opinions, Beliefs, Thoughts, Perspectives, Feelings, Perceptions.
Research Type	Methodology of Interest	Qualitative, Mixed methods, Quantitative.

2.3 Systematic Search and Selection of Literature

An extensive literature search was completed by combining the keywords as indicated in Appendix A. The following eight databases were used to search the literature: Academic Search Ultimate, Cinahl Complete, Medline Complete, PSYch INFO, BioMed Central, Cochrane Database of Systematic Reviews, PubMed, PubMed Central and the Google Scholar search engine. All quantitative, qualitative and mixed-method studies associated with the review questions were considered for inclusion in this review. Smythe and Spence (2012) and Dibley et al. (2020) emphasise that literature may be found in unlikely places such as grey literature, novels and poems which are important to take into consideration in a hermeneutic study. Therefore, an online search was also performed using the Google search engine for all relevant literature and the Open Access Research [OAR@UM] (the online platform of the University of Malta's Institutional Repository) for unpublished dissertations. The last search was done on the System for Information on Grey Literature in Europe [SIGLE] to identify any unpublished grey literature. No limiters such as location of keywords, full text, original articles, language and sample were set during the main search. Limiters were not used since an initial quick literature search indicated that there were a very limited number of studies published on the topic. Hence, to avoid missing any important literature, all that was available was taken into consideration. This was also applicable for the time frame; since no relevant literature dating further back than the year 2000 was found, no time frame limiter was set. Furthermore, the reference lists of the chosen articles were thoroughly scrutinised for any useful literature. Ultimately the retrieved papers were retained according to the inclusion and exclusion criteria to this review.

All searches performed on the previously mentioned eight databases were documented. The table in Appendix B shows the number of hits retrieved in each database according to the different combination of keywords. All literature was transferred to RefWorks (n=2410) and all duplicates (n=1000) were removed. Titles and abstracts (n=1410) were screened and any irrelevant ones (n=1310) were excluded. Full texts of the remaining articles were sought (n=100), however, some of these studies (n=27) were excluded since no full text was available. The remaining articles (n=73) were retrieved in full text. These were thoroughly read and ultimately included or excluded according to the inclusion and exclusion criteria as shown in Table 2.2 and discussed in the next section.

Table 2.2

Inclusion and Exclusion Criteria

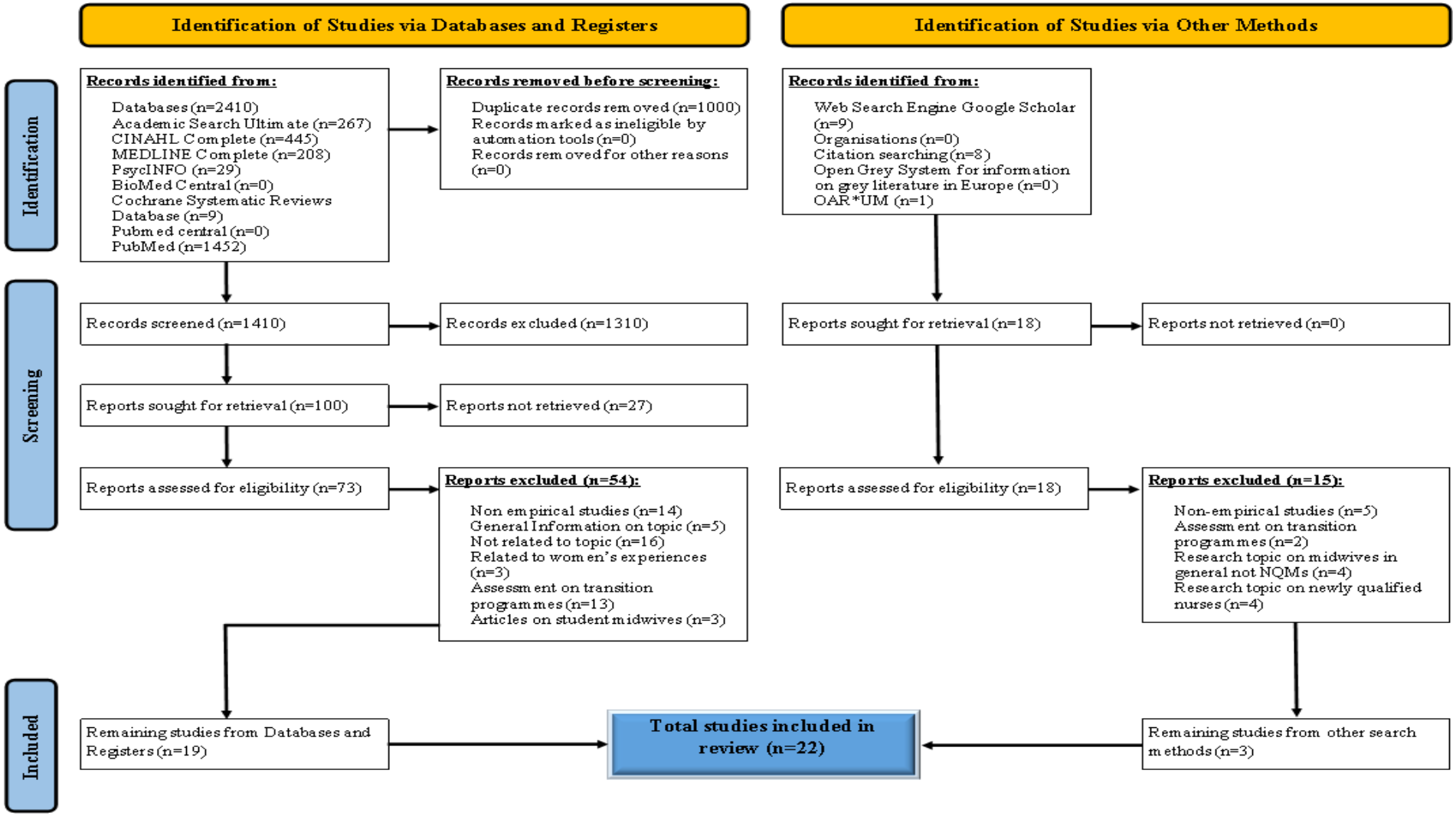
Inclusion	Exclusion
Studies had to include keywords in the title or abstract.	Studies on the experiences of other newly qualified healthcare professionals such as nurses, doctors, physiotherapists, etc.
Studies that were relevant to the review questions.	Studies with the main aim of assessing only the programmes offered to NQMs and not NQMs' experiences.
Studies exploring the experiences of NQMs including enabling and hindering factors.	Studies that only explore student midwives' experiences and not that of NQMs.
Studies that compared senior and student midwives to NQMs experiences.	
Studies retrieved in the English Language.	
Any research design: quantitative, qualitative and mixed methods.	

As indicated by the review questions outlined above, this IR aimed to include literature that showed the experiences and feelings of NQMs while working in maternity settings, that explored what negatively influenced these experiences and /or identified what could help NQMs in their new role. Therefore, to answer the review questions, inclusion and exclusion criteria were drawn up to better understand the current knowledge about the experiences of NQMs. Hence, studies which focused specifically on NQMs were included, rather than those relating to other newly qualified healthcare professionals or student midwives. This assisted me to relate better to what NQMs really go through from their experience as junior midwives in a maternity setting. The choice of English language articles was solely due to my fluency in the language.

After applying inclusion and exclusion criteria, from the remaining 73 full text articles, a total of 19 studies were found to be eligible for the review. Another 3 articles were considered relevant from the other 18 articles which were identified during the search carried out via other methods. Therefore, the 19 eligible studies were included with the further 3 articles, totalling 22 studies which were ultimately included in this review. Figure 2.1 displays the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (McKenzie et al., 2020) which clearly shows the number of records identified, included, excluded and the reasons for exclusion (Page et al., 2020). Appendix C includes more details about all excluded literature.

Figure 2.1

PRISMA Flow Chart



2.4 Quality Appraisal

Katrak et al. (2004) explain that to determine if the results of a study are valid and can be used for further research studies, education, policies or clinical practice, an evaluation for utility and quality must be done using appraisal tools. Table 2.3 shows the appraisal tools used for each study included in this review according to its research approach. In Appendix D, Tables D1 to D3 include the detailed quality appraisal done for each study.

Table 2.3

Appraisal Tools

Research Approach	Authors of Studies	Appraisal Tool
Qualitative Studies	• Avis et al. (2012) • Barry et al. (2013) • Barry et al. (2014) • Cazzini et al. (2022) • Clements et al. (2013) • Fenwick et al. (2013) • Griffiths et al. (2019) • Hobbs (2012) • Kitson-Reynolds et al. (2014) • Kool et al. (2020) • Naqshbandi et al. (2019) • Norris (2019) • Saliba (2011) • Sheehy et al. (2021) • Simane-Netshisaulu & Maputle (2021) • Skirton et al. (2012) • van der Putten (2008) • Wain (2017) • Watson & Brown (2021) • Young (2012)	The Critical Appraisal Programme [CASP] qualitative studies tool
Quantitative Studies	• Davis et al. (2012)	Critical Appraisal of a Cross-sectional Study (Survey) from the Centre for Evidence-based Management [CEBMa]
Mixed-method Studies	• Lennox et al. (2012)	Mixed Methods Appraisal Tool [MMAT]

No studies were excluded based on quality after evaluation, as recommended by Sandelowski (1997). Nevertheless, all the studies included in this review were of good quality, and no study had a high risk of bias, as indicated by the quality appraisal tools used (Appendix D, Tables D1 to D3). After consulting with the research supervisor throughout the processes of searching the literature, the inclusion and exclusion process and the appraisal of the studies, I included all 22 studies considered eligible in this review. One of these 22 studies included an unpublished local dissertation (Saliba, 2011) which was considered important since it is the only local study done on NQMs to-date.

2.4.1 Characteristics of the Included Studies

The table found in Appendix E lists in detail the characteristics of the included studies in this review. All the participants of the studies included were NQMs and the studies were conducted in several countries namely, Australia (n=8), the United Kingdom (n=5), the Netherlands (n=1), New Zealand (n=1), Ireland (n=3), Iraq (n=1), South Africa (n=1) and Malta (n=1). One of the studies, which was carried out by Skirton et al. (2012), focused on three different regions of the United Kingdom: Scotland, Wales and Northern Ireland. Data collection of most studies (n=18) took place during the midwives' first year of qualification, two (n=2) were carried out during the first three years from the midwives' graduation, one (n=1) was completed during the first five years from graduation, and another study (n=1) was carried out during the sixth or seventh year from the NQMs' qualification. Six of the studies included NQMs who had previously graduated as nurses and had immediately continued their studies by undergoing a one-year postgraduate course in midwifery. All studies used non-probability sampling to recruit their participants. These included ten studies which used purposive sampling, seven used convenience sampling, one study used snowball sampling and one study used cohort

sampling. However, three studies did not specify which non-probability sampling was used.

Different methods were used for data collection across the included studies. Qualitative studies mostly used interviews as their main data collection method, of which nine (n=9) used face-to-face semi-structured interviews. While two (n=2) studies used telephone interviews. Other studies (n=3) used interviews together with another method such as focus groups (n=1) or reflective diaries (n=2). Two of the studies used three methods for data collection such as interviews, participant journal and interviewer's journal. Another study used interviews, focus groups and observations and another used interviews, observation, and personal notes. One study used focus groups together with reflective diaries, whilst another study used weekly diary entries only.

The mixed-methods study by Lennox et al. (2012) used semi-structured interviews, recorded telephone logs and visual analogue scales for their data collection. While the quantitative study by Davis et al. (2012) used surveys. The earliest study included in this review was completed in June 2008 by van der Putten, while the latest from Cazzini et al. was published in March 2022. Most of the included studies (n=6) were published in 2012.

2.5 Analysis and Synthesis

Torraco (2016) describes data analysis and synthesis as a challenging phase of the IR process and adds that it should present a combination of research from different sources to show better knowledge of the topic being searched. To get a better understanding of the topic, laborious methods of data analysis were implemented for this

IR, which allowed recasting, combining, reorganising, and integrating concepts across a body of literature (Torraco, 2016). Data analysis was conducted by deconstructing the literature into the simplest element (Torraco, 2005). To efficiently analyse the literature, three review matrixes were constructed each one representing a review question (Garrard, 2017, as cited in Toronto & Remington, 2020). Appendix F represents the analysis matrix for the first review question: *What are the experiences and feelings of NQMs when caring for women in the maternity setting?.* Appendix G represents the matrix for the second review question: *What may influence the NQM experiences on the job?.* Appendix H represents the matrix for the third review question: *What strategies may enhance the NQM in her new role?* Identification, analysis and reporting patterns of data were carried out using thematic analysis (Braune & Clarke, 2006). This type of analysis is mostly used for qualitative data, however, Popay et al. (2006) explain that this can still be used with various sources of literature using different methodologies, to organise and identify the main, recurrent or most important themes or concepts.

The three-analysis matrices used in this review were thoroughly scrutinised for recurrent patterns and the formation of themes were guided by the review questions (Toronto & Remington, 2020). Braune and Clarke's (2006) six-phase process was repeatedly used and included: Familiarising with data: the literature was read multiple times and notes were listed as codes for potential themes; Generating initial codes: data formed from the previous coding was organised into interesting codes; Searching for themes: codes were placed into potential themes and subthemes; Reviewing themes: refining of themes was done by gathering items for each theme and a thematic map was developed; Defining and naming themes: the aspects of the data each theme captured were determined and the story each theme was showing was studied to develop the final

theme names; and Producing the report: a report of the identified themes was developed. Table 2.4 shows the thematic content map.

Table 2.4

Thematic Content Map

1st Level Coding	2nd Level Coding	Subthemes	Themes
• Learning additional skills • Implementing theory to practice • Acquired academic/clinical knowledge • Staff perception of NQM's knowledge • Lack of experience • Self-awareness of skills abilities	• Acquired knowledge and experience • Abilities and skills	• NQMs' perceptions of what midwifery entails • NQMs' views of the real job experience	• **The Shocking Truth**
• Struggles to gain confidence • Confidence increases with time • More confidence in low-risk situations • Job demands and resources • Professional demands • Competence issues • Trust issues • Familiarity with work environment • Pecking orders • Ambivalence • Overwhelming emotions • Decision-making and accountability • Colleagues' supportive measures • Rotation impacting confidence levels • Continuity of care helped in confidence • Personal demands and resources • Increased responsibilities • Time management • Relationship issues • Reality and culture shock • Staff attitudes • Autonomy • Psychological trauma	• Confidence variables affecting NQMs' performance • Factors affecting competence levels of NQMs • Welcoming work environment • Advantages of trust and support of NQMs • NQMs in the real working environment • Role expectations from students to NQMs • Job expectations supersede NQMs' beliefs • Personal coping strategies • Hierarchy and relationships • Staff / Management perceptions of NQMs and their abilities • Crisis with increased responsibilities and decision-making • Increased thoughts and cognitive processes • Feeling and emotions • Psychological impact	• Experiences and feelings of NQMs • Factors affecting NQMs' role performance	• **Beginners' Crisis**
• Quitting or adapting • Transition phase • Training programmes • Preceptorship • Job-satisfaction • Supervision • Transition programmes	• Transition and adaptation phase • Policies and guidelines • Advantages of supervision and training programmes • Keeping up to date and building on existing knowledge	• Coping strategies of NQMs • Supervision and support for NQMs	• **Moving On**

2.6 Emergent Themes in the Included Studies

2.6.1 The Shocking Truth

This theme emerged from the subthemes; NQMs' perceptions of what midwifery entails and NQMs' views of the real job experiences. This theme brings out the stark realities NQMs experience when transitioning from the role of student to that of a registered midwife.

2.6.1.1 NQMs' Perceptions of What Midwifery Entails

The perceptions of what NQMs thought midwifery entails emerged in several studies included in this review. A qualitative study by Kitson-Reynolds et al. (2014) included three semi-structured interviews with each of the 15 NQMs included in their study. Participants were interviewed during their first year of practice and an interpretive phenomenological design was used to understand the participants' experiences of being a NQM. The results showed that, as students, these participants had an idea of what a midwife is, what the job involved and the relationships they will build with their colleagues, the women they care for and their families. However, this changed over time and once they embarked on the journey of truly becoming a midwife (Kitson-Reynolds et al., 2014). In another grounded theory qualitative study by Barry et al. (2013), using interviews together with participants' journals, 11 NQMs were recruited after finishing a year-long postgraduate diploma in midwifery studies after graduating as nurses. Participants expressed a feeling of coming into the workforce proud of their graduation and achievements, embracing the philosophy of midwifery. This philosophy of midwifery referred to the combination of learned theory, accumulated clinical practice during studentship and personal experiences of childbirth (Barry et al., 2013). This study was

conducted in two phases which were published in two papers one year apart; Barry et al. (2013) and Barry et al. (2014). In their first publication, Barry et al. (2013) generated the grounded theory around the social process of how NQMs deal with applying the philosophy of midwifery in their first six-months of practice, while in their second publication, Barry et al. (2014) discussed the final sub-stage of the generated theory.

The previously mentioned study of Kitson-Reynolds et al. (2014) together with the qualitative studies performed by Griffith et al. (2019), Hobbs (2012) and Watson and Brown (2021) all pointed out that the ideals that NQMs' envisioned while they were still students were very quickly changed by the realities faced in their work environment, including relations with colleagues and the true practices of midwifery. This was also expressed by participants in Barry et al. (2013) who felt a sense of frustration when they could not reach their expectation of their midwifery role. Griffith et al. (2019) carried out a descriptive qualitative study with eight NQMs using semi-structured telephone recorded interviews, given the long-distance location of participants. The use of telephonic recorded interviews in this study might have restricted access to important information from non-verbal cues and expressive personalities more commonly noted during face-to-face interviews, thus limiting the research results. On the other hand, the study by Hobbs (2012) was an ethnographic study carried out using three methods of data collection including observation, interviews and a personal field diary. The three phases of data collection took place over a period of 12 months which made it more possible to gather the true meaning of experience throughout each transition phase. Watson and Brown's (2021) study was a qualitative study which included an in-depth narrative exploration comprising of eight semi-structured interviews with eight NQMs.

The participants of both the studies carried out by Griffith et al. (2019) and Kitson-Reynolds et al. (2014) had the opportunity to work in caseload midwifery practice, which included a primary care midwife caring for an assigned woman throughout pregnancy, birth and the postnatal period during their student practice. When employed as midwives in a hospital-based maternity setting, they experienced a completely different aspect of the job description, which is one of the reasons that NQMs ended up disappointed after having different expectations from the role. Moreover, the study of Barry et al. (2013) and Hobbs (2012) did not indicate the settings NQMs' were assigned to during their student clinical placements, making it more difficult to confirm whether these feelings of disappointment were secondary to the nature of midwifery work outside a hospital-based setting. This was noticed in another descriptive qualitative study, where 32 NQMs participated in telephone interviews and seven of the participants also attended a focus group (Clements et al., 2013). The participants who worked their transition period in the midwifery continuity of care model regarded their experience as a positive one, describing it as having the opportunity to work closely with midwives, sharing the same philosophy of care and keeping women at the centre of care. Contrarily, those from the same study who were assigned to a hospital-based setting expressed negative feedback about their experience.

2.6.1.2 NQMs' Views of the Real Job Experience

Participants in various studies experienced a huge surprise when they started practicing in a professional setting. They encountered many unexpected scenarios from what they had been taught and their own views on maternity care, to what was practised in the clinical setting. In a study by Sheehy et al. (2021) which involved semi-structured telephone interviews with 28 participants who were re-recruited from a previous

longitudinal study, it emerged that the working environment is based on a medical setting where certain unneeded interventions take place which led to NQMs looking at the midwifery role as being subordinate (Sheehy et al., 2021). In Cazzini et al. (2022), a qualitative descriptive study consisting of seven interviews, the participants emphasised that the clinical placement could not compare to the midwifery philosophy they believed in. In the study of Barry et al. (2013) it showed that the initial feelings of NQMs as they cared for women, was of "letting women down" (Barry et al, 2013, p. 1354) and not giving them the support, standard of care and attention they had envisioned. This also became evident in another descriptive qualitative study by Kool et al. (2020) with a sample of 21 hospital-based NQMs who had received their registration in the last three years. This study was the only study included in this review that used a Job Demands-Resources [JD-R] model, which helped to concurrently investigate job demands and resources and the NQMs personal demands and resources. Kool et al. (2020), similar to other studies as Griffiths et al. (2019), Skirton et al. (2012) and van der Putten (2008), found that NQMs were not able to provide proper woman-centred care as they had intended. Moreover, Sheehy et al. (2021) also showed that NQMs felt guilty when they did not show enough courage to speak up for women and stand up to other staff members when they felt that women were not receiving the proper care (Sheehy et al., 2021).

2.6.2 Beginners' Crisis

The second theme that surfaced in this review was Beginners' Crisis, which emerged from the subthemes of the experiences and feelings of NQMs and the factors affecting NQMs' role performance. This theme highlights the difficulties found across the literature, that NQMs experience in their new role as registered midwives in a maternity setting.

2.6.2.1 The Experiences and Feelings of NQMs

Literature indicates that it is very common for NQMs to experience a surge of feelings and emotions which may contribute to a lack of confidence and poor performance, making them vulnerable persons during a very difficult and stressful time of their professional career (Naqshbandi et al., 2019; Norris, 2019; Sheehy, 2021). In a mixed-method study carried out by Lennox et al. (2012), eight midwives participated in three semi-structured interviews with each interview being spaced around the beginning, middle and end of their mentored year following registration. Furthermore, data collection included logs of telephone calls, texts or face-to-face meetings with their mentors and a visual analogue scale of confidence. Findings revealed how participants felt helpless and not knowing what to do to perform their role, with one of the participants expressing that she felt "like a fraud" (Lennox et al., 2020, p. 6) while speaking to a mother and who was continuously thinking that this woman should be speaking to "a real midwife" (Lennox et al., 2020, p. 6). On the other hand, in another study, a common expression by NQMs was to "fake it till you make it" (Sheehy et al., 2021, p. 3) which involved the mimicking of skills from other colleagues even if they were not aware of what they were doing (Sheehy et al. (2021).

All included studies (n=22) revealed that NQMs experienced some form of stress. In the study by Sheehy et al. (2021), findings revealed that one of the main stressors was the steep learning curve that was expected by employers where NQMs were expected to increase their knowledge regarding certain skills and practices which they hadn't been previously trained for. Participants expressed that this situation overwhelmed them with emotions and stress. This was aggravated when faced with certain unexpected challenges even though they had the knowledge and the required training (Sheehy et al., 2021). Other

participants mentioned that they needed to look for help from councillors and some participants even thought of leaving the profession due to the increased stress and burden from the responsibility of caring for women in labour (Clements et al., 2013). Participants' stress was thought to be directly related to young age and freshly graduated students, however, this has been proven otherwise in three studies by Griffiths et al. (2019), Simane-Netshisaulu and Maputle (2021) and Wain (2017). The study of Wain (2017) is a phenomenological study that included face-to-face interviews with eight NQMs while the study of Simane-Netshisaulu and Maputle (2021) is a qualitative descriptive, exploratory and contextual design which included unstructured in-depth face-to-face interviews with five NQMs. The Griffiths et al. (2019), Simane-Netshisaulu and Maputle (2021) and Wain (2017) studies show that some of the participants were already qualified nurses who later pursued midwifery training and practice. Such midwives still experienced these surges of stressful feelings. These three studies concluded that even though their participants were expected to be more prepared due to their nursing background they still expressed feelings of being stressed and afraid when they started working as midwives.

However, this was not expressed by some of the participants in the quantitative study by Davis et al. (2012). The NQMs who were already graduated as nurses and participated in this study showed more confidence, having the advantage of experience and, therefore, could direct their focus on consolidating skills related to midwifery as opposed to the undergraduate midwives' participants from the same study who lacked experience. Davis et al.'s (2012) study consisted of surveys that were distributed in the first week of midwifery practice with a response rate of 24% (n=19), and then 12 months later with a response rate of 36% (n=25). However, this study had very limited

participation and a low response rate for a quantitative study and findings cannot be generalised to a broader population of graduate midwives. The tool used for this study was self-designed and not validated, therefore, results must be treated cautiously. Since this study consisted of self-reported surveys, participants may have not been totally honest about their confidence levels which could have also biased the results.

Both Kitson-Reynolds et al. (2014) and Wain (2017) indicate that NQMs' stress was directly linked to the phenomena of sudden status change; from being a protected student to being a fully independent and accountable midwife. The feeling of losing the shelter provided by their university (Kitson-Reynolds et al., 2014), stepping into the unknown (Avis et al., 2012) and starting to find out the true colours of midwifery was all about experiencing the reality of both sides of the profession from happy/joyful moments to sad/heart-breaking situations (Lennox et al., 2012).

Most research studies included showed different feelings and emotions expressed by the various participants, namely; insecurity, anger, feeling traumatised, feeling vulnerable, anxiety, terror, feeling daunted, frustration, exhaustion and fear (Avis, 2012; Barry et al., 2013; Barry et al., 2014; Cazzini et al., 2022; Clements, 2013; Fenwick et al., 2012; Griffith et al., 2019; Kool et al., 2020; Norris, 2019; Reynolds, 2014; Saliba, 2011; Simane-Netshisaulu & Maputle, 2021; Skirton, 2012; van der Putten, 2008; Watson & Brown, 2022). Studies showed that these feelings and emotions were lived differently depending on the maternity wards in which NQMs practiced. A qualitative study which included interviews with 35 NQMs from 18 worksites carried out by Avis et al. (2012), revealed that fear and anxiety were mostly associated with working in the birthing units, which participants described as being a scary place that brought up feelings of stress,

discomfort, and anxiety. One participant expressing that “I feel that going to labour ward is going to kill me” (Avis et al, 2012, p. 6). Similar research findings have also emerged in the studies by Clements et al. (2013), Sheehy et al. (2021), and Fenwick et al. (2012). Moreover, participants in the study by Kitson-Reynolds et al. (2014) emphasised that other maternity wards, apart from birthing suites, were more stressful considering there was only one qualified midwife in a high-risk maternity ward who is responsible for 25 to 30 women and babies.

Both Kool et al. (2020) and Kitson-Reynolds et al. (2014) identified that most NQMs take all these fears, feelings, and emotions back to their own homes, worrying that they failed as a midwife, believing that they did something wrong while caring for women. Worse of all, they even compare themselves to others which, eventually, may take a toll on their personal life. Their coping skills and anxiety were based on how and if they managed to complete the tasks assigned to them (Norris, 2019). Participants complained of not being able to sleep and constantly counting the days until their next duty (Norris, 2019). Others commented on not taking any breaks during their duty or staying on after their duty ends, to see the outcome of the birth even though they were exhausted and needed to go home to their families (Hobbs, 2012; Watson & Brown, 2021). Such findings also emerged from Hobbs’ (2012) study which focussed on Bourdieu’s notion of habitus. In this study habitus is defined as “our overall orientation to or way of being in the world; our predisposed ways of thinking, acting and moving in and through the social environment” (Sweetman, 2003, as cited in Hobbs, 2012, p. 394). Hence, Hobbs (2012) explains that NQMs tend to overlook their own wellbeing since midwifery is a female-dominated profession and it is in their nature to give their 100%

and more, which is described by Bourdieusian terminology as “service and sacrifice” (Kirkham, 1999, as cited in Hobbs, 2012, p. 396).

In contrast to the negative emotions expressed in the above studies, some participants in Kool et al. (2020) admitted that they found in thrilling to have unexpected challenging situations which helped them to strive for success even more. This was not a common factor in the other studies where participants were recruited immediately on employment. Kool et al.’s study (2020) consisted of participants who had up to three years’ work experience which could have influenced their perception of their first year of practice leading to recall bias. Nevertheless, positive emotions were not pointed out in the study by Sheehy et al. (2021), even though participants were recruited between seven to eight years from registration.

Another descriptive qualitative study, which included interviews with 16 NQMs carried out by Fenwick et al. (2012), explained that the negative feedback received could have been due the fact that dissatisfied or unhappy midwives were the only participants interested in participating in the study, hence this was an opportunity for them to vent their negative experiences. It is therefore doubtful whether such research findings can be generalised to the experiences of all NQMs.

2.6.2.2 Factors Affecting NQMs' Role Performance

Three phenomenological studies carried out by Naqshbandi et al. (2019) (n=15), Watson and Brown (2021) (n=8) and van der Putten (2008) (n=6) showed that NQMs went through so many conflicting ideologies when they tried to use the knowledge they acquired from school in practice, that it resulted in impeding their self-confidence.

Although participants mentioned that they were conscious of their abilities in knowledge and skills, they mostly felt that their position as a NQM was subordinate, and this unfavourably affected their ability to be sufficiently assertive to deal with the events and tasks presented to them. Such issues surfaced mostly during vaginal examinations [VEs], the second stage of labour and when interpreting cardiotocography [CTG] results (Hobbs, 2012). The study carried out by Kool et al. (2020) pointed out that participants found interpretation of a CTG very difficult since it can be very subjective. Similarly, findings of VEs were found to be quite subjective and could be interpreted differently among different midwives. Certain skills had to be learned once NQMs embarked on their journey, such as the case of applying a foetal scalp electrode. This factor of learning new skills while adapting to the new role seemed to substantially increase stress in NQMs (Kool et al., 2020). However, Barry et al. (2013) highlighted that consolidating certain skills transforms anxieties into positive emotions, especially once NQMs accomplish these skills. Hence, Barry et al. (2013) highlights the importance of providing NQMs with constant support, encouragement and empowerment for them to stay motivated.

Six of the studies included in this review Avis et al. (2012), Clements et al. (2013), Fenwick et al. (2012), Kool et al. (2020), Sheehy et al. (2021) and Wain. (2017) presented the experiences of NQMs when working on a rotation basis. In the study by Sheehy et al. (2021), participants stated that this brought about instability in their confidence, while the participants in Cazzini et al. (2022) and Kool et al. (2020) described that they felt insecure and had to prove themselves to colleagues in a very limited time frame. Wain (2017) adds that time is needed in one clinical area to consolidate and gain knowledge and experience. However, some conflicting ideas emerged between participants such as in the study by Avis et al. (2012) where some participants agreed with the negative effects of the rotation

system describing it as a “roller coaster ride” (p. 5), while others described it as building their confidence since they had the opportunity to witness various scenarios from different ward settings. Similarly, in Clements et al. (2013), participants working in the continuity of midwifery care setting did not experience any feelings of stress, fear, or anxiety during their rotation. However, the findings of these studies could have been largely affected by organisational structures and dimensions, geolocations of studies and personal character traits.

A longitudinal study by Skirton et al. (2012) consisting of 35 participants, revealed that participants did not realise the responsibility of being a midwife while they were students and, therefore, found it stressful once they were deployed in their new role, taking sole responsibility and decision-making for the women under their care. This sense of responsibility was seen as overwhelming by the participants in Watson and Brown’s (2021) and van der Putten’s (2008) research, and scary for the 11 NQMs that participated in the qualitative case study by Saliba (2011). Participants felt that even though they were educated and trained on responsibility, accountability and autonomy as students, they didn’t feel up to it in their first 12 months of employment (Kitson-Reynolds et al., 2014). These feelings were mostly felt in birthing units, as emerged in both Clements et al. (2013) and Saliba (2011) where NQMs emphasised that responsibility in the birthing unit was overwhelming and difficult to cope with. NQMs were mostly worried about being the ones who must act during emergencies without any shielding (Skirton et al., 2012). As students, NQMs never took decisions on their own while caring for women during labour while, once qualified, they were afraid of the heavy responsibility and that they would make a mistake that will cost them their registration (Clements et al., 2013). Furthermore, participants put themselves under intense pressure due to increased

expectations of their abilities to carry out tasks at the same pace as their senior counterparts (Hobbs, 2012). This led to deep frustration knowing that their ability to transition from novice to expert would be much slower than they anticipated (Benner, 1984).

Workload and time constraints were other factors that made it extremely difficult and stressful for NQMs to provide proper care and attention to women during labour (Kool et al., 2020). Moreover, the inability to provide proper woman-centred care was yet an added concern for NQMs when assigned in shifts, as it made them feel that they lacked continuity of care (Griffiths et al., 2019). However, these participants had been given their midwifery training in a caseload midwifery setting, which differs greatly from a hospital-based maternity setting and hence, their feelings might have been accentuated by this fact (Griffiths et al., 2019).

NQMs described the role of the midwife as intense and emotionally demanding, whilst not finding the right support from colleagues, which proved to have a negative effect (Sheehy et al., 2021; Simane-Netshisaulu and Maputle 2021). Kitson-Reynolds et al. (2014) compared being accepted by senior midwives to an "initiation period" (p. 665) meaning that they felt as if they had to pass a test to be accepted by their senior counterparts. In a qualitative study by Norris (2019) that included an action research approach, participants described their struggle of being accepted by other midwives as a challenge that had to be endured. NQMs felt continuously watched by colleagues, waiting to be judged on whether they step out of line and whether they can be trusted (Clements et al., 2013; Griffith, 2019). They felt that they were mostly seen as a burden, lacking skills, ability and competence (Cazzini et al., 2022; Griffith et al., 2019; Lennox et al.,

2012; Sheehy et al., 2021; Watson & Brown 2021). Studies by Kool et al. (2020), Norrris (2019) and Wain (2017) have all described these dilemmas NQMs face when they need to ask for help from other midwives or refer women to obstetricians. Fearing that they will be seen as weak and incompetent, NQMs feel like a nuisance to ask for help/support especially in busy environments and short-staffed circumstances, shattering their hopes of building a trusting relationship with colleagues (Cazzini et al. 2022; Skirton et al., 2012). Sheehy et al. (2021) and Simane-Netshisaulu and Maputle (2021) speak about a bullying culture where NQMs feel belittled as an impact of a hierarchical system and autocratic personalities. This is also consolidated in the studies of Fenwick et al. (2012) and Lennox et al. (2012) where a pattern of inappropriate working culture has been noted in some units, where midwives rank themselves according to seniority and NQMs are placed at the bottom of this hierarchical order, known as the "pecking order" (Lennox et al., 2012, p. 6). Other participants also expressed their feelings of being assigned the most difficult cases to toughen up and this could have been the reason why they saw midwifery as being so difficult (Fenwick et al., 2012).

