Continued professional development for early career midwives in Aotearoa New Zealand: An appreciative Inquiry

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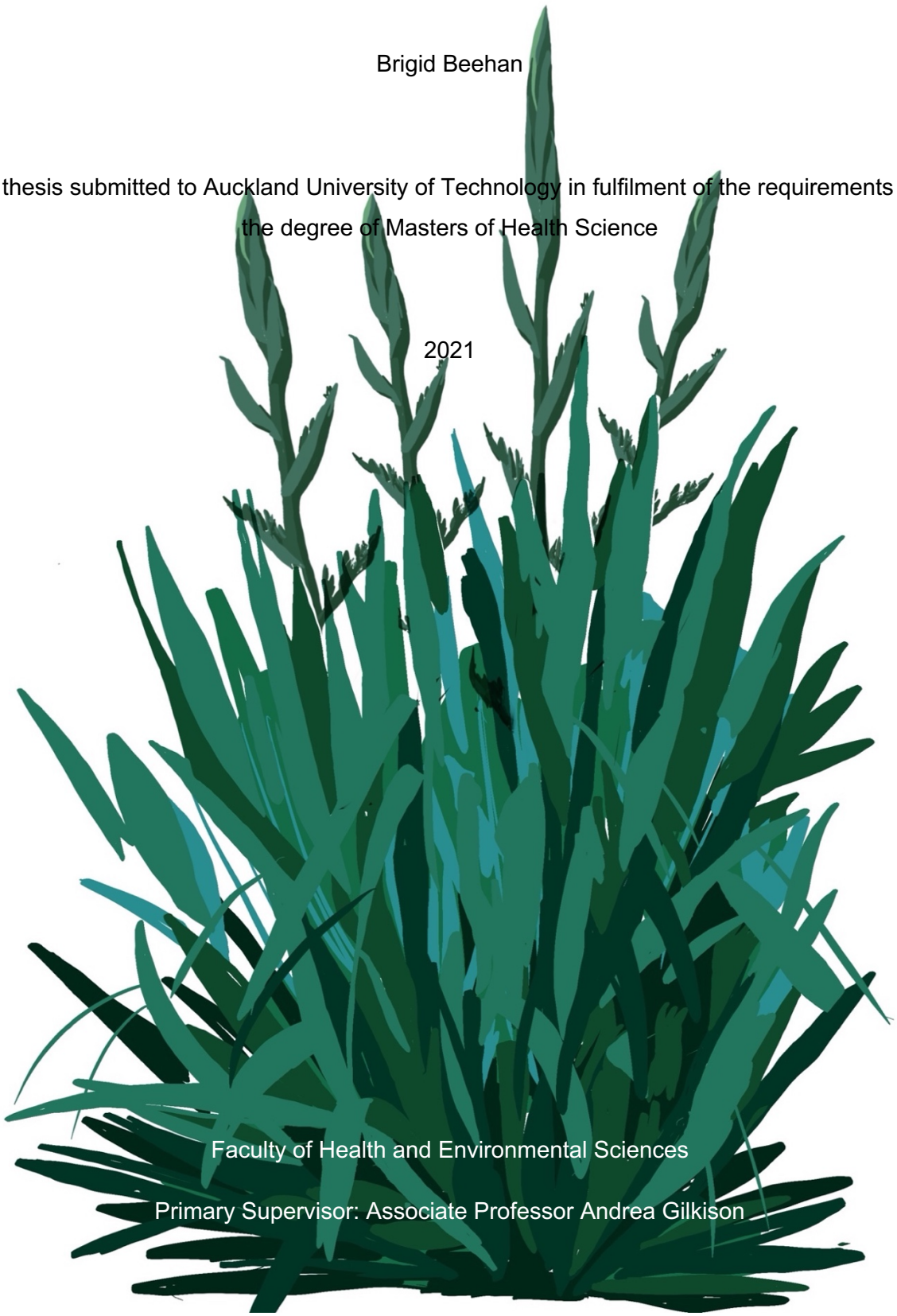

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Abstract

The question this appreciative inquiry study asks is, 'What are early career midwives' experiences of working in maternity hospitals that support their continued professional development?'

Professional development is a crucial part of being a safe competent midwifery practitioner. Currently, maternity hospitals in Aotearoa New Zealand are experiencing severe workforce shortages alongside the increased acuity of the community for whom they care. One of the important aspects of providing quality maternity care and cultural safety is the need to strengthen the sustainability of the workforce to provide better support for the women/people, whānau, and pēpe in Aotearoa New Zealand. In Aotearoa New Zealand, there is a structured professional development transition to practice programme for the first year of practice. However, following the first year, the continued professional development for the midwife is arbitrary. It is crucial for hospitals to know how to support their midwives' continued professional development for the midwife to see a future within the organisation, have job satisfaction, and plan to stay in their role.

An appreciative Inquiry method underpinned my study. Semi-structured interviews were undertaken with eight midwives in the first two to five years post registration, employed in a large maternity hospital in Aotearoa New Zealand, with the aim of revealing what supported their continued professional development. Interview data were analysed by thematic analysis.

Midwives in my study measured their continued professional development as being their own growth as a midwife. Three themes were identified from the data. **'A way of working – Feeling a Culture of trust**,**' 'Being guided**,**' and 'Feeling confident**.**'** The findings highlight the positive experiences from a group of early career midwives working in a maternity hospital, and reveal that an organisation with a trusting culture, and supportive collegial relationships, creates opportunities for early career midwives to develop professionally. The findings will be helpful to informing policy makers, managers, and midwives who are looking to find ways to sustain the employed midwifery workforce.

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed:

Dated: 13 December 2021

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Ehara taku toa i te toa takitahi engari he toa takitini

My success is not mine alone, it is the success of the collective.

(Elder, 2020, p. 45)

Chapter One: Introduction

The intension of my study is to explore the research question: “What are the experiences of early career midwives that supports their professional development working in maternity hospitals?” Currently, maternity hospitals in Aotearoa New Zealand are experiencing critical staff shortages and high staff turnover. Employed midwives are increasingly under pressure with workforce shortages, to provide high quality midwifery care to mama and pēpe.

The employed midwife within a maternity unit has an increasingly pivotal role working alongside the woman/person and whānau with complex medical and obstetric needs. Sustaining safe levels of staff in maternity units in Aotearoa New Zealand is an ongoing problem. Alongside this, there is a need to support midwives continued professional development in order to have the skill base to safely deliver care to women/ people and whānau with these increasingly complex needs. In their role's, employed midwives are known to feel undervalued and invisible; even though they make a considerable contribution, with speciality skills and knowledge, to the maternity service (Gilkison et al., 2017; Guilliland & Pairman, 2010).

Women/people and whānau expect all midwives to be competent in their work setting, regardless of experience and time in practice. However, the reality is midwives’ professional development requirements differ in relation to their experience and the environment in which they practice. There is a lack of research in Aotearoa New Zealand to provide evidence as to what supports continued professional development and sustains midwives to further their careers within maternity hospitals. The sustainability of the employed midwife is a national responsibility to help support maternity services, expand the profession, and keep women safe (Gilkison et al., 2017).

Orientation to the Study

The approach of my appreciative inquiry (AI) study, is to uncover the experiences of continued professional development for early career midwives working in maternity hospitals in Aotearoa New Zealand. In my study, the early career midwife is defined as being within the first two to five years post-registration. Within this group, employed midwives working within a maternity hospital were recruited to participate in the current study.

This chapter offers a brief orientation to the thesis, the research aims, and justification for the study. The background to the Aotearoa New Zealand midwifery practice

environment and legislative and professional responsibilities are outlined. Definitions relevant to my study will be discussed alongside the chosen methodology and methods. A personal reflection gives context and appreciation to why the research was developed. Finally, an outline of the structure of the thesis completes the chapter.

Research Question

What are the experiences of early career midwives working in maternity hospitals that support their professional development?

Study Aims

- To explore the experiences of early career midwives who are currently working in a large maternity hospital and how their continued professional development is supported.
- To determine what is currently working well for the continued professional development of early career midwives and supports them to stay in their hospital based midwifery role.
- To offer recommendations that are appreciative and energising to policy makers, managers, and midwives to inform quality initiatives that sustain midwives employed within maternity hospitals.

Background and Justification for the Study

A midwife's competence and confidence in the early years of practice are impacted by experience, alongside their access to continued professional development support. Kensington et al. (2016) and Van der Putten (2008) found that confidence is critical to newly qualified midwives and affects their decision making in clinical assessments. Confidence in practice is closely linked to experience and awareness of accountability, rather than knowledge.

Within the first five years of practice, and beyond, consolidation of knowledge and skills is still evolving. Practitioners' exposure to experience and skills is different, but there appears to be an expectation that all midwives, post the first year, are competent and confident practitioners. There is no structured professional development for early career midwives past the first year of practice. Midwives are accountable for their practice, regardless of the setting or previous experience. However, Hammond et al. (2013) found that the environment has an impact on the professional, psychological, and social needs of midwives, and is shaped by interactions and responses to each other in the workplace. My preunderstanding before starting the research was that in

Aotearoa New Zealand, once the graduate midwife has finished the first year of practice programme, support within the workplace is varied and dependant on a number of factors, including workforce shortages.

Dixon et al. (2017) and Gilkison et al. (2017) have found that midwives working in maternity hospitals in Aotearoa New Zealand have higher stress levels and often feel disempowered in their roles. It appears that the positive impact of social support, coupled with professional development opportunities, has benefits in sustaining and retaining midwives but is not consistently well practised (Clohessy et al., 2019; Dixon et al., 2017; Macdonald, 2019; McDonald et al., 2016; Pugh et al., 2013; Sullivan et al., 2011; Yukiko & Sandall, 2013). The sustainability of midwifery practice relies significantly on supportive and productive relationships between midwives, colleagues, women/people, and whānau (Gilkison et al., 2017; Hammond et al., 2013; Hastie & Barclay, 2021; Nash, 2021). The findings from my study will uncover what professional development is currently supporting employed midwives in the early years to help sustain and retain them in the midwifery workforce.

My purpose in undertaking my study was to investigate how midwives sustained their involvement in professional development opportunities in the early years of midwifery practice. What supports these future midwifery specialists and leaders to provide an essential service to women/people and whānau? This was the reason this group—early in career, employed midwives—were chosen for the research. I expected the findings would be relevant to all midwives who work across a diverse range of settings and often move between community based self-employed practice and hospital-based employed midwifery throughout their careers. The focus of my study is to uncover, through an AI lens, what is currently successful and working well in the maternity hospitals to support the continued professional development of a midwife in the early years of practice. It was important to contribute recommendations that were energising and affirmative to inform change for the midwifery workforce.

Midwifery Context within Aotearoa New Zealand

In 1990, there was a change to midwives' autonomy and responsibility in Aotearoa New Zealand which saw midwives become the predominant caregivers to wahine hāpu pregnant women/people (Guilliland & Pairman, 2010). In Aotearoa New Zealand, Te Tatau o te Whare Kahu-Midwifery Council was established in 2004, and the profession became fully self-regulated, separated from the Nursing Council. All practising health practitioners are regulated under the Health Practitioners Competence Assurance [HPCA] Act (2003), with the responsible authority for

regulation of midwifery practice being Te Tatau o te Whare Kahu-Midwifery Council (Calvert et al, 2017). The purpose of the HPCA Act and role of Te Tatau o te Whare Kahu-Midwifery Council is to protect the health and safety of the public experiencing midwifery care, by providing mechanisms to ensure that midwives are competent and fit to practice, the competencies and standards are part of how the council does this. (Guilliland & Pairman, 2010; Midwifery Council, 2018).

Aotearoa New Zealand midwifery practice is unique in that it gives midwives the flexibility to work as employed midwives in a maternity unit or as a LMC midwife in a community-based continuity model of care. All practising midwives must have an annual practising certificate (APC), issued by Te Tatau o te Whare Kahu-Midwifery Council, the midwife makes a statutory declaration when applying for an APC that they have maintained their knowledge and skills at required level and complied with Te Tatau o te Whare Kahu-Midwifery Council requirements.(Midwifery Council, 2019; Pairman et al., 2016). Midwives in New Zealand must complete the equivalent of a four-year bachelor's level degree, which includes a minimum of 1920 hours of theory and 2400 hours of clinical practice, to register as a midwife (Gilkison et al, 2016; Midwifery Council, 2019). Alongside this qualification, each midwife must maintain ongoing competence to practise, through engaging in the recertification programme and associated activities stipulated by the Te Tatau o te Whare Kahu- Midwifery Council (Calvert et al., 2017; Midwifery Council, 2018).

As part of the recertification requirement to maintain an APC, Te Tatau o te Whare Kahu-Midwifery Council requires midwives to complete a minimum of 24 hours of education annually, made up from a midwifery emergency skills refresher and professional activities and continuing midwifery education; alongside a three-yearly midwifery standards review (Midwifery Council, n.d.). Midwives are expected to be confident and competent to practise within the Midwifery Scope of Practice; this defined with Council Competencies for Entry to the Register of Midwives (Midwifery Council, 2019). The requirement for all practising midwives in Aotearoa, New Zealand, is to meet the Te Tatau o te Whare Kahu-Midwifery Council midwifery competencies, supported by the New Zealand College of Midwives' (College) 10 standards for practice, regardless of their practice setting, level of experience, knowledge or skill base (Midwifery Council, 2019).

Employed-based midwifery has always existed, unlike the LMC model of care which came about after the introduction of section 51 around 1996 and enabled midwives to work autonomously without supervision from a medical practitioner (Ministry of

Health, 1990). This was when midwives in Aotearoa New Zealand had the option to work employed as a 'core' midwife or as an LMC midwife in community-based practices. Since the passing of the Act, there has been a degree of separation between the two models of care, with the LMC midwifery model perceived as having more autonomy in practice, even though there is no difference in the scope stipulated by the Te Tatau o te Whare Kahu- Midwifery Council. In a local study, Gilkison et al. (2017) found significant challenges to sustainable midwifery practice in all midwifery settings, with increasing acuity of the women/people and staff shortages.

Midwives who work in an employed role make up the majority of the workforce in Aotearoa New Zealand (Midwifery Council, 2020). From the Midwifery Workforce Surveys 2016 and 2020, midwives within the first five years of practice make up about 26% of the workforce (Midwifery Council, 2016, 2020). Unknown, is what percentage of midwives within the first five years of practice choose to work in maternity hospitals in employed capacity versus the LMC midwifery model of care.

The LMC midwife works in a variety of settings and is required to hold a hospital access agreement to access any facility for the purposes of providing maternity care to women and people. The LMC midwife is contracted to the Ministry of Health (MOH), with payment for care being attached to the woman/birthing person, not salaried like an employed midwife. Within my thesis I have chosen to refer to all District Health Boards (DHB) as either 'hospital' or 'maternity hospital'. However, a DHB is not limited to maternity services alone, they are the organisation responsible for the provision of publicly funded health and disability services within a defined geographical area. In April 2021 the Aotearoa New Zealand government announced that the 20 DHB's will no longer exist and will be replaced two national health organisations, called Health New Zealand and the Māori Health Authority (New Zealand Doctor, 2021).

Te Kareti Nga Kiawhakawhānau ki Aotearoa, New Zealand College of Midwives, 'College' is the midwifery profession organisation with voluntary membership, and has a variety of functions including ongoing education and legal and midwifery advice, alongside indemnity insurance to practice. The College is the guardian of the 10 midwifery standards for practice that guide the midwife in giving autonomous, quality evidence-based care to women/people and whānau (New Zealand College of Midwives, 2015). This is based on the partnership model of care provision, in any setting that upholds the woman/person's right to informed choice and is supported by the code of ethics (Guilliland, 1995). The partnership model of care between

wāhine/people and whānau, is the foundation on which Aotearoa New Zealand Midwifery practice is based (Guilliland & Pairman, 2010). A further role of the College is to provide the mandated midwifery first year of practice (MFYP) transition to practice programme for the graduate midwife, alongside provision of workshops and education days to further support the midwife.

In 2002, the College established a trade union, Midwifery Employee Representation and Advisory Service (MERAS); a separate, but associated, organisation to the College, supporting employed midwives' professional needs (MERAS, 2015). More than 90% of employed midwives belong to MERAS, which provides representation for midwives with regards to employment issues, alongside negotiating collective agreements with the hospitals and government around pay and conditions for employed midwives.

The Aotearoa New Zealand Employed Midwife

The majority of midwives are employed by Maternity hospitals and are commonly referred to as 'core' midwives. The words 'core' and 'employed' will be used interchangeably to refer to the employed midwife within my study. The participants refer to themselves and colleagues as 'core' midwives in their narratives. However, to reduce confusion for readers, and to align with international midwifery terminology, I have chosen to refer to all 'core' as employed midwives within my thesis. Employed midwives in Aotearoa New Zealand work in clinical and non-clinical roles, employed by maternity hospitals, primary units, and trusts doing 8-12 hour shifts. In the role of an employed midwife, the midwife works alongside women/people and whānau, attending hospital or primary units for antenatal, labour or birth, and postnatal care, alongside this, they support their LMC midwifery colleagues with more complex care (Calvert et al., 2017). Midwives are also employed and work in roles in management, education, advisory, quality and research within hospitals, educational institutions and governmental organisations.

Following the first year of practice, the midwife determines their hours of work. However, in the first year of practice, the expectation is that the employed graduate midwife working within a maternity hospital will work 32 hours a week; with additional hours funded by the MFYP programme in educational, mentoring, and professional development time. Consequently, there are assumptions that the 'core' midwifery role has been developed by employed midwives themselves in response to the creation of the LMC midwife role (Gilkison et al., 2017).

Gilkison et al. (2017) found that employed midwives sustain themselves by developing essential midwifery skills, including the ability to quickly build partnerships with women/people, while managing critical incidents and unexpected emergencies. They have specialty skills in all areas and have a pivotal role working with women/people and whānau with complex medical, social, and obstetric problems. There are workforce issues causing increased emotional distress for Midwives working within maternity hospitals in Aotearoa New Zealand (Dixon et al., 2017). The sustainability of the employed midwife is in a vulnerable place and relies heavily on effective relationships and feeling valued within their role in the workplace (Coughlan & Patton, 2018; Gilkison et al., 2017; Matthews et al., 2021; Nash, 2021). Catling et al. (2020) found when a workplace culture is perceived as positive, midwives will likely experience job satisfaction and stay on the job.

There has been debate regarding what autonomous practice looks like within the employed midwifery role. There is a discrepancy between LMC Midwives and employed midwives' experiences of feeling autonomous and accountable in practice, which causes tension between midwives, even though they have the same scope of practice (Clemons et al., 2020). The employed midwife frequently practices under the direction of organisational guidelines and medical direction. With increasing acuity and complex care, they often work providing care within multidisciplinary teams, providing interprofessional care to women/people and whānau that challenges and impacts autonomous practice (Catling et al., 2017; Clemons et al., 2020; Sonmezer, 2020). However, Harris et al. (2011) and Zolkefli et al. (2020) found within midwifery-led rural environments, without doctors, midwives—LMC and employed—were reported to be more confident and autonomous in making decisions than their colleagues in urban-based maternity hospital. Additionally, the institutional culture of maternity hospitals in Aotearoa New Zealand impacts the ability of employed midwives to be autonomous in practice (Clemons et al., 2020). Continued professional development is experienced in diverse ways and depends on the workplace. Feeling autonomous contributes to professional development and progression in the career of a midwife. Clemons et al. (2020) and the Midwifery Council (2019) stated that being an autonomous practitioner, working within a midwife's scope, is the expectation of all midwives post-registration and contributes to continued professional development.

Professional Development Support Post-Registration

The transition from student midwife to graduate is well researched, and recommendations have resulted in the embedding of support structures in most workplaces (Lennox & Foureur, 2012; Mills et al., 2016; Patterson et al., 2019). Kensington et al. (2016) found that following registration the first year of practice for a midwife is anticipated to be a steep learning curve, and the need for additional professional support is acknowledged. The MFYP programme was initially voluntary, but is now mandatory for all Aotearoa New Zealand graduates. It is a structured and individualised programme of support that covers the first 12 months of practice post-registration, alongside the professional development and training that each hospital offers to the graduate midwife employed within their unit. While my study is not focused on the MFYP, participants did narrate their experiences of MFYP and these experiences are captured in the findings chapters. In Aotearoa New Zealand, there are two professional development supportive structures for the graduate midwife working in the maternity hospital.

1. MFYP programme co-ordinated by the College
2. The hospital-structured first year of practice programme

Both programmes provide a wrap-around service that involves the professional midwifery body, the midwifery community, and maternity hospital. They take a collective responsibility to support the professional development of the graduate midwife to transition to a safe, confident practitioner (Dixon et al., 2015; Kensington et al., 2016).

The College, with the Ministry of Health (MOH) through Health Workforce funding, developed a voluntary participation MFYP programme in 2007, this was regulated by Te Tatau o te Whare Kahu-Midwifery Council in 2015, and became compulsory for all graduate midwives entering the profession (Dixon et al., 2015; Midwifery Council, 2018). The programme funds all graduate midwives to have a mentor, professional development, educational training, and peer review as part of a midwifery standards review (Midwifery Council, 2019; Pairman et al., 2016). As part of the MFYP contract the Council overseas the mandatory requirements are met and provides the regulatory oversight for the MYFP programme. However, the College is contracted to Health Workforce to implement this compulsory MFYP programme as per the programme specifications, to offer support and safe transition from student to midwife (Dixon et al., 2015; New Zealand College of Midwives, n.d). The MFYP is fully funded for the graduate and the mentor who complete their undergraduate qualification in

Aotearoa New Zealand. The Aotearoa New Zealand graduate is funded for up to 46 hours of compulsory education and up to 34 hours of elective training, alongside 56 hours of mentorship from an experienced midwife mentor. The MFYP programme is also mandatory for Australian trained graduates to practice in Aotearoa New Zealand, at their own or their employers expense.

The programme helps bridge the gap from student to midwife and supports graduates in navigating the midwifery role to increase confidence and consolidate knowledge. The MFYP programme has been evaluated, and the findings reinforce the benefits for the graduate midwife and its positive effects on their confidence and competence in practice (Davies & Mason, 2009; Dixon et al., 2015; Kensington et al., 2016; Lennox & Foureur, 2012).

Continued Professional Development

Continued professional development for practitioners is crucial in healthcare to support lifelong learning of skills and knowledge and ensure responsiveness to diverse healthcare demands in order to sustain safe and effective care for women/people (Haji Mustapa et al., 2021; Manley et al., 2018). In the literature, continued professional development is used synonymously with other terms such as professional development, lifelong learning, and staff development.

The research question for my study sought to uncover what supports 'professional development,' however as my study evolved and narratives interpreted, alongside review of the literature, it became clear to me that 'continued professional development' better represented the findings. The adjustment of my study's intension to include continued professional development was made to reflect the nature of the professional learning journey for the midwife; to be inclusive of collegial impacts, cultural influences and organic learning over time. My study sought to interpret continued professional development in the data rather than be restricted by any specific definition for the early career midwife working within a maternity hospital. However, the narratives revealed that individuals' needs, collegial relationships, alongside the organisation's values, were instrumental to continued professional development in the early years post registration. Both continued professional development and professional development will be used within my study.

The interpretation of professional development within my study is described as more structured tangible learning, like a study day, teaching session or specific learning experience for the midwife. Professional development refers to a process of improving

knowledge, skills, and attitudes through educational activities, management, team building, professionalism, communication, education, technology, and accountability (Filipe et al., 2014). Continued professional development does not limit itself to classroom training and education but includes working alongside other practitioners, developing skills and building knowledge. Participatory continued professional development has been identified as the most effective form of continued professional development in that it supports ongoing learning through working together as opposed to the didactic approach of the classroom (Power & Underwood, 2018). Participatory continued professional development leads to positive changes in practice and better levels of care (Power & Underwood, 2018) .

Continued professional development can be mandatory or voluntary, formal or informal. All contribute to the variance in how it is experienced by the practitioner. Nationally and internationally, continued education and continued professional development are formal requirements to have a licence to practice, and to hold an APC. Alongside this, they contribute to the lifelong learning journey for midwives. The International Confederation of Midwives (ICM, 2014) recognises the need for continued professional development to strengthen and advance the role of a midwife, and makes recommendations to all member associations to mandate continuing education updates to advance skills and knowledge within midwifery worldwide. However, how continued professional development is experienced is multifactorial and influenced by the organisation, the workplace culture, or way of working within a team. Coughlan and Patton (2018) and Matthews et al. (2021) found having supportive organisations and effectively functioning teams enables the active growth of midwives' knowledge, alongside supporting self-esteem and job satisfaction.

How a midwife structures their continued professional development in Aotearoa New Zealand varies. Midwifery standards review and emergency training are mandatory prescribed components; alongside this there are education, professional activities, professional portfolio and clinical practice that are in the domain of the midwife and their continued professional development needs (Calvert et al., 2017; Midwifery Council, 2018). Calvert et al. (2017) stated that within Aotearoa New Zealand, inequities exist in the access to professional development training and education that meet the needs of the midwife. Severe workforce shortages, alongside access to education and training hours within maternity hospitals, is likely to have contributed to my study's findings of what supports the early career midwife's professional development. Access to education and training for professional development for a midwife after the first year is at the discretion of the maternity unit and is often

dependant on staffing capacity to release the midwife from the unit in work hours. Calvert et al. (2017) found that the inability to access education for professional development inside work hours remains a problem in Aotearoa New Zealand and is inequitable across the country.

Calvert et al. (2017) contended that engagement in professional development is instrumental to being a professional midwife. In Aotearoa New Zealand, midwives employed in maternity hospitals are encouraged to be part of a quality and leadership programme (MERAS, 2015). This programme provides a framework for employed midwives to have a professional development pathway that acknowledges leadership, clinical practice development, and reflective practice. The quality and leadership programme is offered to all midwives after completion of the first year of practice. Avis et al. (2013) found that newly qualified midwives need skills such as leadership, teamwork, decision-making, and communication—all of which are essential for midwifery practice. Developing these skills early in practice is multifactorial, and the success of competent, confident practitioners depends on many elements.

Preceptorship, Mentorship, and Clinical Coach

Support and practice development of midwives in the graduate and early years is the responsibility of the whole profession (Kensington et al., 2016). Different models of support such as supervision, preceptorship, mentoring, and Professional Midwifery Advocates (PMA) have been implemented in maternity hospitals internationally to provide collegial support to graduates and the profession (Lennox & Foureur, 2012; Macdonald, 2019; Perkins, 2013). The literature indicates that preceptorship and mentorship assist in the retention and sustainability of midwives and enhances their job satisfaction (Flinkman & Salanterä, 2015; Price; Sullivan et al., 2011).

In Aotearoa, New Zealand, mentorship is part of the MFYP programme and is structured to be flexible and individualised to accommodate the new practitioner's needs (Pairman et al., 2016). Within the programme, the mentor helps the graduate midwife consider and reflect on practice, debrief, set goals for practice, and identify opportunities for further learning (Kensington et al., 2016; Lennox & Foureur, 2012; Pairman et al., 2016). This collegial relationship support is outside of the workplace, with meetings happening at least monthly throughout the first year. Mentorship has a focus on growing midwives' confidence rather than a punitive approach.