2.6.3 Moving On

The final theme emerging from the literature focused on Moving On where NQMs start to accept their role, adapt and move forward. This theme developed from subthemes of coping strategies of NQMs, and supervision and support for NQMs. The literature in this review identifies several factors which NQMs identified as helping them adapt to their new role.

2.6.3.1 Coping Strategies of NQMs

As time passed, participants started to feel more confident, obtaining a clearer picture of what was expected of them (Norris, 2019) and were able to put their knowledge into practice (Saliba, 2011; Skirton et al., 2012). These were expressed in the quantitative study by Davis et al. (2012) where confidence levels of NQMs were compared between the early days of their practice and at the end of their first year of employment. The study found a statistically significant result (p=0.010) of increased confidence levels of NQMs at the end of their first year of employment.

In the second part of their study, Barry et al. (2014) aimed to develop a theory regarding how NQMs deal with applying a midwifery philosophy of care in their first six-months of practice. The theory generated showed that NQMs go through three stages while transitioning from a student to a qualified midwife to provide woman-centred care. These three stages include: being centred on developing own personal qualities, developing an understanding of outside influences which may impact their practice and moving through a process to support change through their plan of action. Findings showed that once NQMs started to adapt, their ability to utilise their current and previous knowledge improved which, in turn, increased their confidence levels to work more autonomously (Barry et al., 2014). Experiences and knowledge gained during the transition phase described, resulted in NQMs becoming more empathic to the women's needs (Barry et al., 2014).

The feeling of belonging to the profession and their role as a midwife helped NQMs not only in providing the best care to mothers but also set boundaries to help themselves survive. These included working autonomously, gaining professional

recognition, respecting their family commitments and supporting their emotional demands (Barry et al., 2014). Other factors that encouraged NQMs to retain their profession, achieve job satisfaction and motivation is the ability to work to the full scope of the midwifery practice and build a good relationship with the women in their care (Kool et al., 2020; Sheehy et al., 2021). Receiving positive feedback and trust from the women they cared for was considered as an important job resource which instilled a feeling of empowerment in new midwives (Barry et al., 2013).

Another factor that helped NQMs cope with their transition, which was highlighted in the studies performed by Cazzini et al. (2022), Saliba (2011) and Sheehy et al. (2021) was that participants who were assigned to work in clinical areas where they previously trained as students adapted faster in their role due to the familiarity with the ward setting and workforce. It also helped them in the steep learning curve and to provide better care to women (Cazzini et al., 2022; Saliba, 2011; Sheehy et al., 2021). Additionally, findings in both Griffith et al. (2019) and Skirton et al. (2012) point out that the structure of clinical placements previously familiar to student midwives directly influence NQMs once they start to work. Hence, being oriented with the clinical setting and equipment (Lennox et al., 2012), whilst being informed about ward/hospital protocols and guidelines, gave NQMs a feeling of security, knowing what is expected of them in the early days of their employment (Avis et al., 2012; Sheehy et al., 2021). Likewise, organisational structures within the hospital helped NQMs to work to the full scope of the midwifery practice (Sheehy et al., 2021).

2.6.3.2 Supervision and Support for NQMs

Studies carried out by Avis et al. (2012), Cazzini et al. (2022), Kool et al. (2020), Saliba (2011) and Wain (2017) show that when NQMs were supervised or assigned to a senior midwife, facilitator or preceptor during duties, NQMs' confidence increased, giving them a sense of security. Participants emphasised that being surrounded by support from colleagues was deemed crucial and helpful (Avis et al., 2012; Cazzini et al., 2022; Kool et al., 2020; Saliba, 2011; Watson and Brown, 2021;). Similarly, the study by Naqshbandi et al. (2019) adds that supportive colleagues help NQMs to adapt faster, have a smooth transition, increase confidence, and make them more likely to retain their profession. This support offered NQMs positive learning experiences in practice (Sheehy et al., 2021; Norris, 2019) and helped with stress and anxiety (Cazzini et al. 2022). Fitting in and feeling accepted and not judged was an inspirational goal for NQMs (Fenwick et al., 2012; Norris, 2019). The NQMs who participated in the studies by Cazzini et al. (2022), Kool et al. (2020) and Sheehy et al. (2021) also expressed that being in the company of colleagues during duties and breaks, team building activities and socialising out of duty hours were all assets in building relationships and enhancing their work practice.

Young et al. (2012) found that NQMs' decision-making skills were developed when they were assigned with another colleague and were given the possibility to speak about their concerns. Moreover, decision-making skills were also improved when senior midwives dedicated time to explain and discuss with NQMs the rationale behind a decision rather than leaving them to fend on their own (Young et al., 2012). Lennox et al. (2012) sustained this in their study after it emerged from their findings that participants stressed the need to be supported by colleagues without their senior counterparts taking

over their work. Senior midwives must become aware that their positive support encourages NQMs to remain in their employment (Nashbandi et al., 2019), especially with the increasing concern of an insufficient number of midwives for future staffing (WHO, 2016).

Apart from being supported, debriefing was also found to be vital for NQMs to survive and move on in their midwifery role (Sheehy et al., 2021). Participants explained that having the space to vent about their experiences and challenges, helped them to relieve their anxiety, learn and progress (Lennox et al., 2012; Sheehy et al., 2021). Furthermore, having a buddy who is going through the same experience also helped in relieving anxiety (Cazzini et al., 2022; Watson & Brown, 2021). Additionally, having the possibility of assigning NQMs to a one-to-one woman care ratio during the first few months of work is deemed to be a beneficial consideration (Wain, 2017). Being placed in a shift that is made up of mixed levels of staffing experience (Sheehy et al., 2021) and being considered as supernumerary (Cazzini et al., 2022; Watson & Brown, 2021) was also seen as an important strategy for learning and safety in practice.

Another factor found to enhance the transition phase of NQMs was having good organisational support, which was shown to be an asset for NQMs. This support translates to having sound preparatory induction programs giving NQMs the opportunity to orient themselves with units and equipment (Lennox et al., 2012), introduction to policies and guidelines (Avis et al., 2012; Sheehy et al., 2021), being assigned to preceptors, having supervision and being assigned over and above the staff requirement of the clinical area (Sheehy et al., 2021; Watson and Brown, 2021). These proved to support NQMs with a smooth transition in the workforce. The organisation should endeavour to support and

empower NQMs to further their studies, as this will allow them to expand their knowledge, stay up to date with the latest evidence-based literature, besides keeping them motivated and giving them a sense of belonging (Kool et al., 2020). Feeling appreciated and being acknowledged by the system as a contributing professional was perceived positively by NQMs (Sheehy et al., 2021).

2.7 Discussion of the Findings in this Integrative Review

The main aim of this review was to explore the available literature about the experiences of NQMs when caring for women in the maternity setting. This review consisted of 22 studies that were utilised to answer three review questions: *What are the experiences and feelings of NQMs when caring for women in the maternity setting? What may influence the NQM experiences on the job? What strategies may enhance the NQM in her new role?* The literature demonstrated how NQMs' wellbeing becomes at stake after registration, as they go through a tumultuous period full of psychological stress, fear and other surges of negative emotions. This difficult period is directly linked to the new responsibilities of the role, especially when it comes to decision-making which may influence their confidence and competency (Kitson-Reynolds et al., 2014). The sudden change of role to a more demanding and responsible one might come to what was explained by Kramer (1974, as cited in Wain, 2017) as a "reality shock" (p. 452), where what is expected and envisioned as students becomes shattered once they join the workforce (Griffiths et al., 2019; Hobbs, 2012; Kitson-Reynolds et al., 2014). Most of the literature reviewed also highlights the transition phase from a student to a midwife.

The findings from the studies included in this IR concur with this three-phase gradual transition where, primarily, participants felt the loss of what was familiar to them;

teachers, school colleagues, mentors and the shelter provided by their university (Kitson-Reynolds et al., 2014), whilst stepping into a whole new world and a role of uncertainty (Avis et al., 2012). This IR also showed the importance for participants to form new and trusting relationships with colleagues and women patients, trying to fit in and carry out the necessary skills needed to perform tasks. Finally, it became evident that as time passed, participants were finally reaching the stage where they wanted to be; "promised land" (Norris et al., 2019, p. 132). At this new phase of adaptation, although still scary and risky, NQMs now feel they have a clearer vision of what is expected of them (Norris et al., 2019) and start to apply all the knowledge already possessed with that which they continue to acquire from their new experiences (Barry et al., 2014). They are ready to let go of what was and try to adapt to their new role and environment as more autonomous midwives (Norris et al., 2019).

In this IR, it was demonstrated that senior midwives play one of the biggest roles in guiding and helping NQMs to succeed (Avis et al., 2012; Kool et al., 2020; Saliba, 2011). When senior midwives were readily available to explain, guide and help without any form of judgement or superiority, this was considered to be the ideal situation for NQMs to learn and advance in their practice (Avis et al., 2012; Clements et al., 2013; Griffith, 2019; Kool et al., 2020; Naqshbandi, 2019; Saliba, 2011). Kitson-Reynolds (2016) and Cazzini et al. (2022) emphasised the importance of giving NQMs time and space for debriefing and considered this as being instrumental for all healthcare professionals. Debriefing should not only be available after an emergency or traumatic experience but for anyone who needs it (Kitson-Reynolds, 2016).

2.8 Conclusion

The literature in this IR shows that NQMs are a precious entity to healthcare as they are the future of midwifery (Barry et al., 2014). However, research on the lived experiences of NQMs is still very limited focusing mostly on the transition to practice and the available supportive programs, such as preceptorship. The reviewed literature has shown that the birthing unit is considered by NQMs to be one of the scariest wards to work in (Avis et al., 2012; Clements et al., 2013; Fenwick et al., 2012; Saliba, 2011; Sheehy et al., 2021). Although the literature reviewed mentions experiences of NQMs in the birthing units, only one of these studies specifically focused on their NQMs' lived experiences while caring for women during labour and birth. The literature shows that the factors that influence NQMs include the working environment, the support given by colleagues and the organisation they are employed with. Transitioning from a student to a midwife brings about certain levels of stress and tension especially when NQMs embark on the role of midwifery, taking full responsibility for the women under their care, knowing that their decisions might have a direct impact on the outcome for women, newborns and families. For this reason, further in-depth studies are deemed of utmost importance to help NQMs to adjust to their new role. Locally to date, no study has explored the lived experiences of NQMs while caring for women during labour and birth. Therefore, this IR shows the importance of exploring the lived experiences of local NQMs as they engage on this new journey. Hence, this study addresses this research gap and seeks to understand and present the meaning of NQMs' lived experiences of caring for women during labour and birth, and to elicit any supportive measures which NQMs would identify that would allow them to better care for women at that stage in their career. The following chapter will explore the methodology used with the rationale behind all

decisions taken throughout the study. It will also include the philosophical framework and theory used to guide this study.

Chapter 3: Research Methodology

3.1 Introduction

This chapter provides a detailed description of the methodology used to conduct this research. The first section of this chapter presents the aims, objectives, research question and operational definitions. The next part describes the rationale for the research approach and research design chosen by explaining the philosophical underpinnings and theoretical framework used to guide the study. This is followed by a full description of how participants were recruited, the method of data collection used, transcribing and the data analysis process. This chapter ends by explaining the steps taken to ensure the trustworthiness of the study as well as highlighting ethical considerations.

3.2 Aim, Objectives and Research Question

The main aim of this study was to elicit and understand the meaning of newly qualified midwives' [NQMs] lived experiences of caring for women during labour and birth. To accomplish this aim, the following objectives were developed:

- To capture newly qualified midwives' lived experiences of caring for women during labour and birth.
- To uncover the meaning of caring for women during labour and birth amongst newly qualified midwives.
- To elicit any supportive measures which newly qualified midwives identify as helpful when caring for women during labour and birth at this initial stage of their career.

The aim and objectives provided the foundation to formulate the research question for this study, which reads: *What are the lived experiences of newly qualified midwives when caring for women during labour and birth?*

3.3 Operational Definitions

The keywords formulated in the research question were analysed to understand their meaning according to the purpose of this study (Cormack, 1996). Therefore, in the context of this study, the term **midwife** is considered to be a newly qualified midwife satisfying the criteria as established by the International Confederation of Midwives [ICM] (ICM, 2017), who has qualified and worked the rotation placement at the Central Delivery Suite [CDS] during the last two years. This **rotation** consists of a two-year period during which all newly employed midwives are expected to work on the different maternity wards for a small period of time, such as a six-month placement. The **lived experience** is defined as one's unfolding experience, caused by both material and social interactions and the physical state at that particular time (Dieumegard, 2019). Therefore, for the purpose of this study, this referred to the lived experience of NQMs during their rotation period at the CDS. The term **caring for women** referred to providing care to all women admitted to CDS from twenty-two weeks gestation to term. **Labour and birth** referred to caring for women who are in labour or giving birth, which included vaginal births, instrumental or operative births and any obstetric emergencies.

3.4 Research Approach

A research approach is established from philosophical worldview assumptions (Creswell & Creswell, 2018). These philosophical worldviews are developed from three components: ontology (reality and the nature of the knowable), epistemology (the

knowledge we have and how this knowledge is gathered) and methodology (the way research is carried out) (Guba, 1990). There are three research approaches based on these philosophical world views; qualitative, quantitative and mixed methods (Creswell, 2014).

A qualitative approach is seen as having a constructivist worldview, which is based on the belief that individuals seek to understand the world in which they live and work, by creating subjective meanings of their experiences towards certain things or objects. In this approach, information is obtained by exploring individuals' experiences, perceptions, intentions, motivations and behaviours (Parahoo, 2006). It investigates how a group of people or one individual relate to a social or personal problem (Creswell, 2014). The main purpose of this approach is to depend on the participants' views on the topic being researched but also to make use of the researchers' background, experiences and knowledge to create meaning and understanding of the data collected (Creswell & Creswell, 2018). Alternatively, the quantitative approach is based on post-positivism, it is based on a reductionistic and deterministic approach used to assess and identify impacts that cause an outcome (Creswell, 2014). It is based on studying the behaviour of individuals numerically by reducing ideas into small sets for testing variables that deal with the research topic and hypothesis (Creswell, 2014). Finally, the mixed-method approach is based on the merging beliefs of positivism (quantitative) and constructivism (qualitative) leading to pragmatic thinking (Moorley & Cathala, 2019). In pragmatism, the focus is on the What and How of the research topic, and evolves from actions, consequences and situations. Contrary to antecedent conditions, it looks at what is working at that time (Creswell & Creswell, 2018). In a mixed-method approach, both qualitative and quantitative data are collected (Creswell & Cresswell, 2018) where both data are equally important to the researcher (Parahoo, 2006). This approach is used so the

researcher can study phenomena from different viewpoints with the help of different research methods allowing the relations and different perspectives of complex research questions to be uncovered and explored (Shorten & Smith, 2017).

According to Creswell (2014), when choosing a research approach, the researcher should not only look at the worldviews, research designs and method but also at the research problem, the targeted population, and the researcher's experience. Hence, in this study, a quantitative approach would have helped to identify certain trends and patterns (Parahoo, 2006) regarding NQMs' experiences at CDS. However, it would have reduced participants' data to percentages and scores for statistical analysis, giving only a glimpse of the phenomena being studied (Weaver & Olsen, 2006) without revealing the true meaning of NQMs' lived experiences. A mixed-method approach gives a clear understanding of what is being studied since the research topic is seen from different viewpoints (Creswell & Creswell, 2018). It would give both quantitative and qualitative findings, having the opportunity to base the data findings on the participants' opinions and have the advantage of being flexible and adaptive to any research design (Wisdom & Creswell, 2013). However, it consists of a laborious approach resulting in a very time-consuming process, being one resource that is not afforded during the compiling of this study. The researcher must also have a deep understanding of different paradigms, approaches, sampling techniques and data analysis methods. Even though it would have been an asset for me as a researcher, to familiarise myself with, and broaden my knowledge on research, giving me exposure to both qualitative and quantitative methods, this approach was not deemed as the right approach for this study since the research question did not consist of both a quantitative and qualitative part. So, the combination of the two approaches in this study was not applicable.

After thoroughly considering these research approaches, a qualitative approach was opted for, as it was deemed to be the most appropriate to explore lived experiences of NQMs as indicated by the aim, objectives and research question set for the study. This approach helped to gain a better understanding of the topic since it allowed me to be part of the population being studied (Creswell, 2014). Hence with this approach, I could explore the beliefs and values of the NQMs, delve into any underlying assumptions and allow the participants to express themselves on the issues which were of great relevance and important to the phenomenon in question (Yauch & Steudal, 2003).

3.5 Research Design

According to Creswell (2013), five research designs can be applied in a qualitative approach, namely: ethnography, grounded theory, case study, narrative research and phenomenology. These designs are quite similar to each other, however, the chosen design depends on the research question, situations or participants being studied, data analysis, interpretation and presentation of results (Astalin, 2013). Ethnography is based on studying the influence of culture on human behaviours, it mostly involves participant observation where the researcher lives among the population being studied (Parahoo, 2006). This design was not considered for this study since NQMs had already gone through the experience and were no longer working in the same ward, therefore, they could not be classified as a culture-sharing group. A grounded theory is an inductive approach where theories and hypotheses emerge from the data itself (Parahoo, 2006). This approach was not deemed appropriate since I was not looking to formulate a theory or hypothesis from the views of the participants, but my main aim was rather to look into NQMs' lived experiences and explore what these experiences mean to them. A case study focuses on a particular event and population that is bounded by time and place (Parahoo,

2006). This approach was not applied since the main focus of this research design is to research a real-life bounded system/s over a set time. Hence, a case study was not a research design of choice since the true research determinant, being the lived experience of NQMs, does not rely on a particular time or case.

Narrative research explores the life of an individual (Creswell, 2013). This type of approach helps the researcher describe and analyse stories and life experiences of an individual or a small group of people. This would have been a good approach if the aim of the research was to focus on the stories of these NQMs throughout their journey from midwifery students to NQMs. However, since I was more interested to elicit the meaning of their experience rather than the story itself, a more appropriate choice for this study was phenomenology. This design is based on an individual's interpretation of lived experiences and the way these experiences are expressed (Parahoo, 2006). The discussion which follows will explore the rationale for choosing this design.

3.6 Philosophical Underpinnings of Phenomenology

Phenomenology was developed in the late nineteenth century and is "derived from the Greek words *Phainoemn* meaning appearance and *logos* meaning reason" (Gearing, 2004, p. 1430). Cluett and Bluff define phenomenology as "A philosophy or research approach that gives meaning to the 'lived' experience of individuals" (Cluett & Bluff, 2006, p. 283). Phenomenology is based on two main approaches; descriptive/Husserlain and interpretive/hermeneutic phenomenology (Cohen & Omery, 1994).

3.6.1 Descriptive / Husserlian Phenomenology

The root of this phenomenology relates to the German philosopher Husserl who had a deep interest in understanding how one gains knowledge and experience and what these mean to the individual (Parahoo, 2006). Husserl's focus was on epistemology, and he described that knowledge was based on experience (Drauker, 1999, as cited in Dibley et al., 2020). He emphasised that empirical science has an objective understanding in research, however, it fails to uncover the true phenomenological meaning of lived experiences. Therefore, his phenomenology underlines the importance of lived experiences since human activities originate and begin with the lived world (Johnson, 2000, as cited in Dibley et al., 2020). Hence, phenomenology contains all aspects of human lived experiences both recognisable and even those hidden from us (Dibley et al., 2020).

To obtain a phenomenological attitude of a lived experience within a philosophical framework, Husserl recommended using "phenomenological reduction, epoche and bracketing" (Stewart & Mickunas, 1990, as cited in Dibley et al., 2020, p. 8). These terms are used interchangeably to describe an approach of understanding and observation, referring to a reflective process where one is expected to put aside their prejudice, understanding and opinion of phenomena and go back to try and look for the meaning itself (Dibley et al., 2020). In summary, descriptive/Husserlian phenomenology is based on nullifying pre-conceived or historical theories by performing bracketing to avoid any influential explanation on the phenomena being studied (Dibley et al., 2020). Nevertheless, many have questioned this Husserlian phenomenology also known as descriptive phenomenology, as one may find it impossible to negate their understanding

of the world and look at situations without any pre-conceived ideas (Heap & Roth, 1973; Koch, 1996, as cited in Dibley et al., 2020).

3.6.2 Interpretive / Hermeneutic Phenomenology

Heidegger was also German and one of the greatest philosophers of the 19th century and was one of Husserl's students (Cluett & Bluff, 2006). His work demonstrates a very unique way of understanding the human lived experience. A number of his philosophical notions are presented in his most renowned publication of 1927 called *Being in Time*. His philosophy has influenced many other key scholars such as Gadamer, who advanced phenomenology into philosophical hermeneutics. Heidegger introduced this ontological turn (Ray, 1994) which looks into "the nature and relations of being" (Dibley et al., 2020, p. 16). He emphasised that one cannot separate or ignore one's experiences and knowledge from the work one is studying. Hence, he explains that bracketing is intrinsically impossible as he looks into "being-in-the-world" (Kearney, 1994, p. 30).

In hermeneutic phenomenology, to understand the deeper meaning of the lived experience, one has to go back and forth, questioning previous knowledge to simultaneously understand the parts as a whole. This is described as the "hermeneutic circle" (Dibley et al., 2020, p. 127). A part of this hermeneutic circle consists of preunderstandings, which consists of three fore-structures that guide the researcher on how to approach the phenomena. The first fore-structure is *fore-having*[1] representing the past, what is already known and brought to the study by the researcher. The second fore-structure is termed as *fore-sight* which refers to the present, how the phenomena is

[1] Words written in italics refer to terms specific to hermeneutic phenomenological notions and terminology congruent with the Bridges transition theory.

approached by the researcher and lastly, *fore-conception* which represents the future, what is expected to be found in the study by the researcher (Crowther, 2021). In this study, it was impossible for me to completely bracket myself from this phenomenon as emphasised by descriptive phenomenology. However, I went into the study with my knowledge (*fore-having*) of being a qualified midwife myself, working at the CDS, always surrounded by NQMs as they embark on this journey and having gone through this experience myself when I too was once a NQM at the CDS. The *fore-sight* is reflected in the way I approached these NQMs, knowing that this experience could either be a positive, gradual, and smooth one, a negative struggle or a mix of both. *Fore-conception* which refers to what was expected to be revealed in the study, guided me on how to carry out and understand this study phenomenon. All the latter helped me to acknowledge that Heidegger's hermeneutic phenomenology was the most applicable method for this study to help answer the research question. This led me to look more deeply into Heidegger's philosophical notions and determine which of these notions were particularly apt in this study.

Heidegger (1927) focuses on "Dasein" (p. 27) meaning *Being-there* as humans. He explains that as humans we are constantly existing in the world in which we are embedded and immersed in the physical tangible day to day lifeworld, hence he created the term *being-in-the-world* (Dibley et al., 2020). It is an involuntary condition of our existence, there is no *Dasein* without a world and no world without *Dasein*, specifying that we are one and the same (Dibley et al., 2020). This was emphasized by Heidegger (1927) who uses hyphens between these words *being-in-the-world* to emphasise that these are inseparable, they are one (Wrathall, 2005). It is important to keep in mind that for Heidegger the term world referred to various aspects such as an environment or a context

(Moran, 2000). In this study, I was concerned with *Being-NQMs*, in their experiences as they cared for women during labour and birth. Another philosophical notion is "thrownness" (Heidegger, 1927, as cited in Horrigan-Kelly et al., 2016, p. 3) and Heidegger explains that, as human beings, we are born into a world with pre-existing values, cultures and norms (Heidegger, 1927, as cited in Horrigan-Kelly et al., 2016). He explains that our behaviour is shaped by environmental factors or life situations that one has no control over and, therefore, there is a lack of authenticity where we are limited by our roles in society (Heidegger, 1927, as cited in, Dibley et al., 2020). NQMs can be considered to be *thrown* into the CDS, where they have to abide by the way it currently operates as an obstetric-led ward having its specific protocols, guidelines, norms and routines, which limit the possibility for midwives to adopt any other model of care in their practice in this specific setting. *Thrownness* is crucial in the understanding of *attunement* which represents another notion that is related to *thrownness*. This is explained as the "attunement to mood" (Heidegger, 1927, as cited in Crowther et al., 2014, p. 21), which comes about from what is *thrown* at us. In these circumstances, this refers to the *mood of the NQMs* as they are placed at the CDS (Crowther et al., 2014).

Another notion particularly applicable to this study relates to Heidegger's *being-in-the-world-with-others* where he speaks of the notion of "solicitude*"* (Heidegger, 1927, translated, 2001, p. 158) referring to the "care" and "concern" (Heidegger, 1927, translated, 2001, p. 158) we have for others (Healy, 2011). He explains that to *care* for others is a way of being connected to others (Schalow, 2013). In this study, the notion relates to the *care* NQMs give women during labour and birth and their *concern* for their ability to provide the best care. Also, *solicitude* is represented in the *care* or *concern* the senior midwives have towards the NQMs. Heidegger (1927) explains that *solicitude* can

be "leaping in*"* (Heidegger, 1927, translated, 2001, p. 158) where one becomes dominated by someone else who takes over the care (Healy, 2011). This is associated with situations where senior midwives take over the care of the mother from the NQMs rather than explaining and guiding them on how to tackle the situation. Alternatively, *solicitude* can be "leaping ahead*"* (Heidegger, 1927, translated, 2001, p. 158) where one is shown their potentiality of how to care (Healy, 2011). This can relate to when NQMs are guided along the way and feel that they are shifting more towards becoming independent practitioners.

The last philosophical notion applied to this study is referred to as "time" (Heidegger, 1927, translated, 2001, p. 47). Heidegger (1927) explains that *time* consists of the past, present, and future. It is not just living in the now but continuously projecting (Dibley et al., 2020). Hence, *time* here is opposed to being a linear measurable and chronological entity (McConnell-Henry et al., 2009). Heidegger (1927) sees *time* as the before and the ahead, believing that what happens in the present was influenced by one's past and will influence one's future, emphasising that the future is based on the *potentiality-for-Being* for one to be existential *for-the-sake-of-oneself*. This correlates with this study as the experiences of NQMs can be affected by past experiences as student midwives and could also affect their future midwifery experiences.

The philosophical notions indicated above, form the basis for the philosophical interpretation of the findings and are further delved into in the discussion chapter.

3.7 Theoretical Framework

Apart from the mentioned philosophical notions used to philosophically interpret the findings of this study, I deemed it necessary to apply a theory to guide the study. As I was attempting to do that, I came across different theories, such as Benner's Novice to Expert model (1984). This model is based on five stages through which individuals journey to acquire and develop skills, including being a "novice, advanced beginner, competent, proficient, and expert" (Thomas & Kellgren, 2017, p. 228). Although I could anticipate that this theory had a lot of similarities to this study, I felt it was not appropriate to apply this model as it would have reflected solely on NQMs' improvement of skills. Moreover, this theory was not deemed appropriate for this study as all NQMs who participated have recently graduated from the UOM and hence considered as competent and accountable professionals. Another theory which I came across was the Weiner's (1974) and Feather's (1982) Attribution theory. This theory is a paradigm of social psychology. These theorists explained that we, as individuals, need to add meaning to our failures and our successes. They explain three factors that an individual goes through to make sense of an experience, including "whether or not the locus is internal or external to them, the degree of stability or instability involved and whether or not they believe that the reason for their success or failure is within or outside their control" (Stockdale et al.,2010, as cited in Bryar & Sinclair, 2011, pp. 104-105). Again, this theory was not applied to this study as the research did not aim to solely look at what was the cause of one's achievements or failures, but to grasp the whole experience of NQMs throughout their journey at the CDS while caring for mothers during labour and birth.

In the end, the Transition Theoretical Framework, developed by William Bridges in 1991, was chosen. The theory was evaluated using Chinn and Kramer's (2004, as cited

in Meleis, 2012) criteria, which included both the Description of the Theory looking into purpose, concepts, definitions, relationships, structure and assumptions, and the Critical Reflection looking into clarity, simplicity, generalisability, accessibility and importance (Meleis, 2012). I believe that Bridges Transition Theoretical Framework (1991) was the most appropriate theory for this study as it focuses on helping people and organisations successfully cope with change. It is based on understanding and differentiating between change and transition (van Ryzin et al., 2011). Bridges and Bridges (2016) describe change as being situational, an event that one has no control over. The term transition falls under a psychological aspect and is based on a three-phase process that one must undergo to come to terms with the new situation (Bridges, 1991, as cited in Bridges & Bridges, 2016). The key importance of this theory for this study lies within the transition process of NQMs from being students to unconfident and insecure NQMs to competent and skilled midwives.

Bridges (1991, as cited in Bridges and Bridges, 2016) emphasise that transition begins with an ending and finishes with a beginning. The first phase is referred to as the "Letting go/Ending/Loosing" (Bridges, 1991, as cited in Bridges & Bridges, 2016, p. 5) phase. This is the ending of a status quo situation, where a person has to let go of the old ways and the old identity (Bridges & Bridges, 2016). In this study, this is the phase where NQMs let go of their student identity, their university years, their lecturers and stop working in the shadows of others. The second phase is known as "The Neutral Zone" (Bridges, 1991, as cited in Bridges and Bridges, 2016, p. 5), also known as the "in-between time" (Bridges, 2003 as cited in van Ryzin, et al., 2011, p. 2268), where the individual starts to accept the ending from the first phase, however, still does not feel comfortable with the new one (van Ryzin et al., 2011). Here the NQMs may start to accept

their new role, however, might still be scared, confused and not confident. Finally, the last phase is known as "The New Beginning" (Bridges, 1991, as cited in Bridges and Bridges, 2016, p. 5) where individuals move on from the transition and create a new beginning, they start to develop their new identity, experience a sense of purpose and experience new energy (Bridges & Bridges, 2016). It is here that NQMs start to accept their new role as fully qualified midwives capable of caring for women in labour and birth, knowing what is expected of them and trying to apply all their knowledge to practice. Therefore, using this theoretical framework has helped to make more sense of the data which emerged from this study and to elicit the meaning of participants' experiences during the time they spent as NQMs on the CDS.

3.8 Inclusion / Exclusion Criteria and Sampling

According to Cluett and Bluff (2006) sampling is a fundamental issue in a study and not choosing the right sample will influence the reliability and validity of that study. Therefore, characteristics, type of population, size, selection and participation rate were all addressed during the recruitment of participants (Cluett & Bluff, 2006). The sampling method is based on the chosen research approach (Cluett & Bluff, 2006). In a hermeneutic study, *Dasein* of all participants is important since the aim is to explore and reveal the meaning of an experience. Therefore, participants who have been subject to the particular experience being studied needed to be recruited to answer the research question (Chun Tie et al., 2019; Creswell, 2013; Dibley et al., 2020). In this study, there was no age limit set for NQMs to be recruited, however, all participants were required to have worked their rotation placement at the CDS during their first two years post-registration. Midwives who had been qualified for more than two years were also excluded so that the participants would have a good recollection and could express their lived experiences. As I was

conducting my interviews, I could feel that participants were vividly narrating their experiences as they were remembering their placement at the CDS. This could be because of the impact the experience had on them, as stated by Smythe (2011). A purposive sampling technique was chosen as the technique of choice, which is synonymous with hermeneutic studies as it allows choosing participants with the characteristics of interest to the study (Chun Tie et al, 2019; Creswell, 2013; Dibley et al., 2020). A total of 10 participants were recruited for this study. Two of these participants were first included in the pilot study and since no changes were needed in the interview schedule, (see Appendix I), for the main study, they were included with the other eight participants recruited for the main study. The number of participants in a qualitative study tends to be small (Cluett & Bluff, 2006). Smythe (2011) explains that the number of participants is also affected by the time available for the study to take place, because of the allocated time needed for the interviews, transcripts and analysis to be done in-depth. Ten participants were recruited for this study, after noting that, although each participant had one's own experience to share, no new issues emerged that added to what had already been found. Hence, it was decided to stop recruiting participants after the 10 conducted interviews. This is accepted in a qualitative study where in-depth data is sought from a small number of participants rather than generalisation of the findings (Vasileiou et al., 2018).

3.9 Data Collection

van Manen (1997) explains three ways of how human science research data could be collected, these include interviewing, observations and writing. The most commonly used method in hermeneutics is open or in-depth interviews (Dibley et al., 2020). Interviews aid the researcher to engage with the participants in a conversation where the

experience of the phenomena can be freely expressed as the interviewer listens in great depth while the participants are allowed to narrate their experiences (Dibley et al., 2020). The interview schedule was self-designed in the English language since all participants were professionals with a good understanding of the language, and with the help of the research supervisor, formulating questions to address the aim and objectives of the study (Appendix I).

Data collection took place between December 2021 and January 2022, after the necessary permissions were granted (Appendix J), and ethics approval from the Faculty of Health Sciences Research Ethics Committee [FREC] was obtained (Appendix K). Participants took part in a one-time, face-to-face interview with me in a private room within the hospital, at a time convenient to them. Each interview lasted between forty-five minutes to an hour. As emphasised by Tod (2010), the choice of the right environment for participants with minimal interruptions makes them feel relaxed to answer. Smith and Osborn (2003) emphasised that data should be gathered through reflection, participation and observation. Therefore, the face-to-face interviews provided the opportunity to acquire both verbal and non-verbal communication alike (Hartas, 2010; Langdridge, 2007). Non-verbal communication such as physical expressions and intonations observed helped to reinforce what was being said by the participants (Flick, 2007). These were jotted down as field notes both during and after each interview not to be forgotten. To be able to transcribe the interviews and to capture the full description of the participants' lived experiences, all interviews were audio-recorded with the consent of participants (Smith & Osborne, 2003). Although this could intimidate the participants, the advantages prevailed over this (Whitehead, 2004), as it would have been difficult to scribe during the interview missing important nuances (Smith & Osborn, 2003). Also, a

reflective journal was kept throughout the journey of this study where notes were jotted down and referred to when needed. This reflective journal was of great importance since I had started to jot down my early thoughts before I had started the study, and I continued to jot them down throughout the end of the study. It helped me to recall certain first impressions I got from participants and any forming ideas that emerged from the data, hence it was a continuous ongoing reflection for me.

3.10 Pilot Study

A pilot study was carried out with two participants who were chosen from the same target population before the main study (Polit & Beck, 2014). Being a novice in interviewing skills, the pilot study was very helpful to develop this skill (van Teijlingen & Hundley, 2001) and to test if the semi-structured schedule truly addressed the research question and also the feasibility of doing this study (Gerrish & Lacey, 2010). The participants in the pilot study were invited to evaluate their participation by answering a few questions on the form provided and giving feedback to determine whether any of the questions asked were unclear (Appendix L). With permission from these two participants, the pilot study was a good opportunity to check the recording device to avoid any faults during the other interviews. The outcome of the pilot interviews was discussed with the research supervisor (Mason, 2002) and no changes in the interview schedule (Appendix I) were deemed necessary for the main study as indicated by the participants' feedback and since the data obtained from the pilot interviews addressed the aim and objectives of the study.

3.11 Data Analysis: van Manen's Six-Step Approach

van Manen, incorporated phenomenology into a methodological approach using a six-step framework which was used in this study throughout the research process including analysis of the data. van Manen (1990) highlights the importance of "turning to a phenomena which seriously interests us and commits us to the world" (p.30). He continues to explain that all research is about "investigating experience as we live it rather than as we conceptualize it" (van Manen, 1990, p. 30). He refers to this as research experience with how it is lived, meaning that even though I am a midwife myself and have had my own experiences as a NQM, I did not let my personal experiences shield me from identifying and understanding the lived experiences of the participants. Rather, I used these thoughts and experiences to try to better understand the meaning of NQMs' lived experiences. The next two steps explained by van Manen (1990) are "reflecting on the essential themes which characterise the phenomenon" (p. 30) and "describing the phenomenon through the art of writing and re-writing" (p. 30). Here, van Manen (1990) asserts that it is difficult to separate writing and reflection as they aim to reveal and discover the essence of lived experiences. This means that until we start to write we are not aware of what we already know (van Manen, 2015).

Another step included "maintaining a strong and oriented pedagogical relation to the phenomenon" (van Manen, 1990, p.31). Here researchers are expected not to take anything for granted, whether opinions, theories or preconceptions, but to stay on track and not deviate from the main objectives of the study (Errasti-Ibarrondo et al., 2019). The final step includes "balancing the research context by considering parts and whole" (van Manen, 1990, p.31) referring to the importance of the text being of high quality to provide a description and revelation of the essence of the phenomenon (Errasti-Ibarrondo et al.,

2019). In the context of this study, all text has been treated with the same importance, whilst seen as a whole to elicit the specific interpretation of all transcribed text (Errasti-Ibarrondo et al., 2019).

This approach was chosen because it goes hand in hand with hermeneutic phenomenology. In a hermeneutic approach, the researcher is seen as an integral tool in the study. Data analysis started before the actual data collection, where notes reflecting my thoughts and preunderstandings of the phenomena were written in a reflexive diary from the beginning of my study (Dibley et al., 2020). These preunderstandings were enhanced when I was interviewed by my supervisor about my lived experience of being a senior midwife and encountering NQMs at the CDS. Heidegger (1995) suggests that by reviewing our own stories as if they were from a participant's point of view, we begin to see how our past experiences, interests, roles, culture and values shape how we experience and understand the world (Smythe, 2011).

Analysis progressed while interviewing participants, where I actively listened to the participants and tried to understand the meaning of what was being said (Cohen et al., 2000). Subsequently, all recorded interviews were transcribed verbatim, also giving attention to non-verbal aspects of communication to elicit a more detailed interpretation. Each transcript was read in detail, notes of what stood out from the text were highlighted and coded (Dibley et al., 2020). I sought to follow the pattern of carrying out an interview, transcribing it, crafting the story, writing the initial analysis and then moving on to the next interview as suggested by Smythe (2011). Transcriptions were done at the earliest possible whilst thoughts were still preserved in memory from the interview.

Once all transcripts were ready, van Manen's (1990) principles of thematic analysis were applied to interpret and analyse all the data. The themes are what constitute the essence of such analysis as it should imply the true meaning of one's experience and, therefore, relaying this meaning to the phenomena (van Manen, 1990). These themes included both explicit themes which were easy to elicit since they included what was immediately demonstrated in the data, and implicit themes which represent what was hidden at first, but which was revealed after reading and re-reading the transcripts (van Manen, 1990). Analysis in hermeneutic phenomenology is a continuous cycle and reflexive process known as the hermeneutic circle, therefore the themes and patterns were formed after going back and forth and reading all transcripts more than once for better understanding (Dibley et al., 2020). Some responses were similar while others were new and not what I anticipated, rather based on the way the participants tackled the questions (Smith & Osborne, 2004). The theme table in Appendix M gives a clear indication of the steps followed using van Manen's (1990) thematic analysis, showing the process from keywords to concepts to subthemes to the themes.

3.12 Trustworthiness of the Study

Morse et al. (2002) explained that without trustworthiness, research becomes fiction, worthless and loses its use. Guba and Lincoln (1980) developed criteria to ensure rigour, which they also termed as trustworthiness in qualitative studies. Trustworthiness includes evaluating the credibility, transferability, dependability and confirmability of the completed research (Guba & Lincoln, 1980).

Credibility, which refers to validity, shows whether the study is represented in a way to confirm the truth (Cluert & Bluff 2006). This was addressed by audio recording

and transcribing all interviews. Additionally, the Jefferson Transcription system (2004) was also used along the transcriptions to give an accurate annotation of the non-verbals within the interviews using specific symbols, as shown in Table 3.1. Moreover, these transcripts were used to present verbatim quotes from participants to support the findings being presented. This helped to show any shared or individual experiences expressed by participants (Dibley et al, 2020). The notion of transferability refers to generalisability. This indicates whether the findings from the study could be applied to other similar contexts (Seale, 1999). The use of transferability in the study was shown by transparency, where a detailed transcription of the demographic characteristics of the selected participants, the procedures used for data collection and analysis and the relationship between the findings and the literature already available, were clearly shown (Dibley et al., 2020).

Table 3.1

Jefferson Transcription System Symbols (2004)

Symbol	Description
Underlined word	The underlined word indicates a raise in volume or emphasis.
(3.0)	A time pause long enough to indicate a pause.
…	Dots imply that a few words were excluded from the data segment.
.	A full stop indicates the finality of the sentence.
((laughter))	A non-verbal activity is enclosed in double brackets.
?	A question mark indicates a question intonation.
!	An exclamation mark indicates an intonation of surprise.
( )	Words in single brackets denote words not spoken but understood by the transcriber as having been implied by the speaker.

Dependability reflects the notion of reliability, referring to the degree to which a study is repeatable (Dibley et al., 2020). Dependability is shown by clearly describing the different stages of the research process by giving an explanation and rationale of why and what was done in the study referred to as an audit trail (Lincoln & Guba, 1985). Reliability was also increased by performing two pilot interviews before commencing the interviews for the main study since this helped with improving my interviewing skills. Audio recording of all interviews also helped to capture intonations and pauses between the participants and the interviewer. Confirmability, which is comparable to objectivity

or neutrality, refers to demonstrating that all findings have emerged from data collected from the participants and not the thoughts of the researcher (Dibley et al., 2020). In this study, a description of the data analysis procedure was given, whilst acknowledging any possible researcher biases. Additionally, to show confirmability of findings, verbatim quotes were used to provide evidence to readers that the interpreted findings were a true reflection of what emerged from the participants. Furthermore, confirmability was enhanced by the use of a reflexive journal throughout the research (Dibley et al., 2020).

3.13 Ethical Considerations

Research aids to guide practice and enhance the wellbeing and health of clients/patients by applying evidence-based practice (Council for Nurses & Midwives [CNM], 2020). However, to carry out research all midwives and nurses/researchers have to adhere to ethical obligations whilst conducting their study (CNM, 2020). The same ethical principles that apply to nurses and midwives in practice, should be applied to research. The International Council of Nurses (1996) outline these six ethical principles to guide both nursing and midwifery research. These include beneficence, which refers to both the participant and the wider community benefitting from the new knowledge obtained during the study (Frith & Draper, 2004), non-maleficence, which implies that the research carried out should not cause any psychological or physical harm to participants of the study (Frith & Draper, 2004), confidentiality, which means that the identity of the participant and the data acquired in the study must be respected and kept confidential at all times (Frith & Draper, 2004), justice, which refers to treating all participants fairly with no preferences (Frith & Draper, 2004), fidelity, which implies that the researcher builds a relationship with the participant based on trust while conducting the study, taking responsibility for the participant's welfare and, therefore, providing

protection from any risk and veracity, which suggests that to have a good bond with the participant the researcher should never trick or deceive the participant and that the researcher should always provide the participant with the necessary information (Frith & Draper, 2004). These six guiding principles represent four human rights; the right not to be harmed, the right of privacy, anonymity and confidentiality, the right of self-determination and the right of full disclosure (Frith & Draper, 2004). These basic ethical principles have been addressed in this study using the following ethical measures and considerations.

As emphasised in the CNM (2020), all the required institutional permissions to be able to carry out this study, were obtained from all authoritative personnel (Appendix J). Ethical approval for the study was gained from FREC (Appendix K). The participants were approached by an intermediary person, who gave her consent for this role as indicated in Appendix N, and provided them with the information letter, explanation and clear details of the study (Appendix O). This made sure that voluntary participation was supported since I did not have any prior contact with the participants until they agreed to meet for data collection. Participation in this study was completely voluntary, and participants were free to accept, refuse or withdraw from the study at any moment without the need to give a reason. A copy of the information letter and consent form (see Appendices O and P) were provided to each participant. Interviews were never carried out at the CDS so as not to disclose participants' identity to other staff members. Before commencing each interview, the participants were asked to sign a consent form (Appendix P), and these were stored safely in a cupboard under lock and key, accessible only to me. Even though participants were aware that they would be audio recorded, permission was sought again before starting the recordings. All participants had the right,

under the General Data Protection Regulation (GDPR) and national legislation, to access, rectify and, where applicable, to request that the data concerning them to be erased.

Throughout the study, confidentiality of the participants was respected (Polit & Beck, 2014). All participants were given pseudonyms before commencing the transcript verbatim. Personal data and codes were stored securely and separately. All the transcripts were done by myself and any information that could reveal one's identity was not included in the reported findings. The data acquired was saved in soft copy in an encrypted format and stored on my personal computer which is password protected. This data was only accessed by myself, while the academic supervisor and examiners could access the coded data only. Confidentiality was maintained throughout the study and all data collected was used solely for the study. The participants' identity and personal information will not be revealed in any publications, reports, presentations or the write up of this dissertation arising from the research. Once the study is completed and the results are published, all personal data will be destroyed, with anonymous data kept for archival purposes.

3.14 Researcher's Reflective Account

Reflexivity is an important process, especially to ensure the trustworthiness of the study (Thomas & Magilvy, 2011). In a hermeneutic study, reflexivity is of greater importance primarily as the researcher partakes in the study with one's own preunderstandings of the phenomenon being researched (Dibley et al., 2020).

The CDS is considered to be a very busy ward, however, the satisfaction that I feel every time I witness the miracle of birth while I assist women in labour is a feeling

which is difficult to put in words. It is because of this that I find it hard to understand why most junior midwives are so scared and do not want to come to work permanently at the CDS. However, before starting my research journey, I needed to first acknowledge my clinical role at the CDS and see how this contributes to this study. Being a senior midwife and a mentor for student midwives at the CDS, I have the opportunity to work with, and witness, NQMs as they go through their six-month rotation. I can also recall my personal experience, having gone through this journey myself when I first graduated as a midwife and had been assigned at the CDS as a NQM as part of the six-month rotation placement. Knowing there was a research gap when it comes to studying the experiences of NQMs in the birthing unit and, especially since no such study has taken place locally, I decided to look into this area.

All of these factors have played a crucial part to form the basis of this research about the NQMs' lived experiences of caring for women during labour and birth. My own experiences of being a student midwife and a qualified midwife in the setting of the CDS helped me better understand NQMs' experiences during the one-to-one interviews and were an asset as I dwelled and analysed the data to interpret the findings. As I carried out each interview, I felt that I could truly understand the needs of the NQMs and what they experienced at the CDS. I was also able to look back into my past and remember my own experiences and get in touch once more with how it had felt at the time to be a NQM at the CDS. I could relate to certain similarities but also could understand that certain experiences of NQMs were caused by the changes brought on over time at the CDS as a ward. One of these changes included the different midwives who presently work at the CDS from when I was a NQM. Listening to all these experiences and reading all the literature on this phenomenon helped me, as a senior midwife, become more aware of

how I should understand, help and guide the NQMs assigned to my shift. It also helped me grow as a mentor and instilled in me the need to help student midwives truly appreciate the beauty of the role of midwife in a birthing unit, perhaps by allowing them to practice more skills keeping in mind Heidegger's philosophical notion of "leaping ahead" as opposed to "leaping in" (Heidegger, 1927, translated, 2001, p. 158).

As a researcher using a hermeneutic phenomenological approach, I know that I am part of the research tool and I have taken this position with full determination. Before I started this study, I kept a personal journal. This journal was my companion throughout this study as I went back and forth through my entries. I felt that this was a crucial move in helping me keep track of the study's progression and to remind me that my interpretation was not based on assumptions but on truly understanding my participants. It also helped me keep a clear mind and maintain my researcher role, especially in light of my current working duties at the CDS. Hence, this journal helped me remain aware of my preconceptions along the research journey.

Another influential event which helped me in this study was participating in the Hermeneutic Phenomenology Methodology course (Appendix Q) (Thomson & Crowther, 2021) conducted by the University of Central Lancashire. Throughout this course, I got to learn and discuss in depth hermeneutic principles with both lecturers who are researchers in the field of hermeneutic phenomenology and other students who, like me, were pursuing postgraduate research using this methodology. This gave me the opportunity to better understand what hermeneutic phenomenology is about and how relevant philosophical notions could be used to interpret my findings.

Moreover, an asset to my preunderstanding of hermeneutic phenomenology was the help of my research supervisor, who is also an expert in this field and who assisted me to undergo a preliminary interview relating to the subject of this study, with her as the interviewer. Being an interviewee helped me better understand how my participants would feel as they are being interviewed. I also had the opportunity to be asked questions about the chosen topic and reflect on my preunderstandings of the research subject. This helped me grasp a better understanding of the lived experiences of NQMs, since I went back to my past experiences, reliving the feelings and emotions I had felt being a NQM. I also had the opportunity to be exposed to many resources such as articles and books focusing on hermeneutic phenomenology, which were provided to me both by my supervisor or through the course I attended. Moreover, there was additional literature that I consulted as my study progressed and this helped me to continue building on what I had already come across.

In conclusion, all of the above factors supported me throughout this research experience. As Heidegger (1962) would term it, I was being *thrown* into this journey as a researcher looking into these lived experiences of these NQMs. Nonetheless, I felt that, as Heidegger (1962) would imply, I was "Being-in-the-world" (p. 137) with these NQMs, my research supervisor, the literature I read and the people I came across during my hermeneutic study. All this went a long way to facilitate understanding, appreciating and interpreting the findings of this study while also allowing me to grow as a researcher and as a senior midwife and mentor.

3.15 Conclusion

This chapter gave a detailed description of the philosophical and theoretical frameworks that guided this study. The approach, design, method and data analysis process utilised for this study were presented and explained in detail. The issues of trustworthiness, together with ethical considerations taken were also described. The next chapter will discuss the findings of this study.

Chapter 4: Results

4.1 Introduction

The findings obtained from the data collected during the one-to-one interviews with the participants of this study, carried out in the English language, are provided in this chapter. The first part of this chapter presents the demographic characteristics of the participants which helps to put the study findings into context. The second part focuses on the participants' experiences, as narrated by them, to elicit and understand the true meaning of newly qualified midwives' [NQMs'] lived experiences of caring for women during labour and birth and delve into what it meant for these participants to go through such experiences. The analysis and interpretation were obtained from the generated data by applying van Manen's (1990) principles of thematic analysis.

4.2 Demographic Characteristics

Ten NQMs employed at the main local public hospital participated in this study. All the participants were given pseudonyms. All NQMs employed by this hospital are assigned to a two-year rotation across different maternity care settings before being deployed in a fixed maternity ward. Therefore, all participants recruited for this study had already completed their six-month placement at the Central Delivery Suite [CDS], as part of their rotation. One of the participants was assigned to CDS during the first six-months of commencing employment, making it her first placement. The other participants had their CDS placements during the middle of their rotation phase (n=7) or in the last part of the rotation (n=2) after being assigned placements to other wards prior to CDS. All participants who participated in this study were between the age of 23 and 26 years old (Appendix R).

4.3 van Manen's Thematic Analysis

A familiar approach to interpreting and synthesising the meanings of a studied phenomenon is thematic analysis (van Manen, 2014). In hermeneutic phenomenology, the interpretation of thematic analysis uncovers knowing under the term *techne*[1] which is based on "the unchanging Being of the changing beings" (Rojcewicz, 2006, p. 61) meaning that a person always has their preunderstanding of the world behind all the varying interpretations of realities (Frede, 2006). This is the process described in hermeneutics where one makes sense and interprets an experience based on their *fore-having* (pre-existing) principles and beliefs of how they perceive the world (Wills, 2001). Hence, in hermeneutic phenomenology the researcher is required to "ek-sist" (Ho et al., 2070, p. 1760), meaning being in the participants' world by dwelling in the participants language (Heidegger, 2008, as cited in Ho et al., 2017) in order to analyse the data. Each participant was interviewed once, and each interview lasted a maximum of one hour. As I tried to interpret the transcribed interviews and crafted stories, I had to reflect and pay attention not just to the spoken words of the NQMs but also delve into the meaning behind any unspoken words (Ho et al., 2017) to truly arrive at the true meaning of the NQMs' lived experiences as they cared for women during labour and birth. As I analysed the transcripts and crafted stories, I moved beyond a descriptive analysis and into an interpretive analysis of the data using van Manen's steps as a guide.

van Manen (1997) describes thematic analysis as "the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work" (p. 78). van Manen (1997) explains that in hermeneutic phenomenology, themes are identified by the researcher by putting into text one's personal embodied

[1] Words written in italics refer to terms specific to hermeneutic phenomenological notions and terminology congruent with the Bridges transition theory.

experiences. Therefore, during the process of identifying, selecting and reporting themes, I tried not to look at the data as objects but instead, I tried to *ek-sist* in the data by dwelling and, therefore, looking at what *Being-a-NQM* meant to these participants (Ho et al., 2017). The following themes emerged from the experiences narrated by the participants together with my preunderstandings of the phenomenon. Therefore, I could not exclude that this is only one way of interpreting the data and that other researchers could interpret the data differently because of their different preunderstandings.

4.4 Emergence of Themes and Subthemes

As I dwelled on the data and reflected, whilst going back and forth through the transcripts and the crafted stories, writing and rewriting to decode the data (Dibley et al., 2020; van Manen, 1990), I started to realise that although each NQM represented their unique lived experiences while working at the CDS and caring for women during labour and birth, their stories revealed common features which were mostly influenced by their characteristics, past working experiences, colleagues they worked with, women they cared for and the midwife role they wanted to grow into. All of this led to the development of two themes and six subthemes as presented in Appendix M and summarised in Tables 4.1 and 4.2. To present the findings in this chapter, direct quotes from the participants were added. For an accurate annotation of the interviews, the Jefferson Transcription system symbols (2004) was used, as applicable, along the direct quotes to reflect particular non-verbal communication during the participants' narrations as previously explained (Section 3.12).

4.5 The First Theme: Baptism of Fire

This first theme *Baptism of Fire* was chosen to reflect the interpretation of Baptism as the beginning of something which therefore reflects the NQMs who are new to the profession and starting their placement at the CDS. Fire represents the challenges, hurdles and impediments NQMs faced once they started their placement at the CDS. These challenges varied from the hectic work environment, their feelings and emotions, and trying to integrate in the team. It also represents how important it was for these NQMs to finish their CDS placement unscathed, hoping that it would turn them into the midwives they aspired to be. The theme *Baptism of Fire* emerged from three subthemes; *Challenging Environment*, *Feelings of a Junior Midwife*, and *Trying to Fit In*.

Table 4.1

First Theme: Baptism of Fire

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"It is a very busy environment when compared to the wards for example there is not much of a routine. At Central Delivery Suite you never know if you are going to start the day at 7, or later on. Because, ehm, you might have a mother coming at the beginning of your shift, or she comes in later. So, the routine is very different. Sometimes, you might even not have time to have a break not like maybe in other wards. So ehm even mentally it is quite exhausting as well." (Ana, p. 3-4)	Busy ward	Demanding ward environment	Challenging Environment	**Baptism of Fire**
	The place with the highest expectations			
	Bad connotations about ward	Mentally/ Physically Exhausting		
	Unpredictable Ward Events			
	Learning while working			
"…we do our deliveries in our third year and we have a whole two months practising our deliveries. In our fourth year, we didn't have any placements at the Central Delivery Suite so we didn't have any deliveries. I mean we practised skills because we were practising for our finals, but we weren't practising as many skills as if we were doing the deliveries. Then I had another year to go to Central Delivery Suite so I was quite a bit in shock that I would, ehm, forget some skills or for example when performing a vaginal examination, that I wouldn't do it right and obviously if another person examines (the woman) after me that it would be a whole, ehm, different findings…" (Olivia, p. 18)	Lost touch	Feelings of Incompetence	Feelings of a Junior Midwife	
	Lost practice			
	Feel alone	Feeling Stranded		
	Feel lost			
	Feel overwhelmed			
	Fear of the unknown	Always on Edge		
	Fear of failing			
	Putting oneself down / not worthy of Profession			
	Whole responsibility on your shoulder	Realities of Becoming a Midwife		
	Not reaching expectations			
	Difficult to adapt to change			
	Giving best care to the mother			
"We try to avoid maybe speaking about sometimes other junior midwives. At times I've heard things about junior midwives who are my friends. And I say "if she found out, if she hears what they are saying about her" and then thinking at the same time I wonder what they say about me (uncomfortable giggle) and the same time you feel, ehm, that type of fear. And it does affect you mentally and how you work with mothers because if you don't feel comfortable with the staff, you fear that they might say something about you. Because without wanting to, you doubt yourself and you don't give your 100 percent to the mothers you are caring for. Because you're constantly with that doubt "Am I doing this right? Or am I not? Are they going to say something if I do this and not that?" That constant feeling you know what I mean? That if they talk something about you. (Ana, p. 43)	Being the outsider	Team Inclusion	Trying to Fit in	
	Going with the current			
	Working against the current			
	Caught in the middle			
	Choosing your people			
	Belittled	Superior and Dominating Personalities		
	Feel let down			
	Working under pressure			
	Victim of gossip			
	Facing traumatic experiences and not understood			
	Staff don't remember they were in the same boat			

4.5.1 Challenging Environment

The subtheme *Challenging Environment* encompasses how the CDS was seen by the participants as the most challenging ward among all the other maternity wards, not only because of the demanding environment but, most of all, due to uncertainties that may arise unexpectedly from day-to-day.

> *"… it keeps you a bit on edge, a bit tense, not knowing what to expect, because as you know CDS it's all about the unexpected so you don't know what you are going to face when you go in… you can have ambulance calls, you can have patients who come in who are about literally about to push the baby out. You can have patients who unfortunately have their baby died in utero so, it's not always like a pretty picture every day… and even if you have the smoothest labour sometimes problems can arise during the second stage, even during the third stage sometimes."* (Maggie, pp. 5-7)

All of these uncertainties left NQMs feeling continuously on their toes, waiting to react at the moment according to what happens at the CDS. However, knowing that they had to be ready for the unexpected, caused them even more stress and challenges, especially knowing that they are now seen as fully qualified midwives in the eyes of their colleagues. They feared that they wouldn't be able to live up to the expectations of being a qualified midwife and, therefore, would be seen as untrustworthy and incompetent. Having just started their placement at the CDS, they felt that they lacked the experience and know-how of the ward, whilst at times they had to learn a skill on the spot, even if it was during an emergency. *"…there are times that the first time you need to perform a skill is in an emergency..."* (Scarlet, p. 21). These situations made them feel as if they were snowed under, taking a toll on their psychological and personal wellbeing. They felt both emotionally and mentally exhausted, which often affected the way they related with their family members at home. Consequently, participants expressed that they were glad

when the six-month rotation placement at the CDS was over, since they needed a break from all the challenges that they encountered.

> *"I ended up going home crying that I've done something wrong (looks very sad) ... I also asked my relatives what they thought, for me it was the time that I was exhausted the most when going home, and they (her family) always said that it was during the rotation at CDS that I always went exhausted at home."* (Olivia p. 7, p. 15)

NQMs felt as if they were going through a vicious cycle, where they spent their off time continuously thinking about any possible mistakes done during their duties, whilst reflecting on criticism received from their colleagues. This meant that their work was constantly on their minds, making them more exhausted, dreading their next duty.

> *"I think it's because of remembering the feelings… of going back from work thinking about everything. "Did I do everything?" "Did I do everything right?" "Did I cater to all the mothers' needs?" "Did I forget something?" ((as she says it her voice takes on a higher pitch and her words are faster as if showing how she used to feel))… So, my work-life balance wasn't that good ((laughs)) and it was very stressful ((in a lowered voice))… it was that feeling of going back home and still not being able to put work aside. I don't think it's good to live like that ((laughs nervously))."* (Nina, p. 25-26)

4.5.2 Feelings of a Junior Midwife

This subtheme *Feelings of a Junior midwife* represents the feelings of someone who is still new on a particular journey. Although participants knew that they had the knowledge and competency from their studies and clinical experiences they had obtained during their student clinical placements, they felt inexperienced at the beginning of their placement at the CDS in comparison to the other midwives. They realised that they have now left the protection status of being students and are now fully accountable midwives, shouldering responsibility for the mother and newborn during labour and birth. They feared letting go of who they were and moving on to who they can become. NQMs felt

that assisting a birth is something very delicate involving two human beings. Therefore, even though they knew that their pre-registration course had been preparing them for this and that they had reached competency level on registration for them to have qualified, being fully responsible made them worry as they lacked the confidence to perform certain skills or make decisions that would directly affect the mother and newborn.

NQMs believed that they were expected to perform skills they had not practised for a long time, at times up to three years from their last CDS placement, which was when they were student midwives in their third year of training. This meant that they were left to make hard decisions without being allowed a period to find their feet first and get comfortable being hands-on again. It didn't make a difference to participants whether it was the first or last placement of their rotation period; they still went through a reality shock, longing for similar support. They confessed that although other maternity wards had their share of demands, these were incomparable to what they felt when constantly assisting mothers through labour and birth or dealing with life-threatening obstetric emergencies at the CDS. NQMs considered that to work at the CDS, it is imperative to know how to perform several skills. They felt that they needed the know-how of detecting deviations from the norm, whilst acting accordingly even under emergency pressure, which they lacked due to experiencing minimal exposure to the ward environment and complications once they had started their employment.

At the beginning of their placement, NQMs felt lost, alone and overwhelmed and these feelings were heightened when they didn't find the support they needed to succeed.

> *"Most of the midwives take care of junior midwives very well because they support you, they help you out, they teach you. But then you find other midwives that sort*

> *of, ehm, do not bother basically and leave you up to it. And I think that is the most stressful part of it. That having a senior midwife with you or an in-charge leaving you alone. It's like moving around without support. Having no legs and moving around without support, I usually feel like this when I am not supported."* (Ella, p. 12-13)

This overwhelming reality made them feel as if they were on the edge of a cliff, where the slightest mishap will make them lose balance and topple over. This feeling was at worst even when they experienced minor deviations from the norm, like a deceleration on a cardiotography [CTG]. Participants panicked about what might go wrong and whether they would be able to handle it. The constant fear of the unknown overwhelmed the NQMs, making them constantly worried that they would fail the mother under their care and the shift they were assigned to. This constant battle of failure was also a personal and internal struggle for the NQMs, questioning their proficiency and their decision to choose this profession. These feelings reflect experiences of being heavily criticised, expected to overperform with minimal guidance and the lack of performance appraisal.

> *"Although I did have another rotator who I could speak to, and we could share our experiences with each other. Sometimes it's good to have, you know, maybe a senior midwife or someone who has been working there a long time, to tell you that you're doing well. It makes you feel a bit better. I think there needs to be those words of encouragement as well that I felt were very lacking… there should be those positive affirmations… I think though it is because of the environment (CDS), it's a bit more stressful when we want to get everything right because the area is more intense. But there needs to be more support."* (Ana, p. 46-47)

NQMs constantly felt as if they needed to wear a brave face and perform at all costs because that is what was expected from a registered midwife. This performance consisted of an act that they had to uphold in front of doctors, especially during a ward round, knowing that doctors knew about them being NQMs. They pretended to overshadow their inexperience behind that brave face, to avoid a scene of embarrassment from being a junior midwife. There were times when NQMs mentally memorised the

details on the mother's co-operation card, just in case they were asked something by the doctor and were unable to answer back correctly or feared a mistake. This brave face is projected once more in front of colleagues, such as during handovers, at the beginning and end of duties, knowing that they have a panel of colleagues ready to criticise them in front of everyone, at the slightest mistake.

> *"I went home lots of times and I cried, or I went in the treatment room and I cried, especially if maybe a doctor or even midwives shouted at me or if I felt like overwhelmed. Like I still remember this, but even giving over on that desk waiting for someone to shout at me ((shows great sadness)). That is how I used to feel with certain head of shifts. I used to say "Oh my god it's that shift, I have to give over. Let me check that everything is perfect because I know that I am going to hear a complaint or something, <u>in front of everyone</u>."* (Dorothy, p. 5-6)

This lack of support led to NQMs feeling let down in different ways, such as not finding the appropriate help needed as juniors. This is a representation of midwives who forgot their roots, of what it felt like starting one's journey as a NQM at the CDS, or when doctors started their journey in the medical field, surpassing hurdles until they achieved the confidence they now possess.

4.5.3 Trying to Fit in

One of the worst fears for NQMs was undoubtedly not fitting in or not being accepted by colleagues. They viewed themselves as being outsiders, a rotator who leaves CDS after six-months. They felt as if they had to prove themselves over and over again to win the team's acceptance. They faced this constant internal battle of not just wanting to prove to themselves they were able to carry out their tasks but, also to prove themselves to their colleagues by showing them they were capable to do what they were asked. However, at times they felt that their efforts were not enough, and they encountered resistance from their colleagues that hindered them from performing well in their job.

NQMs felt they could not work efficiently and how they wanted, when they were pressured by colleagues. At times NQMs were expected to carry out tasks differently from the way they were taught. Other times they were pressured to transfer women immediately after birth, at times even less than an hour from when mothers had given birth. This meant that they were caught between two worlds; one of being the midwife they aspired to be and swimming against the current and the other of just swimming along with the current and being accepted by colleagues.

> *"… There's a lot of pressure from colleagues to transfer the mother to the postnatal ward as quickly as possible. I feel that this is unfair, you know? You need to give that time for the mother and the father to get used to the baby. That first hour after birth is very important ((makes emphasis on this point)). However, I feel there were a lot of pressures to transfer the mother very quickly, even sometimes when we weren't busy… Sometimes you feel like you even need to lie to the mother because you need to transfer her to the other ward because of pressures from other staff. Not because necessarily they would need the room."* (Ana, p. 20-23)

NQMs were mostly scared of going against the current and being the main focus of gossip. They were conscious of being the subject of talk and always under the spotlight and this had a direct influence on their work performance. They also felt scared of being belittled because of their actions and of being scolded in front of the parents. To NQMs, this meant that they were judged by the parents as someone who cannot be trusted and green in her job during such a delicate event. When NQMs faced a traumatic experience, they felt misunderstood, brushed off and shown a lack of empathy from their colleagues. NQMs were experiencing such trauma for the first time and, dealing with the feelings that such experiences brought about, was new to them.

4.6 The Second Theme: Containing the Fire

This theme is a representation of when NQMs start to manage to contain and suppress the Fire that was overpowering and preventing them from moving forward in their transition from a junior to a confident midwife with more experience. The Fire in this theme reflects all the difficulties, obstacles and fears they faced in the first theme *Baptism of Fire*. NQMs finally realise that since they had passed from their pre-registration midwifery course and given their registration, they had the knowledge and competencies needed to fulfil the requirements of a midwife. Participants also realise that the CDS is an important ward after all in their journey to become the midwife they aspired to be and things start to fall into place. The Fire represented in this theme can be suppressed and contained with all the supportive measures needed by NQMs to ease into this transition. This theme was derived from three subthemes: *Of the Essence*, *Better with Time* and *An Eased Transition*.