Graduates who start their careers within the maternity hospital engage in a parallel support programme over the first 12-15 months within their maternity hospital. The

programme structure is determined by the hospital and involves orientation, preceptorship, education, and rotating through different clinical environments across the hospital. A preceptor is provided for a short period to orientate the midwife to each clinical area, providing support and familiarisation with the environment.

A structured preceptorship programme to assess communication, critical thinking, leadership, and teamwork will assist midwives to be successful, confident, and competent practitioners (Nursing and Midwifery Council, 2014). Preceptorship has many definitions in literature. Within my study, preceptorship is defined as the midwifery support that is given for a specific time period, within a unit, to orientate an employed midwife.

Preceptorship support in Aotearoa New Zealand is more commonly available for employed midwives in work time and focuses on clinical practice professional development for specific periods of time (Lennox et al., 2008). Preceptorship is experienced within the maternity hospital as support for practitioners new to practice or the workplace. Internationally, preceptorship is a more commonly used term to describe ongoing clinical practice support for graduate midwives.

It is a requirement in Aotearoa New Zealand to have training to be a preceptor, to work alongside students, however midwifery hospitals provide a diverse range of education to support preceptors working with qualified midwives. It is common for the preceptorship role to be taken on by staff midwives alongside their midwifery role in a unit. There is no Aotearoa New Zealand research that has studied the preceptorship model within maternity hospitals and its effectiveness for early career midwives continued professional development.

In 2021, the MOH prioritised building a sustainable workforce for midwives and ring-fenced funding through the maternity action plan (MOH, 2021). This initiative meant that from September 2021, midwifery clinical coaches are funded in all maternity hospitals to improve retention and safety culture for midwives; thereby improving outcomes for women, people, and babies (MOH, 2021). Before this, there had been no consistent ongoing support or preceptorship for the early career midwife across Aotearoa New Zealand maternity hospitals.

The clinical coach role involves practical clinical education in the workplace, working alongside graduates, new staff, and midwives needing specific refreshment of knowledge and skills (Te Toka Tumai Auckland DHB, 2021). It is a welcomed ongoing

clinical support that has been lacking within maternity hospitals. The timing of my study means the impact of the clinical coach role could not influence the study's findings and participants' experiences.

Study Definitions

As part of my journey in Māori language education, I wanted to use Te Reo within this thesis. Te Reo is the official national language of our indigenous people of Aotearoa New Zealand and is recognised in written and verbal communication in healthcare. I intended to embed more Te Reo into this thesis; however, after consultation with a Māori academic advisor, it was advised that this would only be culturally appropriate if a Māori supervisor was supporting the study from the start. I did not collect data on ethnicity, so cannot confirm if Māori were represented within the data. Following the consultation, Te Reo has been limited within the thesis to the following words;

Whānau – extended family, family group, and inclusive of friends
Wahine – woman/female
Aotearoa – New Zealand
Tāmaki Makaurau – Auckland
Pēpe – baby
Hāpu – to be pregnant

Personal Reflection

My experience as an educator six years ago in a maternity hospital environment prompted my interest in what supports midwives who choose to work in an employed hospital-based midwifery role. Over the last 10 years, midwives' workplace stress and burnout has been more visible; and, alongside, workforce shortages and acuity have increased. In 2015, while working in a maternity hospital as an educator, I was acutely aware of an absence of a coherent career path for the employed midwife. This prompted my interest to investigate what supported and sustained this group of midwives. In my discussions with midwives, in my role as a midwifery standards reviewer and mentor for the MFYP programme, midwives often reflected on the value of the first year of practice support programmes and how they impacted their confidence. However, there was a gap in consistency of practice support past the first year, impacting confidence. It was evident that what supports midwives to specialise, aspire to leadership, and sustain practice within maternity hospitals in Aotearoa New

Zealand, was under-researched. This became the catalyst to why I chose to study employed midwives experiences in isolation of the LMC early career midwives.

I have created two images within the thesis ; the first that opens the thesis as the title page, is the preconceptions of the study and the second image opens the discussion chapter of this thesis. They represent metaphors for the midwives experience of continued professional development. These images were ever-present for me as I began my journey of understanding each of the participants view points, and as I analysed the data and began to look with a more systematic lens. As a visual learner, the images provided me with a simple illustration of where my understanding began and what my research elucidated.

The Aotearoa New Zealand harakeke or flax was chosen as the key image for a poster and used to introduce the study to recruit participants. The harakeke is a native plant to Aotearoa New Zealand, it is a hardy native species, that grows well almost anywhere, it is self-protective, with its young shoots safe guarded by the other layers of the plant. There is strong symbolism to whānau in Māori with the rito (shoot) the child, surrounded by the awhi rito (parents) and the outside leaves representing tūpuna (grandparents and ancestors). This imagery is used on the cover of the thesis as a metaphor of what continued professional development looks like, synthesised from a combination of my own experience, and my preconceptions of how early practice midwives view their learning journey. The midwife grows and develops, protected by the outer layers of support, being the preceptors, mentors & colleagues, the awhi rito. The third layer of support, tūpuna leaves are the wider organisational structure that influence the midwife's experience. These might include hospital guidelines, the professional body amongst others. However, the Harakeke survives and thrives as part of a much larger ecosystem that surrounds and supports the plant, just as it does the midwife within the maternity hospital, alongside the women/person and whānau who access care.

The Aotearoa New Zealand forest illustration opening the discussion chapter, is the metaphor for that much larger ecosystem. The image of the forest is used to reveal the findings; these being the successful initiatives already in place supporting the continued professional development of the early career midwife, alongside those the women/people and whānau, who share the space.

As a midwife working in Aotearoa New Zealand, I hold respect for the model of care we have, that benefits wāhine, people, pēpe, and whānau. However, sustaining and future-proofing midwifery is a challenge and needs to be addressed. There are

strong parallels between the support and nurture of early career midwives and the care and inter-dependency between native flora that protects and nurtures the forests of Aotearoa New Zealand. We must look at ways to protect growth, support those at risk, and sustain the midwifery workforce in maternity hospitals in order to provide culturally safe maternity care for all.

Methodological Approach

The chosen methodology for my study was AI, developed in 1987 and used successfully to bring about organisational change in a number of settings (Cooperrider & Whitney, 2005). It was optimal for my study which endeavoured to support the positive influences that impact midwives' professional development. Identification of progressive aspects of continued professional development gives hope for sustaining and creating career pathways for early career midwives in maternity hospitals.

The aim of AI methodology is that participants contribute to research in a way that gives them a sense of confidence, with their focus being on successes (Hammond, 1998). As a consequence of my study, and the chosen methodology, I have provided recommendations that are affirming, energising, and appreciative for early career midwives (Hammond, 1998). The approach of my study made it easy to recruit midwives with confidence that it was unlikely to harm the participants by reflecting on positive narratives in their workplace.

With my first-hand experience of hospital midwives suffering stress and burnout, it was important to me that I bought hope and positivity to the organisation and contributed through an appreciative not deficit lens. Supporting midwives, not causing harm, was my priority for my research. Many research methodologies look to find problems in the data analysis and recommendations to support change management. Contrary to that approach, AI seeks to uncover positive findings to identify aspects of practice already working for the midwife working for the organisation. Thus, in using this methodology, the ambition is to empower the organisation to assist in positive organisational change.

Thesis Structure

The introduction chapter has positioned the content and provided context and an overview for my study. I have provided rationale to inform the chosen methodological approach of AI. Further, I have provided an overview of the Aotearoa New Zealand midwifery context and maternity system.

Chapter Two: Literature Review provides the reader with an overview of Aotearoa New Zealand and international literature relevant to the research question and the topic of continued professional development. The literature was reviewed with a focus on the early years of practice, continued professional development, and, specifically, the experience for midwives employed in a maternity hospital.

Chapter Three: Methodology and Methods introduces the research methodology—AI—and the analytical method of thematic analysis used to analyse the data. The eight participants are introduced, alongside discussions on the data collection, and issues of ethics, culture, and rigour of the research.

Chapters Four, Five and Six: Findings are where the AI 4 D cycle is presented. The first phase of discovery is profiled within these three chapters. Themes emerged from the data analysis in response to the research question. They are intentionally sequential as they build the professional development of an early career midwife. They are accompanied by graphics to connect the data to themes and be faithful to the context and uniqueness of the study's setting. The findings chapters themes are;

- Chapter Four – A way of working: A trusted culture
- Chapter Five – Being guided
- Chapter Six – Feeling confident

Chapter Seven: **Discussion** considers the findings related to the literature. This chapter works through the final phases of the 4-D cycle:

> Dream; a discussion of the findings against the literature, alongside the limitations and strengths of the study.
>
> Design; where I make future recommendations to midwives, managers, policymakers, and maternity hospitals.
>
> Destiny; offers recommendations for further research, ongoing education, and new roles to further support midwives in practice.

Conclusion

Continued professional development is essential to supporting midwifery expertise, knowledge, and skills development for every midwife. It is recognised worldwide as essential that every midwife engages in continued professional development. For

midwives to maintain evidence-based practice, critical factors must be evident to support midwives' continued professional development early in their career.

My study looks at what is currently working well to support continued professional development of early career employed midwives, working in a large maternity hospital in Aotearoa New Zealand. This chapter has set the scene with an explanation of how midwives work in Aotearoa New Zealand and the structures to support their professional development. The diverse definitions of continued professional development and practice supports have been discussed, followed by an explanation of the context behind the AI methodology and my reflection of how the study evolved. Finally, this chapter has outlined the structure for the thesis and chapter contents.

Chapter Two: Literature Review

Introduction

This chapter explores the literature on what the experiences are for early career midwives and what is supportive for their continued professional development. Reviewing the literature prior to embarking on the research assisted in understanding and refining the topic question and identifying gaps that may offer opportunities for my research. The literature was reviewed from an Aotearoa New Zealand and international perspective related to the research topic: the experiences of early career midwives that support their professional development while working in maternity hospitals.

I undertook a literature search from 2010 to 2021 using the databases: Science direct, ProQuest, CINAHL, and BioMed Central. As part of the search, Google Scholar was also used. Key phrases searched included: 'early career midwife' [adding doctor, health professional, and nurse]; professional development [adding graduate midwife, early in career, and midwife]; midwifery support; preceptorship; autonomous practice; graduate midwife; continuous professional development; leadership early in career;

autonomy in early practice; competence; and 'building confidence in midwifery'. Literature was sourced from New Zealand, Australia, the United Kingdom (UK), and Europe where there were similarities in undergraduate education and ways of working in maternity hospitals.

The literature review focuses on professional development and incorporates the many definitions of what this means in practice. International literature was restricted to midwives working employed within maternity hospitals. In Aotearoa New Zealand, literature studies were often inclusive of the Lead maternity Carer (LMC) model and not limited to employed midwives. I have considered findings of quantitative and qualitative studies, the credibility of findings, and implications for early career midwives' professional development. Gaps in the literature have been addressed that shows what is unknown about what supports continued professional development for early career midwives. It is essential for qualitative research to look at what is pre-existing knowledge from the literature to inform and guide a deeper understanding of the topic. Knowing what research has been done previously, helped guide decisions underpinning the research process. An initial review of the literature developed the research question and identified the gaps that existed nationally and internationally. Following the data analysis, an extensive review of the literature was undertaken with the intention to critique the literature with an Appreciative inquiry (AI) lens; however, the review was not restricted by AI methodology.

One of the limitations to the literature search was the interchangeable use of early career, new graduate, and first-year; with definitions overlapping and inconsistent throughout the literature. There is limited amount of research specific to the first 2-5 years, which is the focus of the current study. The volume of research is mainly around the experiences of healthcare professionals moving from student to professional practitioner.

Within my study, all participants referred to their support and experiences within the first year that had an instrumental impact on the following years. Within the maternity hospital, where my study was undertaken, some participants were still completing their 12-15 month graduate programme. Different definitions of 'early career' exist in the literature, some studies suggest this is inclusive of the first year in practice and up to five years (Coughlan & Patton, 2018; Cull et al., 2020; Hastie & Barclay, 2021; Hunter & Bick, 2019; Mills et al., 2016; Reeves, 2018); and some six to seven years (Sheehy et al., 2019). The decision was made to include the first year of practice in the literature search, acknowledging the importance of this first year being

instrumental in informing the decisions around professional development in the years following. Consequently, the definition of early career was changed in my study to include the first year of practice. My study included literature from outside of the first five years, when it had relevance to contributing to the body of knowledge around continued professional development for early career midwives. In my study, the first year practice midwives are referred to as 'graduate midwives.' However in the literature, nationally and internationally, this is used synonymously with 'new graduate' and 'early career.' The time frame to what is 'early career' is not consistently defined within the Aotearoa New Zealand research. 'Early career midwife' is not a common term used to identify the first year of practice in Aotearoa New Zealand; yet, was the most common description used in the majority of international literature.

Continued professional development goes beyond growing skills and knowledge to encompass collegial relationships, autonomy, and factors that enhance job satisfaction like career advancement strategies (Coughlan & Patton, 2018; Sheehy et al., 2021). These factors contribute to mental wellbeing and quality of life, and retention in the role (Cull et al., 2020; Sheehy et al., 2021). Thus, continued professional development is a complex learning journey for the midwife with many factors contributing to its success. The themes that emerged as part of the literature review, form the structure for this chapter.

- Diversity of continued professional development
- Understanding emotional experiences in early years of practice
- Job satisfaction and retention
- Workplace culture
- Professional development in the first year of practice
- International professional development support programmes
- Feeling Autonomous
- Effective Teams
- Building of knowledge and skills

Diversity of Continued Professional Development

Many definitions exist for what is continued professional development. It is used synonymously with such terms as professional education, staff development, lifelong learning, and professional development. Engagement in professional development is

a crucial part of the midwifery profession and maintaining an annual practising certificate (APC) in Aotearoa New Zealand (Calvert et al., 2017).

Professional development is continuous for a midwife and Embo and Valcke (2017) described it as lifelong throughout a midwife's professional journey. Manley et al. (2018) defined professional development as "the maintenance and enhancement of the knowledge, expertise and competence of professionals throughout their careers according to a plan formulated concerning the needs of the professional, the employer, the professions and society" (p. 134). It is a fundamental factor for all midwives to enable them to acquire, support, and apply skills and knowledge in the workplace to provide safe, professional person-centred care (Calvert et al., 2017; Manley et al., 2018). What effectively supports continued professional development seems to be outcome-based and individualised to the practitioner and the healthcare setting.

Embo and Valcke's (2017) UK qualitative study, analysed 47 reflections from students in their final year of the undergraduate programme about their perceptions of professional development and importance of engaging in lifelong learning for their future careers in midwifery. The findings highlighted the importance of continued professional development in gaining autonomy and building professional confidence. Instrumental, was additional support and guidance in practice to transition from student to accountable practitioner. An interesting finding by Embo and Valcke was that the students put more value on updating knowledge over and above skills training. The findings from this study align to the continued professional development initiatives that the UK, Australia, and Aotearoa New Zealand have implemented with a mandatory preceptorship or mentorship in the first year, alongside professional and educational updates and skill based training continued professional development requirements for maintaining registration to practice.

Aotearoa New Zealand requirements for professional development

In Aotearoa New Zealand, maternity hospital employers contribute to the midwife's professional development by offering maternity hospital-funded study days alongside individualised funding to support the midwife in their education choices. However, the provision of funding for professional development does not guarantee engagement, with barriers such as travel, access, availability of time off, and online options (Calvert et al., 2017). The midwife has mandatory requirements as part of maintaining an APC, stipulated by the Midwifery Council (Midwifery Council, n.d).

Understanding emotional experiences in the early years

Patterson et al. (2019) found that becoming a competent, confident midwife is not an easy road to navigate; and ongoing education, alongside support, must assist in building a midwife's knowledge and skills. Most Aotearoa New Zealand literature focused on the first year of practice for the midwife and the challenges in the transition from student to qualified practitioner (Dixon et al., 2015; Kensington et al., 2016; Lennox & Foureur, 2012; Pairman et al., 2016).

A UK based qualitative and quantitative cross-sectional study by Cull et al. (2020), surveyed 620 early career midwives with less than five years in practice, in an attempt to understand realities of their work, emotional, and health lives. The survey findings reported that early career midwives are more likely to report burnout and intention to leave the profession with feelings of stress and depression, and are commonly overworked (Cull et al., 2020). The protective factors for midwives were positive relationships with their colleagues, getting feedback, and feeling autonomous in their role.

Dixon et al. (2017) surveyed 1073 midwives practising in Aotearoa New Zealand regarding their emotional wellbeing in the work environment. This study found that midwives working in maternity hospitals have higher levels of stress and often feel undervalued in their roles (Dixon et al., 2015; Gilkison et al., 2017). This was similar to the findings by Cull et al. (2020) who noted that midwives experienced extreme stress caused by heavy workloads and poor staffing. Stress is inevitable for new practitioners, and support has been seen to increase practice confidence and transitioning to the job in the early years (Coughlan & Patton, 2018; Dixon et al., 2017; Hastie & Barclay, 2021; Hunter & Bick, 2019; Lennox & Foureur, 2012; Mills et al., 2016; Patterson et al., 2019). The impact on the professional development of midwives when experiencing stress, alongside the high acuity within the maternity hospitals, will be discussed further within this chapter.

In the current climate of staff shortages and decreased morale, Dixon et al. (2017) concluded that it is even more critical to support midwives emotionally and physically in the beginning years of their career to ensure job satisfaction and retention. Literature found that the positive impact of social support, coupled with professional development opportunities, has benefits in sustaining and retaining staff; yet, this is not consistently well practised (Clohessy et al., 2019; Dixon et al., 2015; McDonald et al., 2016; Sullivan et al., 2011; Yukiko & Sandall, 2013), as will be discussed later in the chapter under the impact of the team. Accessing social and emotional support in

practice is not well understood. Mathews et al., (2021) in an Australian study that 80% of midwives with less than five years in practice were worried about approaching senior staff midwives for support. The limitations of the Aotearoa New Zealand studies were that they looked at the experiences of midwives transitioning from student to midwife or experienced in practice, not what happens in the early years of practice.

Job Satisfaction and Retention and its Impact on Professional Development

It is interesting to note that within the literature, the focus on retention and job satisfaction is highly weighted towards the aim of understanding the early career practitioner's experiences within the beginning years working in hospitals. Continuous professional development, autonomy, and a career pathway impacts job satisfaction and are discussed throughout as a key indicators for retention of the workforce (Coughlan & Patton, 2018; Dixon et al., 2017; Matthews et al., 2021; Mills et al., 2016). The research, to date, has primarily identified challenges with a negative impact on job satisfaction, drawn from the experiences of graduate midwives working in employed in hospitals (Avis et al., 2013; Black, 2018; Coughlan & Patton, 2018; Irwin et al., 2018; Reynolds et al., 2014; Wain, 2017).

Considering supported and guided professional care might improve job satisfaction and retention for early career nurses and midwives (Coughlan & Patton, 2018; Duffield et al., 2014), when looking at continued professional development for the early career practitioner, additional needs include acknowledgement and encouragement, alongside providing opportunities for professional development to help sustain future workforce retention (Coughlan & Patton, 2018).

In the study by Sheehy et al. (2021), looking at what strengthens job satisfaction, it was found that continued professional development alongside strategies to progress career opportunities are needed to cultivate midwifery skills and enhance the potential of early career midwives. Sheehy et al. (2021) interviewed 28 midwives in their sixth to seventh year in practice regarding how their undergraduate training impacted their early years. Mentoring and debriefing enhanced the relationships with colleagues, contributing to increased job satisfaction, and were considered part of continued education and training for midwives early in career. Sheehy's findings reiterate continued support past the first year is beneficial for midwives within the workplace in relation to professional development. Finding a mentor after the first year was a more informal midwife-led approach and contributed to success in a new role (Sheehy et al., 2021).

There has been one significant study of note within the last 10 years in Aotearoa New Zealand that reported on midwives' experiences working within the employed midwifery setting. Gilkison et al. (2017) is the only national study to focus specifically on employed midwives experiences working in maternity hospitals. The study participants were a group of 22 midwives practising for over eight years and deemed as experienced in their profession. Themes from this qualitative research parallel those of studies looking at early career midwives internationally (Coughlan & Patton, 2018; Cull et al., 2020; Sheehy et al., 2021). The similarities included the feeling of being invisible and undervalued, the need to be acknowledged, alongside a supportive culture for the women and midwives regardless of years in practice (Black, 2018; Clemons et al., 2020; Cull et al., 2020; Gilkison et al., 2017; Manley et al., 2018).

Retention of midwives within Aotearoa New Zealand maternity hospitals is a significant issue, and the LMC and employed models of care are co-dependent workforces. With employed midwifery currently at critical staff shortages, it directly impacts the community LMC Midwifery workforce; hence the need to address support for staffing in both workforces (MERAS & New Zealand College of Midwives, 2019). This has a flow on effect to the hospital having an ability to support new practitioners with a well-structured orientation programme (MERAS & New Zealand College of Midwives, 2019).

The Midwifery First Year of Practice (MFYP) programme has contributed to a high level of graduate retention in Aotearoa New Zealand. From 2016 and 2020 workforce surveys, graduates in the workforce remain constant at about 9% (Midwifery Council, 2016, 2020). Dixon et al. (2015) confirmed that 86% of midwives who commenced the MFYP programme in 2007 continued to hold an APC; with most graduates remaining in the profession five years post registration. Over the three years, 2007-2010, the study showed that sustaining graduates in the profession after registration was not impacted by the age, work setting, ethnicity, or undergraduate programme but likely as a result of participation in the MFYP transition to practice programme (Dixon et al., 2015). However, Dixon et al. showed a higher percentage of graduate midwives moving out of employment within maternity hospital settings into community-based LMC midwifery care. Therefore, what is unknown is what supports the retention of early career midwives working in maternity hospitals in Aotearoa New Zealand past the first year of practice. Further research is needed to understand this statistic. Studies have revealed that contributing factors may include ability to feel autonomous in practice, continuity of care, and ability to build more meaningful

relationships with flexibility of work hours that LMC midwifery practice can offer (Dixon et al., 2015; Dixon et al., 2017; Gilkison et al., 2017).

A small quantitative study was undertaken in Ireland by Coughlan and Patton (2018) who looked at 12 early career midwives and nurses within the first five years of practice, working within three tertiary neonatal units. The three main themes that came from the research to support midwives and nurses to stay in the profession was support for career advancement, mentoring in the early years by experienced colleagues, and motivating initiatives for career advancement. There was a connection between the health practitioner seeing a career pathway and access to associated educational opportunities.

Seeing a career path was associated with enhanced job satisfaction, commitment, and greater retention (Coughlan & Patton, 2018; Duffield et al., 2014). Coughlan and Patton (2018) found that educational support and encouragement were needed to establish a sustainable career pathway for early career midwives and nurses. However, like the findings from Calvert et al.'s (2017) Aotearoa New Zealand study, there were challenges to accessing educational opportunities that were obstructive to continued professional development.

Workplace culture on professional development

A case study based in United Kingdom by Manley et al. (2018) looked at strategies to achieving effective continued professional development in healthcare. This study found that while practitioner-driven successes mattered, so too did the workplace culture and support networks; both having shared values that contributed to the generation of knowledge and service improvements (Manley et al., 2018).

Similarly to this, Fenwick et al. (2012) found in a small Australian study of 16 graduate midwives that guidance from supportive and approachable midwives positively impacted confidence and perceived competence, assisting midwives early in career to better understand the bigger picture and their professional development. Fenwicks's study highlighted the importance of a supportive environment alongside continuity of collegial support, when transitioning from student to midwife, was instrumental to 'swimming' and not 'sinking ' in practice. Many international studies found that collegial support and the impact of feeling valued as part of the team is a protective factor of stress and burnout (Coughlan & Patton, 2018; Cull et al., 2020;

Hastie & Barclay, 2021; Matthews et al., 2021; Nursing and Midwifery Board of Australia, 2016; Sheehy et al., 2021).

Professional Development in the First Year of Practice

Continuing professional development is well researched in the literature, nationally and internationally, especially regarding the experiences in the first year of practice (Cull et al., 2020; Mills et al., 2016; O'Connor et al., 2018; Pairman et al., 2016; Walker & Spendlove, 2018). A number of Aotearoa New Zealand studies have specifically researched the first year of practice, finding that practice can be a stressful and challenging time for graduates, and can trigger anxiety and fear as they transition to autonomous practitioners (Davis et al., 2012; Dixon et al., 2015; Kensington et al., 2016; Pairman et al., 2016).

Aotearoa New Zealand graduate

Understanding the graduate experience within Aotearoa New Zealand and internationally is crucial to supporting how the midwife transitions from student to midwife and into the early years of practice. Researchers have evaluated the MFYP programme and reinforced the benefits for the graduate midwife and its positive effects on their confidence and competence in practice (Dixon et al., 2015; Kensington et al., 2016; Lennox & Foureur, 2012; Pairman et al., 2016).

Kensington et al. (2016) reviewed the MFYP programme. They surveyed 180 midwives in the first year of the programme, looking to uncover what supported their transition. Bridging the gap from student to midwife requires building confidence, consolidating knowledge through experience, and supporting critical reflection (Dixon et al., 2015; Kensington et al., 2016). Through a qualitative survey, the study highlighted the mentorship relationship as an important part of the MFYP programme to assist midwives in self-reflection, goal setting, and debriefing. However, the study found that it was the midwifery support from colleagues, educators, peers, and managers to provide encouragement and reassurance in the clinical environment that was the most valuable resource for the graduate (Kensington et al., 2016). Kensington et al. (2016) found that graduate midwives gain wraparound support from the wider midwifery community, and midwifery colleagues who feel a collective responsibility to support graduates. This support within the first year helps foster relationships and promotes the benefit of collegial support for the years to come. Findings of this study supported those of Dixon et al. (2015), in that the national transition to practice programme has successfully fostered a cultural norm of nurturing and supporting

early career practitioners in transitioning into the role of a midwife as they gain experience and confidence (Kensington et al., 2016; Mills et al., 2016).

There is a need to provide support to the graduate to help build confidence and assist in sustainability in practice (Dixon et al., 2015; Kensington et al., 2016). Studies have shown that failing to support midwives into practice further contributes to workforce shortages as midwives are more likely to leave the profession and feel disillusioned at work (Dixon et al., 2015; Dixon et al., 2017; Kensington et al., 2016; Mills et al., 2016; Van der Putten, 2008). However, there are gaps in the research in Aotearoa New Zealand in what happens after the first year and into the early years of practice when the structured programme ceases to exist, and midwives still need support in practice.

Mentorship is an important element of the Aotearoa New Zealand MFYP programme for ongoing debriefing and reflection on practice. Within mentoring, professional development is achieved through investment of time, partnership, and being a supportive colleague (Lennox & Foureur, 2012). In a survey of 180 graduate midwives, Pairman et al. (2016) found mentorship successfully met the needs of the graduate and their mentor supporting the graduate in and out of practice. The mentor plays an important role in assisting the graduate in goal setting, debriefing, and building confidence in skills of self-reflection. In an Aotearoa New Zealand study, Lennox and Foureur (2012) found that when experienced midwives mentored new practitioners, it enabled the graduate to self-identify where their needs were for support and professional guidance, helping them develop into a safe and competent practitioner. The support of a colleague like a mentor, has been found to assist in the transition from student to midwife; yet, the research to date has not explored past the first year of practice (Patterson et al., 2019).