Table 4.2

Second Theme: Containing the Fire

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"You'll do a lot of skills in a short period of time for example, I don't know during labour you do a lot of skills so VEs, catheters if you need. In other wards, for example, VEs you don't do a lot of them, maybe in antenatal mothers when you need to. But at labour ward you do them a lot even multiple times during the day. So, I think if you learn that skill it will stay with you. And even if you need to do a VE in another ward, if you worked at CDS I think it would help to do them more comfortable in other wards, rather than just not doing them at all and then you have to do them in other wards." (Rose, p. 21)	It is the heart of midwifery	True Meaning of Midwifery	Of the Essence	**Containing the Fire**
	Individualised one-to-one care			
	Steppingstone to grow as a midwife	Learning and Growing Environment		
	Missed/Gained opportunities			
"The very first delivery I was so focussed on making sure that I'm doing everything right, when you are not that confident that building the relationship with the mother, unfortunately, wasn't my top priority. At times doing a delivery, you feel very connected and emotional. In the very first delivery I didn't feel that because I was so focussed on the birth… So, I think that the emotional and social aspect (of birth) was a bit low on that side so I wouldn't say that it was one of the best. But then after 3 months in my rotation, I felt more confident. I also had some of these complications where I felt that I am capable of handling things independently more. Then I started getting more confident with the work (not only look at the mechanism of birth but notice that dealing with a woman) and even the emotional aspect of bonding with the mother increased." (Lucy, p. 8-9)	Applying knowledge and practice	Things Falling into Place	Better With Time	
	Learning by doing			
	Taking a stand/believing in self	Growing as a Midwife		
	Relationship with mothers			
	Feel accomplished and proud of self			
"There needs to be this more supportive environment for us NQMs. And we have to keep in mind that everyone progresses at different paces as well, because it doesn't mean that every midwife get used to the delivery suite in 3 months, that everyone is going to adapt like that. Everyone is different and everyone learns and gets used to things differently, there are some who take longer to get there." (Ana, p. 45)	Guidance	Supportive Measures	An Eased Transition	
	Reassurance			
	Given feedback			
	Given space to reflect / vent			
	Support system			
	Gain trust and respect	Colleagues' Support		
	Allowed to fly and not be grounded			
	Not compared to others			
	Welcomed			
	Comfort from peers			
	More time in ward	Environment Support		
	Simulations			
	Ward orientation			
	Structured plan			
	Weaned into it			

4.6.1 Of the Essence

Even though being assigned at the CDS was a reality shock for participants, all of them knew the importance of this placement. For NQMs the CDS meant the essence of midwifery; they believed that it was the steppingstone to truly growing into the role. They knew that the CDS is packed with experiences they could only encounter as midwives during this sole placement. Working at the CDS meant that they were able to continuously practise several skills, most of which had never been practiced during their student clinical placements. Ultimately, they realised that certain aspects of the job are learnt through practice and not from books, and started looking at the CDS as an environment of learning and growth.

> *"I think overall I left Central Delivery Suite feeling more confident as a midwife and I could see myself growing. I think that was the main place where I felt myself grow as a midwife. You feel as I am learning more here, it's not that in other places (wards) you don't learn but it is one of the main places (CDS) where you feel like I am doing the job of a midwife and I am learning more. That was mainly it."* (Dorothy, p. 3-4)

All the patient cases NQMs experienced were seen as gained opportunities, whilst feeling that they would have missed out on opportunities had they not been exposed to them. The CDS also provided them with the opportunity of building a trusting relationship and caring for mothers holistically, having the possibility of providing individualised care. NQMs realised that experiences learnt at the CDS eventually made them better midwives in other maternity wards, as they were prepared for most situations that deviated from the norm.

> *"Sometimes when I look back I say, "you know, if I went through that I will manage to go through everything ((laughs))."* (Scarlet, p. 5)

4.6.2 Better with Time

As NQMs worked more and more duties, they noticed that things were starting to fall into place. They started to gain practical experience and were able to integrate the knowledge learned with practicality into their day-to-day practice. They started to choose the colleagues who could help them and eventually started to feel more comfortable with both staff and ward setting. This reduced their feeling of panic and helped them focus more clearly on their tasks, enabling them to learn in the process. When participants were asked about their initial birth experiences, only two midwives were able to go back and even mention their first birth while the rest could not remember their initial births.

> *"The first two or three deliveries that I encountered I was more on edge. Because, I had to be quick with the things that I need to do."* (Ana, p. 13)

The placement was such a stressful experience for them, that this was perhaps why NQMs could not remember their initial deliveries. This was pointed out by Lucy who explained that during the first few births she assisted, she could not provide holistic care at the time as she was only able to concentrate on doing the tasks right. As time went by and started to gain more experience, she realised the appreciation of being with women in labour and building strong relationships with the couples as they embarked on their journey to parenthood. Once NQMs felt more confident, and were able to take a stand and practice what they believed to be the best care for the mothers and babies, they felt more accomplished as midwives.

> *"I felt quite accomplished and I felt proud of myself that I managed to at least save the mother's perineum, and achieve this in my experience."* (Emma, p. 6)

4.6.3 An Eased Transition

All participants expressed that it would have been nice to be welcomed by colleagues on their first day at work. NQMs expressed that they felt lost and did not know where they could find, and how to use, certain equipment, so they expressed that having an orientation of the ward on their first day would have been an asset for them to familiarise themselves with equipment storage, use of instruments and local ward guidelines/policies. They emphasised that this could have helped them feel less lost and more able to function smoothly within the ward environment, especially during an emergency.

> *"Having someone welcome you ((laughs)) and even explain where the stuff is. Going in the nursery and telling you "Listen here is the stuff that you need, this is the cupboard ((laughs)) that you need to open and get the stuff from" ((laughs)), you know? Because everywhere is different. You'd know where everything is in most delivery rooms, but I think, for example, the nursery you'd have no idea. Even having a welcome ((laughs)) will help."* (Scarlet, p. 18-19)

Participants did not want to be compared with other rotators as they felt that everyone adapts and reacts differently to situations, where one might need more time than another to settle down. Some of the participants felt that having a peer helped them psychologically knowing that they can share similar experiences between them and feel understood. Unlike their senior counterparts who, at times, seemed to have forgotten their beginnings and be less emphatic towards NQMs.

> *"... but I felt like there was everyone at the desk and I am here like having this major issue, <u>like come on!</u> I mean and these are people who are not only my colleagues but my friends, "come help me!" you know? "You don't remember the days when you were like me?" ((laughs as if to hide the betrayal she felt at that moment)).* (Dorothy, p. 14)

Participants had varying opinions on what could have facilitated their rotation placement at the CDS as NQMs, however, common features emerged among the ten participating midwives. All participants mentioned that they wished to be assigned to someone during the beginning of their placement, such as a mentor, preceptor or a senior midwife, and be gradually allowed to work independently. They felt that this could have helped them be less stressed and scared, whilst adjusting better and learning more.

> *"I think having one person to refer to, ehm, would be helpful in the beginning particularly."* (Emma, p. 16)

Participants felt that if they were assigned to someone, they could have been better supported and guided whilst caring for women during labour and birth. Moreover, they acknowledged that the person they were assigned to could prevent them from doing mistakes, which would have made them feel safer during their practice.

> *"Like for example inserting a cannula, rather than trying it out and not having someone there to tell you "Listen, I wouldn't choose this vein because I think there is a valve." These things you get with experience, so I think it would be much better if there was someone there directly with me showing me around and being with me to help and guide me throughout the day. I don't know if that's too much to ask ((laughs))."* (Lucy, p. 29-30)

NQMs also expressed that having colleagues who encourage and reassure them in their practice or praise their accomplishments would have helped them perform better and work harder to keep on learning and succeeding. They continuously felt criticised, no matter what they did. Participants felt that they needed a safe space to reflect on their experiences at the CDS and to vent about their feelings. Whenever they had a traumatic experience, such as having an intrauterine death [IUD] or a cord prolapse, they felt that they were not supported and understood by their colleagues. They did not have anyone to

speak to which, they felt, made it worse. NQMs expressed that a simple courtesy of asking them how they were doing or reassuring them that they are on the right path was also seen as a helpful characteristic. Providing feedback to NQMs from mentors or head of shifts would simply help them to know which aspects of care needed to be improved.

> *"I think other staff need to be more understanding, that you're coming to something so new, that you haven't done deliveries in a long time, ehm, so definitely one needs support… most of the time I had to ask for reassurance… So I think the fact that maybe the seniors ask you "Listen are you okay? How are you doing?" It makes a big difference and maybe even towards the end of the rotation they (managers/head of shift) ask you "Is there anything we can improve on?" Because I think the problem with our department is that we get stuck and we don't ask and reflect, so yes, I think that is something we could do." (Referring to head of shifts and charge midwives at the CDS)."* (Dorothy, pp. 32-33)

Participants expressed that even though they needed guidance, they also wanted to be trusted and left to work autonomously at times, especially when the task being performed posed no potential risks to the woman or her infant. They felt that this would help them feel more autonomous and thrive more, knowing that their ideas were supported by their colleagues.

> *"So maybe at first, okay, they shadow you and they teach you, but then towards the end if you're doing well… they shouldn't keep influencing their way of working on yours… towards the end of the rotation you expect that you are respected a bit more, in a way like your own autonomy. You are an autonomous midwife and that's your way..."* (Lucy, p. 27-28)

Finally, participants felt that they could not reach their full expectations as midwives at the CDS; they expressed the need to have longer rotation periods. The six-months stipulated time frame at the CDS was seen as a very limited period, where once the NQM started to feel that they are reaching the climax of their experience they had to

move to a different maternity setting. This situation left them unsatisfied with their experience, yearning for more time to increase their learning curve.

> *"I would say that I needed a bit more time, I think six-months it's not enough, you need at least nine months if not a year. Because the first three months it's running in, that's what I felt it was. So by the end, you know, you start feeling to be more confident and you really start enjoying the work, way after three months in my personal experience."* (Lucy, p. 14)

4.7 Conclusion

This chapter included the findings and their interpretations from the ten NQMs who participated in this study. Two themes emerged from several subthemes, those being *Baptism of Fire* and *Containing the Fire*. The first theme comprises how NQMs were constantly on their toes during their rotation placement at the CDS, afraid of all the uncertainties and challenges they were faced with there. It represents all the emotions NQMs went through which were heightened when they did not find the support they needed from other colleagues since they felt that they had the competency but lacked the experience and were scared that they could not provide the woman and baby with the best care. NQMs constantly tried their best to be accepted and form part of the team they worked with. At times, they also felt caught between doing what is right or going with the current to feel accepted by others. The second theme represents the moment when NQMs realised that working at the CDS will help them grow and learn as midwives. As time passed, NQMs felt that they were fitting in, they knew which colleagues were there to help and understood more about what was expected of them. It also shows that being assigned to a colleague at the beginning of their rotation placement, feeling welcomed and having someone who would give them feedback would have helped during this rotation period.

The following chapter will discuss these findings in relation to the relevant previous literature, the theoretical framework chosen for this study and the relevant hermeneutic notions which were identified in the previous chapter.

Chapter 5: Discussion

5.1 Introduction

This chapter discusses the findings presented in the previous chapter in relation to relevant literature, the chosen Bridges transition theoretical framework (1991) and pertinent hermeneutic philosophical notions. After analysing the findings of this study using van Manen's (1990) thematic analysis, two themes and their corresponding subthemes emerged. As I correlated these themes together with the literature previously presented in the integrative review [IR], I divided this discussion into three subheadings. These subheadings include *The Birthing Unit*, *The Midwives' Journey* and *Needs to Succeed*. The first part of the discussion focuses on the hermeneutic philosophical notions and the Bridges transition theory (1991) as considered relevant to this discussion. These are then explained in more detail throughout the discussion in the different subheadings. Finally, this chapter presents the strengths and limitations of this study.

5.2 The Hermeneutic Philosophical Notions and Bridges Transition Theory

Heidegger's phenomenology is based on the interpretation, also referred to as the art of the understanding of the "meaning of being*"* (Crowther & Thomson, 2020, p. 1). It puts forward various philosophical underpinnings which include concepts of being, being in the world, being with, encounters with entities in the world, spatiality, temporality and the care structure (Horrigan-Kelly et al., 2016). From these underpinnings, five hermeneutic philosophical notions, as put forth by Heidegger (1927), have been identified and seen as the most relevant to help interpret and better understand the findings of this study concerning the lived experiences of *Being-NQMs*. These chosen notions include

Dasein[1]*, thrownness, attunement to mood, solicitude* and *time*. Each of these notions were introduced in the third chapter of this work and will be further discussed in the relevant sections below.

In addition to these notions, the Bridges transition theoretical framework (1991) also aided in the interpretation of the findings. The transition theoretical framework was developed by William Bridges in the year 1991 and it aimed to help organisations and people manage change (van Ryzin et al., 2011). This theory of transition is based on a three-phase process that one goes through as one adapts to change (van Ryzin et al., 2011). Bridges' transition theory (1991) starts by first ending something and finishes by beginning the next. The three phases of this process are named *Endings/Losing/Letting Go, The Neutral Zone* and *The New Beginning* (Bridges, 1990, as cited in Leybourne, 2016). All the mentioned hermeneutic notions, including the theoretical framework, are integrated and discussed throughout the discussion of the study findings in this chapter.

5.3 The Birthing Unit

In this section, the findings of the study about how NQMs perceive the birthing unit as registered midwives, are discussed. Locally, the main birthing unit where most of the local births occur, is the Central Delivery Suite [CDS] which is found within Mater Dei Hospital [MDH], the local general hospital, and follows an obstetric-led care setting.

5.3.1 Challenging Environment

All participants of this study perceived the CDS as a scary and challenging environment even before embarking on their rotation in this ward. Before commencing

[1] Words written in italics refer to terms specific to hermeneutic phenomenological notions and terminology congruent with the Bridges transition theory.

the actual work experience at the CDS, some of the participants dreaded this journey, whilst others experienced anxiety and stress. One of the main reasons for these feelings was that participants constantly felt afraid of the frequent situations that create uncertainties in the birthing unit and their capabilities to match these unparalleled daunting situations, in addition to the unit's demands when compared to the other maternity wards. The findings of this study showed that when NQMs compared working at the CDS to other critical clinical areas, like the neonatal paediatric intensive care unit [NPICU], they still considered the CDS as more challenging. The findings showed that in terms of feelings they felt, no maternity ward could be compared to when they assisted a mother through labour and birth or when they had to face life-threatening obstetric emergencies.

Such findings can be compared to those found in Clements et al. (2013) who similarly found that NQMs also felt the birthing units to be the scariest wards to work in during their transition from students to qualified midwives. Clements et al. (2013) had similar findings to this study since it was the only existing study found that looked at the experiences of participants working in birth settings such as hospital-based wards and continuity of midwifery care models. This study showed that the participants who worked at a hospital-based birthing unit felt it scary and challenging compared to those who assisted women in labour in the continuity of midwifery care models. However, Clements et al.'s (2013) study's main focus was still to look into the transition from student midwives to midwives and formed part of a larger study that wanted to describe midwives' experiences and expectations of their transition to practice. Similar to the findings of this study, Avis et al. (2012), Fenwick et al. (2012) and Sheehy et al. (2021) also found that NQMs feared and perceived birthing units to be the most challenging of

all the maternity wards during their transition from students to qualified midwives. Avis et al. (2012), Fenwick et al. (2012) and Sheehy et al. (2021) were all qualitative studies, the aim of which was to look into the experiences of NQMs as they transitioned from students to midwives. Although these studies did not solely focus on birthing units, but merely on their transition experience from student midwives to midwives, the chosen methodology still managed to elicit such feelings and emotions from the participants regarding the birthing units.

However, contrary to the findings that emerged from this study, some of the participants in Kitson-Reynolds et al. (2014) felt that other maternity wards were more stressful than birthing units. This was noted when these participants had to endure the sole responsibility of about 25 to 30 mothers and their babies in a high-risk maternity ward, which was ultimately a contributing factor to burnout and stress for those shouldering such responsibility. This was probably not determined in the findings of this study since NQMs were never the only midwife on duty while working in other maternity wards, and therefore had help and guidance from other colleagues during their duties. Nonetheless, both high risk antenatal and postpartum women are cared for only at the CDS or the general Intensive Therapy Unit [ITU] since there are no other high risk maternity wards at MDH. Therefore, the experience of NQMs in Kitson-Reynolds et al. (2014) is based on different maternity care settings and not solely on that of the delivery unit, as in the current study, and so a comparison of the findings across the two studies needs to be done with caution.

5.3.2 Different Periods of Placements

The participants of this study were placed at the CDS at different intervals of their rotation, being either their first, middle or last placement during their two-year rotation period. No matter the time frame in which they were placed at the CDS, all the participants pointed out that they still felt scared and needed help. Findings showed that the CDS is a ward with a steep learning curve and, as a beginner, one is subject to rapid and intensified learning of skills, sometimes ones that they would not have encountered yet. This is another potential reason why NQMs perceived the CDS as the most challenging ward since they had to continuously learn skills while caring for women in labour and birth. Findings from this study showed that NQMs who were not placed at the CDS as their first rotation placement could focus more on the skills that are practised at the CDS. They felt that working in the other wards helped them practice basic clinical skills such as parameters, drug administration, caring for women and babies' well-being and other administrative tasks such as documentation charts and writing reports.

Similarly, Kool et al. (2020) and Sheehy et al. (2021) found that having to learn so many things at once is a leading contributor to increased stress when participants were transitioning from student midwives to registered midwives. However, even participants who were previously nurses before graduating as registered midwives such as in studies by Griffith et al. (2019), Simane-Netshisaulu and Maputle (2021), Win (2017) and Davies et al. (2012), still found maternity wards as challenging and scary to work in. Moreover, the participants in the studies by Griffith et al. (2019), Win (2017) and Davies et al. (2012) still managed to accumulate a certain degree of clinical knowledge from their previous nursing experience, to better manage and consolidate certain skills during their placements.

In hermeneutic phenomenology, Heidegger (1927, as cited in Horrigan-Kelly et al. 2016; Thomson, 2011) speaks of *thrownness* as a simple feature of *Dasein* that is, *Being-there* where we human beings are born into a world with pre-existing values, hence humans are continuously being *thrown* into a world with its own culture and history. Heidegger (1927, as cited in Dibley et al. 2020) explains that, as individuals, we have no control over our life situations and environmental factors which limit our roles in society and so our behaviours are being shaped as a consequence of these factors and situations.

In every individual's life, one is continuously embarking on a journey, or as Heidegger would put it as being *thrown* into a new journey, the same happens to NQMs when they get on board their midwifery journey. This philosophical notion applies to this study, particularly since NQMs can be viewed as having been *thrown* into the CDS as part of NQMs' rotation placement owning only their preunderstandings from a previous CDS placement, which occurred when they were still student midwives. The findings of this study showed how participants were *thrown* into the CDS, a maternity ward with its own culture and history, based on an obstetric-led care setting with pre-established norms, values and practices already practised by in-house healthcare professionals. This *thrownness* was continuously repeated during each duty; NQMs were continuously being *thrown* into different challenging situations where they were required to care for mothers with different needs and conditions, whilst expected to act accordingly and deal ad hoc with situations at hand.

The mentioned notion of *thrownness* can also be integrated with Bridges transition theory (1991). Bridges (1991, as cited in Bridges & Bridges, 2016) refers to change as being situational which happens whether or not the individual has any control over it or

even agrees with it. The first phase of Bridges transition theoretical framework *Endings/Losing/Letting Go* (Bridges, 1991) integrates well with the notion of *thrownness*. NQMs were *thrown* into the CDS without having any control over this change as per hospital protocol for all recruited midwives. Therefore, even though NQMs were scared of working at the CDS they had to let go of their previous role; that of a student midwife. Thus, letting go of being a student for the first time in their life, especially if the CDS was their first placement, and find their way whilst refraining from working under the shadow of other midwives and start to take responsibility for the women under their care. Otherwise, they let go of the comfort and familiarity they had obtained in other maternity wards during previous placements in their rotation period and embrace this new placement at the CDS.

5.3.3 Adapting to the Ward Environment

Findings of this study showed that as time passed and participants started to adapt to the CDS, they felt extremely satisfied and fulfilled since they could provide more in terms of woman-centred care during labour and birth. NQMs felt that since they were mostly assigned to one mother at a time providing individualised care, they felt that the CDS was the only ward where they could truly experience a special relationship with the mother or couple they cared for. This represents the third phase of Bridges transition theory, referred to as *The New Beginning* which involves new values, understandings, attitudes and feeling a sense of purpose (Bridges, 1991, as cited in Bridges & Bridges, 2016). In this regard, findings revealed that NQMs considered assisting and being part of the birth of a child as a very emotional and rewarding life-changing situation that, they felt, could not be experienced in other maternity wards. This could be because they felt that in other obstetric wards they had to care for more women and babies at any one time,

thus limiting the time they could allocate to care for each woman and baby. Therefore, how NQMs perceived the CDS started to change as time passed and they felt that the CDS was the ward that gave them the most satisfaction which they yearned for. Participants viewed the CDS as the ward which presented them with the best opportunity to build a trusting relationship and care for mothers holistically.

This conflicts with Griffiths et al. (2019) who found that NQMs who worked in a hospital-based maternity setting showed a heightening concern regarding continuity of care. Having had the experience of caseload midwifery as students, participants felt that they could not provide women with continuity of care when they were employed in a hospital-based setting. Such findings emerged in Griffiths et al.'s (2019) study where the participants had the experience of caseload midwifery during their student years and could, therefore, compare working in a hospital setting versus caseload practice, as opposed to the participants of this study who only had experience in the local hospital, even as students. Hence, the findings between these two studies could not be compared.

Moreover, the last phase of Bridges' transition theory; *The New Beginning* (Bridges, 1991), came up in this study when participants were finalising the six-months placement period. NQMs became aware of the importance of working at the CDS, describing it as a steppingstone to becoming a real midwife. The CDS provided NQMs with learning opportunities and helped them grow in their profession to become better midwives in any of the maternity settings in their midwifery journey. Some participants added that although they had worked in other ward settings, they felt that they truly became a midwife after their CDS placement. This finding has not emerged from reviewed literature, possibly because earlier studies looked into the experiences of the

transition from student midwives to NQMs and not the actual experiences of NQMs as they cared for women during labour and birth. Hence, such findings can be considered as insight which fill a research gap and add to the existing body of knowledge pertaining to the study phenomenon.

5.4 The Midwives' Journey

This section looks into, and discusses, the findings related to the feelings, emotions and experiences NQMs go through when they care for women in labour and birth. This is of utmost importance since labour and birth do not only exert an emotional impact on the parents, who are eagerly awaiting the birth of their child, but also on the midwife who is caring for and assisting the couple (Mander, 2001).

5.4.1 The Past, Present and Future

The findings of this study showed that fear and anxiety were not only a reflection of the present but also a result of NQMs' past experiences at the CDS when they were still student midwives. Those participants who perceived the latter as a negative experience were scared that history would repeat itself and that they would eventually go through another bad experience at the CDS. This led them to start their placement at the CDS already scared of what they will have to face and how they will be welcomed by colleagues. This was a unique finding since no reviewed literature included how personal experiences of NQMs were influenced by their student experiences. However, Cazzini et al. (2022), Saliba (2011) and Sheehy et al. (2021) mentioned participants being employed in the same ward as when they were students, and how they adjusted better knowing what is expected of them and being familiar with the ward layout. The findings that emerged from all other reviewed literature could not be compared to the findings of this study,

since the samples of each study included participants who had either undergone their courses in different universities, had had student clinical placements in different hospitals or communities or had worked in hospitals or communities where they had never worked before. This as opposed to our small island where the midwifery course is only offered by the University of Malta and all students carry out most clinical placements at MDH and some might also have the opportunity to work for a short period abroad on the Erasmus programme. Therefore, this finding could be considered unique to this study since the experiences of NQMs during their student clinical placement affected their experience at the CDS during their rotation placement.

The past experiences NQMs expressed can be integrated into the philosophical notion of *time* explained by Heidegger (1927, translated, 2001, p. 47) as a person's present being influenced by their past and the future being influenced by their present and past experiences. In this context, *time* is not a chronological linear measurable unit (Mc Connell-Henry et al., 2009) but becomes the before and the ahead of one's journey (Heidegger, 1927, translated, 2001). Another representation of this philosophical notion is reflected in another unique finding which transpired from this study. NQMs' narratives revealed that their experiences during their CDS placement will be eternally imprinted on their midwifery career and will affect their decision on whether to go back to work at the CDS or not, clearly indicating that their experience at CDS impacts their future as midwives.

This is a distinctive finding as the CDS sees the majority of births happening in the Maltese Islands. This puts local midwives at a disadvantage due to very limited working experiences, especially with birthing units. Therefore, these findings show how

the career of NQMs could be affected if they choose not to go back to the CDS due to having had a negative experience at the main birthing unit. Hence, NQMs would remain with no alternative if they wish to work in an environment where they can assist women in labour and birth, unless they decide to work abroad. Contrary to this, Clements et al. (2013) found that participants who had a bad experience in the birthing units in the hospital setting decided to change employment and work in maternity settings with continuous midwifery care models, where they still could assist women in labour and birth.

5.4.2 Emotional Turmoil

This study showed other findings which further explained why NQMs felt afraid. These mostly relate to being responsible for the women's and babies' life, fearing causing them unintentional harm, making wrong decisions, not being able to react in an obstetric emergency, not giving the best care they could give to the mother or couple for a positive birthing experience, being continuously watched and criticised by colleagues, letting colleagues down and the fear of the unknown. Participants were always on edge, afraid of what might happen no matter how smooth labour and birth might be. They continuously feared a situation where, in a split second, something would go haphazardly wrong and they would not be capable to deal with the situation, thus jeopardising both the life of the mother and the baby under their care.

Lovecraft (1927, as cited in Carleton, 2015) explained that "the oldest and strongest emotion of mankind is fear, and the oldest and strongest kind of fear is fear of the unknown" (p. 5). Hence, when a person lacks vital information, has no control or lacks insight into what the future offers, this contributes to a major cause of anxiety

(Carleton, 2015). Similar findings were found in the study carried out by Dahlen and Caplice (2014) which looked into midwives' greatest fears when caring for women during birth, which included the death of a mother and baby, missing something that causes harm, and fear of the unknown. This showed that certain fears remain throughout a midwife's journey since the sample of participants in the study of Dahlen and Caplice (2014) included 667 midwives with different years of experience.

Participants in the current study were so scared and anxious in the early days of working at the CDS, that almost all of them could not recall the memory of their initial birth experiences, stating that they had been mostly focused on the skills and the right outcome of the event, rather than providing holistic care to the mother. This was another unique finding which showed that, at times, fear impeded NQMs from thinking clearly and working to their full potential to provide the best care they can. This study also showed that stress endured by NQMs was not only experienced at work but that, most of the time, this continued when at home. In turn, this proved to exert a negative impact on the personal life and well-being of NQMs, feeling as if they were trapped in a cage without an escape route from their work-related worries, making them dread their next duty. Similarly, Kitson-Reynolds et al. (2014), Kool et al. (2020) and Norris (2019) all delved into this matter, acknowledging that their participants all expressed their concern about taking work-related fears, feelings and emotions back home, taking a toll on their well-being and personal life which, in turn, negatively impacted their activities of daily living, including sleeping patterns.

Heidegger (1927, as cited in Crowther et al., 2014) speaks about the philosophical notion of *attunement to mood* where the *mood* one is in is based on one's feelings, which

are brought to them from *being-in-the-world*. This reflects how one adapts and deals with their own *mood* in the world they are being *thrown* into (Healy, 2007). In this study, the *mood of fear* is represented by NQMs' experiences once they commenced their CDS placement, when they suddenly realised the reality of what it truly means to be a midwife. Similarly, Kennedy and Shannon (2004) found that fear experienced by midwives while caring for women during labour and birth was mirrored in their care, impeding them from effectively working to the best of their abilities and negatively impacting the process of birth. The quality and outcome of childbirth are highly dependent on the midwife and many contributing factors may inhibit the midwife from effectively performing her role (Halldorsdottir & Kalrlsdottir, 1996; Walsh, 1999).

Another finding that emerged from this study showed that, apart from fear, the NQMs also experienced feeling lost, alone and overwhelmed. They explained that these feelings were heightened when they did not find the help and support they needed. NQMs started to realise that, as registered midwives, they are now accountable and responsible for their decision-making. Analysis of the findings revealed that, although NQMs were eager not to remain students and to assume their new role as midwives, with all the responsibility that comes with it, they found the process quite difficult with many stumbling blocks. This sudden reality shock prevented them from working to their full potential. This was a massive worry for participants knowing that in their junior state, they felt they lacked the confidence to perform certain skills, let alone take crucial decisions which may negatively influence the care given to the mother and her newborn. Participants stated that they were scared to make certain decisions fearing any legal issues which may arise if they unintentionally err out of their lack of experience, hence questioning their worth as registered midwives.

Similarly, Sheehy et al. (2021) found that NQMs described the role of being a midwife as a very intense and emotionally demanding job, also pointing out that the situation worsened when participants did not find the right support from colleagues, which proved to negatively affect their role as a NQM. Furthermore, Lennox et al. (2012) found that participants felt helpless in the early days of their role enrolment as they did not have the understanding nor the experience to perform their role effectively and efficiently. Congruently, Barry et al. (2013) found that due to the surge of emotions, NQMs felt they were "letting women down" (p. 1354), believing they were not providing women with the necessary support, standard of care and attention they had envisioned. Moreover, Clements et al. (2013) found that feelings of incompetence and lack of self-confidence had an increased influence on the stress levels of NQMs, causing a psychological impact on them since they had become the sole-accountable person for the mother and baby under their care. Most were afraid to assume this newly acquired responsibility out of fear of doing an aggravated mistake which costs them their midwifery licence (Clements et al., 2013). Kramer (1974, as cited in Wain, 2017) was the first to describe that NQMs fitting in their new role equalled going through a "Reality Shock" (p. 452), explaining it as the physical, social and emotional response one has to endure with the reality of their work.

5.4.3 Lack of Self-Confidence

Findings from this study showed that increased insecurities with regards to decision-making were mostly highlighted during skills such as vaginal examinations [VEs] and cardiotocography [CTG], where interpretation of findings may vary from person to person. Most of the time, participants felt scared to disclose VE findings, knowing that they might be interpreted differently by other midwives or doctors and

tended to panic when a CTG showed deviation from the norm. They worried that they lacked the experience to perform skills and procedures up to standard, and act accordingly during a life-threatening situation or obstetric emergency. All this is congruent with the second phase of Bridges transition theory referred to as *The Neutral Zone* which is the in-between zone where even though one did let go of the past, this new zone is still not fully functioning, being the most critical part related to their psychological aspect (Bridges, 1991, as cited in Bridges & Bridges, 2016). Likewise, studies by Hobbs (2012) and Kool et al. (2020) found that NQMs found it difficult to adapt and feel confident with certain midwifery skills most commonly practised during labour and birth which are considered very subjective to interpretation by different individuals.

Participants in this study stressed the fact that, as student midwives, they had to content themselves with being in the shadow of their allocated senior midwife, the one who makes all the decisions, and could only perform the few tasks instructed to them. These past experiences of not being left to carry out certain tasks while they were still student midwives affected them as NQMs when caring for women during labour and birth, since they felt that they had lacked the chance to make certain decisions, perform certain skills or tasks as students which could have prepared them more. However, two participants mentioned they were guided during their student years and allowed to participate more in the care of women in labour and birth, which resulted in a better experience at the CDS. This strengthens the findings that NQMs experiences are impacted by their past experiences as student midwives in relation to Heidegger's (1927, translated, 2001) notion of *time*.

The latter findings that emerged from this study led to the interpretation using another Heideggerian philosophical notion, that of *solicitude* (Heidegger 1927, translated,

2001) explained as *being-with-one-another*, referring to *concern* or *care* one displays for another. The findings of this study look into three aspects of *solicitude*; the *NQM-being-with-the-woman* during labour and birth, *midwifery staff/mentors-being-with-student-midwives* and *midwifery staff/supervisory staff-being-with-NQMs*. Heidegger (1927, translated, 2001) refers to two extremes of *solicitude*, one being *leaping in* and the other *leaping ahead*. The concept of *leaping in* is explained as an individual taking a dominant stance and completely taking over the task, role or situation, leaving the other person in a state of dependency and undermined, while the concept of *leaping ahead* is explained as one giving support to another according to their needs (Heidegger, 1927, translated, 2001).

The concern or lack of concern midwives show towards NQMs during their student years or their CDS placement as NQMs, emerged from the findings. In this study, the concept of *leaping in* relates to instances where NQMs were hardly allowed to take responsibility or make decisions for mothers under their care together with their allocated mentor / senior midwife when they were still student midwives. When the allocated mentor / senior midwives are the ones who completely assume the sole responsibility of the mother under their care, constraining their mentees from participating in the care of the mother, it backfired on NQMs when they were placed at the CDS during their rotation as they felt unprepared and lacking the confidence to perform midwifery skills, make sound decisions, and assume full responsibility of the mother during labour and birth. Hence, participants tended to end up in search of others to fulfil their roles and feel dependent on other midwives to complete tasks and make decisions, especially during obstetric emergencies.

This corresponds with the studies of Clements et al. (2013) and Skirton et al. (2012) who found that, when the participants were student midwives, they were oblivious of the level of responsibility they had to shoulder when they would become NQMs, specifically because when they were students, they lacked the opportunity of experiencing the effects of being responsible and making decisions which, in turn, impacted their experiences as NQMs.

Moreover, during their rotation at the CDS, participants felt intruded on and unable to provide their best care based on the latest evidence-based research, when their senior counterparts objected to their new practices, even though they risked no harm to the mother or her infant. This also represents the notion of *leaping in* where even though NQMs were no longer students but their colleagues, senior midwives were still resistant to any form of change and maintained the status quo, hence taking over the situation at hand and pushing the NQMs away, so they could resume with their agendas and beliefs. It was seen as essential by the participants that they be allowed some form of autonomy during practice and apply their recently learned evidence-based practice as this enhanced self-confidence and motivation.

5.4.4 The Much-Needed Support

Findings showed that participants felt better when they found the right colleague to help them. They felt safer and learnt more when they had a senior midwife just present in the room showing support and guiding them as needed. Heidegger (Heidegger, 1927, translated, 2001) refers to this as *leaping ahead*. Hence, contrary to what happens in a situation where the senior midwives take over, when the concept of *leaping ahead* is applied, the midwifery staff or mentors act as guides and teachers to assist NQMs in

reaching their full potential. Lennox et al. (2012) and Young et al. (2012) found that NQMs' decision-making skills had significantly improved when their senior counterparts dedicated time to explain the rationale behind their decisions rather than taking over without any guidance. This finding has emerged from these two studies with the help of their methodological approach. In the mixed study by Lennox et al. (2012), three interviews were carried out with each participant for the qualitative part of the study, hence, findings represented the experiences of NQMs throughout the different stages of their transition from student midwives to midwives. The study by Young et al. (2012) was a qualitative study using an ethnographic approach and it collected data using a form of triangulation which included focus groups, interviews and observations. Therefore, the researchers could also comprehend how decision making was improved when senior counterparts truly helped and guided NQMs.