International Professional Development Support Programmes

International research around the professional development of early career health practitioners primarily focussed on nurses and understanding of retention and high attrition rates (Mills et al., 2016). Gray et al. (2016) conducted a scoping review looking at the scope of new midwifery practitioners and how they transitioned into practice, comparing five countries with commonalities of practice models. There were similarities of transition to practice programmes between New Zealand, the Netherlands, and Canada, where the midwifery lead private community model of care was commonly practiced. Australia and the UK had commonalities of a mainly hospital-based midwifery service and, consequently, the support programmes for

practitioners were structured around this model. The support programmes between the countries were diverse in their ability to facilitate provision for autonomous midwifery practice and, consequently, decision making experience (Gray et al., 2016).

United Kingdom early practice support

Graduate support programmes within the UK's National Health Service run for a 12-month period to support the new practitioner's transition from student to midwife. The Nursing and Midwifery Council (2019) outline standards of proficiency for midwives that support midwives to demonstrate, over time, the growth of their knowledge, understanding, and skills. These standards are aligned to the International Confederation of Midwives (ICM) (2014) definition of a midwife as being an accountable, autonomous, and professional midwife, and working towards being a skilled practitioner.

The A-EQUIP model (an acronym for advocating for education and quality improvement) of support has been implemented in practice in England since 2017, where midwives are appointed into Professional Midwifery Advocate (PMA) roles in support of all midwives (Dunkley-Bent, 2017; Macdonald, 2019). This model of restorative clinical supervision intends to provide an experienced advocate to support continued professional development, address health and wellness, skills and knowledge development, and assess quality within practice (Macdonald, 2019; Nash, 2021). Support is not limited to the first year of practice; rather, the need for all midwives to have this supportive wraparound guidance is acknowledge. Nash (2021) reviewed the A-EQUIP model and role of PMA in providing opportunities to further support the midwifery workforce. Professional midwifery advocates strengthen the workforce and benefit the care to women and families, offering support to midwifery staff during challenging situations, like the pandemic, that further strains the workforce. Professional midwifery advocates encourage learning from practice, not a blame culture, with promotion of collaborative relationships for quality improvements (Nash, 2021). Developing the effectiveness of the role of PMAs, meant working towards a compassionate culture with multidisciplinary teams working together to provide safe care for the woman/person and the midwife.

In a review of the A-EQUIP model, Macdonald (2019) found that positive interactions with team members contributed to feeling of self-progression for graduate midwives. However, workforce pressures on early career midwives working in maternity units is significant, with poor teamwork, defensive practice and fear of blame being some of the factors that affect midwives' ability to provide quality care (Nash, 2021). These

factors further support the model A-EQUIP for midwives (Macdonald, 2019). The experience for the midwife early in career is variable; and building knowledge and skills come from being part of a team and the support that the team provides.

Australian Graduate Practice Support

Australian graduates do not have mandatory requirements to complete a graduate programme within the first year of practice, although each maternity hospital offers a structured transition programme. However, challenges exist to access, with the ability to secure employment and consolidate theory into practice for the new practitioner (Fedele, 2021). Graduate programmes are offered alongside job opportunities, and are run from 6 to 12 months; unlike Aotearoa New Zealand where the graduate programme is a mandatory requirement to practice within the first year and supports every graduate alongside their role. For Australian graduates, lack of mandatory requirements can further impact their ability to get a job post registration, as graduates need to apply for and gain a position on a transition to practice programme, and places appear to be limited (Fedele, 2021).

Preceptorship

Internationally, in the literature, many definitions exist for the professional support in practice for midwives, including mentorship, preceptorship, PMA, and supervision. The definitions of the different support programmes were discussed in Chapter One. Preceptorship, mentorship, and coaching are terms used interchangeably within the research and can lead to confusion, as some are structured and others more flexible in approach.

Internationally, the more common support during a health practitioner's (or midwife's) first year of working is called preceptorship. A senior practitioner working with the graduate is supportive of the clinical setting (Black, 2018; Rae, 2011). The literature supports having professional and social support in practice plays a significant role in the midwife's confidence, competence, and job satisfaction (Avis et al., 2013; Black, 2018; Coughlan & Patton, 2018; Price, 2009; Wain, 2017). The confidence and experience the graduate gains in the first year is vastly different depending on the clinical setting and degree of preceptorship (Black, 2018; Irwin et al., 2018). Consequently, moving from a supportive preceptorship or mentorship structure into a more autonomous practice situation is different for each midwife. Matthews et al.'s (2021) study of 411 midwives in Australia employed by a maternity hospital, recommended that practice be enhanced by mentorship and supervision. Matthew's

also found that approachable colleagues and team support were highly valued and contributed to feeling supported to practise.

Irwin et al. (2018) found that despite the preceptorship model being part of nursing since 1991, the positive impacts on the competence and confidence of the early career midwife was not yet clear. The timeframe for the Aotearoa New Zealand MFYP mentorship programme is 12 months; while maternity hospitals' preceptorship programmes vary between work settings, lasting a few days to a few weeks. In addition, there is variation within the findings around the different structures and length of preceptorship programmes for early-career midwives and nurses (Avis et al., 2013; Davis & Mason, 2009; Irwin et al., 2018).

In practice, Black (2018) contended that preceptorship should be established for 18 months to 2 years. In New Zealand, inequities of early structured support currently exist with graduate employed midwife based programmes ranging from 12-15 months depending on the maternity hospital. Black found a lack of research around what impacts the competence and confidence of newly qualified midwives and the impact of preceptorship. What is not articulated in the literature is consistency of the length of preceptorship support and whether this support extends past the first year (Avis et al., 2013; Black, 2018; Davies & Mason, 2009; Irwin et al., 2018).

Preceptorship in Aotearoa New Zealand is support given to midwives moving between practice areas. Calvert et al. (2017) found that there was a loss of skills as midwives specialised within some areas that enhanced development in specific skill; however, retaining skills relevant to other clinical areas may be lost. This finding, raised by Calvert et al. (2017), Cronie et al. (2012) and McCourt et al, (2012), identified that midwives needed additional support when moving between practice contexts. Calvert et al. (2017) found that this was especially important with diversity of practice contexts in New Zealand, regardless of experience or time in practice (Calvert et al., 2017).

Feeling Autonomous Concerning Professional Development

Within midwifery, autonomy comes with the freedom to make decisions within the scope of midwife's practice to provide evidence-based, ethical care for wahine, pēpe, and whānau (Clemons et al., 2020; Zolkefli et al., 2020). Defining autonomy in different practice settings is complex and difficult to do, especially within Aotearoa New Zealand. The expectations on new practitioners, alongside the supportive transition programmes, are dependent on the country of registration. Feeling autonomous is benchmarked as an aim to feeling confident and competent to practice.

Clemons et al. (2020) surveyed 253 Aotearoa New Zealand midwives and found that the nature and culture of maternity units can impact the support for autonomous practice and midwifery lead care, alongside individualised care for women and whānau. The research was not limited to early career midwives; however, it brings relevance to my study in that it highlighted themes that had similarities to international research around the impact of autonomous practice on continued professional development working in maternity hospitals. Similarities existed in the literature with the positive impacts of clinical expertise, relationships with colleagues, and the culture of the work environment that are protective of job autonomy (Clemons et al., 2020; Davis et al., 2016; Zolkefli et al., 2020). However, when negative impacts are present, provision of women-centred care is affected (Clemons et al., 2020; Reynolds et al., 2014; Zolkefli et al., 2020). Clemons et al., (2020) found that job autonomy is linked to experience, expertise, and knowledge in practice; yet, is not often felt. Qualities such as resilience, confidence in decision making, and critical thinking skills are linked to professional autonomy, and are crucial to practice within obstetric lead maternity hospitals (Clemons et al., 2020). The impact autonomy has on professional development for the early career midwife is not identified for this group in the research.

Wilson (2012) asserted that the responsibility is with the midwife to be autonomous and identify their skill development. When midwives felt their midwifery decision making was valued, and they felt independent, their collegial relationships, job satisfaction, and body of knowledge were strengthened (Clemons et al., 2020; Zolkefli et al., 2020). In addition, autonomous practice enhances professional development, and improves relationships with colleagues (Clemons et al., 2020; Sonmezer, 2020).

In a UK qualitative study of 12 newly qualified midwives, Reynolds et al. (2014) found that autonomy and support were linked with changing levels of responsibility; however, the authors found that it was rare for the graduates to experience both support and autonomy simultaneously. Alongside gaining expertise and knowledge in practice, continued professional development supports midwives in any stage in their career to feel autonomous; thereby improving job autonomy. Supporting midwives to feel autonomous practitioners is complex and multifactorial.

Contrary to Reynolds et al.'s (2014) findings, multiple studies reveal that midwives rate social support in practice highly, as they see this linked to autonomy within their role, which in turn influences their job satisfaction (Coughlan & Patton, 2018; Gilkison et al., 2017; Pairman et al., 2016; Sullivan et al., 2011; Yukiko & Sandall, 2013). Professional autonomy and meaningful relationships with women sustains midwives

and supports resilience from burnout (Dixon et al., 2016; Yoshida & Sandall, 2013). The emotional strength and wellbeing of practitioners is impacted by the levels of support for professional development provided within the workplace (Clohessy et al., 2019; McDonald et al., 2016).

Zolkefli et al. (2020) conducted a literature review to uncover what impact autonomy has on midwifery practice. Supporting the other studies done in Aotearoa New Zealand, and internationally, Zolkefli et al. concluded that autonomy is a central element in midwifery and links to the midwife having the ability to critically think, contributing to confidence in decision making and building of knowledge and skills. Furthermore, autonomous midwifery lead care will positively impact professional development, giving midwives confidence to exercise their knowledge and skills to feel competent as practitioners and work collaboratively alongside their obstetric colleagues (Zolkefli et al., 2020).

However, Sonmezer (2020) found that autonomous practice is challenging to achieve within maternity hospital environments. Nilsson et al.'s (2019) Swedish study observed six midwives with 1-31 years in practice working in delivery unit. One of the findings was that midwives doubted their midwifery knowledge and skills, and felt reduced freedom to work autonomously in delivery units under the dominant medical model of care (Nilsson et al., 2019)

Effective Teams supports continued professional development

“Teams work best when all members feel safe, have a voice and feel able to contribute effectively” (Nash, 2021, p. 487). Teamwork skills are part of the day-to-day practice of a midwife within any maternity setting. Effective teamwork impacts the experience of workplace culture, retention of midwives, and the capacity to give quality and safe care to mother and baby (Hastie & Barclay, 2021; Nash, 2021).

Matthews et al. (2021) surveyed 411 midwives, 50% being early in career, and found that the qualities that midwives valued most highly to support them in their continued professional development were being approachable, having knowledge, and being team player. Least valued was the years of experience of the supportive colleague. Interestingly, this Australian based study found that acknowledgement and practice support was the remuneration valued by the midwife, not salary. Additionally, leadership and management support were crucial (Sheehy et al., 2019).

Cull et al., (2020), in response to the growing staff shortages in the UK, found that a protective factor against stress was early career midwives with strong, healthy

relationships with colleagues. Experiencing a positive workplace and being part of a team, alongside the midwife feeling valued and acknowledged, was instrumental to early-career midwives' emotional wellbeing (Cull et al., 2020). These findings were similar to other studies and reinforced the importance of collegial support, preceptorship or mentoring being instrumental in job satisfaction, emotional health, and continued professional development for the early career midwife (Coughlan & Patton, 2018; Matthews et al., 2021; Patterson et al., 2019; Sheehy et al., 2021). Literature underscores successful collegial relationships and feeling supported and valued as being crucial in the early years as contributing to job satisfaction and professional career development (Coughlan & Patton, 2018; Cull et al., 2020; Sheehy et al., 2021)

Having supportive organisations and teams functioning effectively enables the active progression of midwives' knowledge, alongside supporting self-esteem and job satisfaction and resulting in professional development (Coughlan & Patton, 2018). Internationally, these areas are being recognised as a key intervention to support retention in midwifery. Employed midwives work in multidisciplinary teams. When the team works effectively, it impacts the quality of care provision and creates a culturally safe place to learn (Nash, 2021).

Another UK study researched the emotional wellbeing of midwives early in their career (Cull et al., 2020) There were similarities in the findings to the New Zealand study by Dixon et al. (2017), except that this group of 620 UK midwives were in the first five years in practice. Both studies found that work stress caused anxiety, depression, and burnout; but, midwives have intense pride in their job and value autonomy and feedback to provide high quality care. The similarities of the two studies were the value in the team, relationships with colleagues, and having control over work rosters with midwifery managers who invested in supporting them (Cull et al., 2020; Dixon et al., 2017). Autonomy was highly valued and impactful on the midwife developing skills and knowledge to build confidence (Cull et al., 2020).

In an Australian study, Hastie and Barclay (2021) researched 19 early career midwives and their development of teamwork skills. They concluded that investing in practising teamwork as part of the undergraduate programme was influential in the early career midwives developing skills in conflict resolution, emotional self-regulation, and social and emotional competency. The study found that effective functioning teams can improve quality and safety of care for women and babies (Hastie & Barclay, 2021). However, in maternity hospitals, training around effective

teamwork is often limited to emergency training or Prompt courses. The emergency centric approach to teamwork supports skills around the medical model of care for institutionalised birth, rather than a focus on teamwork effectively supporting midwives in practice (Hastie

Building of Knowledge and Skills

Midwifery knowledge and skills are essential to enhance the decision making undertaken by midwives as autonomous practitioners (Zolkefli et al., 2020). Midwives are registered to be fully accountable and professional practitioners to promote safe and effective evidence informed care while working in partnership with women and pregnant persons (Nursing and Midwifery Council, 2019). However, within a UK study it was found that new practitioners do not feel ready and confident to practice within the full scope upon completion of their undergraduate training (Davis et al., 2012).

Nearly all decision making is a shared responsibility with the woman/person and her whānau, except in emergencies when this might not be practical. Avis et al. (2013), Black (2018), and Rae (2011) asserted that a midwife's exposure to decision-making, emergency management, and leadership is variable during the early career period. However, this exposure is imperative to support professional development within maternity units. Understanding what midwives need to support practice past the MFYP is a complex issue related to factors such as the individual's confidence, practice context, and model of care.

Patterson et al. (2019) surveyed 42 Aotearoa New Zealand midwives to see what factors from their undergraduate education underpinned competence in midwifery skills and knowledge to support transition to midwife from student. Four themes came from the study: post graduate study, midwifery knowledge and practice skills, management skills and developing confidence, and the impact of an environment of support (Patterson et al., 2019). This study highlighted the importance of social and cultural competence as being as crucial as online, face-to-face, and practice knowledge development (Patterson et al., 2019); as well as the importance of an environment of support to help develop confidence to navigate and collaborate with colleagues and other health professionals. The participants valued the hands on, face-to-face learning to equip them for practice. This is the only New Zealand study focusing on early in career midwives two to five years in practice.

Alongside continued professional development, considering what continued competence means, and its impact on public safety and quality care, is essential

(Vernon et al., 2019). The mandatory components of professional development activities for a midwife in Aotearoa New Zealand are based around ensuring ongoing competence and confidence, and are flexible to accommodate diversity of practice (Calvert et al., 2017; Midwifery Council, n.d). Midwives meet the competencies when they enter the register. They make a declaration each year to be granted an APC, that they are maintaining their ongoing competence to practise. However, what is involved in maintaining continued competence is more complex (Calvert et al., 2017). Professional development and continued competence could be seen as complementing each other. An international literature review by Vernon et al. (2019) analysed the purpose of continuing competence frameworks alongside self-awareness of the practitioner. Vernon et al. found that nurses or midwives who have a lack of self-awareness and insight into their performance in practice are less likely to seek professional development opportunities to support safe practice.

In a grounded theory study, 26 midwives were interviewed in Aotearoa New Zealand to ascertain how they maintain their competence to practice (Calvert et al., 2017). This study was not restricted to early career midwives but has relevance for understanding being ready to practice and the development of knowledge and skills. The study exposed the challenges for all midwives working in the diversity of settings and accessing education to maintain competence and support confidence in practice. As discussed earlier, there are mandatory educational components to practice alongside which are the self-identified areas in which a midwife needs further support.

Supporting skill development is critically embedded in the day-to-day work environment and dependent on midwives locating colleagues who will help and be role models (Hunter & Bick, 2019; Wilson, 2012). Perineal suturing is a skill in which midwives early in their career lack confidence and often require extra support within the workplace (Hunter & Bick, 2019). The skill in assessing and repairing a perineal tear, is one of a midwife's core skills in Aotearoa New Zealand. A qualitative study in the UK by Hunter and Bick (2019) found that support for the skill of perineal suturing within preceptorship programmes is variable and sometimes lacking. Further, the pressures of the limited preceptorship period and access to study days hindered the ability to learn and consolidate the essential skills to practice with confidence (Calvert et al., 2017; Hunter & Bick, 2019). There is a gap in the literature around specific skill development in practice for early career midwives. Knowledge and skills around emergency management and general transition to practice for the student midwife is the focus in most studies.

Conclusion

Within the literature there are interchangeable definitions of an early career midwife, with very few studies defining this period as the second to fifth year in practice, therefore few studies have explicitly explored the early career midwife and their professional development past the first year of practice. How continued professional development is experienced, is multifactorial and influenced by, the workplace culture, or way of working within a team.

This review of the literature found the majority of literature focuses on the continued professional development of early career or graduate midwives, and sought to find levers to retain, motivate staff, and increase working conditions by understanding what supports the workforce. Continued professional development is linked to sustaining and retaining early career midwives early in practice and impacts job satisfaction. The literature found that the emotional experiences, workplace culture job satisfaction, the first year, autonomy, teamwork, professional support programmes and preceptorship alongside building of knowledge and skills, as being the critical elements in continued professional development for the midwife.

There has been no research within the Aotearoa New Zealand context, outside of the first year of practice, that evaluates how continued professional development supports midwives within the early years post-MFYP. This gap was identified when doing a literature search prior to embarking on the study and reinforced the need for a study that explored what is supporting this group of midwives who work in maternity hospitals in Aotearoa New Zealand.

Chapter Three: Methodology and Methods

Introduction

This chapter provides an overview of the methodology and methods used to investigate the research question: "What are the experiences of early career midwives that supports their professional development while working in maternity hospitals"? I will discuss my chosen methodology—Appreciative Inquiry (AI) and the rationale for selecting this methodology. I will discuss the methods used for collecting and analysing the data, alongside discussing the application of AI and the 4-D process of AI. The strengths and challenges encountered with using AI will be outlined I will introduce the eight participants, and the process of participant recruitment and interviewing; as well as considering the ethical approach adopted in the research process and trustworthiness of findings.

Research Design

Qualitative research is a valuable way to gain understandings and meanings from individuals' experiences (Morrow, 2007). In the birth of my qualitative study, various methodologies were appraised, including critical theory. After a literature search, and communication with my supervisors, I favoured a more positive, energising approach to guide interviewing and data collection over a critical approach. Thus, I chose AI, informed by Cooperrider and Whitney (2005). Additionally, thematic analysis, informed by Braun and Clarke (2006), was used to guide and structure analysis of the data.

Appreciative Inquiry

Appreciative inquiry was first developed in 1987 to bring about organisational change (Cooperrider & Whitney, 2005). This methodology offers an approach that focuses on organisational strengths to energise growth for positive solution-based change management (Cooperrider & Whitney, 2005). Appreciative inquiry has been used in other midwifery research; yet, is still a relatively new approach. The original objective in using AI was to offer improvement in the workplace, recognising individuals' differences and how these impact the interpretation of behaviour (Hammond, 1998). With an AI approach, participants are offered the opportunity to look at an organisation's strengths and contribute positively to their role.

Principles and Assumptions of Appreciative Inquiry

Using AI, it was important for me to look at the assumptions that I held before embarking on the research. When working with AI, Hammond (1998) contended that the researcher must understand the organisation's assumptions. These assumptions are vital as they signal understanding of individual behaviour within a group (Hammond, 1998). The assumptions that Hammond outlined are;

1. There will always be something that works within an organisation or group.
2. Our focus within an organisation becomes a reality for us.
3. Multiple realities exist; the truth exists at the moment.
4. When we ask a group or organisation questions about its way of working, it will influence that group somehow.
5. Reflecting and considering experiences from the past gives people the confidence to face the journey into the future.
6. What an organisation or group takes forward from the past should be the best parts.
7. We are all different; it is vital to acknowledge and value differences.
8. Reality is created through the language we use.

Understanding the organisation's assumptions frees the researcher from a problem-based approach, with the ability to see that the description and language of the participants are the vessel for interpretation of knowledge to inform change (Whitney et al., 2010). These assumptions were essential considerations in crafting the interview questions and gave more profound meaning to the participants' voices. I started the study acknowledging my beliefs and realities of what was professional development. However, I expected that multiple realities existed. I needed my questions to give participants the freedom to talk to their reality and not feel restricted by professional definitions and value differences. Hammond (1998) recommended a four-stage approach to the interview: 1) introduction to the study; 2) introduction of some staging questions; 3) questions around specific topics; and 4) concluding questions and guiding the participant to make recommendations or dreams for the future.

Further to the assumptions are eight AI principles derived from general thought processes, social construction, image theory, and grounded research (Whitney et al., 2010). These principles are the practice of AI, revealing how positive change works. Whitney et al. (2010) stated that these eight principles are essential for a researcher in understanding beliefs and values about an organisation and change informing implications for the future.

1. The constructionist principle – Worlds are created by the language and conversations we have.
2. The simultaneity principle – When an inquiry or questioning happens, the opportunity is there to start to create change.
3. The poetic principle – Choosing what to study. There are many aspects to analyse within an organisation that offer learning opportunities.
4. The anticipatory principle – Future images hopefully inspire a more affirmative positive to the present-day actions.
5. The positive principle – When questioning an organisation or group, a positive inquiry is more likely to lead to positive large-scale change and human connection.
6. The wholeness principle – Wholeness brings out the best in people and organisations.
7. The enactment principle – 'Acting' or 'being' the change is instrumental in 'making' the change and is self-fulfilling.
8. The free-choice principle – Free choice is liberating; when humans are given an option to contribute, they will be more committed and perform at a higher level. (Whitney et al., 2010).

Whitney et al (2010) suggest that as AI has developed as a research methodology, the principles have grown to accommodate and apply this methodology to large-scale organisations (for example, public hospitals and District Health Boards), similar to the context in which my study took place. The eight principles of AI guided the discussion and recommendations from data analysis. All questions were crafted with a positive inquiry about the organisation and focused on honouring the eight principles. When participants chose to talk about a challenging or distressing experience, the questioning looked for what supported or successfully navigated

through this event, and how the organisation was impactful—not the consequence of the experience. For example, when a participant spoke about a challenging experience, my questioning would be;

> *During that experience, tell me about a colleague that made a positive difference to you. What was helpful?*

4-D Stages of Appreciative Inquiry

When crafting my interview questions, it was necessary to be true to the AI approach and take the participants through the 4-D cycle (Whitney et al., 2010) which includes discovery, dream, design, and destiny. In following the 4-D cycle, I was committed to researching the positive experience and staying true to this methodology to value differences. In each stage of the cycle's four stages, Cooperrider et al. (2008) posed the research questions: what gives life, what might be, how can it be, and what will be? (See Appendix A).

My research question set the stage for the 4-D cycle that followed, and the groundwork when crafting the interview questions was instrumental to its success (Whitney et al., 2010). Using the 4-D cycle guided the development of the interview questions to ascertain further dialogue that focused on strength and solution-focused conclusions. My interview uncovered the positive experiences and focused on the participants' strengths and affirmative characteristics, even when this may have been challenging or problematic for the participant. With AI's intention and speciality around organisational change, my questioning and prompts guided the participant to take the affirmative, positive approach to reflecting on their experiences while being careful not to constrain narratives about their challenging experiences.

Stage 1 Discovery – What gives life?

The discovery phase introduced the participant to the concept of looking at the best parts of the job and the organisation through tailored questioning (Cooperrider & Whitney, 2005). This stage is about searching for 'what gives life' to an organisation, what inspires and is the catalyst for future organisational change (Cooperrider & Srivastva, 2017). The rich data from the discovery phase informed the questions, alongside my prompts that encouraged appreciation of their experiences. For example;

> *Researcher: What part of your job do you enjoy most?*

Yolanda: *I just thrive on the high acuity that we work with, it's what I value most, and no day is the same. It forces me in improving 'those skills', and being in a place with high acuity allowed me to improve on many skills. Now I feel more comfortable in my area to sit down and support someone else through suturing; that's what makes it enjoyable.*

Appreciative inquiry methodology honoured the participants' voices and their lived experience, and moved them onto the dream phase.

Stage 2 Dream – What might be?

Moving from discovery to dream phase allowed each participant to provide recommendations for the organisation and talk about future aspirations. "The dream phase is centred on what might be, creating a clear-results orientated vision concerning discovering the potential for the participant and the organisation" (Cooperrider & Whitney, 2005, p. 16). In this phase, the participants' stories and experiences give essential responses for the visionary stage, hopes, and dreams (Cooperrider et al., 2008; Whitney et al., 2010). This phase plays a significant part in the semi-structured interview approach, data analysis, and discussion chapter. The participants made recommendations for the future that helped craft my recommendations after data were analysed. For example, Christina articulated what is an essential part of a performance review;

Christina: *I guess it is part of the performance review is looking at what you want to do long term, as a five-year plan, and I've always found management are open to that and open to seeing what they can do to support you.*

As participants share their dreams, and take part in discovering collective dreams for the organisation, they contribute and "grow in the direction of their light, which is their collective image of the future" (Whitney et al., 2010, pp. 138-139).

Stage 3 Design – How can it be?

The design stage, in the 4-D model, is a natural extension of the dream phase. Participants were given opportunities to design what the future could look like with an ideal, perfect profession and workplace that supported their professional development (Cooperrider et al., 2008). This research phase overarched discussion and

interpretation of the participants' voices to offer future recommendations to the DHB. The interview questions moved the participants from dream to design, for example;

Researcher: *Dream into the future. All those futuristic dreams come true, the hospital management has set up a structure to support your professional development and works in partnership with you. What does this look like?*

Yolanda: *A genuine conversation from management! Taking you off the floor to talk, for a genuine conversation when no one is rushed. Not just ticking the boxes, but talking to a person and finding out what they are interested in. If you'd like to do some preceptorship, we'll put you on the course. Management saying let's make concrete plans and recognising that we're all humans; we could get a lot further than what we're doing now. If a midwife wants to specialise, you can get them there with the right support network.*

Stage 4 Destiny – What will be?

The destiny stage is the fourth and final stage of the 4-D cycle, and poses the question of what will be and how to sustain it (Cooperrider et al., 2008). I intend to present my findings to the maternity hospital and draw conclusions from the study to pose actionable recommendations for the future. This stage of the AI cycle is represented in the discussion chapter, recommendations section.