Since participants in this study were still rotators at the CDS, and not permanent staff, they were constantly afraid of not being able to fit in, in turn taking a step back rather than voicing their thoughts out of fear of being the subject of humiliation or gossip. They also refrained from asking for support and guidance from their shift colleagues or senior midwives, not wanting to feel like a burden on others or incompetent and intimidated. This study showed how NQMs felt caught up in a tug-of-war battle between doing what they thought is morally, ethically and duty-bound right or else flowing with the current. This exerted more pressure on NQMs, making them feel guilty about their ability to provide the best care for women under their care. This reflects that NQMs were still in the second phase of William Bridges' (1991) transition theory; *The Neutral Zone,* where NQMs were in the process of trying to fit in and feel accepted by members of the staff. They continuously searched for the right reference person willing to guide them

without seeing them as a burden or nuisance. NQMs felt the need to voice their concerns with their colleagues about working under pressure, that they were not feeling supported and they needed to be given some form of autonomy, but still held back and felt scared to voice these thoughts.

Likewise, in their studies, Kool et al. (2020), Norris (2019), Skirton et al. (2012) and Wain (2017) have all presented similar NQMs' predicaments of wanting to ask for assistance and guidance from more experienced staff but fearing being seen as a nuisance, incompetent and ending up losing colleagues' trust. Similarly, Sheehy et al. (2021) found that NQMs felt a sense of dilemma when they wanted to pursue their own way but, instead, were forced to do another, feeling a sense of guilt when they could not stand up for the mother. Skirton et al. (2012), van der Putten (2008) and Watson and Brown (2021) found that such a situation impeded NQMs from performing to their full potential and prevented them from giving proper women-centred care.

The findings of this study also conveyed that participants felt that during their six-month placement at the CDS they constantly tried to prove their worth and earn the trust of their colleagues. NQMs expressed that they disliked doing ward rounds in the presence of doctors and giving handovers in front of their peers. These insights could not be compared to other literature since the process of handing over at the beginning or the end of each duty, at the station in front of all other midwives, was not discussed in any of the reviewed studies. This could probably be due to the different methods of how handover is carried out in different maternity wards or maternity settings.

This study also showed cases where NQMs felt belittled when shouted at or scolded in front of the couple, bearing the humiliation of facing a mother who would think less of them. Participants who experienced feeling unworthy and belittled regretfully expressed their intentions of not going back to CDS after their rotation period. Congruently, Sheehy et al. (2021) found that participants felt humiliated, demotivated and demoralised when bullied by other healthcare professionals, especially in front of the couple. Lennox et al. (2012) found that feeling belittled in the workplace is mainly due to a hierarchical organisational system that tolerates a system of staff ranking and seniority, leaving the NQMs at the bottom of this ranking. This situation can be worsened when dealing with autocratic personalities who normally take charge of situations according to their own beliefs without letting others express their ideas (Fenwick et al., 2012; Lennox et al., 2012; Watson & Brown, 2021). This is not a new phenomenon, and its effects are well documented in the literature showing the negative impact it exerts on the personal well-being of NQMs and their performance in carrying out the job (Keeling et al., 2006). Keeling et al. (2006) found that feelings of belittlement and unworthiness at the workplace lead to long-term physical and psychological ailments for the person being bullied, but it also has a domino effect on performance outcomes and job satisfaction which may harm the organisation in the long term.

Finally, participants in this study found themselves dealing with challenging situations which, because they were juniors, made them feel not competent or confident enough to tackle. These can be scenarios that are quite challenging for senior midwives let alone to NQMs, such as caring for women who had gone through an intrauterine death experience [IUD] or a life-threatening emergency such as cord prolapse. NQMs felt a lack of empathy and understanding from their shift colleagues when dealing with such cases,

especially when considering they were aware that NQMs were new to this sort of reality which is psychologically demanding. This can also be considered a new insight which adds to the existing knowledge of the study phenomenon. This emerged since this study took an in-depth stance, specifically looking at the experiences of NQMs as they care for women during labour and birth. Another finding was that at times, participants even made comparisons between themselves and other NQMs fearing that they are lagging behind and not reaching their goals. Trying to live up to staff expectations increased the build-up of pressure and stress. They constantly felt as if they were not contributing enough to the workforce or giving their best care to the mothers as they continuously felt let down and never appraised, but were rather ordered around and corrected for their mistakes. Similarly, Clements et al. (2013), Griffith (2019) and Norris (2019) acknowledge in their studies that NQMs had to endure the constant challenge of being accepted by their shift colleagues, knowing that they were being watched relentlessly and ready to be judged by peers if they cross the path of the norm. However, in comparison, Barry et al. (2013) and Cazzini et al. (2022) found that when NQMs were given the right support, encouragement and empowerment they succeeded more and became more motivated.

5.4.5 Embracing the Role of the Midwife

Findings from this study showed that NQMs finally managed to move out of the transition and, though there were still challenges ahead, they had understood their purpose in their new role and knew what was expected of them. NQMs were now used to who were the individuals they could turn to for support and even managed to bridge and apply theoretical and practical knowledge to function more effectively in their role. This represents the last phase *The New Beginning* from Bridges' transition theory (Bridges, 1991, as cited in Bridges & Bridges, 2016) which represents a person forming his or her

new identity, involving new values, understandings and attitudes, and feeling a sense of purpose (Bridges and Bridges, 2016). Therefore, during this phase, NQMs finally saw themselves as true midwives at the CDS who managed to grow in their role and are readily able to apply their midwifery skills as needed, even in other maternity settings. The study findings also portrayed the sense of accomplishment of participants when they started to believe in themselves and stand up for their beliefs over time.

Bridges (1991, as cited in Bridges & Bridges, 2016) also speaks about transition which he defines as our psychological and emotional response to change. This theory looks at how every individual comes to terms with this change on a psychological and emotional level to adapt and move forward. One has to keep in mind that transition can be either positive, therefore evoking psychological growth, or negative, leading to psychological deterioration (Marks, 2007; Moose, 1976). However, the findings of this study showed that transition can be a mixture of both. The CDS proved to be a challenging aspect for NQMs as they were in the second phase of Bridges' transition theory, *The Neutral Zone*. NQMs felt lost and did not fully understand what is truly expected of them, in a very complex and dynamic ward environment. Moreover, undergoing such transformation commonly comes at a price, and for NQMs this was aggravated when they carried their work-related problems into their personal life, drastically affecting their well-being and leading to psychological deterioration.

However, participants also acknowledged the importance of working at the CDS, knowing that this is a crucial placement to shape them and make them grow into the midwives they aspired to be. This represents the positive experiences from Bridges' transition theory (1991) which led NQMs to psychological growth. This is a key part

where NQMs did not lose hope and continued to get accustomed to these changes, find support and guidance from colleagues who coached them in order to prevent them from exceeding the threshold of anxiety and stress levels which would have made them disinterested, demotivated or even renouncing the newly acquired job. Bridges and Bridges (2016) emphasise that "people's anxiety rises and their motivation falls. They feel disoriented and self-doubting. They are resentful and self-protective. Energy is drained away from work into coping tactics" (p. 46).

5.5 Needs to Succeed

This section discusses what NQMs felt they needed during their rotation placement to make the experience easier. Participants were asked to recall their first duties at the CDS and mention what they would have needed to make this experience a better one. Most of their needs were similar, however, there were some differences according to the shift they were assigned to.

5.5.1 Orientation to Ward

Findings showed that NQMs needed to feel welcomed and accepted by ward staff and provided with an orientation of the ward setting. This would have helped them settle better in the ward and level down their anxiety and the feeling-lost factor. They acknowledged that, even though they already had a placement at the CDS a few years before when they were still student midwives, they still needed to be reoriented with the ward environment and in-house procedures and guidelines. NQMs felt that this would have helped them feel more secure and confident to work in the ward. Similarly, Avis et al. (2012), Lennox et al. (2012) and Sheehy et al. (2021) also found that NQMs needed

to be properly orientated to the ward setting, location and use of equipment, whilst also getting familiarised with ward guidelines and protocols.

5.5.2 Being Assigned to a Facilitator

All participants in this study mentioned they felt the need to be assigned to someone, either a senior colleague or an assigned preceptor/mentor for some time when they started working at the CDS. This would have eased their transition during their second phase represented in Bridges' transition theory as *The Neutral Zone* (Bridges, 1991 as cited in Bridges & Bridges, 2016) during which participants would have someone to refer to in challenging times and to guide them in the right direction as in Heidegger's (1927) notion of *leaping ahead*, as they gain experience. This would have also ensured that NQMs would not have gotten caught between dividing opinions among colleagues and reaching out to that one role-model for advice. Participants in this study also emphasised the importance of building good relationships with their shift colleagues. Some of them had the misfortune of being mistreated by some of their colleagues, resulting in the placement turning into a negative experience. Being surrounded by supportive staff who were readily available to build a good rapport with NQMs, gave them a sense of confidence and security. Other studies have also found that being assigned to someone with supervisory roles helped to give NQMs a sense of security and increased their confidence (Avis et al., 2012; Kool et al., 2020; Saliba, 2011; Wain, 2017). One has to note that in all of the three studies by Avis et al. (2012), Kool et al. (2020) and Wain (2017), the data findings were congruent with the research aim of looking at NQMs' experiences when assigned to someone with a supervisory role. The study of Wain (2017) specifically looked into the experiences of NQMs who were assigned to a preceptor. The participants of Avis et al. (2012) were all part of a Midwives in Teaching [MINT]

induction programme, hence, were assigned to a supervisor, while the study of Kool et al. (2020) looked into the job satisfaction of NQMs by looking into the job resources offered to the participants and how they perceived their transition. Avis et al. (2012), Kool et al. (2020) and Saliba (2011) also found that NQMs need to find readily helpful colleagues as this, in turn, showed drastic increases in the levels of confidence and satisfaction among participants. Moreover, Cazzini et al. (2022), Naqshbandi et al. (2019), Norris (2019) and Sheehy et al. (2021) found that having supportive colleagues also helped NQMs to adapt faster, making their transition easier and resulting in a more positive learning experience.

5.5.3 Space for Reflection

This study showed that participants felt alone and craved someone to understand them, they recalled being very keen on having some attention and time for debriefing and reflection. This would have given them the possibility to speak and vent their thoughts and emotions with someone willing to listen to them, understand them, give them time to reflect on these experiences and eventually give them feedback and guidance on their ordeals. This was mostly accentuated in a situation described by participants where they underwent a stressful or psychologically challenging experience and they felt they needed someone to vent their emotions with rather than suppress them as, in the long term, it led to burnout, stress and frustration. Not having the space and time assigned for debriefing and reflection could have been the result of why NQMs felt a sense of relief when they finished their CDS placement. Participants in this study also expressed the need to have a break from the CDS as they felt that the experience was so overwhelming that it had exceeded their psychological and emotional limitations, taking a toll on their personal lives, and left them exhausted and burnt out. Doherty and O'Brien (2022) looked into

factors that drive burnout among midwives and found that the dynamics of colleague relationships was one of the key factors impacting burnout levels, together with the ward setting environment. Similar to the findings of this study, Doherty and O'Brien (2022) also elicited that another important element for increased burnout among midwives, especially those who work within a birthing unit, is a lack of debriefing and reflection. According to Borritz et al. (2006), midwives compared to other healthcare professionals internationally, tend to experience the highest levels of burnout. Hence it is notable that giving participants space to vent helps to relieve anxiety, learn and move on in their midwifery role (Lennox et al., 2012; Sheehy et al., 2021).

5.5.4 Longer Rotation Period

On the other hand, though participants in this study felt more comfortable and confident by the end of their six-month placement at the CDS, they still acknowledged that the timeframe is very limited to make the most of this placement. They would have liked longer periods to strengthen their knowledge and make the most out of the learning experiences that come by only at the delivery suite. Moreover, they realised that with a longer placement at the CDS they would have felt more confident and competent in providing effective woman-centred care. This showed that NQMs had reached the last phase of Bridges' transition theory (1991) known as *The New Beginning*. It was at this time that NQMs felt that they could start to truly move on and apply previous knowledge to their lived experiences. Similarly, this is also supported by Wain (2017) who found that NQMs expressed the need for more time in clinical areas, especially birthing units, to acquire knowledge and strengthen their confidence and be exposed to more experiences. In comparison, Avis et al. (2012) found that when NQMs worked on a rotation basis it felt as if they were on a "roller coaster ride" (p. 5). However, some of

these participants' rotation placements included visiting different wards during every shift and not having a fixed rotation period. Kool et al. (2020) found that NQMs felt insecure about having to impress their colleagues in a very limited time. Additionally, Sheehy et al. (2021) found that rotation also brought about instability in NQMs' confidence.

5.6 Strengths and Limitations of the Study

5.6.1 Strengths

The study adopted a qualitative approach where in-depth data was sought and generalisability was not intended. However, since details relating to the research process, the context of the study and the characteristics of the participants were provided throughout this work, it is possible that the findings may be transferable to other similar settings with participants having comparable characteristics. In hermeneutic phenomenology it is important to have a preunderstanding of the phenomenon being studied. Being a midwife myself at the CDS and having already gone through the experience of being a NQM and also being a mentor to NQMs helped me better understand the lived experiences of the participants in this study. Hence, I was not just an interviewer in this study but a researcher being part of the tool myself having the know-how on the phenomena. All participants willingly accepted to participate in the study and were, therefore, readily available to express their experiences. Before interviewing the main participants, I carried out a pilot study on two participants which helped to determine that the questions being asked were understandable as intended. After transcribing both pilot study interviews, I analysed them to see that the findings and interpretations were in line with the aim and objectives of this study. These were also discussed with my research supervisor. The two participants of the pilot study were also asked to give feedback on

the interview so that any necessary amendments could be done before the main data collection. The pilot study also helped me to practice my interviewing skills and to test the technology I was using for recordings. Furthermore, the interview itself was seen by NQMs as a means to voice and reflect on one's experiences, as acknowledged by them at the end of each interview. Participants were allowed flexibility and could convey their opinions and thoughts freely based on their lived experiences, hence adding to the quality of data collected.

The study looked specifically at the experiences of NQMs when they were assigned to the CDS to care for women during labour and birth. Therefore, all participants expressed their views on a similar experience based on one birthing unit, rather than comparing different lived experiences from the different maternity settings, which could have consequently produced different findings, whilst not reaching the main aim of this research study. A reflective diary was kept from the very beginning of the study, at which point I was interviewed by my research supervisor to understand how participants would feel answering my questions, until the study was finalised. In this diary, I documented my own journey as a researcher together with my reflections on interpreting the data as I went along and interviewed participants. This helped me to keep a clear mind and stay in my researcher role especially because of my working duties at the CDS.

5.6.2 Limitations

Special attention was taken to ensure trustworthiness throughout the study, however, certain limitations need to be taken into consideration. All interpretations of the findings were done by me. It cannot be excluded that different people can have different interpretations of the same data. My lack of experience in research, especially in

phenomenology, could have limited the study and its findings, however, I was thoroughly guided by my research supervisor throughout the research process. To try to overcome the limitations of being a novice researcher in hermeneutic phenomenology I sought to broaden my knowledge in this area before embarking on this study by reading literature on hermeneutic phenomenology and also attending an international comprehensive course entitled Hermeneutic Phenomenology Methodology (Thomson & Crowther, 2021) specifically addressed for students pursuing postgraduate research using such research approach (Appendix Q).

Collecting the data from NQMs who worked only in one birthing unit could also have been a limiting factor to the study since there was no possibility to compare NQMs' experiences who worked in different birthing units and settings. Nonetheless, there is only one main public hospital locally, with the CDS as the birthing unit, hence, there are no other options for NQMs where to practice. Having a timeframe of only one year to complete this study was also a limitation in itself as there was only one occasion to interview the participants, while the study would have benefitted from interviewing the participants throughout their six-month placement at different intervals to truly extrapolate their transition experience. Another limitation is that the majority of participants that accepted the invitation to participate in this study were those NQMs who had gone through a negative experience during their CDS placement and who perhaps felt this would give them the opportunity to vent. It is therefore possible that the ones who had a positive experience did not feel enticed to participate.

5.7 Conclusion

In this chapter, the findings of the study were discussed and compared to reviewed literature. The discussion was also framed around Bridges' transition theory (1991) and philosophical notions which were relevant to this hermeneutic phenomenological study. The findings of this study showed both similarities to findings from existing literature but also several unique findings.

Similarities to existing literature include that working in a birthing unit can be very scary and challenging for NQMs. Once NQMs experienced the reality of becoming registered midwives they underwent both physical and psychological changes that not only affected them at work but also negatively impacted their personal lives and well-being. By the end of the placement at the CDS, they gradually adjusted and became more confident and competent in their role. Finally, the transition from a student midwife to a registered midwife was eased when NQMs found readily available support according to their needs. Nonetheless, there were other findings opposed those in existing studies. Such findings included that participants who went to the same wards where they previously worked in as students, adapted faster to the ward environment as opposed to the findings of this study that showed that the participants still struggled. If local NQMs had a bad experience at the CDS they are left with no alternative birthing unit to choose to work in, as opposed to other studies, which show a lot of their participants opted to simply swap birthing units or the maternity setting they worked in.

Additionally, there were also several unique findings from this study adding new insight to the existing body of knowledge surrounding this phenomenon. These findings showed that the experiences of NQMs at the CDS were primarily affected by past

placements they had during their student days at the CDS. Furthermore, the experiences they encountered during their rotation placement affected their future decision on whether to return to CDS or not. Also, NQMs could not remember the first few births they assisted as qualified midwives because they were rather concentrating on performing the skills effectively than focusing on the holistic approach of woman-centred care. Ward rounds and giving handovers in the beginning and at the end of every duty caused NQMs so much stress. NQMs felt that the CDS was the steppingstone to becoming the true midwife, as it was seen as the essence of midwifery which prepared them for anything they could meet in their future midwifery endeavours. Finally, the CDS was the ward where NQMs felt that they could truly give individualised care and build relationships with mothers.

The next chapter will summarise the relevant conclusions drawn from the findings obtained from this study and propose recommendations for clinical practice, education and research.

Chapter 6: Conclusion and Recommendations

6.1 Introduction

This chapter gives an overview of how the study was carried out and summarises the main findings and the corresponding implications. Various recommendations are put forward for further research, practice, policy and education, with the aim to better assist NQMs as they embark on their journey of caring for women during labour and birth, as qualified midwives.

On successful completion of their course requirements, students of the midwifery course become newly qualified midwives [NQMs] starting their professional midwifery careers. As they embark on their midwifery journey, one of their practice settings is the birthing unit. This study aimed to elicit and understand the meaning for newly qualified midwives' [NQMs] of caring for women during labour and birth. This was achieved through the following objectives: to capture newly qualified midwives' lived experiences of caring for women during labour and birth, to uncover the meaning of caring for women during labour and birth amongst newly qualified midwives and to elicit any supportive measures which newly qualified midwives identify as helpful when caring for women during labour and birth at this early stage in their career.

6.2 Summary of the Study

This study commenced by performing a thorough research of existing relevant literature regarding NQMs. Relevant literature was chosen with the assistance of the PRISMA flow chart and the inclusion and exclusion criteria set for the selection of relevant studies. The literature was appraised using CASP, CEBMa and MMAT tools.

Subsequently, an integrative review [IR] was written based on all the knowledge and literature available to-date.

The IR showed that previous literature on the study phenomenon mostly focused on the transition from student midwives to qualified midwives and the evaluation of the available supportive programs offered during this transition. The literature showed that the transition of NQMs is influenced by the support given by colleagues, the organisation and the working environment. It also indicated that this transition brings about certain levels of stress and tension, especially when NQMs start taking full responsibility for the women, knowing that their decisions might have a direct impact on the outcome for women, infants and families. Reviewed literature focused on different midwifery settings, it became clear that the birthing unit is the scariest environment to work in during this transition from a student midwife to a NQM (Avis et al., 2012; Clements et al., 2013; Fenwick et al., 2012; Saliba, 2011; Sheehy et al., 2021). Although the literature mentioned the birthing units, only one study was found to be specifically based on the experiences of NQMs as they cared for women during labour and birth. Hence, this study addressed this gap in research by looking in-depth at the transition from a student midwife to a NQM in a birthing maternity setting in the local context.

The study was carried out using a hermeneutic phenomenological research design, bearing in mind that the main aim of the study was to understand and elicit the meaning of the lived experiences of NQMs. The study was guided by the philosophy of Martin Heidegger (1927) and William Bridges' (1991) transition theory. van Manen's (1990) six-step framework was used as a methodological approach to guide the research process and data analysis. The collection of data for this study included ten one-time,

one-to-one in-depth interviews with NQMs as participants who had worked at the main local Central Delivery Suite [CDS] during their rotation placement over the last two years. Findings were then analysed and interpreted, and themes and subthemes emerged. These were later critically discussed and compared to the available literature, where new findings that emerged from this study were highlighted.

6.3 Overview of the Key Findings of this Study

Several findings from this study showed similarities to the literature available, such as the numerous emotions experienced by NQMs, which mostly develop from fear of the unknown (Avis et al.,2012; Fenwick et al., 2012; Sheehy et al., 2021). NQMs experienced a "reality shock" (Kramer 1974, as cited in Wain, 2017, p. 452) as they started to realise what it truly entails to be a qualified midwife and take full responsibility for decision-making for the women under their care (Clements et al., 2013; Van Der Putten, 2008). The level of support the NQMs receive from colleagues and managerial personnel, determines how effectively the transition phase is completed (Sheehy et al., 2021). When NQMs were belittled or not accepted by colleagues, this led to a negative experience that also affected their well-being (Kitson-Reynolds et al., 2014; Kool et al., 2020; Norris, 2019). NQMs needed to feel trusted by their colleagues and by the women and families they cared for (Kool et al., 2020; Norris, 2019; Skirton et al., 2012; Wain, 2017). Their main aim was to provide the best care possible, whilst avoiding inadvertent events leading to any harm to women and their babies secondary to bad decisions due to their lack of experience and confidence (Clements et al., 2013).

However, there were also several unique findings which emerged from this study. One of these is that NQMs in this study found it difficult to remember their initial birth

experiences as qualified midwives, no matter how much they tried to recall these experiences. It became clear that this happened because, at that time, they were more focused on doing skills correctly while practicing rather than on the holistic approach of the birthing event. They could not recall anything apart from the fear they felt. This study showed that NQMs' experiences at CDS stemmed from the relationships they had with the midwives or mentors whom they were assigned to when they were still students. Those NQMs who experienced a bad relationship with their assigned shift members or their mentor as student midwives perceived the CDS negatively, therefore, started their rotation placement scared and dreading most duties. The teachings senior midwives imparted on NQMs when they were still student midwives also affected their experience at the CDS, especially when it came to decision-making whilst caring for women under their care.

Another unique finding from this study showed that NQMs felt that working at the CDS and assisting a woman in labour and birth was the steppingstone they needed to grow in their career and truly feel that they were finally a midwife. NQMs expressed that they did not experience this feeling from other wards during their rotation placements, even if the CDS was the last placement of their rotation. NQMs expressed that whatever they learned at the CDS subsequently helped them to practice more effectively in other maternity wards. They also felt that if they could successfully manage the six-month rotation period at the CDS, they could face any challenge throughout their midwifery career. They emphasised that their initial experience at the CDS ultimately determined whether they considered going back to the CDS or not, when the time came to take a permanent post in a maternity ward. Finally, they all expressed that their experience at the CDS helped them hone their skills to become the midwives they aspired to be.

6.4 Recommendations

The following recommendations were drawn from the findings and interpretations of the study and are brought forward to potentially improve the experiences of NQMs as they care for women during labour and birth at the start of their career immediately after finishing their studies.

6.4.1 Recommendations for Clinical Practice

- NQMs should be made to feel welcome in the ward. Also, prior to starting their placement at the CDS they should be given an orientation of the ward setting explaining all important locations and equipment.

- Simulation practices should be held in the ward itself, as this could help NQMs familiarise themselves with the ward and possibly have a better understanding of how to tackle obstetric emergencies, when needed.

- NQMs should be assigned to senior staff or a preceptor for shadowing and guidance during the first weeks of their placement.

- The clinical rotation placement at the CDS should be longer than six-months. This could benefit NQMs because only once they start to adapt and feel more confident in the ward, can they start to build their knowledge and experiences.

- The light of the fact that NQMs felt the lack of psychological support, debriefing sessions should form part of the NQMs' journey throughout their transition. This could serve of great benefit to NQMs as they would have a space where to safely vent their concerns, worries and experiences, especially after dealing with a complicated birth event or life-threatening obstetric emergency.

- Feedback meetings and constructive criticism should be available for NQMs as this could offer them the possibility to strengthen their role as a midwife, improve their practice and avoid inadvertent mistakes. Hence, it is recommended that both positive and negative feedback should be given by NQMs' head of shift, assigned midwives and managerial personnel.

6.4.2 Recommendations for Education

- NQMs should be provided with an induction programme specifically based on CDS practices which must tackle all protocols and guidelines present in the ward. This could help NQMs be better equipped with the needed information and probably function more effectively and efficiently once assigned to the CDS during their rotation placement.

- Workshops with simulations of obstetric emergencies, the likes of which they may encounter at the CDS, should be carried out. This would provide hands-on experience to NQMs to possibly better handle similar case scenarios in the real world.

- A Practice Development Midwife role, whose duty focuses specifically on the CDS, should be created. The main scope of this role would be to cater for the educational needs of NQMs, draw up a strategic job plan for them throughout their rotation placement, assist them in narrowing the theory-practice gap and ultimately make sure that NQMs' needs are met.

- Midwives should be encouraged and motivated to teach and care for student midwives, preferably through mentorship and preceptorship programmes. Midwives should be readily available to guide students on how to practice responsibly and make sound decisions for women under their care. They should also be more flexible towards student midwives and allow them to practice more skills, whilst giving them more exposure to obstetric complications under their supervision. Hence, it is recommended that adequate undergraduate clinical training at the CDS should commence from when students are allocated to this setting, giving them the support needed. This could avoid negative experiences which may impact their placement there as NQMs.

6.4.3 Recommendations for Research

- Further research should look into this phenomenon from a wider perspective including the experiences of student midwives at the CDS, the experiences of senior midwives who work with students and NQMs at the CDS, the experiences of obstetricians at the CDS and also the experiences of mothers who were cared for by student midwives.

- A longitudinal study should be carried out with NQMs throughout their journey at the CDS, looking into their experiences before starting the induction programme and after finishing it, to analyse the outcomes of such a programme.

6.5 Conclusion

From this study it became evident that NQMs struggle to adjust to the stark realities and stress levels of the CDS when they are placed there as part of their placement rotation. The emotional upheaval their experiences brought about also proved to impinge on their personal life because of lack of mentorship, support from colleagues during their student placement and then their rotation placement as NQMs. An account of existing literature was given and, although only one of the studies reviewed specifically focused on NQMs' experiences in birthing units, all the others touched on the fact that this unit was experienced to be the most stressful. Although the participants of this study do not have fond memories of their placement at the CDS, with some even unable to remember their initial birthing experiences, they all agree that it is the unit which gives them most fulfilment, seeing it as the essence of midwifery which helped them to grow and be better midwives. Recommendations were, therefore, put forward for both the educational and clinical placement settings which address the challenges mentioned by NQMs with the aim to bring about change in this area to help NQMs better transition into the best midwives they can be in a healthier and more supportive way.

REFERENCES

Astalin, P. K. (2013). Qualitative Research Designs: A conceptual framework. *International Journal of Social Sciences & Interdisciplinary Research, 2*(1), 118-124.

Avis, M., Mallik, M., & 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. https://doi.org/10.1111/j.1365-2834.2012.01455.x

Barry, M. J., Hauck, Y. L., O'Donoghue, T., & Clarke, S. (2013). Newly-graduated midwives transcending barriers: A grounded theory study. *Midwifery, 29*(12), 1352-1357. https://doi.org/10.1016/j.midw.2012.12.016

Barry, M. J., Hauck, Y. L., O'Donoghue, T., & Clarke, S. (2014). Newly-graduated midwives transcending barriers: Mechanisms for putting plans into actions. *Midwifery*, *30*(8), 962-967. https://doi.org/10.1016/j.midw.2014.01.003

Beaumont, E., Durkin, M., Hollins Martin, C. J., Carson, J. (2016). Compassion for others, Self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: a quantitative survey. *Midwifery*, 34, 239-244.

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. *AJN The American Journal of Nursing*, *84*(12), 1480.

Borritz, M., Rugulies, R., Bjorner, J. B., Villadsen, E., Mikkelsen, O. A., & Kristensen, T. S. (2006). Burnout among employees in human service work: design and baseline findings of the PUMA study. *Scandinavian journal of public health*, *34*(1), 49–58. https://doi.org/10.1080/14034940510032275

Braune, V., & Clarke, V. (2006). *Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.* https://doi.org/10.1191/1478088706qp063oa

Bridges, W., & Bridges, S. M. (Eds.). (2016). *Managing transitions: Making the most of change*. Da Capo Press.

Bryar, R., & Sinclair, M. (Eds.). (2011). *Theory for midwifery practice*. Macmillan International Higher Education.

Carleton, R. N. (2015). Fear of the unknown: One fear to rule them all? *Journal of Anxiety Disorders*, *41*, 5–21. https://doi.org/10.1016/j.janxdis.2016.03.011

Carolan-Olah, M., Kruger, G., & Garvey-Graham, A. (2014). Midwives′ experiences of the factors that facilitate normal birth among low risk women at a public hospital in Australia. *Midwifery*, *31*(1), 112-121.

Cazzini, H., Cowman, T., Fleming, J., Fletcher, A., Kuriakos, S., Mulligan, K., & Healy, N. (2022). An exploration of midwives' experiences of the transition to practice in the Republic of Ireland. *British Journal of Midwifery*, *30*(3), 136-143.

Center for Evidence Base Management (2014), Critical Appraisal Checklist for Cross-sectional Study. Retrieved September 23, 2021 from https://www.cebma.org

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE open medicine*, *7*, 1-8. https://doi.org/10.1177%2F2050312118822927

Clements, V., Davis, D., & Fenwick., J. (2013). Continuity of Care: Supporting New Graduates to Grow Into Confident Practitioners. *International Journal of Childbirth, 3*, 12-3.

Cluett, E. R., & Bluff, R. (2006). *Principles and practice of research in midwifery*. Elsevier Health Sciences.

Cohen, M. Kohn, D., & Steeves, R. (2000). Hermeneutic phenomenology research. Sage: Thousand Oaks, CA.

Cohen, M. Z., & Omery, A. (1994). Schools of phenomenology: Implications for research. *Critical issues in qualitative research methods*, *2*, 136-153.

Connerton, W. C. (2012). Midwifery. Encyclopedia Britannica. Retrieved August 26, 2021 from https://www.britannica.com/science/midwifery

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER Tool for Qualitative Evidence Synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Cormack, D.F.S. (Eds.). (1996). *The Research Process in Nursing*. Oxford, United Kingdom: Blackwell Science Ltd.

Council for Nurses and Midwives Malta. (2020). Code of Ethics and Standards of Professional Conduct for Nurses and Midwives. Available from: https://deputyprimeminister.gov.mt/en/regcounc/cnm/Documents/Code%20of%20Ethics%20and%20Standards%20of%20Professional%20Conduct%20for%20Nurses%20and%20Midwives%202019

Creswell, J. W. (Eds.). (2013). *Qualitative inquiry and research design: choosing among five approaches*. Sage.

Creswell, J. W. (Eds.). (2014). *Research design: qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, California: Sage Publications.

Creswell, J. W., & Creswell, J. D. (Eds.). (2018). *Research design: qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, California: Sage Publications, Inc.

Critical Appraisal Skills Programme (CASP). (2018). CASP Qualitative checklist. [online] Available at: https://casp-uk.b-cdn.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Crowther, S., (2021). Reflexivity Engagement in Hermeneutics. University of Central Lancashire. https://portal.uclan.ac.uk/ultra/courses/_129863_1/cl/outline

Crowther, S., & Thomson, G. (2020). From description to interpretive leap: Using philosophical notions to unpack and surface meaning in hermeneutic phenomenology research. *International Journal of Qualitative Methods*, *19*, 1-11.

Dahlen, H. G., & Caplice, S. (2014). What do midwives fear?. *Women and birth*, *27*(4), 266-270.

Davis, D., Baddock, S., Pairman, S., Hunter, M., Benn, C., Anderson, J., Dixon, L., & Herbison, P. (2012). Risk of severe postpartum hemorrhage in low-risk childbearing women in New Zealand: exploring the effect of place of birth and comparing third stage management of labor. *Birth*, 39(2), 98–105. https://doi.org/10.1111/j.1523-536X.2012.00531.x

Davis, D., Foureur, M., Clements, V., Brodie, P., & Herbison, P. (2012). The self reported confidence of newly graduated midwives before and after their first year of practice in Sydney, Australia. *Women and Birth: Journal of the Australian College of Midwives*, *25*(3), e1-e10. https://doi.org/doi:10.1016/j.wombi.2011.03.005

Dibley, L., Dickerson, S., Duffy, M., Vandermause, R. (2020). *Doing Hermeneutic Phenomenological Research*. Sage.