The Rationale for Choosing Appreciative Inquiry

Appreciative inquiry is firmly planted in a positive solution-based approach, which fitted my research question. It was optimal for my study because it revealed supporting influences that impact midwives' professional development. By identifying affirmative aspects, through challenges and successful professional development experiences, the hope is that findings will contribute to sustaining a career path in maternity hospitals. Thus, the primary reason for choosing AI, in contrast to other methodologies, was to ensure a methodology effective for positive organisational change, hoping that the findings will celebrate and energise midwives and their employers (Cooperrider et al., 2008; Hammond, 2001; Whitney et al., 2010). When choosing to progress positively with my study, it was important that my research was supportive and not harmful to midwives. Furthermore, participation in AI can in itself lead to innovation and employee satisfaction, complemented by the giving of

opportunities to discover and reflect on “their best at work” (Whitney et al., 2010, p. 194). Thus, AI questioning meant their contribution to the data provided recommendations that were affirming, energising, and appreciative for early career midwives (Hammond, 1998).

Dixon et al.’s (2017) Aotearoa New Zealand study found that there were higher levels of stress amongst employed midwives. This study was influential to my choice of methodology for researching the experiences of early in career midwives’ professional development. Dixon et al. (2017) concluded that employed midwives were a vulnerable group and suffering in their roles with a multitude of challenges in the workplace. My aim was to add to the body of research and contribute in an energising and positive way, not take a critical approach. Appreciative inquiry fitted the research question, as it honoured my intentions to support and empower the profession, celebrating what is going well.

Theory and Underpinning Philosophical Approach

Thematic analysis is a beneficial and flexible method, ideal for analysing data from semi structured interviews (Braun & Clarke, 2006; Terry et al., 2017). With AI being an approach rather than a single methodology, I needed to use a more structured approach in the data analysis stage of the research. Thematic analysis approach provided structure and flexibility and complemented the AI methodology. Data were analysed using thematic analysis, as outlined by Braun and Clarke (2006), and assisted me in analysing the participants’ experiences through an inductive approach to coding and, later, thematic development (Terry et al., 2017). Use of thematic analysis will be discussed in detail in the latter parts of this chapter.

Pre-Understandings and Assumptions

This qualitative study intends to capture the essence of the research question, “What are the experiences of early career midwives that supports their continued professional development while working in maternity hospitals?” Understanding my pre-assumptions, alongside any potential personal or professional basis, was essential before embarking on the interview process. My primary supervisor interviewed me to help me reflect on any further pre-assumptions and identify how my questioning and responses would enhance the participants’ freedom and expression. I drew on the experiences that I had in self-employed practice in the first five years that supported my continued professional development. I had not worked within a maternity hospital as an employed midwife. The AI methodology gave me a sense of

positivity and empowerment, reinforcing the things that worked rather than focusing on the aspects of my practice that did not work. This assisted me in feeling a sense of control and not getting bogged down in the challenges around my professional development. Having never experienced working in a maternity hospital as an employed midwife meant I did not have my own experience to draw from to create a potential basis. However, I did work for the first five years of practice alongside my employed colleagues as an Lead Maternity carer (LMC) midwife. Early in my career, I felt a solid connection to my professional pathway, but no understanding of my employed colleagues' experiences working within a maternity hospital.

My recent experience working with the target group for my study was that I worked for one year in a maternity hospital and mentored early career midwives. Any pre-understandings and assumptions came from these experiences. From the interview with my supervisor, I identified the following pre-understandings and assumptions, and points to guide my interview skills;

1. I believed that midwives early in their career were frequently challenged by the busy high acuity environment of their maternity hospital, which impacted their professional development and sustaining themselves within this way of working. Giving time for uninterrupted storytelling was essential to ensure I did not bias the questioning.
2. The language used will impact what is drawn from the experience. I found language and words such as 'challenge' and 'vulnerability' that I naturally used at the start of the interview were replaced by terms as 'positive, enjoyment, specialisation, hopeful' throughout the interview. The inquisitive, positive questioning impacted the responses and drew participants further into recounting the positive initiatives from practice. The questionnaire naturally supported the AI approach.
3. Be careful that prompts or questioning do not reinforce or judge experiences. As part of a facilitated interview, I had the opportunity to reflect on whether any power imbalance was present between the supervisor and me, as I may have expected. I did not experience a power imbalance which I felt was due to my supervisor not attempting to interpret or interrupt my stories from practice to facilitate her understanding. Therefore, I did not feel challenged or judged.

My interview was recorded along with feedback provided by my primary supervisor. Additionally, I transcribed a written reflection on the interview. The intentions of this qualitative study were to look at a specific group of midwives and provide them with

an opportunity to talk about experiences that support them in their professional journey. Taking the time to reflect on my pre-assumptions was valuable to not let these guide my questioning with bias.

Research Methods

In this section, I describe the research methods, including recruiting participants, the processes undertaken to gather the data, and analysis of the participants' experiences that answer the research question. Ethical considerations guide all research to protect the participants, and ensure cultural and physical safety for the researcher and participants.

Ethical and Cultural Considerations

Ethical issues are considered fundamental for any research involving people to ensure that the participants' rights are protected, and that the researcher acknowledges their responsibilities and obligations (Morina, 2020). Considering the ethical 'why' in research, related to the 'end' of the study, is being sure why the research is worth doing and who gains and losses as a result (Terry et al., 2017). To protect the participants, ethical approval was sought and granted from the Auckland University of Technology Ethics (AUTEC) committee on 28 August 2019, approval number 19/317 (Appendix B).

It was also essential for me to gain approval from the Research and Evaluation Office at the maternity hospital, where I planned to undertake the study, in order to access participants; permission was granted on 11 October 2019, research registration number 1074 (Appendix C). The purpose of my applications to these committees was to respect and safeguard the participants, as checked by an external body check, and ensure ethics were considered (Busher & James, 2015).

Alongside gaining ethical approval from AUTEC and the maternity hospital's Research and Evaluation Office, I sought advice and guidance from Mātauranga Māori Komiti, School of Clinical Sciences (Appendix D) regarding the safety and protection of Māori participants, should they choose to participate. It was essential that my study acknowledge Māori as Tangata Whenua and respect and uphold the three fundamental principles of partnership, participation, and protection as laid out in te Tiriti o Waitangi. I intended to cause no harm, be truthful, and protect the privacy and confidentiality of all individuals. My kōrero (chat) with the komiti (committee) was a unique and humbling experience. My study did not collect data on ethnicity. It did not specifically target Māori; yet, my process was challenged and a recommendation

made from the komiti that Māori would benefit from participating in my study to improve equity within the workplace. Through further kōrero (talks) with my supervisors, I made changes to my proposal to encourage Māori to participate. While there was no intention to target Māori specifically, I wanted to welcome their participation in my study.

The Mātauranga Māori Komiti was the catalyst for the change in my poster wording and design. I felt increasingly uncomfortable with an image representing a small group and not having an Aotearoa specific symbolic lens. The initial poster (Appendix E) was an image of a person abseiling down a cliff face that represented challenge and success. My new poster (Appendix F) held the image of a Harakeke (flax) with young buds ready to open. The Harakeke is a hardy plant, with blossoming flowers unique to Aotearoa New Zealand. This image depicted the solid and resilient midwives of Aotearoa New Zealand and the protection they need to thrive. This hardy plant grows almost anywhere and spreads its seeds to facilitate new growth—symbolic of what I hope to achieve within my study. I valued the consultation with the Mātauranga Māori komiti as they challenged me to look beyond my research question and into perspectives and views from a Māori lens. I was committed to honouring te Tiriti in my approach and process, but chose not to change my inclusion and exclusion criteria to specifically target Māori.

Participant Recruitment

My study was conducted in the Auckland region, the home of three large maternity hospitals. The decision to choose one maternity hospital to conduct the research was influenced by the fact that I had the least preconceptions about this maternity hospital. It recruited the largest number of graduates each year on a 15-month programme; therefore, had a bigger group from which to recruit. I had not previously worked in this maternity hospital as a midwife early in my career, so I considered I had fewer assumptions about the experience of midwives starting their career in this setting. As part of the maternity hospital research application, I was asked to nominate a health facilitator who worked in the hospital and would support the research through being the access person for communication within the hospital. I approached a Clinical Charge Midwife (CCM) within the birthing and assessment unit to be the health facilitator. She accepted the role and supported the study; and became invaluable in pointing out my study to potential participants.

Following ethical approvals, an email was sent to the head of Midwifery at that hospital. She supported my study and offered contact details for all the maternity

managers to start advertising the study to recruit participants. Further, I made email contact with four midwifery managers, discussing my intentions for the study, and requesting to advertise it.

Attached to the email correspondence was the advertisement poster, participant information sheet (Appendix G) and consent form (Appendix H), with an offer to meet to discuss the research. All managers met with me and assisted with putting up posters and information sheets in shared spaces such as the lunchroom, bathrooms, and locker rooms. On two occasions, the midwifery managers from community, assessment and birthing, invited me to attend their staff meetings to promote the study. The support from all the midwife managers was overwhelming; they made email contact with midwives in their units to support the research and included the poster in their communication. Although I put posters in all the tearooms and common spaces, it did not seem to be an effective way to recruit, with only two midwives self-referring having seen the poster.

The email, poster, and information sheet stipulated the following inclusion and exclusion criteria for the midwife participants;

- Has spent at least one year in hospital-based employed practice
- Be within five years of practising as a midwife
- Working within the Auckland area maternity hospital
- Has not been mentored by me in the MFYP programme

The study facilitator was copied into all communications and actively invited midwives fitting the inclusion criteria to consider participation in my study. Over three months, I had contact details of 14 potential participants interested in being part of the research. The health facilitator connected with 10 midwives whom she worked alongside and consented for me to approach. The support and enthusiasm from the health facilitator for my research study, alongside her role as a senior charge midwife, meant that I had an experienced, respected champion actively recruiting participants. After contacting the 10 midwives, five resulted in a meeting for an interview.

A further three participants took part in the study. Two self-referred after seeing the poster, and one came through introductions from midwife managers when visiting the unit to promote the research. In my role as an educator for midwifery emergency skills refresher day, two midwives approached me after seeing the poster, alongside knowing me as a clinical educator at AUT.

All midwives who expressed interest were contacted by phone to discuss the study and invited to plan a meeting time to sign the consent form and undertake an interview. The potential participants were emailed the information sheet and consent form before confirming an interview. A follow-up phone call was made at a time agreed by the participant, resulting in an interview schedule. In line with my ethical obligations, I only contacted the midwife once via phone and email. If the midwife did not respond, I did not pursue her further.

Informed Consent

Informed consent means that the participants need to be aware their participation is voluntary, and they have the right to withdraw at any time. They must know the overall purpose and design of the study, any potential benefits or risks involved, and be offered assurance of confidentiality (Terry et al., 2017). Information about the study and its purpose is a careful balance of not over-informing and impacting the data collection, and ensuring that participants know what they are participating in and where the information will go.

After the initial phone contact to talk about the study, I emailed the participants the information sheet and consent form. Potential participants were given two weeks from the phone call and email to read the information, consent to be part of the study, and make a plan to meet for the interview. A return phone call was made to check for further questions about the research and arrange a time and place suitable for the interview. The information sheet was concise and informative, offering the right balance of information; yet not over-informing, so as to impact the spontaneous nature of drawing from their experiences. Before the participant signed the consent form, they had an opportunity to ask any further questions. Signed consent forms are stored in a locked cupboard as required by AUTEC and will be kept for six years.

Anonymity and Confidentiality

Because of anonymity, the participants were asked to select a pseudonym before the interview and were assured that their maternity hospital was not named as part of the findings. All transcripts were labelled in this way, and I was only person who knew the identity of the midwives. My supervisors only knew the participants through their pseudonym. All data were kept on my OneDrive, password-protected, and I am the only person with access. The transcriber, who transcribed the first interview only, sent an electronic and paper copy back to me and then deleted the recording. The role of the supervisors in access to the data and overseeing my analysis process was explained to the participants, and their anonymity was assured. The participants were

also assured that the anonymity of their colleagues and maternity hospital would be upheld. When the name of a maternity hospital was stated, I removed this from the data and replaced it with 'DHB or maternity hospital'. No names were mentioned in the data, and all participants responded with ease to their pseudonym when interviewed.

Concerns for the Researcher

When starting on this journey, I had concerns that my job as an AUT educator would impact the participants' freedom to share experiences if they had been a student of mine. I had a mix of participants that I knew from my role as an educator at AUT and those educated at other institutions. This balance was about 50/50 and did not prove to influence the interview process or freedom of sharing experiences. A midwife whom I had mentored in the past could not be part of the study for fear that this previous close working relationship would somehow sway the data collection.

Concerns for Participants

Being an AI study, it was unlikely that participating in the research would cause discomfort or embarrassment as the approach guides the questioning but cannot influence the participants' experiences and stories that they wish to tell. However, it was acknowledged that when midwives talked about work-related experiences, there was potential for upset or distress. Hammond (1998) stated that a positive result from the AI methodology study is that participants contribute to research to give them a sense of confidence, focusing on their successes. Therefore, there was a possibility that there would be benefits for the participants. Before the interview, I assured each participant that she could choose to pause or reschedule the interview if she felt any discomfort or distress. After the interview, I checked on the participant's wellbeing, and all eight participants felt comfortable.

The participants voiced an appreciation for the opportunity to talk about what was positively playing out for them and not focus on the negative aspects of work. Each participant was given a koha (gift) in the form of a $20 voucher at completion of the interview to acknowledge their time and contribution.

The Participants

The sample size for this research was expected to be six to ten participants, in line with a small qualitative study. The eight midwives who volunteered to participate did so without coercion. All participants held a midwifery APC in Aotearoa New Zealand and were currently working within the maternity hospital. The participants worked in

various maternity services from community, postnatal, assessment, and labour and birthing. Their years of experience ranged from 1 to 5 years in practice, with average years in practice being about two and a half years (see Table 1).

Table 1. Participants' Time Post Registration

Participants	Rose	Shania	Cindy	Michelle	Charlotte	Maisy	Christina	Yolanda
Years in practice	1.2	1.5	4.5	1.5	2.3	2.5	3	3

Two participants had worked in more than one hospital in their early years. It was essential to maintain the confidentiality of the participants and, for this reason, all chose to conduct their interview outside of their workplace. The midwives had busy work lives and with interviews taking place outside of work hours, I needed to be flexible and accommodate short notice and choice of venue to suit each participant. All participants, when approached, were given the option to bring a support person to the interview; none chose to do so. All interviews took place at the time first scheduled.

Interview Process for Data Collection

Participants chose an interview location that felt comfortable for them. The majority of participants chose their own home; one chose AUT, one my home, and one a private room at a café. The AUT safety protocol was followed in line with interviewing in the participant's home (Appendix I). The freedom of sharing their stories in a way that would cause minimal distress was essential. Understanding the AI approach was critical for the participants, alongside why the questioning approach was searching for positive experiences. The interview started with welcoming them and finding out the length of time they had been in practice. The discussions intended to take 30 to 45 minutes, with all completed within this timeframe.

A semi-structured interview approach allowed the participants to respond to questions around a topic using an interview guide. Cornelissen (2017) noted that qualitative research is helpful in understanding and giving meaning to the experiences of individuals; and using a semi-structured interview approach will provide rich data to make sense of their lived experience. The interview guide used questions around topics that were overarched by the AI methodology. Interviews and having 'special conversations' allow the researcher to learn about feelings, experiences, and the world in which they live (Liamputtong, 2020). Understanding the context and environment in which the participants worked, alongside the nature of the job, meant

that I could use probing questions to deepen the understanding of the experiences and enrich the data.

After introducing the study and explaining the significance of an AI interview, I asked them to feel free to share their stories from practice. Staging the topic included questions such as;

> *Can you tell me about what professional development means to you within your role as a midwife?*

I then followed up with a broad question supporting the AI methodological approach and assumptions four and five;

> *What do you value most about your role as a midwife?*

Within the staging questions, and in line with assumption six, I asked;

> *Describe for me your peak experience/high point in your career as a midwife?*

When developing the research questions, the topics leadership, autonomy, and support were identified in line with assumptions three, four, and five. An example was;

> *Please tell me a time when you felt supported to be an autonomous practitioner?*

Lastly, the concluding questions acknowledge assumptions six, seven, and eight to look to the future and value difference.

> *How would your DHB and your manager contribute to the success of your professional aspirations?*

The AI lens guided the interview questions (Appendix A). In keeping with the critical assumption of "appreciative inquiry is to learn to value differences" (Hammond, 1998, p. 53), the questionnaire was developed to positively inquire about experiences; yet, give a sense of freedom and flexibility to the interview. I had various questions to choose from to guide and grow the discussion. When interviewing, there is a partnership between the interviewee and the researcher, which requires the asking of questions and the process of active asking and listening (Liamputtong, 2020). It needed all of me to be present, without distraction, to fully elicit the rich information imparted from the participant's perspective. Interviews were digitally audio-recorded, for which the participant consented.

My interview skills developed over time, with the ability to take a positive inquisitive approach without losing the essence of the participant's story. Teasing out the information that supported my topic while allowing the participant the freedom to express their feelings and share their stories was an art, not a science. Prompting appropriately, in a timely manner, developed over time and influenced the quality of the data.

The emotional connection attached to our words affects our thinking and that of others (Hammond, 1998). Raising consciousness of not reinforcing the dialogue from the midwife as 'great' or 'that's fantastic', developed, as did my experience in interviewing. Such reinforcement was prevalent in the first half of the interviews and was not helpful in the data collection. The timing of the interviews before Christmas break, alongside a degree of enthusiasm, allowed me the luxury to stop and reflect, and learn from my first three interviews. Making space after the first three interviews to reflect on the data and start the beginning stages of coding was beneficial. It helped my interview skill development and to notice where to prompt participants to expand on valuable dialogue to enrich subsequent data collection.

The timing of the interviews was impacted by my interviewing skills and the midwife's ability and willingness to access and reflect on specific experiences. It was a challenge as many participants were more comfortable generalising their responses instead of telling me about a particular experience. Specific stories were more freely expressed near the end of the interview when they potentially started to feel comfortable and had time to reflect on experiences and recall memories from practice.

Within the interview, the questions were staged to introduce the topic and structured to help set the scene positively, focusing on the 4-D cycle (Hammond, 1998). Examples of questions are;

Stage setting –

- Please tell me how many years you have been in practice post registration?
- Please tell me what does professional development means to you working in your role?
- What do you value most about your role as a midwife? What about the people you work with? The DHB you work for?

Topic questions – Feeling questions that focused on broad topics as leadership, support, and autonomy were developed in the body of the semi-structured questionnaire.

- Tell me about a time that your colleagues contributed to your professional success and fulfilment at work?
- Please tell me about a time when you felt supported to be an autonomous practitioner? What contributed most to this feeling of being autonomous?
- Please explain a successful experience where you took the lead at work or developed a new skill? How were you supported to feel successful at this time?

Concluding questions – Dreaming concluded the interview with an inquiry that allowed the participant to visualise or dream into the future.

- Dream into the future, the hospital management has set up a structure to support your professional development and works in partnership with you. What does this look like? What three things have been done to create this healthy partnership between management and the midwives?
- In an ideal world, how would the DHB support you to specialise in an area that you like most about your job?

The above structure allowed the midwife to engage in the dialogue of their own experiences, loosely guided by the questions to keep them focused on the appreciative concepts and what benefits their professional development. The midwives had freedom of expression, made possible by applying a semi-structured approach within the time frame. I intended to take notes as I interviewed. This was challenging as it diverted me from engaging in the interview. Eye contact is vital to engage the participant and something I was not willing to sacrifice, so I chose not to take notes. Thus, my reflections and notes were written after the interview so as to ensure my mind and body were fully engaged during the 30-45 minutes without distraction.

Data Analysis

Transcriptions

The participants were aware that a third party may transcribe the interviews and that this person would sign a confidentiality agreement (Appendix J). Midwives, who consented to participate in the study, agreed to have the interview audio-recorded for accurate transcription. A transcriptionist transcribed the first interview; after which, I transcribed all recordings myself, keeping with the recommendation from an earlier thematic analysis workshop on best practice as a researcher, that this brings the researcher closer to the data. After the first interview, I switched to the transcription

app ‘Otter’ as an efficient way to transcribe the subsequent interviews. This kept the written and oral interview connected throughout the data analysis stage. Correcting the transcription from the app, Otter bought me closer to the data and became beneficial in maintaining the accuracy, alongside retaining the emotion to the words. Returning to the interview at any stage using the Otter transcription app allowed me to recall the feeling attached to the data and immerse myself more profoundly in the meaning.

The interview transcripts were returned to the participant within five days of the interview to check for accuracy, edit, or delete information. ‘Member checking’ is an integral part of the process of qualitative analysis and is expected to strengthen the analytical phase of research (Caretta & Pérez, 2019). It is done to ensure the accurate interpretation of participants’ voices (Korstjens & Moser, 2018). All participants chose to look over their transcripts with no changes.

Thematic Analysis

Thematic analysis appeared in qualitative research in the 1980s and 1990s, and was used successfully to analyse qualitative data in health and social sciences (Terry et al., 2017). This method is used to analyse and report on patterns in the data, and give meaning to the participants’ experiences, reflecting and unpicking the layers of reality (Braun & Clarke, 2006). In the process of thematic analysis my quest was to analyse the data, noting the patterns within to answer the research question. Under the umbrella of AI, I followed the six phases of thematic analysis by Braun and Clarke (2006): familiarisation with the data, generating the codes, searching for themes, defining themes, naming themes, and producing a final report (Vaismoradi et al., 2013).

The Six Phases of Thematic Analysis.

1. Familiarising myself with the data.

Terry et al. (2017) stated that familiarisation with the data is the entry point into analysis and is the “bedrock” for doing high-quality thematic analysis. This was where I engaged with my data and took time to gain insight into the data. Before correcting and transcribing the data, I listened to each interview twice. After transcribing, I took many walks listening to each participant’s voice and understanding how the emotion was attached to the words. The process of listening, reading, and writing in a cyclical way helped me immerse myself into the data and moved me onto the process of coding. I made further notes along this journey with new insights, as I had the opportunity to revisit the power of the pauses and emotion in the responses in the

data, to get a deeper, richer understanding of what the words were saying. The benefit of the Otter app was I could read the words alongside the audio. The method of recording and transcribing that Otter offered, meant that when I took a six-month leave of absence, I was able to go back to the data alongside the audio to refresh my memory with the benefit of the audio giving emotion to the transcription.

2. Generating the codes.

The coding phase was about making sense of, and immersing myself in, the data, with the prime focus of answering the research question. NVivo was an effective tool to assist me in my qualitative analysis, and allowed me to identify and test codes that fit the data. Being a subjective researcher was essential to the rigour of the study. The coding process is organic and flexible and requires full engagement with the data, alongside patience (Braun & Clarke, 2006; Terry et al., 2017). Attending two short courses on thematic analysis and NVivo gave me the tools to maximise my beginner skills in data analysis and supported my intention of not rushing the process.

This stage was a time-consuming, yet enjoyable process. The cyclical coding process built towards the singular, shared, and correct data analysis (Braun & Clarke, 2006). Using NVivo meant that my coding process could be viewed by my supervisor to ensure rigour. The flexibility of thematic analysis was felt in the coding and constructing of themes, and making sure I was not trying to be rigid with rules. Staying true to the participants' voices was critical in the AI methodology and meant looking deep into the data, being patient with the process, to discover how the midwives' experiences gave meaning to their professional development. Building big codes and clustering the more minor codes beneath them was how the themes started to be made from the meaning of the data. Keeping the research question visible at all times was essential.

3. Generating initial themes.

"A theme captures something important about the data and the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). This stage was exciting, as I discovered the themes that came from the coding. The challenges in this stage were to see the patterns in the data and leave data behind that were interesting to the profession but did not answer the research question. Such data were around the midwives' value of being a part of the woman/person and whānau journey, as seen in part of Rose's story;

> *I had one woman who had a traumatic first experience. I put a lot of emotional effort into keeping her in a good headspace, including her husband, family and*

her friend and working together. I had a really lovely time working to give her a positive experience, making sure she was in control. That's a pretty special time for me as a midwife.

Ensuring that I keep the data analysis close to answering the research question was essential. Many thematic maps were drawn to help understand what themes were being built and how to organise the data (Terry et al., 2017). I had to be careful not to form one word themes that may be restrictive for analysis.

4. Reviewing themes

This stage involved looking "beneath the surface" of the data, finding the meaning in words, and building themes from the meaningful codes (Terry et al., 2017). This process took time, and the rigour came from sharing my process with my supervisors who bought a different lens, assisting and guiding me from getting stuck or restricting my thinking. My supervisors asked vital questions to check the themes had come from correctly coding the data. This was when I was challenged to let data go that did not answer the research question. A final thematic map was created, and, in doing this, theme names were re-written to capture the essence of the data (see Figure 1).

Figure 2. Example of a Thematic Map Close to Final Development

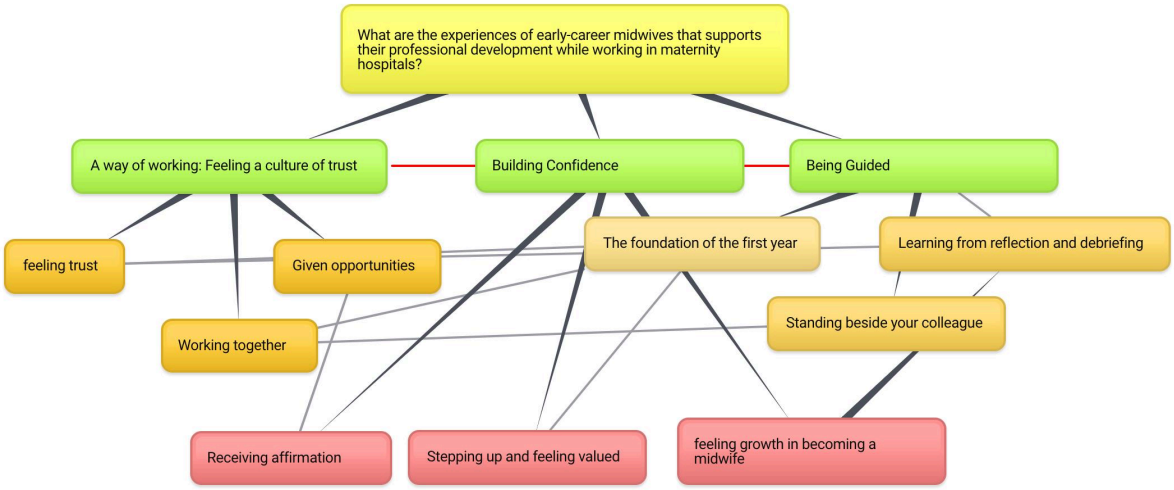

Figure 2 Example of a Thematic Map Close to Final Development

5. Defining and naming the themes.

The theme names were fluid and even after final write-ups of analysis chapters, the wording of these themes was still to change. Multiple thematic maps helped make sense of the themes and start the final decisions of what was the best fit. Using the

website bubbl.us meant that I could share my theme maps with my supervisors with easy visibility. Stages two, three, and four required me to check in regularly with my supervisors to ensure my process was robust, thus ensuring the rigour of the thematic analysis process. With thematic analysis being a flexible method, with few rules around themes and no magic formula, it gave freedom to complete analysis.

6. Writing up the report.

This stage involved weaving the data narratives together under each of the three themes and contextualising the data, looking at how these relate to existing literature (Braun et al., 2019). The best of the data were chosen to represent the themes. Three themes were derived, and each had three sub-themes. The narratives came to life as I worked to discuss the meaning within them and honour the participants' stories. It was essential to define each theme and ensure that the data and analysis were organised to stay true to the theme. This is when the names of themes needed to be changed in keeping with the meaning of the data. The term 'culture' was embedded in the data and commonly used in participants' narratives. On reflecting upon what lay beneath the word and exposing its many meanings from the data, I changed 'culture of the DHB' to 'a way of working', following an insight that 'culture' was attached to a way of working and relationships within the workplace. In consultation with my supervisors, the word may have multiple meanings within healthcare, being careful to use the word 'culture' in a way that correctly interpreted the data was essential.

Trustworthiness

Ensuring research trustworthiness of qualitative research is essential in presenting the data and gaining confidence from research professionals (Rose et al., 2021). My supervisors oversaw every stage of the research to ensure the study reflected rigour in the data collection and analysis stages, and subsequent trustworthiness of the results. The methodology and methods were described and reviewed to be sure of their appropriateness for the study. The continued checking at each stage and validating, of the methods and analysis ensured the trustworthiness of the research. The participants owned their data and were given the opportunity to check their words to be sure that the data correctly represented their experiences.

Using NVivo added to the trustworthiness, as when the data were being coded, they were not separated from the original transcript. When I needed further clarification regarding context to the words, during analysis and writing up, NVivo enabled me to go back to the initial interview transcript. Korstjens and Moser (2018) proffered that data analysis continues while one writes, reflecting the iterative nature of the

qualitative research process. I was challenged by my supervisors to stay true to the methodology and the research question, and not rush the data analysis stage. Continuing to question the relevance of the analysis to answer the research question was instrumental at all stages; as was acknowledging my pre-assumptions at the beginning of this research study and having discussed these with my primary supervisor to make sure they did not form any bias in the thematic analysis stages.

Conclusion

The first part of the chapter critiques the appreciative inquiry methodology. AI is a qualitative methodology, with an underpinning understanding that there is the ability to find good in all organisations and experiences (Whitney et al., 2010). It is a solution-based approach, not a problem solving one; therefore, it was necessary as the researcher that the AI assumptions were appreciated in this way. My questioning came from an understanding of how AI builds on the organisation's strengths, not the problems (Reed, 2007). The assumptions, principles, and the 4-D cycle guided all stages of the study.

In an increasingly vulnerable profession, I dream that my study contributes positively to inspiring early career midwives and showing appreciation for the profession. When morale is low and maternity hospitals are struggling to retain staff, it is all too easy to look for the negative aspects that contribute to the situation. Choosing to look at experiences that support development early in the career for the midwife meant my study sought to uncover what was successful and promoted positive high performing midwives (Cooperrider & Whitney, 2005).

The methods section of this chapter discussed the methods involved in supporting the chosen methodology to structure the data and answer the research question. The methods used to collect and collate the data were discussed, alongside the ethics and rigour to ensure that AI was honoured throughout the study. The mandatory aspects of a quality qualitative study such as recruitment, participants, informed consent, confidentiality, concerns for participant and researcher, were described. Semi-structured in-depth interviews were used to collect the data and support the flexible thematic analysis method to give meaning to the midwives' voices and experiences from practice in analysis and writing data chapters. Trustworthiness was discussed within the framework of qualitative research.

Chapter Four: A Way of Working- Feeling a Culture of Trust

The purpose of the findings chapters is to discuss the main themes that emerged from analysing the data related to the research question: What are the experiences of early career midwives that supports their professional development working in maternity hospitals? Eight participants shared experiences and through the lens of appreciative inquiry (AI) and a thematic analysis approach, three themes emerged from the data: 'A way of working – feeling a culture of trust,' 'Being guided,' and 'Feeling confident.' In the AI 4-D cycle the findings chapters are where 'discovery' happens. These three findings chapters are about 'what gives life,' what inspires the early career midwife and her professional development. Although my study's focus was professional development, the midwives responses were about the environmental and human impacts on their ability to experience continued professional development. This is the stage the narratives from the participants offer opportunities to the organisation for positive change.

The theme 'A way of working – Feeling a culture of trust' is representative of the midwife's environment and its impact on her continued professional development. The trust in the culture of the organisation is both instrumental for the midwives' development of skills and knowledge, and protective and nurturing of them as health professionals. The workplace 'culture' has a significant impact on the way a midwife experiences support for their continued professional development in the early years.

Three sub-themes emerged from the data as essential indicators that supported maternity hospital culture alongside the midwife's continued professional development.

1. Working together
2. Feeling trusted
3. Taking opportunities to learn

Working Together

Through the AI approach, during interviews the participants talked about the culture being about support which meant having access to approachable colleagues to offer guidance. When asked questions about the team and support, participants all spoke about the culture of the hospital.

Michelle elaborated on support and the impact of the team.

> *I think the team helps support you while you're learning and giving you opportunities; for example, the new graduate programme. I had a preceptor for two to three weeks initially, and by the end of the three weeks, they have you on a lower caseload so that you are working independently, but you have someone to go back to. I've just found the team I work with so supportive, and it's a culture. My preceptor was constantly happy to answer questions and always asked me to give it a go first and then seek help if I need to. Having people around you that support you to help with whatever you need, also opportunities to keep developing and known places to progress.* (Michelle)

Michelle viewed the team as "really helpful" and supportive of her learning. The new graduate programme enabled a preceptor to work alongside Michelle for several weeks. In the first year of practice, the graduate midwife has a preceptor within the maternity hospital when orientating to a unit, and Michelle's preceptor assisted her transition to work independently, knowing there was always a colleague available to "go back to" and answer any questions. She valued this support as encouraging "to give it a go first" alongside general guidance from colleagues. In Chapter Five, guidance is explored as different to support. Participants in my study described support is an intangible thing linked to a culture whereas guidance is tangible and a collegial practice.

Michelle saw preceptorship as a culture that fostered support and gave her opportunities to "keep developing." There was always someone in the team around and investing in her continued professional development. Cindy, one of three participants who started her career in another maternity hospital, drew comparisons to the impact of the maternity hospital culture on her learning early in her career.

> *I enjoy the colleagues that I'm working with at the moment. The women and the families that I work with are important. When you get a nice family who really appreciates what you're doing for them or if you're working as a team with your colleagues, that's what I love most about my job. It's a cultural thing, and it is simply so ingrained in the culture of this DHB (District health board/maternity hospital). It's so difficult sometimes, being genuinely supportive of each other; it is part of the culture of my DHB that is more supportive than other DHBs.* (Cindy)

Cindy felt enjoyment in her job when she had good relationships with women, whānau, and her colleagues. She felt that when the family "really appreciate what you are doing" and the team works well, that contributed to her job satisfaction. In my study,

the midwives valued how the team functioned alongside their relationships with the woman and whānau, which Cindy believed was about "the culture." She talked about a culture which helps to support the difficulties of day to day work.

Cindy expressed team support within her maternity hospital, an aspect of the work cultures that she does not necessarily believe exists in other hospitals. Cindy had experienced two maternity hospitals and the cultural differences between the two were significant to her experiences. Being "genuinely supportive" is about how people behave and becomes part of the culture of an organisation. Cindy articulated the challenges to colleagues giving 'genuine support;' however, she recognised the 'cultural value' of her current maternity hospital.

Maisy described her feelings about her maternity hospital and how it is supportive.

> *I feel like my DHB has worked exceptionally hard to make the environment positive. There is this kind of expectation that people get along with everyone; it's like a culture. All of my feelings of growth and of becoming more confident are associated with the DHB, my colleagues, and my mentors within my DHB.*
>
> *They (charge midwives) are just so supportive of their attitude towards new midwives. I think a lot of that support happens around and in the assessment unit. You're not quite sure what kind of management plan you're supposed to be making. Do I discharge this woman, or does she need to be admitted? So I think it's just that collegial attitude, particularly at my DHB, that they've fostered.* (Maisy)

Maisy describes an environment where 'becoming more confident' is enhanced by positive relationships. Her continued professional development is attributed to the culture of collegiality, supportive mentors, and assistance with decision-making when assessing women. Within the busy high acuity assessment unit, Maisy experienced a supportive culture when making management plans for women. She voices that "collegial attitude" supports new midwives in practice. Maisy experiences her continued professional development as a combination of three factors—her maternity hospital, her colleagues, and the midwives that mentor her.

Christina viewed the investment in graduate midwives as beneficial to the future of the maternity hospital.

> *They (graduates) can sometimes be seen as a bit of a nuisance, or they feel like a liability. You have to keep an eye on them, but they're the future, and*

> *you do have to invest in them because if they don't get the support they need right from the beginning, they're not going to want to come back. The DHB has got to create an environment where they (graduates) feel comfortable and safe. We need to focus on new grads and also the relationship between core and LMCs. I think we're all midwives, and there doesn't need to be a 'them and us.' If we all respect and work together, then how much better will it be?* (Christina)

Relationships with core and LMC midwives impact the midwife's ability to work in a safe environment. She feels that the maternity hospital culture impacts building and supporting positive relationships between the two groups of midwives—LMC and employed. Feeling comfortable and safe with supportive colleagues helps Christina feel optimistic about prospects within the maternity hospital. Employed midwives and LMC midwives working as a team is essential; however, when unsuccessful, a culture of "us and them" is experienced. Christina expressed how having her maternity hospital invest in graduate midwives where respect and a team approach promotes working together, creates the optimal workplace for her.

Charlotte sees the "positive" environmental culture impacting her ability to learn.

> *I feel like my DHB has worked quite hard to make the environment positive. I guess there is this kind of expectation that people get along with everyone; it's a culture. My DHB has been fabulous to come into; they've been incredible and supportive. I always feel like there is someone around that I can ask to help me. Most people, actually everyone, I could ask for help, even if it was a really stupid thing. I feel like there is always someone willing to lend a hand, give advice and knowledge. They are really great.* (Charlotte)

Charlotte attributes the success of the positive environment to the hard work within the hospital. She moved from another maternity hospital that did not provide the same supportive attitude. Her ability to feel confident to ask for help is impacted by the team culture and how approachable her colleagues are. Gaining advice and sharing knowledge comes from a collegial way of working, having someone around helps build Charlotte's confidence and supports her continued professional development.

Christina voiced she felt "awesome" in the ability to manage an emergency well.

> *I think most times when we (the team) have an emergency, the team just go in there, and we smash it! We do well, not always, and it does sometimes depend on who you're working with or what doctors on. But, I often walk away*

feeling, it's pretty awesome how quickly we got on top of that, or how that was handled. Sometimes I don't come out feeling great but generally speaking, I do. (Christina)

Christina revealed that the way an emergency is managed by teamwork gives her a positive sense of success. Feeling successful is essential for building confidence in skills and knowledge. Christina expressed, "we smashed it;" a sense of immense achievement in successfully managing an emergency as a team and thereby creating a positive culture. Mutual trust is linked to the team culture and what is systemic within the maternity unit. The second sub-theme, 'feeling trusted,' is closely related to a sense of safety and feeling safe.

Feeling Trusted

This sub-theme reveals how 'trust' is three tiered. Mutual trust for the participants means that they feel trusted, they trust themselves, and they have the support of trusted colleagues to feel safe. The participants' voices echo that mutual trust is a part of the culture that has been fostered by the workplace and employees. Trust contributes to a feeling of safety, which is instrumental to continued professional development.

Most participants do not talk about trust being dependent on experience or time; rather, a 'cultural value' present within the unit between practitioners.

Rose experienced trust between colleagues as mandatory towards the safety of the environment.

I think just knowing that your colleagues have got your back, and they trust you and you trust them. It just creates that safe environment. I feel more confident when I know that people trust me. I think, if you have that mutual trust that keeps everything safe, I am capable enough. If I feel like the people I'm working with see me as a capable midwife, it's much easier to be that midwife. Whereas, if I feel like they doubt me, then I'll just doubt myself and have no confidence in my decisions; it makes such a big difference.

It's nice not being controlled and having colleagues who will hear your decision making, listen to your rationale and support you with it, even if it's not how they would practice. If I've talked about my decision making with the charge midwife, and I know she's okay with it, then I know if anything goes wrong, she

will come in, and I'm going to be supported and not cut down or undermined for anything.

If you have a mutual trust that keeps everything safe, I can't imagine working with people that you disagree with or that just tell you what to do and don't accept any other way, and I think I'd feel quite unsafe. (Rose)

Rose explains that when her colleagues trust her it builds her confidence; and, when she feels confident, she feels capable as a midwife, supporting her growth and belief in herself. Rose talks about the importance of keeping "everything safe" and its impact on her belief in herself as a midwife; "If they trust you and you trust them, it creates a safe environment." Having the ability to talk about her rationale for her decision making, feel heard and supported, affects her ability to learn and grow; this defines trust as a collaborative concept. In this way, Rose experiences trust in her colleagues as protective for her decision making. This fosters a kind approach and avoids Rose feeling "cut down or undermined." Feeling safe is a significant part of feeling confident in her decision making ability. Rose wants to make the decisions, rather than be directed. She appreciates the flexibility of the charge midwives when they can see multiple ways of practising. For Rose, feeling trusted opens up the chain of communication with colleagues and increases her confidence in practice and creates an environment of safe practice. A consequence is support to be autonomous in practice.

Charlotte also spoke about the impact of taking on more responsibility and feeling more autonomous.

With inductions at my DHB, the midwives make a lot more decisions than in my last DHB. It was quite empowering for me to come to this DHB and having more responsibility for inductions. My last DHB felt a lot more medically run than this DHB. My current DHB is a tertiary hospital, but doctors respect the midwives and their role much more than my last DHB. I was early on in my career when working in my previous DHB where the charge midwives and the doctors made the decisions. I am still young in my career now, but in my last DHB I could not make any decisions. Now I have to think about what I am comfortable within prescribing and consulting. It feels really good. (Charlotte)

In her last maternity hospital, Charlotte experienced charge midwives and doctors making clinical decisions. As a consequence, feeling autonomous in midwifery practice was uncommon. When she moved to her current maternity hospital, still early

in career, she felt she was given more responsibility with decision making, and felt comfortable and supported to do more complex midwifery care. Charlotte found the current DHB was more supportive with autonomous midwifery care regardless of years in practice. Being offered more responsibility she felt supported her growth and gave her confidence. This was impacted by the respectful behaviour that doctors showed for midwifery skills, knowledge, and decision making. Charlotte felt empowered in her role when given more responsibility and respect in her role as a midwife.

Like Charlotte, Yolanda expressed how her colleagues assisted in building her trust and self-assurance to be an autonomous midwife.

> *This was not long after I'd come back to the DHB. I remembered approaching one of the registrars for advice. I approached the registrar for a consultation and presented my plan of care, when asking for advice. He (the registrar) looked at me and said, 'you are a midwife, right?' He said, 'you can make that decision; you do not need my input into that.' It became clear to me that this was within my scope to make that decision. Interestingly, in this case, my medical colleague affirmed to me, I am an autonomous practitioner; I am in charge of this woman's care at the moment. He gave me the confidence to trust that the decisions the woman and I discussed were appropriate and the correct process. I then felt confident to go ahead and follow through with it.* (Yolanda)

For Yolanda, continued professional development and autonomy were impacted by an obstetric colleague trusting and reminding her that she was an autonomous midwife. Within the obstetric hospitals, midwives commonly work alongside their medical colleagues, with many women having complex needs and requiring both obstetric and midwifery care. Feeling autonomous as a midwife in a maternity hospital comes with blurred lines of accountability, but the scope of practice is clear. Passing the responsibility back to Yolanda, when this was not obstetric but midwifery care, affirmed that midwifery practice and decision making is valued in the maternity hospital alongside collegial trust.

Similarly, Cindy felt that trusted colleagues impacted decision-making ability.

> *I think it's challenging to be an autonomous practitioner in the DHB because you are not working in isolation as such, and you are following policies and guidelines. You're often not working with primary women (low risk), so there*

> *can be lots of people involved. Identifying a perineal tear and knowing whether it needs to be stitched shows midwifery care and decision making. It depends who is on, but it's your colleagues and your charge midwives who have the confidence in you to make decisions, and it's really important to feel they trust you to make decisions. Then you trust yourself.* (Cindy)

Cindy describes the ability to trust herself because colleagues trust her and have "confidence" in her midwifery practice. It can be challenging for Cindy to be an autonomous practitioner in a high acuity hospital. Cindy gave an example of managing a perineal tear; a situation where she acknowledged the importance of feeling trusted. Cindy saw opportunities for autonomous practice within the hospital; however, she felt that this was more difficult with the limited access to primary women. Perhaps some midwives find it harder to see themselves as autonomous practitioners when the care is shared with the medical team in the tertiary maternity hospital environment.

Christina echoed the benefit of collegial trust in providing midwifery care.

> *I guess keeping autonomy and the balance of working within the team and consulting when you need to. When we get primary situations (women/people with no risk factors) within the tertiary base hospital, and when that happens, we need to protect those primary women(low risk women). That's when I can make autonomous decisions. There have been times when I've wanted to run a decision past the charge, and they're like, 'well, you know, you can make that decision. What do you think?' So, you know, I've got to make that decision that I guess is being pushed to be more autonomous in my practice.* (Christina)

"Keeping autonomy" is a concept that Christina feels is a choice. Whether this is 'keeping' or protecting autonomous practice is unknown; however, for Christina, being autonomous in practice built her confidence to be independent when accessing support and reassurance from her senior colleagues like CCMs.

Christina feels confident to make decisions when the charge midwife passes decision making to her with trust in her practice. In doing so, the charge midwife empowers Christina to be autonomous and make "that decision" appropriate for her practice scope. Christina sees a common assumption that 'being autonomous' is more closely connected to providing primary care when working independently with primary women. "Being pushed to be more autonomous" within a hospital environment by the clinical charge midwife supported Christina's continued professional development. This was an act of trust, affirming and supporting decision making.

Similar to Christina, Yolanda experienced how the clinical charge midwife trusting her enhanced her learning.

> *The trust into what I'm doing and where I'm going, alongside knowing that if I'm not sure about something, I won't sit on it and hide it, but I will walk out and go, 'hey, this is not okay can someone else have a look at this?'*
>
> *You know, that was a huge thing to know that I'm on the right track and getting direction with the physical skills. Not long ago, we had a shoulder dystocia, and I had a charge in the room, and of course, no one else was on the floor. The charge midwife just trusted me that I knew what I was doing to birth the baby. She didn't rush to guess. And you know she didn't push me out of the way. She calmly asked if I felt like I have the right traction and did. I feel like there was movement. She didn't say, 'can you move out of the way? I know what I'm doing and can do it better.'* (Yolanda)

Yolanda felt that trusting herself meant that she accessed the support outside the room for a second opinion from her colleagues. Her confidence in asking for help was important for her not to doubt her care or a situation of which she was unsure. Yolanda spoke of an experience during a shoulder dystocia emergency when a charge midwife successfully supported her through standing beside and gently guiding Yolanda. Yolanda valued the support beside her, and the charge midwife allowed her to perform manoeuvres to manage the emergency; thus, showing trust in Yolanda's ability. The senior or clinical charge midwife has a role in empowering the early career midwife in a way that builds confidence. In this instance, "calmly" guiding with an approach that "trusted" was instrumental to Yolanda feeling she was learning; the outcome was a successful experience of safely delivering the baby in an emergency.

Taking Opportunities to Learn

Feeling part of the bigger picture means that the midwife feels part of the future of the maternity unit, and the manager sees the midwife as part of the maternity hospital's future. Feeling noticed when given opportunities, made the midwife feel visible and a part of the organisation's plan for the future. The manager is the conduit between the midwife and the organisation. The manager helps navigate the career path of the early career midwife alongside valuing the midwifery role and job progression within the maternity hospital. Feeling noticed and having one's individualised needs accommodated is instrumental in the organisation showing commitment to the midwife's professional growth.

Rose feels part of the team when opportunities are presented.

> *I want to feel trusted with something or able to be a part of a project or improvements. If I felt like management saw me. If management wants me to help, then I would feel like I was a part of the team, valued and needed. I think that would make it a lot more rewarding. I think my career means a lot to me, and I don't want just to turn up and do my job. I want to feel like I'm part of something bigger. It's hard to know where I want to be or know a clear pathway, but the steps I need to get there would be good. I think just having lots of opportunities to go further with knowledge and skills and whether that's moving upwards like leadership roles or whatever, having those opportunities and training available.* (Rose)

Rose expressed the importance of management noticing who she is. She wants to be seen and invested in by her organisation. Being "valued and needed" contributes to feeling rewarded in her job and part of the team. For Rose, being a midwife is more than "just to turn up"—it is about being part of the bigger picture. Having an impact on quality improvements, projects that see her part of the future progression and contributing to the success of a team are highly valued by Rose. Feeling part of "something bigger" is an acknowledgement of seeing herself growing with the organisation, part of the organisation's future goals and plans. Building her career intentionally, knowing what her pathway looks like, is instrumental to Rose feeling a part of the organisation. Guidance of what pathways and opportunities are on offer to progress is appreciated.

Rose echoed the importance of having opportunities to "go further," like leadership roles. Rose sees a pathway to leadership roles as an essential part of career progression and wants to know what the training and opportunities to look for to achieve this future. Similarly, Yolanda expressed the value of an investment in her needs.

> *For any midwife to grow, they need to be supported to do so, and when you're just coming to do your shift work and you don't necessarily have the opportunity to go and see what the DHB offers. The DHB should be taking notes about you.*
>
> *If you were in an office environment, for instance, my husband's, his manager says, 'well… he could be a manager. He shouldn't be just doing what he's doing.' They would say, 'how can we get you to that position?'*

> *We can do the same thing in a DHB, and they (the manager) think, 'how can we get this midwife to that position?' It's not like they don't see us on the floor (working on the wards/units). They see every single person, and they know the personalities of every single person. There is nothing that stops them (the manager) from improving their workforce.* (Yolanda)

Yolanda voiced that managers have a part to play in progressing the career of a midwife through noticing when midwives have a readiness or opportunity to step up. Being acknowledged and seen for successes is important to support professional growth. Yolanda feels that the manager knows her well and that there is an opportunity to intentionally build their workforce to optimise expertise. When the participants talk about the maternity hospital, they refer to their unit manager as representing the maternity unit. Yolanda has a unit manager to whom she reports and meets with regularly. Her manager helps guide her through achieving QLD (quality leadership domains), if this is her chosen path. The future dream is that the manager has an investment in each midwife and is aware of their different needs and aspirations. Yolanda can see that this will "improve their workforce" and add value to each midwife.

Maisy, like Yolanda, views this investment as an intentional career path.

> *We have three monthly performance reviews, and we're supposed to set goals. I might be putting the portfolio together from competent to confident as a midwife or looking at options to take on leadership roles. I've just talked to somebody about joining the MERAS Union and becoming a MERAS rep for the union. If they (the manager) could come to us and say, 'look, these are the options, and that's how you get there.' If they just created a document or maybe something within the online intranet, where to go if I want to be a specialist midwife or work towards a certain role. Knowing the steps that I need to take to get there because, at the moment, it just feels like I have to get myself there.* (Maisy)

Maisy, similar to Rose and Yolanda, talks about the importance of having a navigated pathway for her career aspirations. "Knowing the steps" is vital for Maisy in forwarding her career. One of the opportunities that Maisy valued was becoming a MERAS (midwifery union organisation) representative alongside other leadership roles. Leadership roles, and navigation tools to get there, were identified as helpful in the transition from competent to a confident midwife. Like Yolanda, Maisy saw the manager's role as an informant to assist her in career progression and navigator of

pathways. Maisy considered there was shared responsibility towards career progression and continued professional development, not a journey the midwife wanted to walk alone. The dream to provide opportunities to an early career midwife could have far-reaching benefits towards sustaining each midwife.

Similarly, Michelle talked about the opportunity to become a MERAS representative supported by her manager as further developing her career.

> *When I was applying for my Quality Leadership Programme (QLP), at my performance review, I talked to my manager; she just went through ways that I could take up a role in our ward. I decided to become a MERAS rep. I did that, and she was supportive and wanted me to find something that I'm passionate about on the ward.* (Michelle)

MERAS representation was an accessible way for the midwife to take on a leadership role, as noted by both Michelle and Maisy. Maisy and Yolanda both voiced appreciation of support and the opportunity offered by their line manager. Michelle, similarly, noted that the manager showed an interest in helping her find something she was "passionate about" and, therefore, supported her to progress her continued professional development.

Maisy offers recommendations of how the DHB can assist with continued professional development;

> *It's not inspiring to think that you're just going to be doing the same role until you might leave the profession, have a baby, or a change happens in your life. I want to build my career more intentionally. I know some courses you can do, like a complex care course or a diabetic midwife specialty or something like that. But I don't know what else there is beyond that.*
>
> *When my DHB supports my professional development, it looks like;*
>
> - *Regular checking in on me to help me find opportunities to work alongside different specialist roles within the hospital, to see if that's something I'm interested in.*
> - *Further opportunities like mental health and other interprofessional opportunities so you can go and spend some time in areas you are interested in.*
> - *Management trying to keep us working within the DHB, knowing what each person's individual goals are.*

> *Personal relationship and personal development are crucial and give us that vision of where we will go as midwives. If I want to be a charge midwife, that's fine; you just stay, work shifts, and work towards it.* (Maisy)

It is important to Maisy's continued professional development when the maternity hospital acknowledges who she is and 'sees' her in their future plans. The maternity hospital (manager) 'checking in' and being aware of her goals was how Maisy described the crucial role of her hospital in navigating her career pathway. This experience is similar to that of Rose's; they both consider the value of being part of a team and the bigger picture of the organisation. Maisy can see some career pathway opportunities but many are not visible beyond the obvious ones like complex care and speciality midwifery as diabetes. Maisy, like many of the participants, see a shared responsibility with the maternity hospital in retaining and sustaining her in her job, and supporting the growth of the workforce.

Similar to Maisy, Cindy experienced confusion about her career pathway options.

> *They (managers) are behind you and encourage you to do it and give you all the tools and resources to do what you want to alongside supporting you along the way. I want my manager to be open to options that aren't directly going to affect them. If you don't want to be a charge midwife then, I want them (manager) to be more flexible and consider my goals.*
>
> *It's hard to know who to go (referring to following a pathway outside of the unit in midwifery) and who is my manager when I leave? Who do I go to and ask for support with career choices when I want to work in other areas? The manager is directing your area, but you may want to specialise somewhere else. I don't know where to go to lead me in the right direction. If I knew who to talk about my interests in other areas and follow my interest in sexual health, that would be great.* (Cindy)

Cindy voiced an interest in sexual health but, as noted by Maisy, while the pathway to charge midwife seems clear, specialist roles outside of the unit were not visible. Having someone to guide her to achieving her career goals outside of her maternity ward would have been appreciated. Cindy felt if the manager could see other options and be flexible to her career aspirations outside her unit she could see a visible career path.

Managers play an essential role in directing future pathways. Cindy looks to her manager to "direct her in the right direction." When the manager cannot do this, Cindy

is left confused about her pathway and achieving her goals. Cindy voiced that she knew that many options existed for her to specialise, but she did not have the 'know how' to navigate the path. Supporting her interests and leading her in the "right direction" was essential to her career development. In supporting Cindy's goals there is potential for the managers to be torn from midwives' career development outside of the immediate workforce, like Cindy's interest in sexual health, and the fact that this does not sustain their immediate workforce and support the continued professional development of early career midwives.