Dieumegard, G., Ollagnier-Beldame, M., Nogry, S., & Perrin, N. (2019). Lived experience as a unit of analysis for the study of learning. *Learning Culture and Social Interaction*. https://doi.org/10.1016/j.lcsi.2019.100345

Donovan, P. (2008). Confidence in newly qualified midwives. *British Journal of Midwifery*, 16(8), 510-514. https://doi.org/10.12968/bjom.2008.16.8.30784

Ecker, E. D., & Skelly, A. C. (2010). Conducting a winning literature search. *Evidence-based spine-care journal*, *1*(1), 9–14. https://doi.org/10.1055/s-0028-1100887

Edwards, N., Mander, R., & Murphy-Lawless, J. (Eds.). (2018). Untangling the Maternity Crisis. Routledge. https://doi.org/10.4324/9781315277059

Errasti-Ibarrondo, B., Jordán, J. A., Díez-Del-Corral, M. P., & Arantzamendi, M. (2019). van Manen's phenomenology of practice: How can it contribute to nursing?. *Nursing Inquiry*, *26*(1), e12259. https://doi.org/10.1111/nin.12259

Feather, N. T. (1985). Attitudes, values, and attributions: explanations of unemployment. Journal of personality and social psychology, 48(4), 876-889. https://doi.org/10.1037/0022-3514.48.4.876

Fenwick, J., Hammond, A., Raymond, J., Smith, R., Gray, J., Foureur, M., Homer, C., & Symon, A. (2012). Surviving, not thriving: A qualitative study of newly qualified midwives' experience of their transition to practice. *Journal of Clinical Nursing*, *21*(13-14), 2054-2063. https://doi.org/10.1111/j.1365-2702.2012.04090

Flick, U. (2007). Qualitative research designs. *Designing qualitative research*, 109-114.

Frede D. (2006). The question of being: Heidegger's project. In C. B. Guignon (Ed.), *The Cambridge Companion to Heidegger* (pp. 42-69). Cambridge University Press.

Frith, L., & Draper, H. (Eds.). (2004). *Ethics and Midwifery*. Books for Midwives.

Gatt, M. (2021). NOIS Annual Report, 2020. National Obstetric Information System, Directorate for Health Information and Research. Available at: https://deputyprimeminister.gov.mt/en/dhir/Pages/Registries/births.aspx

Gearing R.E. (2004). Bracketing in research: A typology. *Qualitative Health Research* 14, 1429-1452.

Gerrish, K. & Lacey, A. (Eds.). (2010). *The research process in nursing.* Oxford: Wiley Blackwell.

Griffiths, M., Fenwick, J., Carter, A. G., Sidebotham, M., & Gamble, J. (2019). Midwives transition to practice: Expectations and experiences. *Nurse Education in Practice*, *41*, 102641. https://doi.org/10.1016/j.nepr.2019.102641

Guba E.C. (Ed.). (1990). The alternative paradigm dialog. In Guba E.C. *The Paradigm Dialog* (17-27). Sage Publications.

Halldorsdottir, S., & Karlsdottir, S. I. (1996). Journeying through labour and delivery: perceptions of women who have given birth. *Midwifery*, *12*(2), 48-61.

Hartas, D. (2010). *Educational Research and Inquiry: Qualitative and quantitative approaches*. London: Continuum.

Healy, M. (2011). Heidegger's contributions to hermeneutic phenomenological research. In G. Thomson, F. Dykes & S. Downe (Eds.). *Qualitative Research in Midwifery and Childbirth: Phenomenological Approaches* (pp. 215-232). Oxon, United Kingdom: Routledge.

Heap, J. L., & Roth, P. A. (1973). On phenomenological sociology. *American Sociological Review*, 354-367.

Heidegger, M. (1927). 1962. Being and time. *Trans. John Macquarrie and Edward Robinson. Southampton, UK: Basil Blackwell.*

Heidegger, M. (1995). *The fundamental concepts of metaphysics: World, finitude, solitude*. Indiana University Press.

Ho, K. H., Chiang, V. C., & Leung, D. (2017). Hermeneutic phenomenological analysis: the 'possibility'beyond 'actuality'in thematic analysis. *Journal of Advanced Nursing*, *73*(7), 1757-1766.

Hobbs, J. A. (2012). Newly qualified midwives' transition to qualified status and role: Assimilating the 'habitus' or reshaping it? *Midwifery*, *28*(3), 391-399. https://doi.org/10.1016/j.midw.2011.04.007

Hong, Q. N., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M. P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M. C., Vedel, I. (2018). The Mixed Methods Appraisal Tool (MMAT), version 2018 for information professionals and researchers. *Education for information*, 34(4), 285-291.

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the key tenets of Heidegger's philosophy for interpretive phenomenological research. *International Journal of Qualitative Methods*, *15*(1), 1609406916680634.

Humenick, S. S. (2006). The Life-Changing Significance of Normal Birth. The Journal of Perinatal Education, 15(4), 1–3. https://doi.org/10.1624/105812406X151330

International Confederation of Midwives. (2014). *Philosophy and Model of Midwifery Care*. Retrieved January 15, 2022 from https://internationalmidwives.org/assets/files/definitions-files/2018/06/eng-philosophy-and-model-of-midwifery-care.pdf

International Confederation of Midwives. (2017). *International Definition of the midwife*. Retrieved August 26, 2021 from https://internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed.), *Conversation Analysis: Studies from the First Generation.* (pp: 13-31). Amsterdam: John Benjamins.

Katrak, P., Bialocerkowski, A.E., Massy-Westropp, N., Kumar, S., & Grimmer, K. A., (2004). A systematic review of the content of critical appraisal tools. *BMC Medical Research Methodology* 4(1), 1-11. https://doi.org/10.1186/1471-2288-4-22

Keeling, J., Quigley, J., & Roberts, T. (2006). Bullying in the workplace: What it is and how to deal with it. *British Journal of Midwifery*, *14*(10), 616-621.

Keighley, T., & World Health Organization. (2009). The European Union standards for nursing and midwifery: information for accession countries revised and updated by Thomas Keighley. (No. EUR/08/5085937). Copenhagen: WHO Regional Office for Europe. https://apps.who.int/iris/handle/10665/107957

Kennedy, H. P., & Shannon, M. T. (2004). Keeping birth normal: research findings on midwifery care during childbirth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *33*(5), 554-560.

Kitson-Reynolds, E., Cluett, E., & 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.

Kool, L. E., Schellevis, F. G., Jaarsma, D., & Feijen-De Jong, E. I. (2020). The initiation of Dutch newly qualified hospital-based midwives in practice, a qualitative study. *Midwifery*, *83*, 102648. https://doi.org/10.1016/j.midw.2020.102648

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and practice.* Essex, United Kingdom: Pearson Education Limited.

Lennox, S., Jutel, A., & Foureur, M. (2012). The concerns of competent novices during a mentoring year. *Nursing Research and Practice, 2012,* 812542. https://doi.org/10.1155/2012/812542

Leybourne, S. A. (2016). Emotionally sustainable change: two frameworks to assist with transition. *International Journal of Strategic Change Management*, *7*(1), 23-42.

Lincoln, Y. S., & Guba, E. G. (1980). The distinction between merit and worth in evaluation. *Educational Evaluation and Policy Analysis*, *2*(4), 61-71.

Mason J. (Eds.). (2002). *Qualitative Researching*. London: Sage.

McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Unpacking Heideggerian phenomenology. *Southern Online Journal of Nursing Research*, 9(1), 1-11.

Meleis, A. I., (2012). *Theoretical Nursing: Development and Progress*. Lippincott Williams and Wilkons.

Moorley, C., & Cathala, X. (2019). How to appraise qualitative research. *Evidence-Based Nursing*, 22(1), 10-13.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods*, 13–22. https://doi.org/10.1177/160940690200100202

Naqshbandi, P. S., Karim, M. A., & Qadir, D. O. (2019). A Qualitative Study of the Recent Midwifery Graduates' Lived Experiences during Transition Period. *International Journal of Medical Investigation*, *8*(4), 63-71.

Norris, S. (2019). In the wilderness: An action-research study to explore the transition from student to newly qualified midwife. *Evidence Based Midwifery, 17*(4), 128-134.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hrobjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International Journal of Surgery*, *88*, 105906.

Parahoo, K. (Eds.). (2006). *Nursing Research Principles, Process and Issues*. Macmillan International Higher Education.

Polit, D. F. & Beck, C. T. (Eds.). (2014). *Essentials of nursing research: Appraising evidence for nursing practice*. Lippincott Williams & Wilkins.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme Version, 1(1), b92.

Rahmadhena, M. P., McIntyre, M., & McLelland, G. (2017). New midwives' experiences of transition support during their first year of practice: a qualitative systematic review protocol. *JBI database of systematic reviews and implementation reports*, 15(5), 1265–1271. https://doi.org/10.11124/JBISRIR-2017-003374

Ray, M. A. (1994). The richness of phenomenology: Philosophic, theoretic, and methodologic concerns. *Critical issues in qualitative research methods*, 117-133.

Rojcewicz, R. (2006). *The gods and technology: A reading of Heidegger*. SUNY Press.

Saliba, A. (2011). Becoming a midwife in Malta: a single case study (Master's dissertation). https://www.um.edu.mt/library/oar/handle/123456789/41418

Sandelowski, M., Docherty, S., & Emden, C. (1997). Focus on qualitative methods qualitative metasynthesis: Issues and techniques. *Research in nursing & health*, 20(4), 365-371.

Schalow, F. (2013). Philosophy of Heidegger. [Audio podcast]. Retrieved from http://itunes.apple.com

Seale, C. (1999). Quality in qualitative research. *Qualitative inquiry*, *5*(4), 465-478.

Sheehy, D. A., Smith, M. R., Gray, P. J., & Ao, P. C. H. (2021). Understanding workforce experiences in the early career period of Australian midwives: Insights into factors which strengthen job satisfaction. *Midwifery, 93*, 102880. https://doi.org/10.1016/j.midw.2020.102880

Shorten, A., & Smith, J. (2017). *Mixed methods research: expanding the evidence base*. BMJ Publishing Group Ltd and RCN Publishing Company Ltd. https://doi.org/10.1136/eb-2017-102699

Simane-Netshisaulu, K. G., & Maputle, M. S. (2021). Exploring supportive relationship provided to newly qualified midwives during transition period in Limpopo province, South Africa. *African Journal of Reproductive Health*, *25*(5).

Skirton, H., Stephen, N., Doris, F., Cooper, M., Avis, M., & Fraser, D. M. (2012). Preparedness of newly qualified midwives to deliver clinical care: An evaluation of pre-registration midwifery education through an analysis of key events. *Midwifery, 28*(5), e660-e666. https://doi.org/10.1016/j.midw.2011.08.007

Smith, J. A. & Osborn, M. (2003). 'Interpretative Phenomenological Analysis.' In J. A. Smith, (Ed.), *Qualitative Psychology: A practical guide to methods.* (pp. 51-80). London: Sage.

Smythe, E. (2011). From beginning to end: how to do hermeneutic interpretive phenomenology. In G. Thomson, F. Dykes & S. Downe (Eds.), *Qualitative Research in Midwifery and Childbirth.* (pp. 35-54). Routledge Taylor & Francis Group.

Smythe, E., & Spence, D. (2012). Re-Viewing Literature in Hermeneutic Research. *International Journal of Qualitative Methods*, 12–25. https://doi.org/10.1177/160940691201100102

Sweet, B. R., Tiran, D., & Mayes, M. (1997). *Mayes' midwifery: A textbook for midwives*. London: Bailliere Tindall.

Thomas, C. M., & Kellgren, M. (2017). Benner's Novice to Expert Model: An Application for Simulation Facilitators. *Nursing Science Quarterly*, *30*(3), 227–234. https://doi.org/10.1177/0894318417708410

Thomson, G. (2021). *Introductions and Beginnings.* University of Central Lancashire. https://portal.uclan.ac.uk/ultra/courses/_129863_1/cl/outline

Thomson, G., & Crowther, S. (2021). *Hermeneutic Phenomenology Methodology course*. University of Central Lancashire. https://www.uclan.ac.uk/events/listing/hermeneutic-phenomenology-methodolgy-course

Tod, A. (2010). Interviewing. In K. Gerrish & A. Lacey (Eds.), *The research process in Nursing. (pp. 345-357).* Oxford: Wiley Blackwell.

Toronto, C. E., & Remington, R. (Eds.). (2020). *A step-by-step guide to conducting an integrative review*. Springer.

Torraco, R. J. (2005). Writing integrative literature reviews: guidelines and examples. *Human Resource Development Review*, 4(3), 356–367.

Torraco, R. J. (2016). Writing Integrative Literature Reviews: Using the past and present to explore the future. *Human Resource Development Review, 15(4), 404–428.* https://doi.org/10.1177/1534484316671606

University of Malta. (2021, August 26). UOM: Bachelor of Science (Honours) in Midwifery: Course Information. https://www.um.edu.mt/courses/overview/UBSCHMIDI-2022-3-O

van der Putten, D. (2008). The lived experience of newly qualified midwives: A qualitative study. *British Journal of Midwifery*, *16*(6), 348-358. https://doi.org/10.12968/bjom.2008.16.6.29592

van Manen, M. (1990). *Researching lived experience Human Science for an action sensitive pedagogy*. State University of New York Press.

van Manen, M. (1997). From Meaning to Method. *Qualitative Health Research, 7*(3), 345–369. https://doi.org/10.1177/104973239700700303

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Left Coast Press.

van Manen, M. (Eds.). (2015). *Researching lived experience: Human science for an action sensitive pedagogy*. Walnut Creek, CA: Left Coast Press.

van Manen, M. (2017). Phenomenology in Its Original Sense. *Qualitative Health Research, 27*(6), 810–825. https://doi.org/10.1177/1049732317699381

van Ryzin, M. J., Mills, D., Kelban, S., Vars, M. R., & Chamberlain, P. (2011). Using the bridges transition framework for youth in foster care: Measurement development and preliminary outcomes. *Children and Youth Services Review*, 33(11), 2267-2272.

van Teijlingen, E. R., & Hundley, V. (2001). The importance of pilot studies. Social Research Update. Available from https://www.um.edu.mt/library/hydi/libweb/action/search.do

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, 18(1), 1-18. https://doi.org/10.1186/s12874-018-0594-7

Wain, A. (2017). Examining the lived experiences of newly qualified midwives during their preceptorship. *British Journal of Midwifery*, *25*(7), 451-457. https://doi.org/10.12968/bjom.2017.25.7.451

Walsh, D. (1999). An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend. *Midwifery*, *15*(3), 165-176.

Watson, H., & Brown, D. (2021). Experiences of newly qualified midwives working in clinical practice during their transition period. *British Journal of Midwifery*, *29*(9), 524-530.

Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of advanced nursing*, *53*(4), 459–469. https://doi.org/10.1111/j.1365-2648.2006.03740.x

Weiner, B. (1974). *Achievement motivation and attribution theory*. Morristown, N. J.: General Learning Press.

Whitehead, L. (2004). Enhancing the quality of hermeneutic research: decision trail. *Journal of Advanced Nursing*, 45(5), 512-518.

Whittemore, R., Chao, A., Jang, M., Minges, K. E., & Park, C. (2014). Methods for knowledge synthesis: an overview. *Heart & Lung*, *43*(5), 453-461.

Wills, P. (Ed). (2001). The 'things themselves' in phenomenology. Indo-Pacific Journal of Phenomenology, 1(1), 1-12.

Wisdom J, Creswell J. W. (2013). *Mixed methods: integrating quantitative and qualitative data collection and analysis while studying patient-centered medical home models*. Rockville, MD: Agency for Healthcare research and quality.

World Health Organisation. (2016). Global strategic directions for strengthening nursing and midwifery 2016-2020.

Wrathall, M. (2005). *How to read Heidegger*. New York, US: W. W. Norton & Company.

Yauch, C. & Steudel, H. (2003). Complementary Use of Qualitative and Quantitative Cultural Assessment Methods. *Organizational Research Methods, 6(4),* 465-481. http://doi.org/10.1177/1094428103257362

Young, N. (2012). An exploration of clinical decision-making among students and newly qualified midwives. *Midwifery, 28*(6), 824-830. https://doi.org/10.1016/j.midw.2011.09.012

Appendix A

Keywords used for Search

Acronym Components Combined	Keywords used for Search
S	"Newly qualif* midwi*" OR "new* graduate* midwi*" OR "junior midwi*" OR "midwi* on rotation" OR "novice midwi*" OR "beginner midwi*" OR "trainee midwi*" or "newcomer midwi*" OR "apprentice midwi*" OR "learner midwi*" O R "amateur midwi*" OR "new* practi?ng midwi*" OR "new* registered midwi*"
S AND **PI** AND **D** AND **E** AND **R**	"Newly qualif* midwi*" OR "new* graduate* midwi*" OR "junior midwi*" OR "midwi* on rotation" OR "novice midwi*" OR "beginner midwi*" OR "trainee midwi*" or "newcomer midwi*" OR "apprentice midwi*" OR "learner midwi*" O R "amateur midwi*" OR "new* practi?ng midwi*" OR "new* registered midwi*" **AND** "lab?r" OR "birth" OR "intrapartum" OR "parturition" OR "Childbirth" OR "different stages of labo?r OR "obstetric emergenc*" OR "normal vaginal deliver*" OR "NVD" OR "confinement" OR "Operative birth*" **AND** "Interview*" OR "structured interview" OR "Unstructured interview" OR "Semi-structured" OR "Open-ended interview*" OR "Face-to face" OR "Telephone interview" "Focus group*" OR "Survey*" OR "Observation" OR "Audio recording" OR "Field note*" OR "Personal diar*" OR "tape record*" **AND** "Meaning" OR "Understanding" OR "Lived experience*" OR "View*" OR "Attitude*" OR "Opinion*" OR "Belief*" OR "Thought*" OR "Perspectives" OR "Feeling*" **AND** "Qualitative" OR "mixed method*" OR "Quantitative"

S AND **PI**	"Newly qualif* midwi*" OR "new* graduate* midwi*" OR "junior midwi*" OR "midwi* on rotation" OR "novice midwi*" OR "beginner midwi*" OR "trainee midwi*" or "newcomer midwi*" OR "apprentice midwi*" OR "learner midwi*" O R "amateur midwi*" OR "new* practi?ng midwi*" OR "new* registered midwi*" **AND** "lab?r" OR "birth" OR "intrapartum" OR "parturition" OR "Childbirth" OR "different stages of labo?r OR "obstetric emergenc*" OR "normal vaginal deliver*" OR "NVD" OR "confinement" OR "Operative birth*"
S AND **E**	"Newly qualif* midwi*" OR "new* graduate* midwi*" OR "junior midwi*" OR "midwi* on rotation" OR "novice midwi*" OR "beginner midwi*" OR "trainee midwi*" or "newcomer midwi*" OR "apprentice midwi*" OR "learner midwi*" O R "amateur midwi*" OR "new* practi?ng midwi*" OR "new* registered midwi*" **AND** "Meaning" OR "Understanding" OR "Lived experience*" OR "View*" OR "Attitude*" OR "Opinion*" OR "Belief*" OR "Thought*" OR "Perspectives" OR "Feeling*"
S AND **PI** AND **E**	"Newly qualif* midwi*" OR "new* graduate* midwi*" OR "junior midwi*" OR "midwi* on rotation" OR "novice midwi*" OR "beginner midwi*" OR "trainee midwi*" or "newcomer midwi*" OR "apprentice midwi*" OR "learner midwi*" O R "amateur midwi*" OR "new* practi?ng midwi*" OR "new* registered midwi*" **AND** "lab?r" OR "birth" OR "intrapartum" OR "parturition" OR "Childbirth" OR "different stages of labo?r OR "obstetric emergenc*" OR "normal vaginal deliver*" OR "NVD" OR "confinement" OR "Operative birth*" **AND** "Meaning" OR "Understanding" OR "Lived experience*" OR "View*" OR "Attitude*" OR "Opinion*" OR "Belief*" OR "Thought*" OR "Perspectives" OR "Feeling*"

S AND **D** AND **E**	"Newly qualif* midwi*" OR "new* graduate* midwi*" OR "junior midwi*" OR "midwi* on rotation" OR "novice midwi*" OR "beginner midwi*" OR "trainee midwi*" or "newcomer midwi*" OR "apprentice midwi*" OR "learner midwi*" O R "amateur midwi*" OR "new* practi?ng midwi*" OR "new* registered midwi*" **AND** "Interview*" OR "structured interview" OR "Unstructured interview" OR "Semi-structured" OR "Open-ended interview*" OR "Face-to face" OR "Telephone interview" "Focus group*" OR "Survey*" OR "Observation" OR "Audio recording" OR "Field note*" OR "Personal diar*" OR "tape record*" **AND** "Meaning" OR "Understanding" OR "Lived experience*" OR "View*" OR "Attitude*" OR "Opinion*" OR "Belief*" OR "Thought*" OR "Perspectives" OR "Feeling*"
SPI AND **DER**	"Newly qualif* midwi*" OR "new* graduate* midwi*" OR "junior midwi*" OR "midwi* on rotation" OR "novice midwi*" OR "beginner midwi*" OR "trainee midwi*" or "newcomer midwi*" OR "apprentice midwi*" OR "learner midwi*" O R "amateur midwi*" OR "new* practi?ng midwi*" OR "new* registered midwi*" "lab?r" OR "birth" OR "intrapartum" OR "parturition" OR "Childbirth" OR "different stages of labo?r OR "obstetric emergenc*" OR "normal vaginal deliver*" OR "NVD" OR "confinement" OR "Operative birth*" **AND** "Interview*" OR "structured interview" OR "Unstructured interview" OR "Semi-structured" OR "Open-ended interview*" OR "Face-to face" OR "Telephone interview" "Focus group*" OR "Survey*" OR "Observation" OR "Audio recording" OR "Field note*" OR "Personal diar*" OR "tape record*" "Meaning" OR "Understanding" OR "Lived experience*" OR "View*" OR "Attitude*" OR "Opinion*" OR "Belief*" OR "Thought*" OR "Perspectives" OR "Feeling*" "Qualitative" OR "mixed method*" OR "Quantitative"

Appendix B

Database and Other Method Search

Database	Date	Keywords and Boolean							Hits
		S	S AND PI AND D AND E AND R	S AND PI	S AND E	S AND PI AND E	S AND D AND E	SPI AND DER	
Academic Search Ultimate	July 21 – May 22	78	8	59	54	43	17	8	267
CINHAL Complete	July 21 – May 22	190	11	29	118	23	63	11	445
Medline Complete	July 21 – May 22	77	7	16	53	15	33	7	208
PSYch INFO	July 21 – May 22	9	1	2	8	2	6	1	29
BIOMED CENTRAL	July 21 – May 22	0	0	0	0	0	0	0	0
Cochrane	July 21 – May 22	3	0	1	3	1	1	0	9
PUBMED CENTRAL	July 21 – May 22	0	0	0	0	0	0	0	0
PUBMED	July 21 – May 22	734	0	119	512	87	0	0	1452
Open Grey System for information on grey literature in Europe	July 21 – May 22	0	0	0	0	0	0	0	0
Reference Lists	July 21 – May 22	-	-	-	-	-	-	-	8
Google Scholar	July 21 – May 22	-	-	-	-	-	-	-	9
OAR@UM	July 21 – May 22	-	-	-	-	-	-	-	1
	Total Hits	1091	27	226	748	171	120	27	**2428**

Appendix C

List of Excluded Research Literature

Authors / Year	Title	Reason for Exclusion
Anderson, 2015	From pink champagne to breech presentation: Essentially MIDRIS editor, Michelle Anderson, talks to newly qualified midwife, Penny Luxford about her new job	Non-Empirical Study
Axcell, *(date unknown)*	Six month qualified	Non-Empirical Study
Bacchus and Firth, 2017	What factors affect the emotional well-being of newly qualified midwives in their first year of practice?	Non-Empirical Study
Barker, 2014	Newly qualified midwives: Be confident and competent	Non-Empirical Study
Cheri, *(date unknown)*	Making the most of your elective placement	Non-Empirical Study
Cole, *(date unknown)*	Transition	Non-Empirical Study
Dunn, 2019	Never be afraid to question practice: The professional dilemma of a student midwife	Non-Empirical Study
Edwards, 2010	On course. Keep calm and carry on!	Non-Empirical Study
Evans and Choucry, 2012	Transitioning from a student to a midwife: A first-hand account	Non-Empirical Study
Ekele, 2009	Skilled attendance at delivery: Who or where?	Non-Empirical Study
Ford, 2008	Reflections on journeying off the map and beyond the conveyer belt: The story of a newly qualified midwife	Non-Empirical Study
Hunter et al., 1996	Student to nurse-midwife role transition process smoothing the way	Non-Empirical Study
Ladkin, 2020	From one drama to another	Non-Empirical Study

Ladkin, 2020	Learning to be a midwife	Non-Empirical Study
Ladkin, 2020	Supporting the next generation	Non-Empirical Study
Price, 2013	Starting my first post as a newly qualified midwife	Non-Empirical Study
Rubio-Batanas, 2013	Reflections as a newly registered midwife	Non-Empirical Study
Stone, 2016	Taking the first steps in practice	Non-Empirical Study
Wilson, 2020	First week on the job	Non-Empirical Study
Allen & Anderson, 2019	Promoting evidence-based practice and raising concerns: considerations for the newly-qualified midwife	General Information on Topic
Ashforth & Kitson-Reynolds, 2019	Fairy tale midwifery 10 years on: re-evaluating the lived experiences of a newly qualified midwives	General Information on Topic
Nolan, 2017	Leadership, autonomy and the newly qualified midwife	General Information on Topic
Panettiere & Cadman, 2002	Do new graduate midwives need extra support?	General Information on Topic
Walledge & Arrowsmith, 2016	The transition from student to newly qualified midwife	General Information on Topic
Broad et al., 2011	Developing a 'model of transition' prior to preceptorship	Not Related to Topic
Carolan-Olah et al., 2015	Midwives' experiences of the factors that facilitate normal birth among low risk women at a public hospital in Australia	Not Related to Topic
Cummins et al., 2017	A toolkit to enable new graduate midwives to work in midwifery continuity of care models	Not Related to Topic

Cummins et al., 2018	Enabling new graduate midwives to work in midwifery continuity of care models: A conceptual model for implementation	Not Related to Topic
Darra & Thomas, 2019	An evaluation of the midwifery Pre-Qualifying Skills Passport in Wales	Not Related to Topic
Dixon et al., 2015	Supporting New Zealand graduate midwives to stay in the profession: An evaluation of the Midwifery First Year of Practice programme	Not Related to Topic
Donovan, 2018	Confidence in newly qualified midwives	Not Related to Topic
Gonzales, 2021	Qualifying as a Midwife in Argentina	Not Related to Topic
Goshomi et al., 2021	Facilitators and barriers to competence development among students and newly qualified nurses, midwives and medical doctors: a global perspective	Not Related to Topic
Hollins et al., 2004	Does status have more influence than education on the decisions midwives make?	Not Related to Topic
Hunter, 2004	Conflicting ideologies as a source of emotion work in midwifery	Not Related to Topic
Mander, 1987	Change in employment plans…decisions of newly qualified midwives in Scotland	Not Related to Topic
Moores et al., 2016	Education, employment and practice: Midwifery graduates in Papua New Guinea	Not Related to Topic
Mottershead, 2016	Newly-qualified midwife Natalie Mottershead at the Birth Centre in London gives an account of independent midwifery in a group practice	Not Related to Topic
Rice & Warland, 2013	Bearing witness: midwives experiences of witnessing traumatic birth	Not Related to Topic
Wilson et al., 2020	Being a Newly Qualified Midwife in Continuity of Carer: what is it really like?	Not Related to Topic

Barry, 2011	Newly-graduated midwives in the state of protection	Related to Women's Experiences
Hollins, 2007	How can we improve choice provision for childbearing women?	Related to Women's Experiences
Thompson, 2013	Midwives' experiences of caring for women whose requests are not within clinical policies and guidelines	Related to Women's Experiences
Black, 2018	Does preceptorship support newly qualified midwives to become confident practitioners	Assessment on Transition Programmes
Clements et al., 2012	Core elements of transition support programs: the experiences of newly qualified Australian midwives	Assessment on Transition Programmes
Feltham, 2014	The value of preceptorship for newly qualified midwives	Assessment on Transition Programmes
Foster & Ashwin, 2014	Newly qualified midwives' experiences of preceptorship: a qualitative study	Assessment on Transition Programmes
Hobbs & Green, 2003	Development of a preceptorship programme	Assessment on Transition Programmes
Hughes et al., 2011	'SINK or SWIM': the experience of newly qualified midwives in England	Assessment on Transition Programmes
Kensington, 2006	The faces of mentoring in New Zealand: realities for the new graduate midwife	Assessment on Transition Programmes
Kitson Reynolds et al., 2015	Transition to midwifery: Collaborative working between university and maternity services	Assessment on Transition Programmes

Maggs et al., 1996	Getting a job and growing in confidence: the dual experience of newly qualified midwives prepared by the pre-registration route…including commentary by Renfrew M	Assessment on Transition Programmes
Mason & Sarah, 2013	A qualitative evaluation of a preceptorship programme to support newly qualified midwives	Assessment on Transition Programmes
Mitchell, 2016	Implementation of a structured programme of preceptorship for newly qualified midwives in a maternity setting	Assessment on Transition Programmes
Murray-Parahi et al., 2018	A new career pathway for new graduate midwives: Barriers or opportunities?	Assessment on Transition Programmes
Pairman et al., 2016	The Midwifery First Year of Practice programme: Supporting New Zealand midwifery graduated in their transition to practice	Assessment on Transition Programmes
Passant et al., 2013	From student to midwife: the experiences of newly qualified midwives working in an innovative model of midwifery care	Assessment on Transition Programmes
Williams et al., 2010	Team objectives structured clinical examination for obstetric emergencies	Assessment on Transition Programmes
Hunter, 2005	Emotion work and boundary maintenance in hospital-based midwifery	Articles on Student Midwives
Lennox et al., 2012	The Concerns of Competent Novices during a Mentoring Year	Articles on Student Midwives
Nash et al., 2021	Learning throughout the storm	Articles on Student Midwives
Back et al., 2016	Developing competence and confidence in midwifery-focus groups with Swedish midwives	Research Topic on Midwife in General not NQMs

Pezaro et al., 2015	"Midwives overboard!" Inside their hearts are breaking, their makeup maybe flaking but their smile still stays on	Research Topic on Midwife in General not NQMs
Sookhoo and Biott, 2002	Learning at work: Midwives judging progress in labour	Research Topic on Midwife in General not NQMs
Weltens et al., 2018	Influencing factors in midwives' decision-making during childbirth: A qualitative study in the Netherlands	Research Topic on Midwife in General not NQMs
Driscoll et al., 2019	Enhancing the quality of clinical supervision in nursing practice	Research Topic on Newly Qualified Nurses
Kajander-Unkuri et al., 2014	Self-assessed level of competence of graduating nursing students and factors related to it	Research Topic on Newly Qualified Nurses
Mhango et al., 2021	The challenges of precepting undergraduate nursing students in Malawi	Research Topic on Newly Qualified Nurses
Powell et al., 2019	Altered nursing student perspectives: Impact of a pre-clinical observation experience at an outpatient oncology setting	Research Topic on Newly Qualified Nurses

Appendix D

Table D1: Questions and Answers of CASP TOOL for Qualitative Studies

Section	Question Number	Appraisal Question
Section A: Are the results valid?	1	Was there a clear statement of the aims of the research?
	2	Is a qualitative methodology appropriate?
		Is it worth continuing?
	3	Was the research design appropriate to address the aims of the research?
	4	Was the recruitment strategy appropriate to the aims of the research?
	5	Was the data collected in a way that addresses the research issue?
	6	Has the relationship between researcher and participants been adequately considered?
Section B: What are the results?	7	Have the ethical issues been taken into consideration?
	8	Was the data analysis sufficiently rigorous?
	9	Is there a clear statement of findings?
Section C: Will the results help locally?	10	How valuable is the research?

Research Study	Section A					Section B				Section C
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Cazzini et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	It showed that NQMs truly need support during their transition, however, they do not always find it.
Simane-Netshisaulu & Maputle, 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Shows that support from qualified midwives needs to be enhanced for a smoother transition from student midwives to NQMs.
Sheehy et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Showed that having the proper support and enhancing job satisfaction will help in the scope of midwifery care.
Watson & Brown, 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	This study gave insight of what can be offered to NQMs during their transition phase to enhance their role as midwives.
Kool et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Shows that NQMs need induction programmes and support the settle in. It was the only study that used a theoretical framework JD-R model which helped to identify job demands, job resources, and personal demands. Only study that explored personal demands.
Naqshbandi et al., 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	It showed how colleagues of NQMs, and the work environment play a very important role in the transition of NQMs.

Norris, 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	It helped to identify challenges faced by NQMs and what are the needs of these NQMs to have a better transition to their role.
Griffiths et al., 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The expectations and experiences in the first years of being NQMs.
Wain, 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	It concluded that further investigations should be done to evaluate ways to improve NQMs transition.
Kitson Reynolds et al., 2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	To acknowledge that some NQMs are still in student mode, and they need to be helped in their transition.
Barry et al., 2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	That graduates are affected be both intrinsic and extrinsic factors.
Barry et al., 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	That NQMs should be helped to operate within their full scope of practice.
Clements et al., 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Showed that experiences of NQMs are mostly influenced by colleagues' support.
Avis et al., 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NQMs improve when they have senior midwives and colleagues who are supportive. Hence, having a well structure and supportive team member in a shift is an asset for NQMs.
Young, 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The importance of what helps NQMs to become more confident in taking decisions.

Hobbs, 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NQMs try to keep on practicing what is thought in university and not follow the current practices.
Skirton et al., 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	It highlighted that NQMs need more simulation training and more decision-making training.
Fenwick et al., 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	It highlighted the importance of positive midwife-to-midwife relationships. This could be used to help understand why Australia faces a midwifery workforce shortage
Saliba, 2011	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Its need was very important since a local study of NQMs was never conducted.
van der Putten, 2008	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	It helped to gain a better understanding of the experiences and concerns of NQMs.

Appendix D

Table D2: Questions and Answers of Critical Appraisal of a Cross-sectional Study (Survey) CEBMa

Research Study	Question Number	Appraisal Question	Answer
Davis et al., 2012	1	Did the study address a clearly focused question / issue?	Yes
	2	Is the research method (study design) appropriate for answering the research question?	Yes
	3	Is the method of selection of the subjects (employees, teams, divisions, organisations) clearly described?	Yes
	4	Could the way the sample was obtained introduce (selection) bias?	Yes
	5	Was the sample of subjects representative with regard to the population to which the findings will be referred?	Yes
	6	Was the sample size based on pre-study considerations of statistical power?	Yes
	7	Was a satisfactory response rate achieved?	Yes
	8	Are the measurements (questionnaires) likely to be valid and reliable?	Yes
	9	Was the statistical significance assessed?	Yes
	10	Are confidence intervals given for the main results?	Yes
	11	Could there be confounding factors that haven’t been accounted for?	Yes
	12	Can the results be applied to your organization?	Yes

Appendix D

Table D3: Questions and Answers of a Mix Method Appraisal Tool - MMAT

Research Study	Question Number	Appraisal Question	Answer
		Screening Questions (for all types)	
Lennox et al., 2012	1	Are there clear qualitative and quantitative research questions (or objectives), or clear mixed methods question (or objective)?	Yes
	2	Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	Yes
	3	Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	Yes
	4	Is the integration of qualitative and quantitative data (or results) relevant to address the research question (objective)?	Yes
	5	Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results) in a triangulation design?	Yes

Appendix E

Literature Included in the Review

Authors	Year of publication	Region / Country	Methodology	Sample size	Sample technique	Participants	Data collection
Cazzini et al., 2022	2022	Republic of Ireland	Qualitative study	7	Convenience Sampling	NQMs who had commenced their post registration clinical practice in a large teaching hospital	Semi-structured interviews
Simane-Netshisaulu & Maputle, 2021	2021	South Africa	Qualitative study	5	Non probability purposive sampling	NQMs working in selected maternity units during their first year from completion of training	Unstructured in-depth interviews
Sheehy et al.,	2021	Australia	Qualitative study	28	Non probability sampling	Re-recruited participants from a previous longitudinal study	Semi-structured telephone interviews
Watson & Brown, 2021	2021	Northern Ireland	Qualitative study	8	Purposive sampling	NQMs who had obtained their registration in the last 12 months and taken a post with Health and Social Care [HSC] trust	Semi-structured in-depth interview
Kool et al.,	2020	Netherlands	Qualitative study	21	Snowball sampling	NQMs graduated less than 3 years ago and work as hospital-based midwives in Netherlands	Interviews
Naqshbandi et al.,	2019	Erbil Iraqi	Qualitative study	15	Convenience Sampling	NQMs who were in their transition period	Semi-structured in-depth interview

Norris	2019	United Kingdom	Qualitative study	5	Convenience sample	NQMs in a maternity unit	Focus groups & reflective diary
Griffiths et al.,	2019	Australia Queensland	Qualitative study	8	Purposive Sampling	Midwives who had just completed their BMid as part of the RPMEP	Semi-structured telephone interviews
Wain	2017	United Kingdom	Qualitative study	8	Purposive sampling	NQMs who had completed their preceptorship	Semi-structured interviews
Kitson-Reynolds et al.,	2014	United Kingdom	Qualitative study	12	Cohort sampling	NQMs during their first year of practice	Semi-structured interviews
Barry et al.,	2014	Perth Western Australia	Qualitative study	11	Purposive sampling	NQMs who were previously nurses	Interviews & participants journal
Barry et al.,	2013	Perth Western Australia	Qualitative study	11	Purposive sampling	NQMs recruited on their last day as student midwives	Semi-structured interviews & researcher field notes
Clement et al.,	2013	Australia	Qualitative study	38	Purposive sampling	NQMs recruited from 14 public maternity hospitals	Telephone interviews & focus groups
Lennox et al.,	2012	New Zealand	Mixed-Method study	8	Purposive sampling	NQM's who had just been registered as midwives.	Semi-structured interviews & telephone logs
Davis et al.,	2012	Australia	Survey	25	Convenience sample	All NQM's employed within three participating Area Health Services	Surveys

Avis et al.,	2012	United Kingdom	Qualitative study	35	Convenience sample	NQM's from 18 work sites.	Diary & interviews
Young	2012	United Kingdom	Qualitative study	36 student midwives 5 midwives 12 mentors	Convenience sampling	Student participants were recruited from the 3-year Preregistration Midwifery	Focus groups, observations & interviews.
Hobbs	2012	United Kingdom	Qualitative study	7	Non-probability sample	NQM's working in the major maternity department	Observations, interviews & personal field diary.
Skirton et al.,	2012	UK	Qualitative study	35	Purposive sampling	Final year midwifery students	Diary
Fenwick et al.,	2012	Australia	Qualitative study	16	Convenience sampling	Newly qualified midwives who were participants in a longitudinal project	Interviews
Saliba	2011	Malta	Qualitative study	11	Purposive sampling	Newly qualified midwives who had just started their employment at Mater Dei Hospital	Interviews
Van Der Putten	2008	Ireland	Qualitative study	6	Purposive sampling	Newly qualified midwives who qualified in the last 6 months	Interviews

Appendix F

Matrix 1: What are the experiences and feelings of NQMs when caring for women in the maternity setting?

Description of Study: Author(s) / Year / Method / Sample	Negative Feelings and Emotion		Positive Feelings and Experience
	Personal Emotions	What NQMs thought of Midwifery	
Cazzini, Cowman, Fleming, Fletcher, Kuriakos, Mulligan & Healy, 2022 Qualitative Descriptive Study: 7 NQMs	Felt challenged and overwhelmed; Overburdened by responsibility and accountability of working under registration; Felt they needed to prove themselves		
Simane-Netshisaulu & Maputle, 2021 Qualitative Explorative Descirptive and Contextual Study: 5 NQMs	Felt neglected and alone; Scared to speak up; Worried they would be judged		
Sheehy, Smith, Gray & Homer, 2021 Qualitative Study: 28 NQMs	Like they were sinking and swimming; Stress; Heart pounding; Mind going blank; Head going to explode; Felt like a pawn; Burden to other staff; Fear	Swift and Sudden; Unprepared transition not gradual	
Watson & Brown, 2021 Qualitative Study: 8 NQMs	Fear and anxiety; felt afraid of being a burden		

Kool, Schellevis, Jaarsma & Feijen-De Jong, 2020 Qualitative Descriptive Study: 21 NQMs	Felt couldn't give proper care; effort and adaptation; insecure; Had to always prove themselves; Kept on thinking even when off duty; Self-criticism; Compared themselves to others; Feeling of fail		Variety of work helped them feel challenged: Openness to new experiences
Naqshbandi, Karim & Qadir, 2019 Qualitative Phenomenological Study: 15 NQMs	Quit; Hindered self-confidence		
Norris, 2019 Qualitative Action-Research Approach: 30 NQMs	Angered; Overwhelmed; Traumatised; Vulnerable; Unsupported; Sleeplessness; Anxious; Powerlessness; Disappointment; Loosing whatever made them feel safe		
Griffiths, Fenwick, Carter, Sidebotham & Gamble, 2019 Qualitative Descriptive Methodology: 8 NQMs	Daunting; Terrified; Nervous; Difficult and difference from what imagined; Questioned ability and skills; Being watched; Not trusted	Care not based on woman centred care	Passionate about midwifery; Confident they could adjust
Wain, 2017 Qualitative Phenomenological Study: 8 NQMs	Lack of confidence; Under Pressure; Overwhelmed; Vulnerable; Stressful; Frightening		

Kitson-Reynolds, Cluett, Le-May, 2014 Qualitative Study: 12 NQMs	False promises; Frustrated; Stressed; Worried couldn't switch off after work; self-doubt; Struggling; Anxiety		
Barry, Hauck, O'Donoghue & Clarke, 2014 Qualitative Study Grounded Theory Methodology: 11 NQMs	Anxiety; Feel letting the woman down; Put women's emotional need before theirs; Exhausted; Loyalty towards the mother		
Barry, Hauck, O'Donoghue & Clarke, 2013 Qualitative Study Grounded Theory Methodology: 11 NQMs	Anxiety; Feeling letting the woman down; Losing control; Disbelief; Exasperation and frustration; Willingness to sacrifice; Urge to protect woman		Strong; Feel they can succeed; Proud of achievements; Once their skills consolidate their emotions become positive
Clement, Davis & Fenwick, 2013 Descriptive Qualitative Approach: 28 NQMs	Stress; Discomfort; Anxiety during birth suite rotation; Scariest and daunting; Fear of making a mistake: Pecking order		
Lennox, Jutel & Foureur, 2012 Mixed-Method Study: 8 NQMs	Felt like a 'fraud' and not a real midwife; Insecure; Tension; Women's emotions were too much and upsetting	They found out what midwifery was all about; Experienced both happy and sad situations	

Davis, Foureur, Clements, Brodie & Herbison, 2012 Survey: 44 NQMs	Confident		
Avis, Mallik & Fraser, 2012 Qualitative Study: 35 NQMs	Rotation felt stressful; Felt their competence and adaptation to environment changing regularly and frequently; Anxiety		Some participants felt rotation built their confidence
Young, 2012 Qualitative Ethnographic Study: 5 NQMs	Confusion		
Hobbs, 2012 Qualitative Ethnographic Study: 7 NQMs	Not cushioned; Not geared up; Jump and a trot; Fear and anxiety; Racing around like a looney	Not what was expected; Fairy tale in head	
Skirton, Stephen, Doris, Cooper, Avis & Fraser, 2012 Prospective Longitudinal Study: 35 NQMs	Described as a lack of confidence and experience but not lack of knowledge and competence; Not shielded in emergencies; Terrified; Felt sick; Scared; Unable to apply their knowledge		

Fenwick, Hammond, Raymond, Gray, Foureur, Homer & Symon, 2012 Qualitative Descriptive Study: 16 NQMs	Low life; Bottom of the barrel; A nobody; When face with challenges felt chuckled in deep and being left to drown; Guilt; Blamed; Excluded; Uncomfortable; Chastised; Ignored; Felt small; Belittled; Foolish; Intimidated; Humiliated; Isolated; Palpitations; Knit in stomach		
Saliba, 2011 Qualitative Case Study: 11 NQMs	Insecurity; Anxiety; Stressful		
van der Putten, 2008 Qualitative Heideggerian Phenomenology: 6 NQMs	Insecurity; Stressful; Overwhelmed; Reality shock; Guilt when didn't have courage to speak for women	Diminishing role of midwife due to women centred care and management	Theoretically felt well and prepared

Appendix G

Matrix 2: What may influence the NQM experiences on the job?

Description of Study: Author(s) / Year / Method / Sample	Influencing Factors			
	Working Environment	**Other Staff**	**Responsibility**	**Decision-Making & Time Management**
Cazzini, Cowman, Fleming, Fletcher, Kuriakos, Mulligan & Healy, 2022 Qualitative Descriptive Study: 7 NQMs	Hospital environment too busy and understaffed	Lack of support; Enable or hinder progress; Having a buddy to share experience together	Overburdened by immense sense of responsibility and accountability	Double checked everything they performed; Hurrying to complete tasks rather than providing women-centred care
Simane-Netshisaulu & Maputle, 2021 Qualitative Explorative Descriptive and Contextual Study: 5 NQMs	Environment not conducive to learning	Unaccepted by midwives; Received threats from midwives		Decision-making learnt through trial and error
Sheehy, Smith, Gray & Homer, 2021 Qualitative Study: 28 NQMs	Rotation brought fluctuation in confidence; Steep learning curve	Senior midwives thought they did not have the ability and skills	Too much responsibility, they didn't realise it before	They had to make decisions
Watson & Brown, 2021 Qualitative Study: 8 NQMs		Not always supported; Not allowed to practice evidence-based knowledge		Too many tasks at hand to allocate time with mother
Kool, Schellevis, Jaarsma & Feijen-De Jong, 2020 Qualitative Descriptive Study: 21 NQMs	Learning new skills; Caring for women who are high risk; Rotator	Building trust; Knowing when to delegate	Interpreting CTG since subjective	Fast decision-making during emergencies; Time management

Naqshbandi, Karim & Qadir, 2019 Qualitative Phenomenological Study: 15 NQMs	Couldn't put theoretical knowledge to practice		Difficulty to adapt due to responsibility	
Norris, 2019 Qualitative Action-Research Approach: 30 NQMs	Felt their competence was measured according to completed tasks	Unsupported		Due to workload couldn't ask for help in decision-making
Griffiths, Fenwick, Carter, Sidebotham & Gamble, 2019 Qualitative Descriptive Methodology: 8 NQMs	So many interventions were challenging			
Wain, 2017 Qualitative Phenomenological Study: 8 NQMs				
Kitson-Reynolds, Cluett, Le-May, 2014 Qualitative Study: 12 NQMs	Autonomous	Unkindness; Intimidated by staff	Responsibilities increased	Decision-making
Barry, Hauck, O'Donoghue & Clarke, 2014 Qualitative Study Grounded Theory Methodology: 11 NQMs				

Barry, Hauck, O'Donoghue & Clarke, 2013 Qualitative Study Grounded Theory Methodology: 11 NQMs	Hospital policies influence their ability to provide woman centred care; When trust was challenged between woman and NQM			
Clement, Davis & Fenwick, 2013 Descriptive Qualitative Approach: 28 NQMs	Birth suite; Hierarchical rules, status and power valued	Rules made by senior midwives to control both the mother and NQM; Surveillance of senior midwife	Responsibility overwhelming and difficult to cope with; Level of responsibility too high	Making decisions not like when they were students
Lennox, Jutel & Foureur, 2012 Mixed-Method Study: 8 NQMs	Documentation, agreements etc.; Having to rely on others such as obstetricians; Unfamiliarity to ward environment	Tension how staff perceived them; Tension about relationships with colleagues; Pecking order		
Davis, Foureur, Clements, Brodie & Herbison, 2012 Survey: 44 NQMs	Knowing hospital setting	Good staffing		
Avis, Mallik & Fraser, 2012 Qualitative Study: 35 NQMs	Not knowing team, environment, policies, and procedures			

Young, 2012 Qualitative Ethnographic Study: 5 NQMs		When senior midwives exerted authority and were rigid in their practices; When senior midwives expected NQMs to follow their rules or challenge their decisions already taken by the NQM		
Hobbs, 2012 Qualitative Ethnographic Study: 7 NQMs	Choosing how to practice	Conflict and competition between staff; Influence of doctors; Senior staff just take over		
Skirton, Stephen, Doris, Cooper, Avis & Fraser, 2012 Prospective Longitudinal Study: 35 NQMs	Shortage of staff made it difficult to ask questions; Unfamiliarity with paperwork		Became a reality when took the role of midwife	Capability of applying what was taught in theory to practice
Fenwick, Hammond, Raymond, Gray, Foureur, Homer & Symon, 2012 Qualitative Descriptive Study: 16 NQMs	Very busy environment; Mental and emotional work	Felt world belonged to senior staff; Expected to toughen up and get on with it; Staff behaviour left them struggling to work, learn and cope		

Saliba, 2011 Qualitative Case Study: 11 NQMs	The clinical placement made a difference in their adaptation; Feelings of detachment from other group member; Uniform gave them a sense of belonging and projected as midwives with other staff members	Staff perceiving that they were knowledgeable in tasks; Felt that when they were students there was a competition to build up relationships with midwives; felt the need to show staff they had the knowledge	More responsibility scary; More obligations to fill	
van der Putten, 2008 Qualitative Heideggerian Phenomenology: 6 NQMs	Expectations from women increased; Conflicting ideologies while caring for women; Difference between theory and practice	Expectations from colleagues	Overwhelmed with level of responsibility; Needs continuous education	

Appendix H

Matrix 3: What strategies may enhance the NQM in her new role?

Description of Study: Author(s) / Year / Method / Sample	Strategies Most Helpful		
	Personal	**Environment**	**Other Staff**
Cazzini, Cowman, Fleming, Fletcher, Kuriakos, Mulligan & Healy, 2022 Qualitative Descriptive Study: 7 NQMs	Having a buddy to share experience together	Considered as supernumerary for the first two weeks; Having a clinical skills facilitator; Training skill and drills for emergency situations	Clinical experience helped to develop competence during development stage; Team building; Debriefing and reflection session
Simane-Netshisaulu & Maputle, 2021 Qualitative Explorative Descriptive and Contextual Study: 5 NQMs	Finding support helped to perform better		
Sheehy, Smith, Gray & Homer, 2021 Qualitative Study: 28 NQMs	Having the skills, competence and knowledge	Having already worked in unit as student; More clinical support; Mentoring and debriefing; Being allowed to practice to the full scope; Feeling appreciated; Policies and guidelines	Having a midwife-to-midwife relationships; Socialising out of work; Leadership and management; Adequate staffing of different levels
Watson and Brown, 2021 Qualitative Study: 8 NQMs	Finding supportive colleagues was an important source; Peer support to share experience	Benefitted from SMARRT pack which consists of practical guidelines and shows evidence of skill competence of NQMs; Being considered supernumerary	

Kool, Schellevis, Jaarsma & Feijen-De Jong, 2020 Qualitative Descriptive Study: 21 NQMs	Managing to build a relationship with the woman under their care; Having opportunity to study; Having confidence to interact with team and woman; Keeping calm during stressful situations; Working accurately		Working in a team; Not feeling left out in breaks; Having supervision; Getting feedback from other colleagues
Naqshbandi, Karim & Qadir, 2019 Qualitative Phenomenological Study: 15 NQMs			Support from colleagues increased self confidence
Norris, 2019 Qualitative Action-Research Approach: 30 NQMs			Fitting in a feeling accepted felt inspirational
Griffiths, Fenwick, Carter, Sidebotham & Gamble, 2019 Qualitative Descriptive Methodology: 8 NQMs			
Wain, 2017 Qualitative Phenomenological Study: 8 NQMs		Supernumerary; Time on ward to consolidate knowledge experience; Having a ratio of one midwife to one mother; time with a preceptor	Support from midwives; Supervision
Kitson-Reynolds, Cluett, Le-May, 2014 Qualitative Study: 12 NQMs			Teamwork; Having a positive leader

Barry, Hauck, O'Donoghue & Clarke, 2014 Qualitative Study Grounded Theory Methodology: 11 NQMs	Previous knowledge helps to instigate pathways	Feel respected	
Barry, Hauck, O'Donoghue & Clarke, 2013 Qualitative Study Grounded Theory Methodology: 11 NQMs	The knowledge they have and the clinical practice as student; When women trust them, they feel empowered; Support from peers; When align expectations with experience they feel satisfied		
Clement, Davis & Fenwick, 2013 Descriptive Qualitative Approach: 28 NQMs			
Lennox, Jutel & Foureur, 2012 Mixed-Method Study: 8 NQMs	Having mentors; Sharing achievements and failures; Integrated their new experiences to understandings; Having the space to vent emotions	Knowing the system of the hospital; Administrative details; Not knowing where certain equipment is; Not knowing certain protocols	Being able to vent out;
Davis, Foureur, Clements, Brodie & Herbison, 2012 Survey: 44 NQMs	Uses research to keep up to date with midwifery practices	Knowing hospital setting; Orientation; Good staffing; Preceptorship to help build confidence	Positive staff attitude

Avis, Mallik & Fraser, 2012 Qualitative Study: 35 NQMs	Having the opportunity to work with minimal supervision as students decreased the big shock	Having a preceptor helps in development and gaining confidence; Getting familiar with staff policies and unit procedures; Some reported that unfamiliarity helped them to work more autonomously hence speeding transition	Great importance on positive support received from fellow midwives and senior midwives; Having positive feedback helped in work satisfaction and confidence
Young, 2012 Qualitative Ethnographic Study: 5 NQMs	Used experiences for future practice; Decision-making was based on knowledge gained from theory learnt from school; Self-study and working in clinical practice	Having guidelines helped even for decision-making; Culture of workplace	When mentors and staff explained why decision was taken, helped in decision-making skills; Having space for dialogue; Colleagues willing to help for decision-making; Positive midwifery role models; Sought midwives from peer groups rather than seniors
Hobbs, 2012 Qualitative Ethnographic Study: 7 NQMs			Feeling part of the team
Skirton, Stephen, Doris, Cooper, Avis & Fraser, 2012 Prospective Longitudinal Study: 35 NQMs	Placements worked as students; Practice as students in labs; Midwifery teacher played an important role		Supportive staff members

Fenwick, Hammond, Raymond, Gray, Foureur, Homer & Symon, 2012 Qualitative Descriptive Study: 16 NQMs			Positive relationships felt as life raft; Comfortable and confident; Could ask questions without feeling judged or stupid; Willing to help and share knowledge
Saliba, 2011 Qualitative Case Study: 11 NQMs	Placed with course colleagues; Being placed in wards when they were students helped to integrate more with staff; Clinical practice as students	Being placed under supervision in specialised units is found to be crucial; being a supernumerary instead of compliment of staff	Support from other staff was crucial; Being part of a shift; Recognition; Acceptance; Working alongside midwives; Feeling of belonging and trusted
van der Putten, 2008 Qualitative Heideggerian Phenomenology: 6 NQMs	Continuous education	More practical time as students	Support needed by colleagues and mentor, or preceptor

Appendix I

Interview Schedule

Newly qualified midwives' lived experiences of caring for mothers during labour and birth

Semi-structured interview schedule

Demographic Data

In what year did you graduate as a midwife?

When were you recruited by Mater Dei Hospital?

In which part of your rotation have you arrived?

When were you placed at the Central Delivery Suite (CDS)?

How long was your first placement at the Central Delivery Suite?

As you know, I am interested in learning about your experience of being a newly qualified midwife during your rotation placement at the Central delivery suite:

1. Can you tell me about your experience of working on the Central Delivery Suite (CDS) as a newly qualified midwife?
2. Tell me how your experience developed during your placement at the Central Delivery Suite as your cared for different women during labour and birth.
3. Tell me about your experience with the other staff (other midwives, doctors and other staff members) as you cared for women during labour and birth.
4. How similar or different was your experience on CDS at the end of your placement compared to what you thought it would be like before commencing your placement?
5. Reflecting back on your experience on the CDS, can you tell me what such experience mean to you?
6. Can you think of anything which you feel can help to better support newly qualified midwives on the CDS?

Appendix J

Permissions Obtained to Conduct Research

L-Università ta' Malta

Jeanette Gauci
[redacted]

21st April 2021

Mr. Simon Caruana
Data Protection Officer
Mater Dei Hospital,
Tal-Qroqq, Msida, MSD2090.

Request for permission to conduct research in Mater Dei Hospital

Dear Mr. Caruana,

My name is Jeanette Gauci, and I am a student at the Faculty of Health Sciences, University of Malta, presently reading for a Master of Science in Midwifery. As partial fulfilment of my studies, I am requested to conduct a research study. This will involve studying the 'Newly qualified midwives' lived experiences of caring for women during labour and birth'. This project will be conducted under the supervision of Dr. Rita Pace Parascandalo.

I am hereby seeking your permission to collect data from approximately 12 newly graduated midwives who have completed their six months rotation placement at the Central Delivery Suite in the last two years. Participants will include a one-time, face-to-face interview lasting about one hour. Interviews will be audio recorded with the participants' consent. I am aware that I have to abide by the ethical regulations of the local Data Protection Act (2001), thus I am going to ensure participants' confidentiality and gain informed consent prior to the interviews. I am also seeking ethics approval from the Faculty of Health Sciences Research Ethics Committee. I am anticipating that data collection will take place between May 2021 and January 2022.

Your support for this research would be greatly appreciated and should you require further information, please do not hesitate to contact me or my supervisor; both our contact details are provided below.

Thank you for your kind consideration of this request.
Sincerely,

Ms. Jeanette Gauci
[redacted]

Dr. Rita Pace Parascandalo
[redacted]

L-Università ta' Malta

Re: Request for permission to conduct research in Mater Dei Hospital

Data Protection at MDH 22 April 2021 at 10:34
To: Jeanette Gauci
Cc: Young Sharon at Health-MDH Data Protection Approval Form at Health-MDH

Dear Ms Gauci

On the basis of the documentation you submitted, from the MDH data protection point of view you have been cleared to proceed with your study titled ***Newly qualified midwives' lived experiences of caring for women during labour and birth*** provided that you obtain approval from MDH CEO (please provide the relevant documents including the Chair's approval and this email).

-

-

All data stored must be anonymized and in no way should you retain any personal details you obtain from your research and these should be destroyed at the end of your study and /or if any of your participants decides to withdraw. Remember that participants reserve the right to be forgotten.

Anonymisation and Data minimisation

Participant consent forms must be separated from the interview answers at source meaning that there will be no correlation between one and the other that will indicate how participants replied.

-

ALL data presented to your supervisors / tutors or examiners or any other personnel from UOM or anyone else must be already anonymized; meaning that you must not divulge to anyone the identity of your participants and / or how they replied. If our newly qualified Midwives want to enquire who accessed their personal data for exceptional verification purposes by the supervisor or / and examiners, they may contact Dr Rita Pace Parascandalo on .

Consent Criteria

This clearance does not allow viewing of medical records nor access to Health Information Systems.

This clearance does not allow patient contact.

Since you haven't declared otherwise, all your participants must be reached and approached by Ms Mary Buttigieg Said when physically at MDH grounds and NOT via postal services, email, telephone or any other means. You cannot be handed any contact details of potential participants, otherwise consent would be bypassed and breach GDPR.

Potential participants must be approached by your intermediary Ms Mary Buttigieg Said for invitation and not directly by you. You can approach only after they consent.

Personal identifiable data such as signed consent forms or pseudonym lists are not to be sent via email (not even relayed to yourself), replicated and/or uploaded in any server, cloud storage, site or any other media since participants did not consent any service provider to store their personal identifiable data.

Since you haven't declared otherwise, audio recordings must be strictly accessed and listened only by you (not even by your tutors, supervisors or any personnel from UOM/ FHS) and that all data (including transcripts) presented to UOM / FHS must be completely anonymised. Such recordings are not to be sent via email, replicated and/or uploaded in any server, cloud storage, site or any other media. Audio recordings must be destroyed after the conversation will be transcribed or if the participant decides to withdraw from the study.

Video recordings and photography are not allowed for this research.

Clarifications

This clearance does not cover ethical approval.

Your potential participants for this study are newly qualified Midwives only.

Your potential participants are newly qualified Midwives employed at the Obstetrics and Gynae Department MDH and not elsewhere outside the department or hospital.

All documents presented to your participants must include UOM's logo.

Your submitted documentation must remain unchanged.

What was declared during this clearance process is what you will abide to.

You must abide with all the articles of the GDPR (EU) 2016 / 679 throughout the data collection process and thereafter.

You are requested to submit a copy of your findings to this office at the end of your study.

Please communicate with Ms Mary Buttigieg Said to present her this clearance email.

To sign the data protection form, please contact Ms Aquilina through *and provide the following:*

- *This clearance email in PDF format – to provide in PDF*
- *CEO's approval in PDF format - pending*
- *State the period of data collection - May 2021 and January 2022*
- *Title of your research - Newly qualified midwives' lived experiences of caring for women during labour and birth*
- *Your ID Number - pending*

NB: you must sign this form before you start

In summary

1. Obtain MDH CEO's approval
2. Sign the data protection form at Ms Aquilina through

[Quoted text hidden]

SPTAR MATER DEI

Data Protection Clearance Declaration Form

REF: 98/2021

Full Name: Jeanette Gauci

ID/ Passport:

Approval Date from DPO: 22nd April 2021

Approval Date from CEO: 22nd April 2021

Data Collection Period (From – To): May 2021 – January 2022

MDH Official Approval Names: Prof Y Muscat Baron, Ms C D' Amato

Name of Study / Audit: Newly qualified midwives' lived experiences of caring for women during labour and birth

Applicant's Signature: Jeanette Gauci (Apr 25, 2021 11:53 GMT+2)

Data Protection Approval Form - Jeanette Gauci

Final Audit Report 2021-04-23

Created:	2021-04-23
By:	Data Protection Approval Form
Status:	Signed
Transaction ID:	CBJCHBCAABAAyP6Yf0bYSC-8UJBNTiuMLmf7h4BeU_pv

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Adobe Sign

L-Università ta' Malta

Jeanette Gauci
[redacted]

21st April 2021

Ms. Celia Falzon
Chief Executive Officer
Mater Dei Hospital,
Tal-Qroqq, Msida, MSD2090

Request for permission to conduct research in Mater Dei Hospital

Dear Ms. Falzon,

My name is Jeanette Gauci, and I am a student at the Faculty of Health Sciences, University of Malta, presently reading for a Master of Science in Midwifery. As partial fulfilment of my studies, I am requested to conduct a research study. This will involve studying the 'Newly qualified midwives' lived experiences of caring for women during labour and birth'. This project will be conducted under the supervision of Dr. Rita Pace Parascandalo.

I am hereby seeking your permission to collect data from approximately 12 newly graduated midwives who have completed their six months rotation placement at the Central Delivery Suite in the last two years. Participants will include a one-time, face-to-face interview lasting about one hour. I am aware that I have to abide by the ethical regulations of the local Data Protection Act (2001), thus I am going to ensure participants' confidentiality and gain informed consent prior to the interviews. I am also seeking ethics approval from the Faculty of Health Sciences Research Ethics Committee. I am anticipating that data collection will take place between May 2021 and January 2022.

Your support for this research would be greatly appreciated and should you require further information, please do not hesitate to contact me or my supervisor; both our contact details are provided below.

Thank you for your kind consideration of this request.
Sincerely,

Ms. Jeanette Gauci
[redacted]

Dr. Rita Pace Parascandalo
[redacted]

L-Università ta' Malta

RE: Requesting permission to conduct Research Study at Mater Dei Hospital

CEO at Health-MDH 22 April 2021 at 12:30
To: Jeanette Gauci

Dear Ms Gauci,

Kindly note that approval has been given by Ms Celia Falzon for you to conduct this study in line with applicable hospital protocols.

Please also be reminded that Ms Marsette Portelli's approval on behalf of the CEO has to be sought before any data being shared outside of hospital locally or abroad.

Regards

Carmen Farrugia
Personal Assistant To CEO

SPTAR MATER DEI

Mater Dei Hospital, Triq id-Donaturi tad-Demm, l-Imsida, Malta MSD 2090 | Tel +356 2545 0000 | https://deputyprimeminister.gov.mt/en/MDH/Pages/Home.aspx | https://www.facebook.com/materdeihospital/

L-Università ta' Malta

Jeanette Gauci
[redacted]

20th April 2021

Professor Yves Muscat Baron
Director of the Department of Obstetrics and Gynaecology
Mater Dei Hospital,
Tal-Qroqq, Msida, MSD2090

Request for permission to conduct research in Mater Dei Hospital

Dear Prof. Muscat Baron,

My name is Jeanette Gauci, and I am a student at the Faculty of Health Sciences, University of Malta, presently reading for a Master of Science in Midwifery. As partial fulfilment of my studies, I am requested to conduct a research study. This will involve studying the 'Newly qualified midwives' lived experiences of caring for women during labour and birth'. This project will be conducted under the supervision of Dr. Rita Pace Parascandalo.

I am hereby seeking your permission to collect data from approximately 12 newly graduated midwives who have completed their six months rotation placement at the Central Delivery Suite in the last two years. Participants will include a one-time, face-to-face interview lasting about one hour. I am aware that I have to abide by the ethical regulations of the local Data Protection Act (2001), thus I am going to ensure participants' confidentiality and gain informed consent prior to the interviews. I am also seeking ethics approval from the Faculty of Health Sciences Research Ethics Committee. I am anticipating that data collection will take place between May 2021 and January 2022.

Your support for this research would be greatly appreciated and should you require further information, please do not hesitate to contact me or my supervisor; both our contact details are provided below.

Thank you for your kind consideration of this request.
Sincerely,

Ms. Jeanette Gauci
[redacted]

Dr. Rita Pace Parascandalo
[redacted]

L-Università ta' Malta

Re: Request for permission to conduct research in Mater Dei Hospital

Muscat Baron Yves at Health-MDH 20 April 2021 at 13:26
To: Jeanette Gauci

Go ahead

From: Jeanette Gauci
Sent: 20 April 2021 11:20:58
To: Muscat Baron Yves at Health-MDH
Subject: Re: Request for permission to conduct research in Mater Dei Hospital

[Quoted text hidden]

L-Università ta' Malta

Jeanette Gauci
[redacted]

20th April 2021

Ms. Carmela D'Amato
Nursing and Midwifery Director
Mater Dei Hospital,
Tal-Qroqq, Msida, MSD2090

Request for permission to conduct research in Mater Dei Hospital

Dear Ms. D'Amato,

My name is Jeanette Gauci, and I am a student at the Faculty of Health Sciences, University of Malta, presently reading for a Master of Science in Midwifery. As partial fulfilment of my studies, I am requested to conduct a research study. This will involve studying the 'Newly qualified midwives' lived experiences of caring for women during labour and birth'. This project will be conducted under the supervision of Dr. Rita Pace Parascandalo.

I am hereby seeking your permission to collect data from approximately 12 newly graduated midwives who have completed their six months rotation placement at the Central Delivery Suite in the last two years. Participants will include a one-time, face-to-face interview lasting about one hour. I am aware that I have to abide by the ethical regulations of the local Data Protection Act (2001), thus I am going to ensure participants' confidentiality and gain informed consent prior to the interviews. I am also seeking ethics approval from the Faculty of Health Sciences Research Ethics Committee. I am anticipating that data collection will take place between May 2021 and January 2022.

Your support for this research would be greatly appreciated and should you require further information, please do not hesitate to contact me or my supervisor; both our contact details are provided below.

Thank you for your kind consideration of this request.
Sincerely,

Ms. Jeanette Gauci
[redacted]

Dr. Rita Pace Parascandalo
[redacted]

L-Università ta' Malta

Re: Request for permission to conduct research in Mater Dei Hospital

Damato Carmela at Health-MDH
To: Jeanette Gauci

20 April 2021 at 13:09

Dear Jeanette

You can proceed. Good luck for your study.

regards
carmen

Get Outlook for Android

From: Jeanette Gauci
Sent: Tuesday, April 20, 2021 11:30:11 AM
To:
Subject: Re: Request for permission to conduct research in Mater Dei Hospital

[Quoted text hidden]

L-Università ta' Malta

Jeanette Gauci
[redacted]

20th April 2021

Ms. Catherine Cilia
Senior Midwifery Manager
Mater Dei Hospital,
Tal-Qroqq, Msida, MSD2090

Request for permission to conduct research in Mater Dei Hospital

Dear Ms. Cilia

My name is Jeanette Gauci, and I am a student at the Faculty of Health Sciences, University of Malta, presently reading for a Master of Science in Midwifery. As partial fulfilment of my studies, I am requested to conduct a research study. This will involve studying the 'Newly qualified midwives' lived experiences of caring for women during labour and birth'. This project will be conducted under the supervision of Dr. Rita Pace Parascandalo.