Conclusion

This chapter has explored how a way of working being a trusting culture is impactful on the working experiences of early career midwives and supporting their continued professional development while working within the maternity unit. Three sub-themes were identified; 'working together,' 'feeling trusted,' and 'taking opportunities to learn.'

The maternity unit's culture and working way is instrumental in nurturing the fertile ground for the midwife's development and growth early in her career. The team are the culture and its make-up has a significant impact when fostering a safe space to build trusting relationships with colleagues alongside directing future pathways and offering opportunities within the maternity hospital. The participants voiced the importance of togetherness and how collegial support helped create a safe feeling. Trust was mandatory towards feeling autonomous; the midwives felt empowered to feel autonomous when they trusted themselves and had colleagues' trust. Even though the participants identified that their DHB/hospital was instrumental in creating and fostering the culture of trust, it was evident that this was about how the team functioned and colleagues' behaviours that supported their DHB/hospital to have a trusting culture. This was interprofessional, not just midwifery workforce.

Midwives valued being part of the bigger picture, including acknowledgement and investment in their career from their manager. The manager was a key contributor to their positive experience within the team and was influential in navigating career pathways. That visionary approach from their manager supported their continued professional development alongside investing in their future goals and dreams. Participants valued that the team and the manager trust each midwife as they do themselves. When participants experienced an investment in their future, they were more likely to see themselves as part of the future of the hospital. A positive culture of trust is intrinsically built when a midwife feels valued and acknowledged as a part of the team and the future of the organisation.

Chapter Five: Being Guided

In the second findings chapter, the discovery of the impact of 'Being Guided' will be explored. The midwives in this study described colleagues who gave support and guidance as an essential part of their learning journey. Three sub-themes emerged from the data when the midwife felt she was being guided.

1. Building Foundation for Practice
2. Professional Development in Reflecting and Debriefing
3. Having the Presence of Experience

Building Foundation for Practice

Support in the first year of practice had a significant impact on the foundational stability of the midwife's continued professional development. The first year experience set expectations around access to guidance and work culture support. Guidance from colleagues, mentors, and preceptors was essential in the first year of practice, and the study participants spoke about the positive consequence of having accessible and approachable colleagues to answer questions and offer advice.

Michelle voiced the value of asking questions to support her decision making and gain trust in her practice:

> *The fact is that you've completed the degree, become registered, passed the national exam, and have some level of skill and knowledge. But there is always an element of fear. It's trusting that you know what you're doing. Mentally, I know that no question is a silly question, and I'd much rather ask people questions. All midwives ask questions so as not to do something silly.* (Michelle)

For Michelle, the importance of knowing there is a culture of "no question is a silly question" opens up opportunities for guidance. Within this maternity hospital, Michelle is encouraged and supported to ask questions, which helps develop trust in her decision making. She sees asking for guidance and reassurance as an everyday practice for "all midwives." The "element of fear" was reduced for Michelle, knowing she could seek guidance to prevent doing something in error or, in her words, 'silly'.

Shania, like Michelle, echoed the importance of having those approachable people to guide when she had questions:

The midwife I was sitting next to (at a course), I could ask them any question, and they answered it. That wasn't one of my peers, it was a more experienced midwife. It's able to ask little questions all of the time. I think it's approachable people. Someone approachable, and when you have a question about a wound or anything really, you go to the most approachable midwife and then they will answer straight away.

Having the title of being a new graduate means everyone seems to go a little bit easier on you. The ideal is fewer women to look after, alongside someone to look after you. But sometimes it doesn't work out, they (preceptors) look after you for the first couple of weeks, and then you go to the person who is the most approachable. So probably having those approachable people when you are a new graduate. (Shania)

When Shania connected with her colleagues on a study day, there were opportunities to debrief and reflect on practice experiences. She identified which colleagues were available and approachable. Similar to Michelle, Shania was able to 'ask little questions all the time' once she knew who was an approachable midwife. Feeling open to asking any questions, alongside having approachable colleagues, is instrumental to practising with confidence early on in a career when knowledge and experience are new to the midwife. Shania also felt that, early in the first year of practice, relationships with preceptors, alongside a graduate's "title," helped build a support network for gaining knowledge and skills.

It was important to feel "someone was looking after you" when orientating to a new environment. When the structured orientation discontinued, or the environment's business made it difficult to maintain, having approachable colleagues was essential for building knowledge and skills. For Shania, there was an expectation of ease of access to help in the first year, in contrast to her belief of what might be expected of her in subsequent years. During the first year, graduates had more structured scaffolding to guide the foundation of midwifery practice. The beginning support they received from a preceptor midwife helped build a culture of "approachable" colleagues that was the benchmark for future years.

Furthermore, Maisy noted the importance of acknowledging the starting points and differences in early career midwives' professional development;

The DHB had a bit of an expectation of knowing that you should be able to do that (all aspects of care); you've been out two years now. Whereas I might

> *only have done that skill once or twice. Because everyone comes out at a different point, some midwives in my cohort (graduating midwives) were confident in some of those skills, but many of us weren't. It's (the DHB) recognising that we all get different experiences within the degree programme. The midwife we are when we graduate is quite different to someone else.* (Maisy*)*

Maisy, like Shania, voices the importance of each midwife having accessible support early in practice. Maisy believes there is a gap in her midwifery colleagues' knowledge in recognising the difference in skill development and midwifery experience in the early years. She voices the need to identify the diversity of each midwife and individualise learning needs and goals. Maisy experienced an "expectation of knowing" in clinical practice; even though there is a vast degree of difference between experience and years in the job as a midwife. This perception is also present in the first year of practice with the 'expectations' around experiences, knowledge, and skills built from the undergraduate programme.

Cindy's experience of assistance in the first year helped her transition from student to being a midwife.

> *The person who looked after us new graduates was so supportive, just invaluable, amazing, and you can still go to her. She probably has too much to do, but you feel she has a genuine want to help everyone. Knowing that she's behind you is awesome. Knowing there are so many new graduates in the same boat as you. In the workshops we are together as a group, you get to know the faces, and you can talk about stuff (experiences from practice), which is hugely supportive and helpful. The structure of knowing you're going to be rotating into different areas (maternity areas) for three blocks of 5 months gives you the feeling that this is not me forever. I left not long after the new graduate rotation was finished, and, now coming back, I feel like a graduate again. I haven't practised for so long, so I'm kind of bumbling my way back a little bit without the new graduate title. Sometimes the 'new graduate' title helps situations where you don't know what you're doing.* (Cindy)

Like Shania, Cindy talked about having the "new graduate title" as protective and "invaluable," alongside a structured mentoring programme. After a time out of practice, having assistance, similar to the graduate programme, would have helped Cindy return to practice. Cindy recalls the title of new graduate meant she was not expected to know everything. Furthermore, there was a sense of someone "behind

you." However, a break from practice meant Cindy felt "like a new graduate again… bumbling my way back without the graduate title." Knowing that she has support from the educator, from her first year of practice, was appreciated and Cindy voiced this support as "invaluable and amazing." She also gave future recommendations that more structured support, like the first year programme, would benefit midwives returning to practice after a break when unfamiliar with the hospital. Within the first year of the practice programme, Cindy attended mandatory workshops, connecting and talking about practice. At these workshops, the comfort of familiar faces, alongside opportunities to chat and share clinical practice experiences, was "supportive and helpful" in developing her professional journey.

Like Cindy, Michelle was appreciative of the midwifery graduate educator's help—both to guide and in an advocacy role.

> *There is the midwife who was in charge of the first year of the practice programme, and she is a really good advocate for graduates. If there are any problems, she would help you and support us. There was no one in that same mentoring role past the first year who regularly checked with us. The team I work with are frequently happy to answer questions and always ask me to give it a go first and then seek help if I need to. They are always willing to help.*
>
> *In the DHB, we have a preceptor for the first three weeks. The DHB tried to have the same preceptor who followed my shifts, which was good. I had the preceptor for three weeks initially, and by the end of the three weeks you take a lower caseload when you are working independently, but you have someone who checks in if needed. Once that was over, you're just another member of the team. When I was coming out of my preceptor time, I was in the birthing suite, and I had someone (a preceptor) for me. By the third week, the midwife let me do everything. She wasn't even in the room, I was doing labour care, and she was just there in the hub for me to check in if I had any questions. She was there for me, and she enabled me to do what I needed to do because I was a midwife now.* (Michelle)

Professional development was optimised when Michelle had accessible guidance from her preceptor. The preceptor was assigned to her for orientation and professional support. Michelle experienced the benefit of a preceptor who "checks in" and advocates for her, supporting her early practice. The hospital educator, in the first year of practice programme, also provided this form of guidance. Michelle emphasised the value of someone to "just be there… someone for me." Michelle was

appreciative of being able to become “just another member of the team” while maintaining the preceptor close by to “check-in if I had any questions.” When the preceptorship finished, continuing to have a ‘go-to’ person was instrumental to Michelle feeling confident to be “a midwife now.” Michelle had a similar experience to Cindy. She echoed the value of approachable accessible colleagues, “just there in the hub for me to check-in,” who supported in a way that allowed the midwife to practise independently. The ability to be “a midwife now” was felt following preceptorship, alongside continued support to practice independently, knowing supportive approachable colleagues were nearby.

Shania experienced a different type of support that came from her peers.

> *It was other past graduates that helped me. They had already been in my position, and gave their time, sympathy, and empathy, and would say, ‘look, this is what you do, you just have to do this, then that.’ When we needed to learn those stupid little things, that was our peers that supported us. It was past new graduates, who let you know everything there is to know about where you’re going and giving you some information like notes or whatever they used, it was helpful, like little cards that they created. I knew they (my peers–early career midwives) had come out of this sort of hurricane of learning. They were fresh out of it, and they knew what I needed.* (Shania)

Peer to peer support was invaluable for Shania. She described experiencing a “hurricane of learning” in the first year of practice. Guidance from past graduates helped with the “stupid little things” important to Shania as an early career midwife. She believed questions might be seen as unimportant or “stupid” but were valuable to her building knowledge and learning, significant in the first year of practice. Identifying the parts of the job in which she could gain support from past graduates was an opportunity to build further support networks. The benefit of a sympathetic and empathic ear from those who had been there before, offered Shania support and positive connections. She talked about being new to the profession and how valuable information was; tangible things such as cards or notes helped Shania navigate her way in the new environment. Recent graduates were described as accessible and approachable, as Shania felt “they were fresh out… they knew what I needed;” and were, therefore, instrumental in support for Shania.

Maisy reflected on the value of the mandatory midwifery first year of practice mentor.

> *Having a mentor in the first year was really valuable. She (my mentor) didn't work in the DHB, she worked originally as a home birth midwife, she was older, and she worked in a primary unit. Having someone outside the DHB world was great as she could remind me of the things that I really loved about midwifery. I didn't see so much of this (what I loved) in the core environment and being able to reflect on cases or experiences with her every few weeks was really valuable.* (Maisy)

Alongside the support that the DHB/hospital offers in the first year, Maisy talked about the benefit of having a mentor who sat outside her workplace to provide guidance. Maisy had a mentor available for regular catch ups with opportunities to debrief and reflect on practice. Her mentor allowed her to look outside of the "DHB world" to appreciate the practice that felt uncommon. The ability to reflect on clinical experiences (cases) that were less common within the maternity hospital was beneficial for Maisy and her professional development. The opportunities for Maisy to reflect on physiological practice, which she did not "see so much," assisted her within her role in the maternity hospital and were "really valuable."

Shania also felt that one-on-one support, experienced within the education class environment, helped build knowledge and skills that benefited her professional development.

> *Instead of just doing online courses when we all want to get through them as fast as we can. We want to go through it with someone like one on one. It helps, especially when it's not in a testing scenario but a 'ask me anything.' I think that's a really good way of learning when you're not afraid to make mistakes, and someone approachable is there for you, who's interested in the topic. I felt like the neonatal life support day, she (the educator) was interested, and she wanted to let us know everything about the oxygenation of a baby. So, we wanted to ask all the random questions.* (Shania)

Shania revealed that the support of approachable colleagues, alongside the educational days, were beneficial within the first year of practice. The face-to-face workshops and study days held by the maternity hospital gave opportunities to reinforce knowledge and skills for practice alongside an approachable educator. The educator positively contributed to learning with a non-punitive approach and openness to participants being able to ask "random questions." When educators were seen to be "interested in the topic" and "approachable," a safe environment to learn was created that facilitated successful professional development for the midwife.

Shania felt the online courses were not able to offer the same opportunities for professional development that came from the human element of having "someone approachable there for you." She experienced the benefit of the learning environment that offered an educator interested and engaged in the topic versus the online courses that were more focused on completion rather than the learning experience for the midwife.

Maisy also echoed the importance of the study days and guidance with skills;

> *The study days were helpful, particularly the perineal suturing workshop at my DHB, because I don't feel like the skill was well developed when I was a student. It wasn't till I was in practice that I found I needed to work on the skill (perineal suturing.) As a new graduate, having one of the obstetric consultants from that study day was cool.* (Maisy)

Interprofessional teaching around skills like perineal suturing was beneficial within the educational lab environment for Maisy in the first year. Support to develop competence in such skills was welcomed, as confidence in some skills was limited as a student midwife. Maisy felt the midwifery study days were supportive for building her skills and foundation for the first year. In addition, she appreciated the interprofessional approach to learning.

Professional Development when Reflection and Debriefing

Managers, charge midwives, and work colleagues were instrumental in guiding the midwife in taking time to check-in and debrief, alongside being available and approachable to support professional development. Guidance came from the benefit of time to talk and the gift from colleagues who gave their time to listen as the midwife reflected and debriefed about her practice experiences.

Shania valued the opportunity to debrief with the midwife manager:

> *The manager was so lovely. I said, 'Hey can I talk to you for a second?' She said, 'Absolutely, come on in.' I just sat down with her, and I told her everything. She said, 'Oh my gosh, you know that just happens, doesn't it… I'm sure you've learned so much from this experience.' I remember her saying, 'It doesn't matter how new you are or how experienced you are… we are all learning.' I can now go and talk to the woman I am working with and continue care whereas before I was so scared. That's the power of being able to debrief. When you're going through something really scary, you don't need someone*

to teach you in that situation. It's just someone listening and understanding (afterwards). It is a scary occupation sometimes.

Supervision is definitely something we need. I think it's just crazy we don't have that. Every six months, someone dedicated to coming in during work time allowed us to debrief situations that we've had. It should be compulsory because people wouldn't do it as they don't realise they need to. We are supposed to just get on with our work without having any kind of therapy—we need someone to build a relationship with to debrief experiences. It needs to be for us (midwives) because we see some crazy stuff, especially when you are new to practice. (Shania)

Guidance comes from debriefing with colleagues. "The power of being able to debrief" was how Shania described the support that enabled her to move on after an adverse event. Self-compassion was experienced when Shania had an opportunity to debrief with her manager. The manager took the time to guide her by listening and understanding without judgment; support which helped Shania rebuild her confidence and care for the woman and whānau. Debriefing dispelled the feeling of being scared. Shania appreciated the supportive approach from the manager who listened, without feeling the need to guide, and provided empathy.

Shania said she would value supervision by a known colleague to offer formal opportunities for debriefing. Supervision was seen as "therapy" that was needed; although potentially invisible to some, instrumental in navigating the "crazy stuff." Shania felt midwives might not realise the importance of the need for supervision, and it should be "compulsory" support. It was important to Shania that this supportive supervision to debrief was during work time.

Maisy, echoed Shania's thoughts, and felt that structured supervision would be beneficial to support her professional development.

I've heard some people call it midwifery supervision. It's not in that punitive sense of being supervised, but it's just having someone you can go to from time to time and say, 'this is how I practise; can you give me any help?' When you're on the wards, like in birthing, you don't get the chance to reflect on cases because there is no time to sit down with charge midwives and say, 'oh my gosh, we have resuscitated four babies today, we've had so many PPHs(post-partum haemorrhage).' Instead you go home so tired, you don't spend your

personal time reflecting on the day and your practice. Some form of supervision or mentorship I think would be valuable.

Suppose you were appointed someone who has been in the DHB, maybe 10 years or more. Someone who you could meet with every month or every two months. It's paid time, so it's not taking time outside of work. Someone you can build that trusting relationship with, say like I don't feel confident in this particular skill or those scenarios. Maybe, someone you could have the chance to do some shifts with and to work alongside. (Maisy)

Maisy voiced the benefit of a designated person to support early career midwives with their professional growth and development. She valued the trusted support in a designated person that felt invested and interested in her continued professional development. Maisy voiced the benefit of debriefing at work instead of spending time outside of work "reflecting on the day and practice." When asked about her aspirations and dreams for the future, Maisy, like Shania, felt that having a trusted designated supervisor who was there to guide her "would be valuable." The "trusting relationship" from the colleague was essential to build confidence in skills. The support from the supervisor or mentor meant having that person in practice to "work alongside."

Rose valued colleagues who gave their time;

I think knowing and trusting your colleagues. That's been huge for me like the mentoring has been great, but it's often quite a bit later when things happen that you get to talk about it, but colleagues are so helpful for asking questions, opinions, advice, debriefing, everything. It's probably the most significant thing to have my colleagues. At the moment, being in a birth centre where there's less staff, and I have more time for building those relationships. In the hospital you're generally working with different people every day. But I'm hoping if I go back to birthing and assessment and being there for a bit longer, I will have time to build those relationships (with colleagues). (Rose)

Rose describes how knowing and trusting her colleagues are crucial to her development. She can approach colleagues to ask questions, talk through practice, and seek advice. Rose explained there is often a time lag from an event to talk with colleagues or an appointed mentor. Like Shania, Rose felt that there would be a benefit in a known colleague with whom to unpack what happened. Rose expressed how colleagues have been "the biggest thing" for "questions, opinions, advice." The opportunity to debrief for Rose means up packing practice with colleagues to guide

her. The graduate midwife rotates around the units when in the midwifery first year of practice programme, and building trusting relationships when only there for a short time may be challenging. Rose expressed wanting to go back to work for longer in birthing and assessment to enable time to form knowing and trusting relationships with colleagues to guide and support her continued professional development.

The data reveals that positive connections and relationships with colleagues facilitate easy access to support, advice and second opinions. Rose considered that when you work within a smaller unit, with less staff, the ability to form relationships with colleagues and develop support structures requires less effort. The larger hospital, which is busier and has more significant staffing requirements, makes it more challenging with a short rotation to build the relationships needed to support the early career midwife. “Knowing and trusting” happens when building relationships with colleagues that provide support and reassurance.

Like Rose, Cindy echoed the importance of the team to debrief with.

> *If you’re working as a team with your colleagues, that’s what I love the most about the job—having them around, being able to talk to them, and not feeling isolated within your practice. Someone to bounce ideas off, having second opinions, and that kind of thing. I think that’s important, and I value that a lot.* (Cindy)

For Cindy, ‘practice’ is collegial; it is about the team approach and having colleagues helping her to feel connected and not “isolated in practice.” Having accessible colleagues available to “bounce ideas off, give second opinions” is essential to being part of the team and contributes to one’s love of the job. Colleagues that are available and approachable to support the early career midwife’s continued professional development are instrumental to avoiding feelings of being “isolated in practice.” These colleagues facilitate healthy communication—a core value system for Cindy.

Rose, too, appreciated the benefit when she had the opportunity to connect with her colleagues after an event;

> *I found on birthing, you often do your 8 or 12 hours and then leave. Everyone’s so busy. It can be quite isolating. You don’t know if you made the right decisions because there’s so much decision making in labour and birth. Even down to the small details, you’re always left kind of wondering. I had one situation where a senior midwife came in for the baby’s birth that was born right on handover and ended up being a ventouse delivery. She had a huge*

> *baby, and we were all shocked at how big it was. Afterwards, I felt really bad because I thought I should have known it was a big baby or I'd done something wrong. The other midwife that had been in the room was able to spend 5 or 10 minutes talking to me about it. It made me feel better, and it helped me process the situation. There are quite intense times at work, and I tend to carry it a lot.* (Rose)

Rose appreciated the timely manner of debriefing after what was, for her, a significant event. Like Cindy, Rose's ability to connect and talk to the senior midwife diminished feelings of isolation and encouraged professional reflection to support professional growth. Having the opportunity to debrief helped Rose "feel better" about her practice and offered a chance to reflect on her clinical practice and outcomes. Even when there is no immediate emergency or significant event, the early career midwife is often left with unanswered questions that arise from learning in practice. With the high acuity of the maternity hospital contributing to the volume of decision making, one on one debriefing with a colleague helps to process the day and reflect on midwifery care; providing another opportunity to build knowledge and create learning opportunities to enhance practice.

Michelle reflected on how collegial trust impacts skill development:

> *At my DHB the programme is little bit longer than the MFYP programme. I wasn't treated necessarily like an experienced midwife and was well supported. Even though I am relatively junior, I feel like the team listens to me when things aren't fair or need help. They're happy to help. I enjoy them, and they are approachable. Probably the senior staff are most valuable to me. There's not always a charge midwife on shift where I work, and so it's whoever is senior on the team.* (Michelle)

When Michelle felt "things aren't fair" or she needed help, feeling supported and 'listened to' as a 'relatively junior' midwife was appreciated. Her senior colleagues were as valuable as the charge midwives, and their willingness to help was "most valuable" to support continued professional development. It is interesting to note that having preceptor support set up early on meant that the midwife felt part of the team, as did having colleagues to go to for support. Michelle echoed the words of others in considering how the team approach of being "willing to help" and "approachable" creates a positive team culture.

Charlotte and Christina felt that having someone to debrief with was a valued part of their professional practice.

> *I think it was just knowing that you had someone you could talk to if you needed to. I need that opportunity to get something off my chest. Just knowing I had a person there to debrief with if there was something that was an issue or something I that I needed to chat about. Having that person there in the background, knowing that they're there to support you.* (Charlotte)

> *You need someone who is your designated question person for you. They might have a little bit less on their plate to facilitate helping you ease back into it, rather than just being expected to hit the ground running again. It would be something that I would suggest.* (Christina)

Charlotte noted the importance of someone "for you," to lighten the burden from her chest through debriefing. Christina spoke of the importance of "someone who is a designated question person." Having a colleague available for questions who has "less on their plate" means they are able to offer support. Christina and Charlotte felt professional growth when they had opportunities to affirm knowledge, ask questions, and get second opinions from a known supportive colleague. When Christina returned from time away from the unit, having someone to "ease you back in" was critical to avoid feeling like she was "hitting the ground running," which reflects the everyday normal of the maternity hospital's high acuity and business.

Christina valued the advice that came from her senior colleagues when they took the time to check in.

> *On a day-to-day basis of having the charge midwife check in and make sure that you are okay, getting a break or if it's a particularly unfamiliar situation. Knowing they (charge midwives) are there in the background that you can ask them questions or just get them to double-check something, having that kind of help to bounce stuff off, that reassurance that you're on the right track. It is a very busy, busy unit. You can't expect to have someone necessarily there all the time, but I think… continuing the continuation of the support they're already providing. I'd say most days you cruise through it, but some days you feel out of your depth and having those senior midwives and those charge midwives there is amazing.* (Christina)

Knowing that support and guidance is "in the background" was valued highly by the participants. Their confidence grew when they knew that they could access

colleagues to guide practice. Work colleagues, especially the senior and charge midwives, enhanced their ability to take breaks and navigate the unfamiliar environment or experiences with success. Christina talked about the benefit of having someone to "bounce stuff off" and provide guidance when needed. In the days when Christina felt out of her depth on a busy unit, "continuing the continuation of support" was appreciated and enabled her to build knowledge and skills. Like Maisy, Christina could see the benefit of having a supportive person to offer guidance when early in her career. The Clinical charge Midwives (CCM) were instrumental in that role, being approachable and available to offer support.

Having the Presence of Experience

The gift of guidance in skill development from a colleague 'standing with' or 'standing behind' was a significant factor that supported early career midwives' continued professional development. Unlike the benefit of reflection, clinical midwifery skills were built from the volume of experience within the high acuity maternity hospital, alongside the physical presence of expertise to guide skills and build knowledge.

The CCM is significant to the team and plays an essential part in the development of experience and confidence in practice. All the wards within the tertiary units have a CCM who facilitates the shift and manages acuity. These health professionals were instrumental in offering guidance for the early career midwife.

> *I think just having them (charge midwives) available all the time for a second opinion, or if they were in another room. Another senior midwife would come in and have a look at your CTG (cardiotocography), or you tell them the situation and say, 'I'm thinking about doing this. Do you agree, or what other options do you have?' They (charge midwives) are there for decision making and that sort of thing. Having people around, I think, is the biggest help, especially on the birthing ward, the charge midwives, having them there for any question, about every little detail. For example, I give the charge midwife all the details, and she would say, 'that's fine' or 'do you think she needs an IV leur (intravenous catheter) ?' or 'this is her haemoglobin, and these are her risk factors.' I would say, 'I don't think she needs an IV leur, would you agree?', and then she (the charge midwife) would be like 'yeah, that's okay.' It's just to get that reassurance, and being able to vocalise it with someone helps me. You always doubt yourself, so to get that reassurance is important. They (charge midwives) were supportive, and they didn't make me feel silly for*

> *asking questions; they were so patient. I was always amazed at how patient they are.* (Rose)

Rose appears not to want immediate answers; rather, wants to check that she is on the right track. She asks for reassurance and talks about her decision making in practice, not requesting the charge midwife to take over: "I'm thinking about doing this" and "I don't think she needs an IV leur". Rose was looking for support and reassurance to confirm her decisions. She talks about doubting herself; reassurance and support are the countering factors to underlying doubt. Rose was not given the answers but guided by the presence of her colleague in her decision making, which saw her professional confidence grew. The way the charge midwife responds to the early career midwife's questions, contributes to confidence in decision making and reducing self-doubt. Trusting and listening are attributes that support continued professional development.

Michelle echoed the importance of trusting and listening when learning the skill of perineal suturing;

> *I could count on one hand how many times I was able to suture. There's a particular charge midwife who, even though the ward was really busy, got an LMC just to come in and check on me. Then she came in and stood with me and made sure I was doing it right. She comforted me and made sure I was doing the right things. She was supportive afterwards, and she told me something that would help next time. I knew the ward was busy, her taking the timeout to check-in made a difference—having someone check-in and see your progress because when you rotate through the wards, you're starting fresh every time. You don't know everything because it might not translate from the last ward.* (Michelle)

Michelle's previous exposure to perineal suturing impacted her ability to feel confident in the skill. When the charge midwife took time out of her "really busy" shift to provide guidance and reassurance, Michelle found it comforting. Checking in to affirm or further guide practice skill development was essential to give the midwife confidence in building knowledge and skills. Providing advice and checking in to support her to do "the right things" reassured and helped build skills. Michelle appeared to express an emotional feeling of being "comforted" when she had a colleague stand beside her. Her colleague's physical presence to guide was affirming—"She came in and stood with me." This type of guidance was seen as supportive, not critical or judgmental. Michelle related her development of learning to

suture; initially, the charge midwife asked an LMC midwife on-site to "check" on her. On a subsequent occasion, the charge midwife provided oversight by standing beside Michelle and ensuring she was suturing correctly. Further, the charge midwife gave additional advice after the event to guide Michelle's skill for the next occasion when she sutured the perineum.

Yolanda, like Michelle, also experienced the benefit of support that came without judgement in perineal suturing.