I am hereby seeking your permission to collect data from approximately 12 newly graduated midwives who have completed their six months rotation placement at the Central Delivery Suite in the last two years. Participants will include a one-time, face-to-face interview lasting about one hour. I am aware that I have to abide by the ethical regulations of the local Data Protection Act (2001), thus I am going to ensure participants' confidentiality and gain informed consent prior to the interviews. I am also seeking ethics approval from the Faculty of Health Sciences Research Ethics Committee. I am anticipating that data collection will take place between May 2021 and January 2022.

Your support for this research would be greatly appreciated and should you require further information, please do not hesitate to contact me or my supervisor; both our contact details are provided below.

Thank you for your kind consideration of this request.
Sincerely,

Ms. Jeanette Gauci
[redacted]

Dr. Rita Pace Parascandalo
[redacted]

L-Università ta' Malta

Re: Request for permission to conduct research in Mater Dei Hospital

Cilia Catherine at Health-MDH
To: Jeanette Gauci

24 April 2021 at 16:58

Dear Ms. J. Gauci,

I am pleased to inform that I give you permission in respect of your research request at Mater Dei Hospital.

I wish you all the best in your research.

Kind regards,

Catherine

Catherine Cilia
Senior Midwifery Manager
Department of Obstetrics and Gynaecology
Health-Mater Dei Hospital

L-Università ta' Malta

Jeanette Gauci
[redacted]

20th April 2021

Ms. Charmaine Psaila
Senior Midwifery Manager
Mater Dei Hospital,
Tal-Qroqq, Msida, MSD2090

Request for permission to conduct research in Mater Dei Hospital

Ms. Psaila,

My name is Jeanette Gauci, and I am a student at the Faculty of Health Sciences, University of Malta, presently reading for a Master of Science in Midwifery. As partial fulfilment of my studies, I am requested to conduct a research study. This will involve studying the 'Newly qualified midwives' lived experiences of caring for women during labour and birth'. This project will be conducted under the supervision of Dr. Rita Pace Parascandalo.

I am hereby seeking your permission to collect data from approximately 12 newly graduated midwives who have completed their six months rotation placement at the Central Delivery Suite in the last two years. Participants will include a one-time, face-to-face interview lasting about one hour. I am aware that I have to abide by the ethical regulations of the local Data Protection Act (2001), thus I am going to ensure participants' confidentiality and gain informed consent prior to the interviews. I am also seeking ethics approval from the Faculty of Health Sciences Research Ethics Committee. I am anticipating that data collection will take place between May 2021 and January 2022.

Your support for this research would be greatly appreciated and should you require further information, please do not hesitate to contact me or my supervisor; both our contact details are provided below.

Thank you for your kind consideration of this request.
Sincerely,

Ms. Jeanette Gauci
[redacted]

Dr. Rita Pace Parascandalo
[redacted]

L-Università ta' Malta

Re: Request for permission to conduct research in Mater Dei Hospital

Psaila Charmaine at Health-MDH 20 April 2021 at 17:32
To: Jeanette Gauci

Dear Jeanette,

Hope this email finds you well and I wish you luck for such an interesting topic much needed in midwifery locally.

From my point of view you may go ahead with the studies however may I please ask if you asked approval from Ms. Carmen Damato – Director for Nursing and Midwifery.

Once again I wish you luck and if you need any help do not hesitate to come forward.

Thanks and regards,

Charmaine

Charmaine Psaila
Senior Midwifery Manager

Department of Obstetrics and Gynaecology
Health-Mater Dei Hospital

https://health.gov.mt | www.publicservice.gov.mt | fb.com/servizzpubbliku

MINISTRY FOR HEALTH

MATER DEI HOSPITAL, TRIQ ID-DONATURI TAD-DEMM,
MSIDA, MALTA

Appendix K

FREC Approval

Rita Pace Parascandalo
to me, Research

Dear Jeanette,

your amendment as requested by FREC, has been reviewed and approval is granted oBo FREC. You may proceed with data collection.

Good luck

Regards
Dr Rita PP

L-Università ta' Malta

Dr Rita Pace Parascandalo PhD (UClan)
BSc(Hons) (Melit.), MSc(Melit.), RM

Senior Lecturer, Department of Midwifery
Chairperson, Faculty Research Ethics Committee

Faculty of Health Sciences
Office No. 48

Appendix L

Participation Evaluation Form

L-Università ta' Malta

Evaluation Sheet

1.What was the overall experience of the interview?

2. Were there any questions that needed further clarification?

3.Were there any question/s which you feel you did not understand what was being asked?

4.Have you got any recommended questions that should have been included within this interview? If yes, kindly outline.

Appendix M

Thematic Content Map Table

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"It is a very busy environment when compared to the wards, for example, there is not much of a routine. At Central Delivery Suite you never know if you are going to start the day at 7, or later on. Because, ehm, you might have a mother coming at the beginning of your shift, or she comes in later. So, the routine is very different. Sometimes, you might not even have the time to have a break, not like maybe in other wards. So, ehm, even mentally it is quite exhausting as well." (Ana, p. 3-4)	Busy ward	Demanding Ward Environment	Challenging Environment	**Baptism of Fire**
	The place with the highest expectations			
	Bad connotations about ward	Mentally/ Physically Exhausting		
	Unpredictable Ward Events			
	Learning while working			

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"…we do our deliveries in our third year and we have a whole two months practising our deliveries. In our fourth year, we didn't have any placements at the Central Delivery Suite so we didn't have any deliveries. I mean we practised skills because we were practising for our finals, but we weren't practising as many skills as if we were doing the deliveries. Then I had another year to go to Central Delivery Suite so I was quite a bit in shock that I would, ehm, forget some skills or for example when performing a vaginal examination, that I wouldn't do it right and obviously if another person examines (the woman) after me that it would be a whole, ehm, different findings…" (Olivia, p. 18)	Lost touch	Feelings of Incompetence	Feelings of a Junior Midwife	**Baptism of Fire**
	Lost practice			
"In the beginning I did feel a bit alone. I admit because, you don't know the staff that well, and you fear that if you ask too much, they won't trust you as much." (Ana, p. 18)	Feel alone	Feeling Stranded		
"I didn't feel that I was equipped with enough knowledge when starting the placement. So, I believe if there was someone who sat down with me and told me "listen if you have this and that, this is what you are going to do." And a list of points "listen this is what you need to do." Not just something on the spot, wothout even knowing where the things are on the ward. Because nobody really sits with you, or just takes you around the ward and tells you "listen this is where the ventous pack is, you need to take this if you have a ventous, you need to check this, and that, the machine is working correctly." But nobody tells you this and then you have to just figure it out." (Nina, p.9-10)	Feel lost			
"…In the first week I had a mother who ended up with a major PPH (postpartum haemorrhage) and obviously when you are a student, I mean you see, obviously you don't take care of the complications (as a student). They end up being cared for by the midwives. So, obviously that rush from having an emergency in the first week that you are on rotation it was quite overwhelming. I ended up going home crying that I've done something wrong…" (Olivia, p.6-7)	Feel overwhelmed			

"…on the first day I was quite afraid, ehm, when I was preparing at home to come to work, I was quite tense I remember. Obviously you'll never know what you will expect. It could be something straight forward, however, ehm, it might turn out to be an emergency." (Emma, p.7)	Fear of the unknown	Always on Edge	Feelings of a Junior Midwife	**Baptism of Fire**
"…you are with the mother, you're with the father , then you have to go to the wardround which is a challenge in itself, then you have to give over in the end of the shift in front of everyone ((laughs)). At the obs wards usually it is one to one but at the delivery it's one to many." (Scarlet, p. 17)	Fear of failing			
"I felt like I am the worst midwife on the planet, that I am not good enough and I think the fact that I am not very confident and back then I was less confident it made me feel even worse." (Dorothy, p.8)	Putting oneself down / not worthy of Profession			
"So mainly that issue that I felt that now I have to take the decisions and I am responsible like I cannot keep depending on my, ehm, senior midwives…ehm, having to deal with giving birth and the life of the mother and the baby…." (Lucy, p.3)	Whole responsibility on your shoulder	Realities of Becoming a Midwife		
"The fact that sort of my team are trusting me with a patient and I am not, ehm, I am not managing to keep up and do the skills that I am expected to do." (Dorothy, p.9)	Not reaching expectations			
"I was very scared down there (operating theatre situated downstairs) because, ehm, the environment wasn't in my comfort zone at all." (Ana, p. 8)	Difficult to adapt to change			
"So, it does make you feel a bit frustrated. Because, it's like when you try to do something, ehm, to make you know? The mother, because after all it is all about the mother and having a good and safe delivery and a good experience and it's like trying to help someone to achieve that." (Nina, p.3)	Giving best care to the mother			

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"I think at first you start feeling a bit intimidated because somehow it's like they know that you are a newly graduate midwife, and they don't fully trust you. So, they always refer to someone else." (Lucy, p. 15)	Being the outsider	Team Inclusion	Trying to Fit In	**Baptism of Fire**
***"**On most occasions I try to give her at least 45 – 50 mins (after birth) but usually I feel pressured from other senior members in the shift and it's a pity. I mean I I try to prolong it as much as possible. I don't say ((starts to laugh)) the truth much of the time when they ask me "is the mother having a shower?" I tell them "Yes" but in reality, she would be still breastfeeding for example. So, I try to prolong it as much as possible, but it is quite stressful as well to try to give her the best that you can while being pressured from other senior staff… I usually say in my my mind sort of "it would be really nice to give this care to all mothers and not just on this occasion." Because, ehm, no other midwife is sort of moving around me ((laughs)) you know, trying to transfer the mother as soon as possible. So sometimes, I truly feel guilty transferring the mother, for example, 45 mins after having given birth." (Ella, p. 9-10)*	Going with the current			
	Working against the current			
"I think that was the worst bit getting sort of the mothers wishes, the doctors and the midwives and trying to see sometimes the mother wants one thing, the doctor wants another thing, the midwife wants another thing and then things tend to be a lot you know." (Scarlet, p. 4-5).	Caught in the middle			
So, I got there and ehm, ((takes a deep breath)) things were a bit difficult at first with certain people… but you tend to choose your people ((laughs)) in the sense that you choose whom you are more confident with. It's not that nothing is wrong, but you tend to choose the people you like to even someone who is more approachable than others you know... I hate loud people ((laughs)) and people who make a fuss about everything you know? if I want to tell you only ((laughs)), I will not tell everyone! So, I think that was a bit challenging. I mean having to go to someone who you don't particularly feel like they are quite approachable. So that was quite difficult. (Scarlet, p. 10-11)	Choosing your people			

"Obviously when I didn't know something, I go and ask for others' opinions because we don't know everything. But when someone comes and tell you something "no, don't do that" in front of the mother it makes you feel very bad. Because both the mothers and fathers will say "this one doesn't know what she is doing, if she is doing a mistake." If on the other hand they will call you outside of the room and they will tell you kindly what you were doing wrong it would be different. Because you will know that you did a mistake and next time you can do better. But not in front of the parents, the mother and the father, and shouting in front of them that you are doing something wrong." (Rose, p. 9-10)	Belittled	Superior and Dominating Personalities	Trying to Fit in	**Baptism of Fire**
I had this image that I would be delivering mothers, ehm, more spontaneously, in different positions. Whereas the shift that I was in they were more exposed to, for example, women delivering on their backs and I felt that I wasn't exposed enough to try positions in labour, for example, squatting or standing. I felt a bit scared to try those positions with mothers because I would be afraid that a midwife would come in and she'd tell me "No, why is she in that position?" Ehm, "you don't have control over the mother and the baby in that position." and I used to feel very scared. And once I had a mother on all fours, the baby was coming, a midwife came in and she told me "turn her on her back, turn her on the back" and I felt I couldn't try my maximum." (Ana, p.31)	Feel let down			
"*On most occasions I try to give her at least 45 – 50 mins (after birth) but usually I feel pressured from other senior members in the shift and it's a pity. I mean I I try to prolong it as much as possible. I don't say ((starts to laugh)) the truth much of the time when they ask me "is the mother having a shower?" I tell them "Yes" but in reality, she would be still breastfeeding for example. So, I try to prolong it as much as possible, but it is quite stressful as well to try to give her the best that you can while being pressured from other senior staff… I usually say in my my mind sort of "it would be really nice to give this care to all mothers and not just on this occasion." Because, ehm, no other midwife is sort of moving around me ((laughs)) you know, trying to transfer the mother as soon as possible. So sometimes, I truly feel guilty transferring the mother, for example, 45 mins after having given birth." (Ella, p. 9-10)*	Working under pressure			

"We try to avoid maybe speaking about sometimes other junior midwives. At times I've heard things about junior midwives who are my friends. And I say "if she found out, if she hears what they are saying about her" and then thinking at the same time I wonder what they say about me (uncomfortable giggle) and the same time you feel, ehm, that type of fear. And it does affect you mentally and how you work with mothers because if you don't feel comfortable with the staff, you fear that they might say something about you. Because without wanting to, you doubt yourself and you don't give your 100 percent to the mothers you are caring for. Because you're constantly with that doubt "Am I doing this right? Or am I not? Are they going to say something if I do this and not that?" That constant feeling you know what I mean? That if they talk something about you. (Ana, p. 43)	Victim of gossip	Superior and Dominating Personalities	Trying to Fit in	**Baptism of Fire**
"…if I was the senior midwife or the in charge, I would have come to that midwife, in this case it was me, and ask her how she was feeling at the end of the day because, ehm, experiencing such a complication (cord prolapse) at such a young age of experience it is quite a toll on the midwife… I think it comes to professionalism and respect to one another on the workplace. So you take everything with a pinch of salt. There were some midwives who asked me but in a more sarcastic sort of way so. I found it very surprising that one of the senior doctors came to ask me how I was feeling because it was quite a shock? I never experienced a cord prolapse in my life up to that point, and she asked me directly "how are you feeling after that experience?" I told her "Quite overwhelmed!" She told me "go home, relax, think about what you did, what you could have done better, maybe in that situation." For me it was just enough to just ask me how I am feeling? So, I think from a midwife point of view we need to be not only compassionate to the mothers but also to one another because after all our job is not plain sailing. I mean, we do not come here to sit on a desk and do work on a computer which can be reversed. We work and the care we give at that point in time is crucial to the mother and to the baby." (Ella, p. 5-6)	Facing traumatic experiences and not understood			
"…then she ended up being with a caesarean section. I remember just going outside for help and everyone at the desk and nobody come to ask me "Listen are you okay?" It was just this one friend (rotator like her) who I could talk to and tell her "can you come and help me?"… but I felt like there was everyone at the desk and I am here having this major issue, <u>like come on!</u> I mean and these are people who are not only my colleagues but my friends, "come help me!" you know? "You don't remember the days when you were like me?" ((laughs as if to hide the betrayal she felt at that moment)). (Dorothy, p. 14)	Staff don't remember they were in the same boat			

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"...I mean it was a very good feeling you know, this is something which I really like, this is why I became a midwife after all! So, I used to feel really happy and enthusiastic to put the baby on the mother, and like witnessing their first meeting, and doing that one-hour post birth, and helping the placenta out and whatever. So that sort of thing, I think that bit is the best part of it. Also, I mean seeing the baby being born it's quite a miracle in my opinion." (Nina, p.14-15)	It is the heart of midwifery	True Meaning of Midwifery	Of the Essence	**Containing the Fire**
"...getting to know more the mother you will take more the lead, obviously depending on the situation, so ehm, I think I built a much better relationship when I went to the CDS rotation. Especially because we stay with them quite a long time, a whole day sometimes and you would only have her (mother) sometimes. Usually, it is one to one patient ratio. For example, in other wards you will sometimes have one midwife to 5 mothers so you wouldn't have exactly that much time to get to know them and build a relationship towards them. So, when I went to CDS, ehm, I think that was one of the factors that I really enjoyed because I actually had time to build a relationship with the mother and the father during those few hours."(Olivia, p.28-29)	Individualised one-to-one care			
"You'll do a lot of skills in a short period of time for example, I don't know during labour you do a lot of skills so VEs, catheters if you need. In other wards, for example, VEs you don't do a lot of them, maybe in antenatal mothers when you need to. But at labour ward you do them a lot even multiple times during the day. So, I think if you learn that skill it will stay with you. And even if you need to do a VE in another ward, if you worked at CDS I think it would help to do them more comfortable in other wards, rather than just not doing them at all and then you have to do them in other wards." (Rose, p. 21)	Steppingstone to grow as a midwife	Learning and Growing Envirnoment		
"...It is not fair that, for example, as a rotator you had a certain experience because you were with this shift. And then because another rotator was with another shift, for example, they have a completely different experience, we talk you know among each other, we have friends, it is not fair. And you are there to learn , you are a rotator for a reason that's why you rotate so you can get a lot of experience and you try to learn as much as possible." (Maggie, p. 35-36)	Missed/Gained opportunities			

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"…then having a lot of admissions, they end up with a lot of different scenarios so then when you start tackling an emergency you will end up learning from that emergency and then you will be able to tackle up, ehm, those situations later in life. Obviously, they come with experience, sometimes reading about it in theory is not the same" (Olivia, p. 8-9)	Applying knowledge and practice	Things falling into place	Better with Time	**Containing the Fire**
"The skills, ehm for example, in the beginning ARMs, the artificial rupture of membranes the one that I managed to encounter… There were times, when I was in the very beginning where I said "let me try by myself. No one offered and I didn't ask as well. I didn't feel that comfortable at times, we had just started the rotation and to ask someone to come with me. I feared that they might think that I don't know what I am doing. So maybe that would be, that someone who is shadowing you would ask "listen, do you want I come with you for the first one?" The first ARM I tried to do I went in by myself. I could have asked someone to come with me to be fair. I didn't manage okay, then I asked someone to come, and they were very helpful. But yes that fear. But I think that it is part the experience. You have to try to, because if you don't try you will remain stuck, it's part of learning as well that sometimes you have to go by yourself and you try it out." (Ana, p.50)	Learning by doing			
"However, once I had an induction of labour and usually us the rotators always have induction of labour during our day shift. So, ehm, I had an induction of labour with another senior midwife and she was telling me at which synto level I was and we brought them together. She expected that we had the same, ehm, dose of synto infusion since we started it together. But obviously not every case is the same and she went into my room to increase my synto infusion and I stopped her and she started like to argument with me. However, I told her that if she increases the synto infusion I will write on the documentation that you increased it and not me and, ehm, from that time she never inputted where there wasn't any reasoning. So, I think that was truly the time that I felt I had taken a stand for it. ((her voice sounds so proud of herself that she had finally found the courage to stand up for her beliefs)) (Olivia, p. 13)	Taking a stand/believing in self	Growing as a Midwife		

"The very first delivery I was so focussed on making sure that I'm doing everything right, when you are not that confident that building the relationship with the mother, unfortunately, wasn't my top priority. At time doing a delivery you feel very connected and emotional. In the very first delivery I didn't feel that because I was so focussed on (birth)… So, I think that the emotional and social aspect (of birth) was a bit low on that side so I wouldn't say that it was one of the best. But then after 3 months in my rotation, I felt more confident. I also had some of these complications where I felt that I'm capable of handling things independently more. Then I started getting (not only look at the mechanism of birth but notice that dealing with a woman) more condident with the work and even the emotional aspect of bonding with the mother increased." (Lucy, p. 8-9)	Relationship with mothers	Growing as a Midwife	Better with Time	**Containing the Fire**
"There was a particular mother, she was in 2nd stage, ehm, 2nd stage was slightly long. We called the doctors for a ventous delivery soon. As we were preparing for ventous, ehm, the baby was sort of coming out and everyone was telling me ((laughs)) to perform an episiotomy. However, with perineal support I managed to avoid the episiotomy and the mother had no tears, so that was quite positive (Face lit up)… I was quite happy about it… However, ehm, at that point in time I felt quite in control of the delivery, so I think… I was feeling the baby's head coming out slowly and by supporting the perineum I felt that it could be done without the episiotomy. (Emma, p. 3-5)	Feel accomplished and proud of self			

Newly Qualified Midwives' Voices	Keywords	Concepts	Subtheme	Theme
"Like for example inserting a cannula, rather than trying it out and not having someone there to tell you "Listen, I wouldn't choose this vein because I think there is a valve." These things you get with experience, so I think it would be much better if there was someone there directly with me showing me around and being with me to help and guide me throughout the day. I don't know if that's too much to ask ((laughs))." (Lucy, p. 29-30)	Guidance	Supportive Measures	An Eased Transition	**Containing the Fire**
"But, ehm ,at first, I did feel that maybe I was a bit afraid of the staff always going to ask them "listen can you come help me, ehm, to insert the cannula because I'm not managing?" However, with time, even speaking to the staff, they tell me "Listen it's okay, it's normal at first, it won't always be easy until you get used to the technique." And after hearing those words of encouragement, you feel more relaxed and, ehm, you feel it gives you this the courage (looks at me like she is relaxing) to try again the next time. And if you don't manage, you know, there are people who will support you and help you to do it as well." (Ana, p. 10-11)	Reassurance			
"Maybe I think one of the in charges at Mater Dei, ehm, does this already. But I think one to one meetings with the in charge will help as well. Because she will discuss the things you do right and those you do wrong and this way you could see, sort of, your best skills and your bad skills sort and you continue working on your best skills. Because it makes no sense to continue working with your bad skills. And with these meetings, I think because she is the one that targets these skills. So, with these midwives doing such meetings I think you can better your skills and do the best you can." (Ella, p. 23-24)	Given feedback			
	Given space to reflect/vent			
"I think maybe having not a mentor but someone maybe, example at NPICU they have this system, so when you first go there you have someone that you are assigned to and in the first few weeks you work with them. So, you get used to the NPICU area. I think if its like that at labour ward, I think it will help." (Rose, p. 19)	Support system			

"But these small things such as switching the light, if the mother is in this relaxed environment and someone just comes in and switches on the lights. For example, my way, I used to love working in the dark and sometimes I had a lot of comments about this. Because people coming in telling me "why in this dark?, switch on the lights" and they just kind of intrude the mother's environment, and also your way of working. So maybe at first, okay, they shadow you and teach you, but then towards the end if you're doing well, obviously not if you are doing a bad thing, but if you're doing a good thing they shouldn't keep influencing their way of working on yours. Because I still felt that sometimes I had to tell them "Listen this is the way I work.." Small things maybe, but then towards the end of the rotation you expect that you are respected a bit more, in a way like your own autonomy. You are an autonomous midwife and that's your way unless obviously you are doing something wrong." (Lucy, p. 27-28)	Gain trust and respect	Colleagues' Support	An Eased Transition	**Containing the Fire**
	Allowed to fly and not be grounded			
"There needs to be this more supportive environment for us NQMs. And we have to keep in mind that everyone progresses at different paces as well, because it doesn't mean that every midwife get used to the delivery suite in 3 months, that everyone is going to adapt like that. Everyone is different and everyone learns and gets used to things differently, there are some who take longer to get there." (Ana, p. 45)	Not compared to others			
"Having someone welcome you ((laughs)) and even explain where the stuff is. Going in the nursery and telling you "Listen here is the stuff that you need, this is the cupboard ((laughs)) that you need to open and get the stuff from" ((laughs)), you know? Because everywhere is different. You'd know where everything is in most delivery rooms, but I think, for example, the nursery you'd have no idea. Even having a welcome ((laughs)) will help." (Scarlet, p. 18-19)	Welcomed			
"I think, ehm, the junior midwives helped us a lot. Because for them it was quite recent experience as well, that they graduated so they knew actually what we were going through. So, sometimes we would even, ehm, try to first find a junior midwife rather than a senior midwife on what certain decisions to take. It depends obviously who we will find so, ehm, I think the junior midwives really helped us and made us feel like we were part of their shift as well and even told us what they had went through. (Olivia, p. 20-21)	Comfort from peers			

"I would say that I needed a bit more time, I think six months it's not enough, you need at least nine months if not a year. Because the first 3 months its running in, that's what I felt it was. So by the end, you know, you start feeling to be more confident and you really start enjoying the work, way after 3 months in my personal experience." (Lucy, p.14)	More time in ward	Environment Support	An Eased Transition	**Containing the Fire**
"You will actually be given complications, where at least if not real life complications, having a simulation. Example, if this patient had to have a PPH what are you going do? In real time but you know where the things are because that is something that affected me that I have a complication and I don't know where things are." (Lucy, p.24)	Simulations			
"Having someone welcome you ((laughs)) and even explain where the stuff is. Going in the nursery and telling you "listen here is the stuff that you need, this is the cupboard ((laughs)) that you need to open and get the stuff from" ((laughs)), you know? Because everywhere is different. You'd know most delivery rooms where everything is but I think, like for example, the nursery you'd have no idea. Even having a welcome ((laughs)) will help." (Scarlet, p. 18-19)	Ward orientation			
"Maybe since my experience was that I didn't have exposure to so much complications during my student years maybe they would actually choose cases" (Lucy, p. 23)	Structured plan			
	Weaned into it			

Appendix N

Acceptance Letter from Intermediary Person

L-Università ta' Malta

Jeanette Gauci
[redacted]

20th April 2021

Ms. Mary Buttigieg Said
Practice Midwife
Mater Dei Hospital
Tal- Qroqq, Msida, MSD2090

Dear Ms. Buttigieg Said,

My name is Jeanette Gauci, and I am a student at the Faculty of Health Sciences, University of Malta and, presently reading for a Master of Science in Midwifery. As part fulfilment of the course, I am required to undertake a research study. This will involve studying the '*Newly qualified midwives' lived experiences of caring for women during labour and birth*'. This study is being conducted under the supervision of Dr. Rita Pace Parascandalo.

The study will adopt a qualitative research approach using one-time, face-to-face interviews to generate data from study participants. The study will recruit a maximum of 12 qualified midwives who have completed their six months rotation placement at the Central Delivery Suite (CDS) in the past two years. Interviews will be held at a time suitable for participants in a private room at Mater Dei Hospital. Hence, I kindly request your permission to act as an intermediary to help in the recruitment of participants according to the above inclusion criteria.

Participation is voluntary, and participants will be free to withdraw at any point, without any repercussions. Participants will be asked to sign a consent form before starting the interview, after having read through an information letter detailing the purpose of the study and what participation entails. Hence, should any eligible participants show interest in participating, I would appreciate it if you provide them with an information letter and those interested are directed to contact me so that a suitable time is agreed for an interview. I am anticipating that data collection will take place between May 2021 and January 2022.

I would be grateful if you accept to act as my intermediary as detailed above.

L-Università ta' Malta

Re: Research study

Buttigieg Said Mary at Health-MDH 20 April 2021 at 17:10
To:

Dear Jeanette

Sure, Available to act as an intermediary to support in the recruitment of participants and in any other concerns you feel I can be of help.

Kind regards

Mary

Mary Buttigieg Said
Practice Midwife

SPTAR MATER DEI

Mater Dei Hospital, Triq id-Donaturi tad-Demm, l-Imsida, Malta MSD 2090 | Tel +356 2545 0000 | https://deputyprimeminister.gov.mt/en/MDH/Pages/Home.aspx | https://www.facebook.com/materdeihospital/

Appendix O

Participants' Information Sheet

L-Università ta' Malta

Participants` Information Sheet

Dear Participant,

My name is Jeanette Gauci, and I am currently reading for a Master of Science in Midwifery at the University of Malta. As part of my course requirements, I am conducting a research study entitled, **"Newly qualified midwives' lived experiences of caring for women during labour and birth"**. The aim of this study is to understand the meaning of newly qualified midwives' experiences when caring for women during labour and birth. Participants will not directly benefit from participation in the study, but the information provided can help in better understanding of these experiences which can lead to better practices that would support newly qualified midwives in the future. Furthermore, all data collected from this research shall be used solely for the purpose of this study.

You are being invited to participate in an interview exploring your experiences of working at the Central Delivery Suite during your rotation period in the last two years. Hence, you will only be asked to share data that is necessary for this research. The interview will take approximately an hour and will be held at a time convenient to you in a private room at Mater Dei Hospital. You are not obliged to answer all the questions and may withdraw from the study at any time without giving a reason. Furthermore, withdrawal from the study will not have any negative repercussions on you and any data collected will be erased. Data will be stored anonymously if it is impossible to delete (e.g., if it has already been anonymised). Unless you have any objections, this interview will be audio-recorded. I can assure you that confidentiality will be maintained throughout the study and that your identity and personal information will not be revealed in any publications, reports or presentations arising from this research. All data collected will be pseudonymised meaning that the transcripts will be assigned codes and that this data will be stored securely and separately from any codes and personal data. This data may only be accessed by the researcher. The academic supervisor and the examiners will typically have access to coded data only. There may be exceptional circumstances which allow the supervisor and examiners to have access to personal data too, for verification purposes. If you want to enquire who accessed your data, please contact Dr. Pace Parascandalo on . The coded audio-recordings, and transcripts will be stored on the researcher`s personal computer that is password protected and in an encrypted format. Any material in hard-copy form will be placed in a locked cupboard.

Participation in this study is completely voluntary and you are free to accept or refuse to take part without giving a reason. A copy of the information sheet and consent form will be provided for future reference. As a participant, you have the right, under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, to access, rectify and where applicable ask for the data concerning you to be erased. Once the study is completed and the results are published, the data will be retained in anonymous form. Any personal details will be destroyed.

This study has been approved by the Research Ethics Committee of the Faculty of Health Sciences at the University of Malta. Should you be interested in participating in this study please contact me via email or phone as in order to agree on a date and time for data collection.

Thank you for your time and consideration. Should you have any questions or concerns do not hesitate to contact me on [redacted] or by e-mail [redacted] or my supervisor Dr. Rita Pace Parascandalo on [redacted] or on [redacted].

Yours Sincerely,

Ms. Jeanette Gauci
Researcher

Dr. Rita Pace Parascandalo
Research Supervisor

Appendix P

Participants' Consent Form

L-Università ta' Malta

Participants` Consent Form

Newly qualified midwives' lived experiences of caring for women during labour and birth

I, the undersigned, give my consent to take part in the study conducted by Jeanette Gauci. The purpose of this document is to specify the terms of my participation in this research study.

1. I have been given written and verbal information about the purpose of the study and all questions have been answered.

2. I understand that I have been invited to participate in an interview, in which the researcher will ask questions to understand the meaning of newly qualified midwives' lived experiences when caring for women during labour and birth.

3. I am aware that the interview will take approximately one hour. I understand that the interview is to be conducted in a private room at Mater Dei Hospital and at a time that is convenient for me.

4. I am aware that this interview will be audio recorded and transcribed (written down as it has been spoken).

5. I am aware that the transcripts will be coded and that this data will be stored securely and separately from any codes and personal data.

6. I am aware that the researcher is the only person who has access to this data. The academic supervisor and examiners will typically have access to coded data only. There may be exceptional circumstances which allow the supervisor and examiners to have access to personal data too, for verification purposes. If you want to enquire who accessed your data, please contact Dr. Pace Parascandalo on 2340 1176.

7. I am also aware that the coded audio-recordings and transcripts will be stored on the researcher`s personal computer that is password protected and in an encrypted format. Any material in hard-copy form will be placed in a locked cupboard and kept until results are published.

8. I am aware that my identity and personal information will not be revealed in any publications, reports or presentations arising from this research.

9. I also understand that I am free to accept, refuse or stop participation at any time without giving any reason. This will have no negative repercussions on myself and that any data collected from me will be erased. Data will be stored anonymously if it is impossible to delete (e.g., if it has already been anonymised).

10. I also understand that my contribution will serve to help gain a better understanding of newly qualified midwives experiences of caring for women during labour and birth. Though I may not directly benefit from participation, the information I provide can contribute to inform better practices that would support newly qualified midwives in the future.

11. I understand that under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, I have the right to access, rectify, and where applicable ask for the data concerning me to be erased.

12. I also understand that once the study is completed and results are published the data will be retained in anonymous form. Any personal details will be destroyed.

13. I will be provided with a copy of the information letter and consent form for future reference.

14. I have read and understood the points and statements of this form. I have had all the questions answered to my satisfaction, and I agree to participate in this study.

Participant: _____

Signature: _____

Date: _____

Jeanette Gauci
Researcher

Dr Rita Pace Parascandalo
Research Supervisor

Appendix Q

Hermeneutic Phenomenology Course Certificate

University of Central Lancashire
UCLan
Where opportunity creates success

Certificate of Attendance

Hermeneutic Phenomenology Methodology course

~ July 2021 ~

This is to certify that:

Jeanette Gauci

Attended the above CPD Workshop held by the

University of Central Lancashire

Professor Gill Thomson & Professor Susan Crowther
(Facilitators)

Appendix R

Demographic Characteristics of Participants

Pseudonymised Participant	Age	Year of Qualification	Year of Employment	Present Rotation	Part of Rotation at CDS	Year placed at CDS
Ana	24	2019	2019	Finished	Last placement	May 2021 – November 2021
Emma	25	2020	2020	Mid-Rotation	2nd Placement	May 2021 – November 2021
Scarlet	25	2019	2019	Finished	3rd Placement	May 2020 – November 2020
Olivia	24	2019	2019	Finished	3rd Placement	May 2020 – November 2020
Maggie	26	2019	2019	Finished	3rd Placement	May 2020 – November 2020
Ella	23	2020	2020	Mid-Rotation	2nd Placement	May 2021 – November 2021
Nina	24	2020	2020	Mid-Rotation	1st Placement	November 2020 – May 2021
Lucy	25	2019	2019	Finished	Last Placement	May 2021 – November 2021
Dorothy	25	2019	2019	Finished	2nd Placement	May 2020 – November 2020
Rose	23	2019	2019	Finished	3rd Placement	November 2020 – May 2021