> *I was suturing a labial tear, and I wasn't quite sure about it. I asked someone to come and just talk me through what I was doing, ensuring that I was on the right track. It was nice not being judged, especially coming back to the DHB, where you practised as an independent midwife.*
>
> *Asking, 'can I have some supervision?' can lead to a lot of talk. It was really lovely just to have a midwife come in and go, 'hey, this is not a problem; we all sometimes need help.' It's trust in what I'm doing and where I'm going that's important. Knowing that if I'm not sure about something, I will not sit on it and hide it, but I will walk out and go, 'hey, this is not okay. Can someone else have a look at this?'*
>
> *I remember talking to a midwife and saying, 'oh my god, I have no idea what I'm doing. Am I doing this right?' They (colleague) said, 'you know what, you're absolutely fine, you're doing this, you know you're doing exactly what we would have all done.'* (Yolanda)

There was a comfort in the normality of asking for help. Yolanda was grateful for her colleague's attitude of "not a problem; we all need help sometimes." Guidance comes in the form of a reassuring ear that affirms knowledge alongside physical support from approachable senior midwives. Like Michelle, Yolanda felt offering assistance without judgment meant that she would not "sit on it or hide it" but readily access guidance and reassurance. Affirming words and advice to inform learning and clinical decision making helps build trust in the midwife's clinical practice. Yolanda felt that formally requesting supervision could "lead to a lot of talk." However, having a less structured approach requires supporting the everyday culture of asking for help.

Perineal suturing was a skill in which many participants appreciated guidance from colleagues; not only midwife to midwife but from the wider interprofessional team. Maisy and Cindy acknowledged the support of colleagues when guidance was given while standing beside them.

There was a time when I was on birthing when one of my colleagues took the time to sit down with me and talk to me from beginning to end, suturing quite a complex tear. She showed me how to hold my instruments better and helped me make sure everything was sterile. It was perfect for me when she came and gave me the opportunity for one-to-one teaching. (Maisy)

My colleague helped me identify what I'm looking for and the little things like how to hold the instruments and was non-judgmental. Allowing me to ask my silly questions and not feel like I have to be knowing it all makes you feel like you can do it. …and you've got someone there just guiding you through it. I think that's also nice for the woman, seeing our work together. (Cindy)

The guidance that supports continued professional development is non-judgmental, and the midwife feels she can ask questions that she may perceive as "silly." Cindy and Maisy voiced that the collegial support of "standing behind... to help" and "talk… through" creates confidence and professional success in developing the skill of suturing. It is comforting to the midwife that in growing her knowledge and skills, she does 'not need to know it all.' In mastering a skill like perineal suturing, Cindy and Maisy felt assurance when their colleagues helped in a practical way; for example, "how to hold the instruments," alongside guidance without judgement. Additionally, Cindy could see the positive benefits for the woman in this collegial team approach.

Access to colleagues contributed to Charlotte's skill development.

I started to suture the perineum, and then I just couldn't quite figure it out. I was freaking out that I was going to make a mess of this woman's perineum. I got a colleague to come in and help me. She talks me through it, and we got the perineum all sorted. Then she (the woman) had a couple of labial tears as well, and I'd never done or sutured those before. I hadn't had tons of experience. She (the registrar) then talked me through suturing the labial tears as well. She showed me a couple of stitches and then let me carry on. That was cool. She didn't jump in and try and take the equipment away from me, and she didn't try and take my place. She just asked me what I needed help with, where I thought I'd gone wrong and where I felt I needed help. She asked what I didn't understand and what I didn't feel comfortable with. Then she talked me through it, which was so great. (Charlotte)

The power of presence and vocal guidance, supporting and building skills, were valued highly. Charlotte voiced, "she didn't jump in, take the equipment away or take my place." Quality time given to guide without taking over was necessary and allowed

Charlotte to build competence by doing the skill, not simply watching. In this approach, Charlotte felt supported in the skill development alongside allowing her to self-identify "what I needed help with and where I'd gone wrong." Guidance to determine her own learning needs, alongside completing the skill, effectively enhanced her skills and confidence in practice. The opportunities with this approach for constructive feedback and advice were welcomed.

Christine echoed the importance of an experienced colleague's voice when giving quality time to observe and guide.

> *It can be a really busy unit sometimes, and some shifts are okay when someone can be with you and talk you through it (skill development). It does not only talk you through it but observe you doing it. I had one great experience when my colleague said, 'I don't have anything to do now; let's suture this episiotomy together.' She just observed as I sutured it and the amount that I learned from that experience was amazing. It felt like it clicked, I'm not fully confident, but my confidence has grown significantly. I feel like I could do it again now. I learnt so much, and my skills improved significantly from that time.* (Christine)

Like Charlotte, Christine felt that doing the skill without someone taking over was a positive part of feeling supported to learn. When a colleague approached Christine to offer guidance, while she sutured, Christine could tangibly see her confidence grow. Having the benefit of a colleague's presence was instrumental in the development of this skill for Christine. Christine felt successful in the skill when physically supported to learn, voicing "it felt like it clicked." Having a colleague take the time to stand with her and "observe" was the contributing factor in the ability to go on and "do it again."

Conclusion

Being Guided is about the benefit of receiving advice and reassurance in the gift of quality time from a colleague. Guidance informed continued professional development through colleagues connecting to talk, listen, and stand beside the early career midwife; and was instrumental in their confidence and competence in practice. The participants voiced that building of skills and knowledge were significant in the first year, and colleagues that were approachable and accessible, alongside the first year of practice programmes, were instrumental in the foundation of that first year. Guiding by reassurance, debriefing, and check-in; alongside calm, trusted, clinical support, was impactful to the participants.

The experiences of many of the midwives revealed how this foundational support that came from the first year, and having the ‘graduate title,’ impacted their professional growth for the years beyond. Perineal suturing was identified as a significant skill that early in practice midwives needed guidance to master. A colleague taking time out of their day to ‘stand with’ the midwife, guiding in a non-judgmental way, positively impacted their confidence and growth as a midwife.

The labour, birthing and assessment unit was an important place to have known colleagues. This high acuity, busy unit is a place where steep learning curves happen; an exciting place to work, yet one that could be scary without trusted, supportive colleagues. The participants felt the value of guidance in early practice when colleagues were available to help by offering time to support reflection and debriefing on practice, alongside standing beside them. Being guided without judgement was what the early career midwife valued as supporting their continued professional development.

Chapter Six: Feeling Confident

This chapter explores the theme 'Feeling Confident.' As noted in the previous chapters, when a trusting culture of the workplace exists, where normal practice is to support and guide early in career midwives to flourish, continued professional development is enabled. Internal and external factors build the midwife's confidence as a competent practitioner working within the busy maternity hospital. The experience gained from stepping up, feeling valued, alongside words of affirmation from colleagues and women, contributed to pride in the job. It also positively impacted confidence in the early years of practice. Working in a busy, high acuity maternity hospital, participants engaged in continued professional development as part of "becoming a midwife." The maternity hospital's educational workshops further supported the midwife's continued professional development. An underlying ethos in this current data chapter was the gift of 'receiving' that built confidence; whereas the previous theme of 'being guided' was the gift of 'giving' to guide practice—both essential elements to the foundation of continued professional development.

Three sub-themes emerged from the data and contributed to the overarching theme of Feeling Confident.

1. Receiving affirmation
2. Stepping up and feeling valued
3. Professional development in becoming a midwife

Receiving Affirmation

Receiving affirmation fostered midwives' pride in their work and a sense of achievement, doing one's job well. Participants felt motivated when their colleagues took time to give feedback and engage with them positively. Words of affirmation contribute to professional growth and gave the midwife incentive to continue building knowledge and skills.

Many of the participants experienced continued professional development when someone took the time to give affirming words of encouragement and reassurance. Rose voiced that receiving feedback contributed to her confidence.

> *One thing that makes me happy is when people (colleagues), give you a bit of feedback or give some encouragement, reassurance that you're on the right track, I think that is important. A midwife said, 'Maybe you should look after this woman because you care and because you have a calming influence,' it*

was really encouraging that she had noticed, and she (charge midwife) trusted me. The charge midwife thought I'd be the best person to look after this woman. Having that reassurance that you're on the right track, is so important. Sometimes you think you do a good job, but you are never quite sure. I don't always get that feedback. It's great when feedback is really genuine, like 'so I saw that you did this really well' or 'I think you're a really great midwife.' We don't give feedback or encouragement as much as we should. For me, it makes a big difference, I can get quite stuck in my thinking with, I'm not doing it right or I don't know very much. If someone gives me a bit of encouragement, it makes a huge difference. (Rose)

For Rose, having colleagues take the time to give feedback is affirming of her belief in herself as a professional. Positive affirmations in the form of feedback are not always commonplace; yet, make a difference to the enjoyment of the job and offer the midwife reassurance or guidance she is "on the right track." For Rose, feedback is a contributing factor for confidence and reduces her worry of having inadequate knowledge; thus, giving Rose belief she is professionally capable and valued within the team. Feedback enhanced the ability to learn and made a significant difference to Rose feeling she was being "noticed" and trusted. There is a risk of Rose feeling 'stuck' and her confidence being negatively affected; therefore, the genuine nature of the feedback was received with gratitude by Rose. Whether the feedback was affirming, reassuring, or promoting change of practice, Rose felt it contributed positively to her confidence.

Maisy, like Rose, experienced "professional growth" in the same way as professional development when she received feedback.

I enjoy feeling like I've done a good job. That might be some feedback from a colleague or from the family and feeling like I'm getting better at my job. It's those words that really impact my professional growth. For example, in the birthing suite, being able to suture a perineal tear independently, it's been significant to look back over the last two years and see my growth. The positive feedback you get on the wards (as opposed to birthing and assessment) in the DHB, is from a place of 'oh my gosh we survived the shift together.' (Maisy)

Maisy talked about progressing and improving in the job, especially around the clinical skill of perineal suturing. Having feedback from colleagues added to a feeling of success. Being independent with skills like suturing, contributed to her confidence in working in birthing and assessment unit. Maisy was able to reflect on her continued

professional development and saw feedback as contributing to her sense of "getting better at my job." Maisy echoed the importance of "those words" from families or colleagues being instrumental to her professional growth. She experienced a different form of feedback from colleagues when working on the maternity wards, almost like a 'pat on the back' from being part of a team and "surviving the shift together." The affirmation of "surviving" a busy shift together reflects the challenges of working in this unit and the impact her colleagues have in offering her support. It is the feeling of being "together" as a team that impacts Maisy's continued professional development.

In the interview questions, in line with AI methodology, the participants talked frequently about what positively underpinned their confidence. Christina, like Rose, echoes the importance of feedback from the charge midwives.

> *Charge midwives help with confidence. Professional support and getting feedback from them is important. Without that support from charge midwives, I probably wouldn't still be there. It's the support in place at the DHB that makes it, a sustainable place for me to be.* (Christina)

Christina noted that "professional support and getting feedback" from charge midwives was instrumental to both sustaining her in her job and encouraging her to stay in the job. As with the previous participants, Michelle reflected on how feedback from her colleagues contributed to confidence.

> *I won an award and I got to read the nomination comments. That was great, because sometimes you do feel like a deer in the headlights. It was nice that the work I do translates well to other people, they see that you know what you're doing and know that people think you are good at your job as well which is awesome, it felt amazing.*
>
> *There was an admission of a woman to the ED (emergency department) with her LMC midwife, it was a high-risk labour. I was only a few weeks into my new grad year when I was called to assist the woman and LMC midwife. I connected and made eye contact with her (the woman) and helped the LMC midwife in ED, which was an unfamiliar environment to the both of us. The parents had said, it felt like I was the only one on their side from the team. It was nice that kind of feedback, I feel like I make great relationships with women, but it's nice to hear it back.* (Michelle)

Feedback from women and colleagues appear to be equally important to the midwife. Michelle described her work as sometimes feeling like "a deer in headlights;" this

could be a possibility that Michelle feels afraid, overwhelmed, or stunned in her role at times. Yet, encouragement, in the form of feedback, can settle and dispel these feelings. When Michelle was given feedback that affirmed her feeling valued in her job, it helped build her self-esteem and self-confidence. Michelle was confident that she provided good care to women. It was evident from the data that Michelle gained self-confidence from knowing that her colleagues thought she was doing a good job.

Stepping Up and Feeling Valued

Alongside the appreciation and acknowledgement from colleagues and students, was the appreciation from the woman/ people and whānau. For the participants, feeling valued was an important contributing factor in being good at their job and having the confidence to step up. Confidence was built when midwives gave of their time to help colleagues, alongside the woman and whānau. Taking opportunities to step up and support a colleague, or student, enabled the midwife to affirm her knowledge and skills giving her the confidence to pass these on.

In this sub-theme, Shania talked about the feeling of success in helping others and how this contributed to her feeling she did a “good job”.

> *Going to the emergency study days and having to do resus on dummy babies and to know exactly when to turn the oxygen up and how to have the baby positioned. It was helpful practising resuscitation on the dolls. At the neonatal resus workshop, understanding made me feel confident*. *Knowing the angle and just being familiar with the anatomy of a baby*.
>
> *Then a resus happened in the unit, and the LMC was looking after the woman and baby. I could see she was really frazzled from what was going on. I said to her, do you want me take over? I took over and did a really good job! I thought, because I was doing it a lot, I knew I was quite confident at it (newborn resus). I thought, ‘Oh my god, I really helped.’ Not only helping the woman and the baby, but to help that LMC. It felt nice, and the LMC appreciated my help with clinical skills.*
>
> *I had been on the birthing ward for a while, and I was doing quite a lot of resus. We were going to emergency study days, so we knew exactly what to do, it was fresh in my mind.* (Shania)

Shania felt confident in her knowledge and application of the skill of neonatal resuscitation, as she worked in a unit that did this skill frequently. This confidence

helped her to support her colleagues in practice. The ability to step up and help others contributed to her self-assurance as a midwife. Feeling she, “really helped,” was affirming of Shania’s role in the resuscitation and capabilities as a midwife. That appreciation from the LMC midwife bolstered Shania’s confidence in her clinical skills.

Similar to Shania, Rose took the opportunity to take the lead in a resuscitation of a baby and it abetted her confidence in the skill.

> *I had to take the lead when the LMC came in with a woman who had a baby at the LMC’s midwifery clinic… the baby was looking quite dusky when it arrived, I was the only one there at the time …the LMC was running from one place to another, not in a very good headspace. I took the woman to a room and started CPAP (continued positive airway pressure) on the baby. The LMC cared for the woman and then the charge midwife came in to help. She (the charge midwife) took over the CPAP and I got other things ready. It was an interesting situation, I am still a junior midwife, but I had to take the lead. I felt alright at the time. But the LMC apologised and said, ‘oh my god, I had no idea, you’re a new graduate’ I thought well, ‘if you have the uniform so you just have to do the job.’*
>
> *It was good learning for me because I’ve never had to do resus on a baby many hours after birth …I doubted myself. When I talked to the charge afterwards, she told me I was on the right track. She took over from where I left off, it was good learning situation.* (Rose)

Having the opportunity to take the lead and manage an unexpected neonatal resuscitation when early in one’s career, builds confidence in this emergency skill. Rose voiced that often the senior midwives lead the resuscitation, but when given the opportunity to manage the emergency it affirmed her skills in neonatal resuscitation. Following this event, Rose reflected on the LMC midwife not knowing she was an early career midwife—when your experience in practice is not known by LMC midwifery colleagues, it creates an opportunity to step up and be a midwife. There is no identifiable uniform or badge, to say “junior midwife.” Rose took the opportunity to lead the emergency when she voiced “I was the only one there at the time,” and this built her confidence. The affirming words from the charge midwife praising Rose’s clinical skills, opened her mind to being supported to learn. This feedback meant that Rose felt supported, not incapable, when the charge took over. Consequently, the experience was offered positive learning.

Receiving feedback was affirmed by Cindy who stepped up to manage an emergency.

> *I remember an emergency that happened at a primary unit, and I had to take charge which is unusual because I'm still quite early on (in career) and it's not in my nature to do that. I work across different areas, I kind of felt like I knew what I was doing a bit more. Afterwards, I got lots of feedback. I feel a little bit embarrassed and hoped that no one thought "what the hell?" I feel like when you're early in your career, you let the more senior midwives take charge. When you step up and lead, you may feel like you're stepping on toes. I'm not usually one to do that. But in this case, they (my senior colleagues) congratulated me afterwards. They said, 'everything went well, and you did this really well' and that made me feel relieved that they hadn't taken offense, I was proud of myself, that was really nice they acknowledged me. I felt really good about that moment. I think the praise that I got after that because of that experience, made me more comfortable to then go on and do it again.* (Cindy)

Cindy describes an emergency in a primary unit where fewer midwives are on site compared to a secondary/tertiary hospital. When Cindy stepped up and took the lead, her colleagues' reaction and support was instrumental in her sense of growth and confidence to "go on and do it all again." Cindy was unsure of how stepping up and taking the lead would be perceived by senior colleagues. However, taking the opportunity to safely and confidently step up, contributed to her positive self-esteem and feeling proud. Professional growth and development come from a positive sense of self; "the praise" was instrumental in Cindy feeling she could continue to take the lead in an emergency.

Alongside having the confidence to help colleagues, supporting midwifery students positively contributes to confidence. Charlotte felt proud to step up and support a student midwife.

> *I was on assessment the other day, was probably a month ago, when we (staff midwives) were all in handover. I went and answered the bell, because there was no one else on the floor and the baby had been born a couple of minutes past 7. Everything was still pretty fresh. The midwife handed over to me and there was a midwifery student still in the room. She (the student) had just met the woman as well and I was able to help the student with suturing. I was really proud of myself and pleased that I was able to help the student out, it was the first time she had sutured, and I told her, she did really well. Helping others just made me feel like I knew what I was doing and my skills are worth passing*

on, and she was super stoked because she hadn't sutured before. That was really cool. (Charlotte)

Charlotte, like many of the participants, talked about mastering the skill of perineal suturing as significant to the development of confidence and competence when working in the birthing and assessment unit. Stepping up and being able to support others with this skill contributed to her feelings of pride and confidence. Charlotte also experienced enjoyment in sharing of skills when feeling confident to step up. Charlotte voiced, "Helping others made me feel like I knew what I was doing," a comment that supports the notion that the passing on of skills and sharing knowledge is a positive cyclical professional development process. The midwife gained confidence in her own practice while helping others practice. Feeling proud was empowering for Charlotte in her own practice and self-belief. This confidence in practice also affirmed that her knowledge was "worth passing on," thereby enhancing continued professional development in her job. Feedback of encouraging words to the student contributes to the confidence of the next generation of midwives and the cycle of trusted support. The data revealed that a midwife who feels pride in her role, grows confidence and, subsequently, professional growth in feeling valued as part of the team.

For Christina, professional development is a continuum. Christina relates her experience.

It was quite an intense situation to walk into that room and I look at the CTG. I knew that this needed to go further, and the woman's care needed to be escalated.

I guess the sense of achievement was walking into the room, knowing the CTG trace was abnormal, knowing what to do to respond to that, and get the woman, and the baby the help that they needed. (Christina)

When Christina identified an abnormal clinical picture, and responded appropriately, her confidence grew. Being able to escalate care correctly and professionally, Christina's knowledge and identification of the abnormal picture reinforced her skill as a midwife and achievement in identification. This successful experience was marked by being able to "get the woman and baby the help they needed." Christina's actions translated to her advocating for the provision of safe care for the mother and baby, alongside building confidence and trust in her own practice and decision making.

Yolanda's experience of "volume" and "acuity" of women has given her the confidence to step up to support others.

> *Just, realising the sheer amount of volume of women I care for and the high acuity of them. It was a big moment of realisation, the impact of what I'm doing. I just thrive on the acuity that we work with, and it would be what I enjoy the most, because no day is the same. The high acuity of the hospital means you don't muck around, you just go and do it. I think it forces me to improve my own skills, even simple skills such as IV cannulation. Working in a place with high acuity enabled me to improve and build on those skills. We have such a high turnover of LMC midwives, alongside new graduate midwives, it's great to support them with those skills. Now that I feel more comfortable in my area to sit down and support someone through suturing, that confidence is what makes the job really enjoyable.* (Yolanda)

For Yolanda, the high acuity contributed to her continued professional development with the volume of work gifting her experience and opportunities to build her knowledge and skills. This maternity hospital services a community with high medical and obstetric needs. This high acuity of the women and people who access the services at the maternity hospital is a stimulating and an enjoyable part of the work for Yolanda. With the diverse high acuity challenges presented as part of her role, Yolanda is given a chance to "thrive" as a midwife. It provides opportunities for continued professional development when she is supporting others. Like Christina, Yolanda sees the benefit in consolidating her own knowledge and skills to be confident to support her colleagues. The enjoyment of sharing that knowledge, to "sit down and support someone" contributed to Yolanda's confidence, encouraging her to step up when she felt valued. The high acuity and volume of workload positively contributed to Yolanda's ability to improve and build on her skills, such as IV cannulation and suturing.

Charlotte also builds confidence from the unpredictable nature of the day that the busy high acuity unit brings.

> *I think I enjoy how dynamic it is, how it's always changing. You're never really doing the same thing over and over again. Even if you have your systems in place and you know what your day looks like a lot of the time. In different situations, every woman is different. Every family's different, and what I enjoyed the most is getting to know families and just being with them in their experience and how everything's new all the time.* (Charlotte)

Much like Yolanda, Charlotte can see that the high acuity alongside the ever-changing diverse clientele is a supportive factor for continued professional development and

enjoyment. “Having systems in place and knowing what the day looks like” underpins confidence in the workplace and stabilises the foundation of the “dynamic always changing” environment. The diversity of the women and the whānau, for whom Charlotte cares, makes every day different and, for this reason, the acuity of the unit contributes to a big part of her love of her job. The relationships built and the part that the midwife plays in the woman’s journey were a core value for all the participants and contributed to their feeling valued in the workplace.

Becoming a Midwife

There was a tangible link between professional development and participants experiencing ‘becoming a midwife.’ The high acuity of the maternity hospital challenged participants to ‘step up’ into becoming and being the midwife. Furthermore, some midwives were given opportunities to develop leadership skills that enhanced feelings of confidence. This is a motivating factor for continued professional development. The midwife feels rewarded with confidence when working within the busy high acuity unit and the opportunities it offers. The impact of ‘becoming a midwife,’ as opposed to ‘learning to be a midwife,’ comes from the relationships that she builds and the environmental influences. An environment of trust, outlined in Chapter Four, that is created by the support of the team is the gift that helps enable the midwife to experience growth and feel confident.

Yolanda talked about what continued professional development means to her “growing as a midwife.”

> *Professional development is growing as a midwife, regardless of what areas you go into. It means developing and being supported with physical skills. It can also mean helping you look into different roles whether you’re looking towards leadership positions or being supported in learning new skills or academia. That would be what professional development means to me.* (Yolanda)

Yolanda voices that “developing and being supported” are valued highly within the work environment. Yolanda’s experience of “growing” is how she defines continued professional development. She voiced that “to grow as a midwife” means to develop her midwifery skills and have support into areas of leadership and academia. “Being supported” is a conduit to learning and teaching practise skills and her ability to see the future career paths is part of this support to continued professional development.

Maisy echoed similar views to Yolanda regarding the importance of individualising continued professional growth in the first few years.

> *It was a bit of an expectation that you should be able to do that, you've been out two years now; whereas I might only have done that once or twice. I think because everyone comes out at a different point and there are definitely people in my cohort (class of student midwives) who were really confident in that skill. But then there were a lot of us who weren't, so I think it has to be particular to the person. I think it's just about recognising that even in a degree all of us get really different experience. The midwife we are when we graduate will be quite different to someone else.* (Maisy)

There is a connection to self-recognition of skill and experience alongside the feeling that the team and senior staff need to recognise the difference in, and individualised needs of, each early career midwife. Maisy experienced an "expectation of knowing" around a midwife's time in practice, even though there is a vast degree of difference between experience and years in practice. The data are linked to the undergraduate degree and the 'expectations' around experiences from clinical verses time.

However, alongside the expectation of knowing, Maisy appreciated the opportunities to offer continuity of care in her growth as a midwife.

> *Facilitating a normal birth, being with a labouring woman, and being able to be with her from assessment side, through the labour and birth, and then immediate postnatal care. Getting to do continuity of care alongside the LMC is great. Getting to a point where I feel confident to do all parts of the care, has been a 'peak' feeling. Like I've discovered what it is to be a midwife.* (Maisy)

Continuity of care was an important and valued part of Maisy's job, it contributed to her confidence. Maisy talked about this being the "peak" affirmation of self, when she can capably undertake all components of the woman's care. Continuity of care is a challenge to achieve within a busy tertiary maternity hospital. When opportunities for continuity of care happen, there is an improved sense of satisfaction and enjoyment with affirmation of "what it is to be a midwife." The discovery of 'being a midwife' is a positive feeling for Maisy; being a midwife is a personal immeasurable state of professional self. The satisfaction of linking with the spectrum of the woman's journey was a valued part of being a midwife for Maisy and contributed to her continued professional development.

Yolanda placed value on supporting the essential physiological aspects that are important to woman and the midwife's professional role.

> *I think for me it's always been that it doesn't matter who I work with, I'm part of their journey, and I'm supporting their journey*. *I still see for me, that it doesn't matter where I work, it's about normality. Working in a very high acuity ward I always love to bring the normality back to people whether it's in the small things of allowing the family time to do a karakia (prayer) before we go to theatre, or in recovery helping skin to skin breastfeeding. Those things I hugely value as a midwife, I'm there to provide help with the normal physiological process of birth and just supporting the families into becoming families because each time a new baby arrives in the family, it's a whole new family or it's in addition to the family and just supporting them into that transition.* (Yolanda)

The challenge within high acuity maternity hospitals is being able to provide care that is woman and whānau centric.

All participants talked about the importance of finding the normal physiological parts of the care within the high-risk busy units. The space and time to do so was challenged but, when they found the space to make it happen, they talked about the importance of remaining committed. Being with women and creating time to provide the care enhanced the feeling of 'becoming a midwife.' When Yolanda was able to support the normal physiological aspects of care, like a "karakia" and breastfeeding, it became less important where she was working. Having space and time to be with families was a priority and important to being a midwife. The care Yolanda gives and her professional progression as a midwife does not sit siloed from the woman's experience. She expresses the importance of "being part of their journey" encompassing the holistic model of care that involves valuing the cultural, physical, and emotional needs of the person for whom she cares and their whānau.

Michelle acknowledged the importance of being an advocate for the woman.

> *We play an important part in the woman and whānau lives. It might be one of the only times that they interact with health professionals, and I find that a really important part of my job, because I get to be an advocate for many things in terms of their general health, not just the pregnancy and birth. I find that really fulfilling, a really nice part of my job.* (Michelle)

Michelle talked about professional fulfilment in her role, and the importance of being an advocate for the woman. She looks further than the skill set around the pregnancy and birth towards that of a health advocate for whānau as well. Many of the participants echoed the value of caring for the whānau alongside the woman/person, which contributed to feeling valued as a midwife and extended their skill set to encompass the health needs of both as one and not separated parts. Strengthening relationships, alongside being "an advocate" for the woman/people and whānau, was an essential part of the care. An important part of the role of a midwife required Michelle to impart knowledge as a health professional and contribute to the health and wellbeing of all whānau. Whānau-care was a key part of being a midwife for Yolanda and Michelle.

To advocate and provide appropriate care, Charlotte voiced the importance of quality time with the woman as underpinning good practice.

> *I'm on birthing now but if I was to go back up to maternity postnatal unit, the thing that I valued the most and want to do more of, is have more time with the woman. You're so busy, and you've got such a high demand (acuity) caseload. It's hard to spend quality time, teaching the women and being with them and especially supporting breastfeeding. On birthing unit, the women are super generous with their lives, they let you in, and I love being part of their experience. The women feel really grateful that you're there to help them.*
>
> *I quite like it when it is busy, but I prefer it not to be super nuts. The relationships that you build with the woman that you are looking after in the birthing unit, that's what makes a good day at work, especially if you're able to be there when they have their baby and also if the outcome is good in the end. It's important for me that I feel like I've made an impact in the lives of the people that I've been caring for.* (Charlotte)

Charlotte greatly valued the time she spent with the women/people and the ability to be part of their experience, articulating that being available and present is being a midwife. However, there were challenges within the high acuity units that impacted the midwife's ability to build relationships with women/people and whānau. Having quality time to be with those for whom she cared, to teach and support them, was an important part of midwifery care for Charlotte. Furthermore, the outcome for the women/people and pēpe contributed to her confidence and success. Helping and supporting the skill of breastfeeding was an important success indicator in having quality time with women and was an essential element of being a midwife. Being able

to help and support offered a positive contribution to continued professional development.

Yolanda felt the positive influence the environment posed to her confidence and growth.

> *I felt really confident and competent in my skills as an LMC midwife and when I worked in a smaller DHB I felt like I've lost a lot of those skills. Coming back here (maternity hospital), it was hugely about improving those skills before I can look into different roles. Ideally, one day, I would like to look into a leadership role. If I can't support my own practice, it would be difficult to support someone else's practice, which I think is an important part of those leadership qualities.* (Yolanda)

Yolanda saw opportunities for future leadership in the consolidation of growth in her own practice. The move for Yolanda back into the maternity hospital, from a smaller hospital, was instrumental to her feelings of growth. Yolanda had future aspirations for leadership and the larger maternity hospital offered opportunities to build those skills, alongside a pathway to leadership. Her growth as a midwife meant being confident in her own practice to be "able to support someone else's practice," And she identified this as supporting and building future leadership qualities.

Charlotte was empowered by a colleague giving her a supportive "push."

> *The second day on my orientation there was no one to orientate me, it was a frustrating day I came home at the end of it feeling like I didn't know anything. I didn't want to go back to work the next day. When I went back the next day, one of the midwives grabbed me and pulled me into a room, and I just seconded a birth. Within half an hour she identified what I needed. Then an LMC helped me with some perineal suturing which was cool. I hadn't done that in a long time. That was really awesome. The core midwife that I was orientating with said, 'go on, get your gloves on, you can do it.' She said, 'you know how to be a midwife, just get in there and I'll set your trolley up.' She pushed me into it, which was very helpful. When I finished that woman's care, the midwife I was orientating with came and grabbed me, and she put me into another room with a woman who was close to birth, she was 9cm. The baby came out soon after, the same story as before, the midwife just said, 'Go for it, I'll help you, you can ask me anything, and I'm here to help you.'* (Charlotte)

Having someone to help and offer opportunities was instrumental in building confidence early in a midwife's career. Charlotte appreciated the care from the preceptor midwife in affirming "you know how to be a midwife," thus helping facilitate her to move forward in her role as a midwife in the early days at the hospital. After her first day, Charlotte was left feeling she 'didn't know anything' and was reluctant to return to work the following day. Fortunately, Charlotte returned and the orientation support from a preceptor helped affirm her knowledge and build confidence. The affirming words of a colleague that "you know how to be a midwife," alongside that physical support, were conducive to Charlotte moving forward and building competence. A gentle push that encouraged and helped was instrumental in Charlotte developing her confidence in the first year of practice.

Maisy voiced that the units that challenge her greatly also contribute to her confidence.

> *It's just going back time and time again and not giving up. When I finished the new graduate rotation and we had to choose what we were going to do. Even though birthing was the most draining and sort of scariest place to be, I felt like it's where I needed more growth so going back there for another year contributed to being able to feel confident.* (Maisy)

Maisy revealed that she chose opportunities to challenge herself to further knowledge and skills. She identified her own needs and "where she needed more growth." Some of the units, particularly birthing and assessment, were seen as places that created opportunities to build her knowledge and skills. These units were excessively busy with frequent obstetric emergencies that challenged the midwife to escalate growth. Maisy was able to self-identify her areas for growth and development, choosing to return to a workplace that was "most draining and scariest." However, this was the place she wanted to reinforce her knowledge and skills. In this environment, emergencies are commonplace; and feeling confident in managing emergencies is valued as an important part of being a competent midwife. Maisy could see that the place that challenged her was also the place she needed to consolidate her knowledge and skills.

Conclusion

Confidence, defined by the Merriam Webster dictionary, is feeling certain and reliant of one's self and circumstances (Hacker, 2011). Building confidence in an early-career midwife's practice and establishing growth in knowledge and skills is bolstered

by receiving affirmation, stepping up and feeling valued in becoming a midwife. The participants valued the internal and external affirmations of doing a good job and feeling like their continued professional development reflected their growth as a midwife.

Feeling appreciated and receiving feedback was an important factor in feeling confident. The participants' colleagues were vital to development of self and their affirmations helped build a sense of confidence as a midwife. In an environment of trust, with access to guidance that supports and empowers, midwives feel confident. Additionally, participants took opportunities to share their own knowledge and skills to support new colleagues and students; this contributed to growth in their confidence and professional self-worth. When ready to contribute to others' learning journey, the early career midwife enhanced her own knowledge and skills; thus impacting her continued professional development. When midwives felt valued, the early career midwife is more likely to step up, advocate for whānau, and build leadership qualities.

The midwives' experiences of feeling confident, alongside the ability to have a sense of becoming a midwife, were influential in their belief of their capabilities as a midwife. Midwives spoke of their own growth as a midwife in 'becoming' a midwife as being their measure of continued professional development. The Midwives confidence was strengthened through appreciative words and gestures of support from their colleagues, women/people, and whānau. The participants gained a feeling of professional success in 'doing a good job' alongside managing the safe care for women, pregnant people, and whānau.

Chapter Seven: Discussion

Figure 3 Aotearoa New Zealand forest eco system. Image by Eli Lyons

The question of this research was, “What are the experiences of early-career midwives that supports their professional development working in maternity hospitals?”

In this chapter, I describe and discuss the study's significant findings and compare what other studies have found about early career midwives’ continued professional development. Literature supporting the findings from my research is woven throughout the chapter. I make recommendations to guide maternity hospital leaders, policymakers, unit managers, and midwives to support continued professional development for early-career midwives. Further, the strengths and limitations of the study will be discussed, and suggestions for ongoing research provided. A summary of the study will conclude the thesis, alongside a recommended job description for the clinical support roles within the hospitals. As discussed in Chapter One, the terms continued professional development and professional development are interpreted within my study to have separate meanings. Continued professional development represents the evolving value and support part of a lifelong journey for the midwife. Professional development is more tangible and a mark in time, like a study day, workshop or specific learning experience.

The thesis started with a visual metaphor of harakeke, a robust and hardy plant that can survive alone with its interwoven structures and self-protection mechanisms. At the start of the study, this image represents my preconceptions from my experience working alongside midwives early in their careers. My understanding was this group were robust, resilient practitioners surviving many challenges working in maternity hospitals.

The second of my images, created for this chapter, is the Aotearoa New Zealand forest ecosystem. This is a metaphor for a broader support network surrounding the midwife that allows them not just to survive but to thrive, sustaining ongoing professional development in the early years working within maternity hospitals. The presence of the taller trees provides essential shelter and protection, allowing smaller plants and bushes and the ground-dwelling plants to thrive despite their stressors, surviving by supporting each other. This is like the ecosystem that surrounds the midwife. It represents the collective impact; it takes more than preceptors, mentors and managers, the midwifery profession, and the maternity hospital's culture and values together underpin the sustainable ecosystem that surrounds the early career

midwife to support their continued professional development as part of a team. The midwifery ecosystem, as in the forest, sustains and supports the healthy environment of the maternity hospital, where health professionals, women, birthing people and whānau work in partnership together.

This thesis is structured and guided by the AI methodology (Cooperrider & Whitney, 2005). In Chapter One, I defined the research before describing the methodology of the research in Chapter Three. The findings chapters—Four, Five, Six—are the discovery phase of what is already working, and to appreciate the best of "what is" through the experiences of eight early career midwives' narratives.

In this discussion chapter, the last three phases of the 4-D cycle are completed; to dream what might be, to design what should be, and its destiny to empower and learn and sustain for the future. In this chapter, the imagination and vision of the dream is articulated, and 'what could be' in discovering the positive core. Recommendations are made to design options to help build and maintain a sustainable workforce. The last phase is destiny, the actions of the organisation to acknowledge and honour the voices of the midwives in order to support them in the early years of practice. In AI methodology, this last phase opens up opportunities for further research and an ongoing appreciative living and learning culture (Cooperrider & Whitney, 2005). In this last phase, the outputs of the research for future use are offered as a job description for recruiting a clinical coach (Appendix K). Choosing to study a group of midwives within the first two to five years in practice, working in maternity hospitals, with an AI lens, was purposeful—the motivation being to uncover what is working well and give recommendations to the organisation in supporting the professional development of early career midwives.

The Discovery Phase

The discovery phase of my study found that the maternity hospital's culture of trust, alongside access to approachable midwifery colleagues, directly impacted the continued professional development of the early career midwife. When the midwife feels supported and trusted in their learning journey, they feel that they have confidence to 'become' a midwife.

Three themes emerged from the discovery phase in the findings; first, 'A way of working – Feeling a culture of trust,' where the organisation's cultural values are around trust and the workplace nurtures the development of the midwife when they feel invested in. Arising from the participants' voices, the concept of the hospital

culture is a philosophical way of working embedded within the organisation within which trust was the main factor. The culture was comprised of teamwork and mutual trust, which fostered the participants' sense of feeling valued within the team. The second theme was 'Being guided' where the midwife has guidance from accessible, approachable colleagues. The support is tangible, it comes from the foundational structure of the first year, debriefing and reflecting alongside a colleague's to stand beside and guide practice. The third theme, 'Feeling confident,' is the conduit to the trusting culture of the workplace and the ability to access guidance. My findings reveal that when this combination happens the midwife's continued professional development evolves regardless of the conflicting challenges in the workplace. The discovery phase of my study confirms that environmental and human impacts of trust and guidance create confidence, and is a recipe for continued professional development and sustainability in employed-based midwives.

Introduction

Midwives valued their continued professional development as part of ongoing advancement and commitment to clinical expertise. What my study uncovered was how continued professional development was defined for this group of midwives. The expectation from the research was that there would be a variety of factors that support continued professional development, and that these would align to definitions that already exist in healthcare. However, the surprise was that for early career midwives, their intrinsic motivators for continued professional development were the impacts of human interactions, where they felt belonging to a team and the supportive professional behaviours of colleagues enabled them to thrive within the organisation. The human factors from all levels of the organisation—women/birthing people and whānau—were the major contributing factors for growth and development in midwives' early career.

The majority of the participants defined continued professional development by the interactions and tangible guidance that they received from colleagues in practice and as part of workshops. For the midwives, continued professional development in the form of mandatory or voluntary education days was identified as being the connection with peers and colleagues, alongside one to one guidance from the educator. The key finding of my study is that it was not the content of the structured education workshops that was instrumental to continued professional development; rather, the collegial discussions and support from their colleagues with whom they attended the days.

Participants did, however, identify barriers to accessing education as part of this study. These": barriers included critical staff shortages, accessing time off, and difficulty accessing information on education. Similarly, Calvert et al. (2017) found structural and organisational conditions were a barrier to midwives accessing workshops and study days outside of the workplace to support professional development. However, the midwives in the study did not feel a significant loss to their continued professional development when they had approachable and accessible colleagues to teach skills in the clinical environment. This further enhanced their development and relieved the anguish of not having access to study days.

Dream – What might be: The results and impact of becoming a midwife and supporting the early career midwife to develop professionally grow and flourish.

In the dream phase of my study it was revealed that continued professional development for early career midwives encompasses many factors. This phase of the 4 -D cycle when moving from discovery into dream phase, I identify how my study findings sit alongside the literature to reveal the results in what supports the continued professional development of this group of midwives.

How the First Year Impacted the Years Ahead

My study intended to look at what supported midwives' continued professional development in their first two to five years in practice; however, participants' narratives strongly echoed that their first year of practice experiences were contributed to their continued professional development journey past the first 12 months. The first year of practice is a time when midwives make their connections with colleagues, and is an instrumental time for building their networks of support past the first year. In that first year there is individualised support from a mentor and preceptors, however there is an 'expectation of knowing how to be a midwife,' that exists despite the diversity of knowledge and skills from the undergraduate training. Participants feel a positive impact of the "new graduate title" that came with wraparound support. However, there is a need to identify the difference in exposure to decision making and emergency management to be able to individualise the support and guidance for midwives early in their career. This was especially evident in my findings, and that of three other studies, which revealed a vast difference in the confidence and experience from exposure, depending on the clinical setting and degree of preceptorship for the midwife (Avis et al., 2013; Black, 2018; Irwin et al., 2018).

Mentorship is a highly valued part of the MFYP programme in Aotearoa New Zealand. Within it, the mentor that supports outside of the immediate workplace for graduate midwives, is instrumental in offering opportunities for reflecting and debriefing practice experiences. This is a valued component of continued professional development for midwives past the first year and beyond , yet the support for this stops at 12 months post registration. The MFYP programme fosters support and nurturing from a mentor, through face-to-face time, to reflect on practice experiences (Pairman et al., 2016). Within the workplace, collegial support in the first year is instrumental in building a support network of approachable, trusted colleagues to go back to when they move into the second year of practice. This finding was described in a previous study by Kensington et al. (2016) as part of the culture of a wraparound support network of colleagues that took a collective responsibility for the graduate midwife.

Giving accessible support and guidance in the first year will encourage midwives to return to the unit after the first year to practice. This was evident from many of the participants who chose to go back to the most challenging places to continue to build their skills from the first year, acknowledging where they felt they needed further support for their continued professional development. When midwives are supported by preceptors, senior colleagues, and the team in practice, they feel confident in being a midwife. The participants' narratives supported other literature that within the MFYP programme there is significant professional growth in confidence and competence in practice in the first year (Dixon et al., 2015; Kensington et al., 2016; Pairman et al., 2016). The participants in my study gave recommendations that added support was essential for midwives that were returning to practice after a break away, and moving between work environments, similar to the first year practice. The relevance of the first year to this study is to inform the need to continue support for midwives past the first year when transitioning back to practice or rotating around different work settings within a maternity hospital.

My study found that it is vital not to make assumptions about experience related to years in practice, and to individualise learning needs from the first year of practice and beyond. Other studies have supported the understanding that transition to practice programmes create the groundwork within workplaces of a cultural norm of nurturing and supporting early career practitioners as they gain confidence and experience in the workplace (Kensington et al., 2016; Mills et al., 2016).

The hospital midwifery graduate educator is an essential go-to colleague for support within the maternity hospital. The maternity hospital where the research took place

has an identified educator whose role is in support of the first year of practice midwives and those returning to practice after time away. While midwives are navigating the new environment and transitioning from student to midwife, the educator is significant part of the wraparound support, and the conduit to the maternity hospital's tangible investment in their learning from the outset.

For midwives early in practice it is instrumental for their professional development to have a known person to go to, check in and debrief with. Alongside this structured support in the first year, was the importance of their trusted colleagues and the value in building relationships with midwives to ask questions and obtain decision making support. These findings were supported by Pairman et al. (2016) who noted that graduates experienced midwifery support widely from their peers and colleagues in the first year; thereby, building the culture for accessing support in the years following.

Dream Summary -The First Year Matters

It is helpful to have a known educator that is responsible to professionally care for graduate midwives to support continued professional development when orientating to the new environment and building a support network of colleagues. The first year of practice support is instrumental in continued professional development support post the first year. A similar support network needs to be considered for midwives who are returning to practice after time away, moving between maternity hospitals and workplaces, over and above the preceptor of the unit.

Maternity Hospital Culture Supports Continued Professional Development

The culture of the work environment has an impact on midwives' continued professional development and provides the foundational support and way of working within the maternity hospital. Never has there been a more important time to address workplace culture and support a trusting safe workplace for midwives, especially within the current climate of severe workforce shortages' and stressed midwives. The midwives within my study defined organisational culture as the maternity hospital's value and expectation for the health professionals that worked within the it. When the culture of the organisation matches the culture of the people within it, then a supportive place to work will foster continued professional development. A literature review by Pavithra (2021) found three approaches informed a positive person-centred culture—belonging, behaving, and being; with all three aligned against organisational goals, individuals' behaviours, and organisational identity. These approaches were

also found to match the findings from the current study and how ‘a culture’ was defined and experienced by early career midwives.

The maternity hospital culture is how the participants made sense of the way that people chose to work together. This culture of the organisation is its ‘way of working;’ and the philosophy of an organisation is instrumental to the ability to develop skills and knowledge. The maternity hospital culture must be based on trust—in others, self, and the organisation. The midwives in my study revealed that when an environment of support and trust existed, potential stress triggers could be experienced as challenges that contributed to supporting continued professional development for the midwife. However, when the environment was disrupted, so too was participants’ experience of feeling safe. Hammond et al. (2013) connected this to neuropeptide oxytocin and found that it played a significant role in humans’ behaviour within the workplace for midwives. Hammond et al. found the culture of a workplace with increased trust, reduction in stress, and empathetic colleagues had positive impacts in triggering oxytocin for midwives, increasing job satisfaction and provision of quality care. The findings of my study echo those of an Aotearoa New Zealand study which found that creating and sustaining a supportive culture was beneficial for the women, people, whānau, and the workforce (Gilkison et al., 2017).

Having a culture of trust is an asset to the organisation, one in which the workforce functions well, and can sustain and retain its workforce. A trusting culture of an organisation is instrumental to the stability for healthy collegial relationships to develop, and where midwives feel supported, access guidance and develop confidence in being a midwife.

In Aotearoa New Zealand, midwives are autonomous practitioners in whatever setting they work. However, my study found similarities with Clemons et al. (2020) where the culture of an organisation can hinder a midwife being able to make midwifery decisions and work within their scope. The midwives in my study felt that the maternity hospital had a responsibility for their future career goals and inclusion in the organisation’s future. As part of this they spoke of being invested in, and offered opportunities within the organisation, several midwives wanted to be involved in projects for quality improvement. The study findings resonate with those of Manley et al. (2018) where effective continued professional development came from practitioner driven successes within a positive workplace culture and contributed to generation of knowledge alongside improvements for the organisation as a whole.

In Tāmaki Makaurau Auckland, there are three maternity hospitals within which midwives may choose to work. In my study, the midwives identified the culture of the hospital as their reason for choosing their workplace rather than geographical or monetary reasons. A third of the participants were able to draw comparisons with previous maternity hospitals and how the culture hindered their ability to experience continued professional development and job satisfaction. Trust was the cultural identity of their current hospital that was a positive factor in their professional growth and wellbeing. The participants felt protective of their maternity hospital culture and the study showed that they viewed the hospital as invested in their culture. This finding is echoed by Zolkefli et al. (2020) who contended that attitudes and ways of working are influenced by the environment and are instrumental to how knowledge and skills are developed.

Dream summary – It's a Culture of Trust

Building a culture of trust is an integral part of a way of working within the organisation and is a catalyst to helping midwives feel confident and safe. When women, birthing people, and whānau, as well as colleagues, trust the midwife, then continued professional development is supported.

Midwives See Their Manager as the Conduit to Their Career Pathway

The maternity manager is instrumental in the connectivity of the early career midwife to finding a pathway within the maternity hospital; this finding concurs with Coughlan and Patton (2018) who showed that when midwives are able to see a career path for themselves, it is associated with job satisfaction and increased commitment to the job. The participants believe that the manager has the road maps to navigate the pathways for future career development. Early career midwives are motivated to achieve their career aspirations and, with the right support, will increase job satisfaction and are more likely to be supported into future leadership positions (Coughlan & Patton, 2018).

The Quality Leadership Programme (QLP) exists to help midwives develop skills and knowledge, and is remunerated by maternity hospital (MERAS, 2015). However, it is not a tool that facilitates continued professional development for early career midwives; rather, the added human elements of accessible and approachable managers to navigate the QLP process were most helpful. The QLP process gave the midwives an opportunity to share their goals with their managers and feel an investment in the future of the organisation. This was similar to the findings in an

Aotearoa New Zealand study (Kensington et al., 2016) wherein managers were one of the most valuable resources to provide encouragement and reassurance in the clinical environment. Managers have a profound impact on supporting midwives to have a voice and express autonomy employed in the maternity hospital (Scott, 2011).

Professional development is impacted positively by the early career midwife feeling noticed and valued by their manager, as well as the wider team. This finding was echoed by Coughlan and Patton (2018) who noted that in times of staff shortages, early career midwives require acknowledgment, encouragement, and opportunities for professional growth to maintain satisfaction in their role.

The early career midwives in the study felt that career pathways outside of the Clinical Charge midwife (CCM) role were mostly invisible, and the pathways to specialist areas of midwifery or leadership opportunities were a shared responsibility with their manager. The manager, is seen as the person who holds the visionary approach to their future and guides the career pathway for the early career midwife. The literature tells us that, professional development goes beyond growing skills and knowledge and encompasses factors like autonomy, collegial relationships, and visible strategies for career advancement (Coughlan & Patton, 2018; Sheehy et al., 2021). Participants voiced that when the manager knew who they were and where their strengths lay, their career advancement was made more visible. However, when they did not feel acknowledged or noticed, pathways to advancement were mostly unknown and they found it difficult to see pathways within the organisation for their future. The midwives believed their manager was the conduit between them and being part of the bigger picture of their organisation and their future career pathway. These findings align with those of Gilkison et al. (2017) who noted that managers have an impact on the supportive culture of an organisation. Being compassionate, approachable, and accessible to debrief and check-in with, were essential elements of a manager. Participants felt a manager that stops and regularly checks in, would affirm them as being a valued member of the team, and was invested in their continued professional development.

Midwives revealed that they wanted to intentionally build a career with guidance from their manager. Participants valued joint goal setting as a shared responsibility between the midwife and the manager. The hospital's core value of trust became a protective element for midwives experiencing continued professional development, and is a shared responsibility with employment in a maternity hospital. This study supports the findings from Sheehy et al. (2019) that strategies for continued

professional development are needed for cultivating a midwifery workforce to support ongoing midwifery skills and knowledge development.

Dream Summary – The Visionary Manager

Managers of the units must be visible and connected to their workforce, regularly checking-in and acknowledgment matters. Discussions that go further than the QLP and assist the midwife to set future goals to work together, will sustain midwives and support their continued professional development.

Being a Valued Member of the Team supports knowledge and skill development

Organisations are made up of individuals that form groups to get the work done, and the behaviours of the groups are often predetermined by shared assumptions and beliefs (Hammond, 1998). Having a team that works together with healthy relationships that offer support and guidance are foundational values embedded in the unit's culture.

There is a strong emotional attachment to being part of a team that contributes to social and professional development support. The team is instrumental to working in and developing skills and knowledge within a maternity hospital. Indeed, probably the most important factor for success is how a team functions. Many studies have found that the positive impact of the social support of the team, coupled with professional development opportunities, contributes to job satisfaction and retention (Dixon et al., 2015; McDonald et al., 2016; Sullivan et al., 2011; Yukiko & Sandall, 2013). Midwives in my study, found that teams that support early career midwives are based on mutual trust. A number of studies support the finding that interactions with team members are protective of job satisfaction and encourage self-progression (Cull et al., 2020; Macdonald, 2019; Matthews et al., 2021).

Midwives enjoy working within a busy tertiary maternity hospital, and colleagues are a vital part of the enjoyment of the job. Being together was a positive part of coping, 'surviving,' and setting the culture of the organisation. Midwives talked positively about working collaboratively as part of a team, knowing they were part of something bigger than themselves alone and functioning as part of a group culture. A study by Matthews et al. (2021) supports my findings that midwives valued their colleagues being approachable and supportive within the team. When midwives work alongside approachable supportive midwives that guide them, it positively impacts confidence and they feel more competent (Fenwick, et al. 2012). The

participants in my study believed when they were supported in practice they were more likely to understand their role in the 'bigger picture' of the organisation, they felt valued and as a consequence experienced continued professional development. When the team works well together midwives experienced a safe working environment, this enables early career midwives to have positive professional development opportunities.

Within a maternity hospital, interprofessional teams are valued; however, midwifery colleagues are especially important for support and guidance. All participants' narratives affirmed that being part of the team was a positive part of working in the maternity hospital. My study is inconclusive as to whether it was the team that gave the maternity hospital its culture of mutual trust and/or the maternity hospital that provided the foundation to allow it to happen. It was likely a combination of both, although the midwives said that this was not a part of all maternity hospitals or their colleagues' experiences from other hospitals in Aotearoa New Zealand. A study by Hastie and Barclay (2021) supported the findings that effective teamwork impacts the experience of workplace culture and further assists in quality of care.

Within a team there are known confidants that offer further one on one support. These colleagues are preceptors, senior midwives, CCMs, doctors, and peers. Midwives voiced that this was mostly not structured but was instinctive. Feeling part of a team, when managing an emergency, was found to be particularly protective of the impact of the midwife's experience. When an emergency went well and the team worked together, the midwife felt supported in their continued professional development. When emergencies did not go to plan and the team worked well, this equally resulted in a positive learning experience. This finding was echoed by Hastie and Barclay (2021) wherein effective functioning teams can improve both midwives' competency and better outcomes and safety of care for mothers and babies. Within the maternity hospital of my study, obstetric emergencies are common place, especially in the birthing and assessment unit. When given opportunities to rotate around different areas, several participants chose to return to the place that was 'stressful and scary' to further support knowledge and skill development, because the team was supportive of their needs. Birthing and assessment unit is identified as one of these workplaces where support, stress, and challenge are experienced together. If midwives are supported in these high stress areas, where their knowledge and skills are challenged, there is a resulting sense of pride and achievement. The findings resonate with Cull

et al. (2020) and Hammond et al. (2013) who found that relationships and trust with colleagues are protective against stress and afforded pride in the job and better quality midwifery care.

Working with Acuity and diversity

The busy, high acuity maternity hospital has the ability to be supportive and energising for the midwife when working in a well-functioning team. Some of the participants articulated this as 'being in it together' and feeling like we 'survived together'. Working together as a team lead to building healthy trusting relationships, feeling valued, and having access to approachable colleagues to guide. This is a common theme across studies that support my findings that professional development and job satisfaction is protected and enhanced when feeling valued and part of a team (Coughlan & Patton, 2018; Cull et al., 2020; Hastie & Barclay, 2021; Matthews et al., 2021; Sheehy et al., 2019).

The high acuity and workforce shortages of tertiary hospitals were expected to contribute to dissatisfaction and frustration for midwives. However, participants experienced acuity as positive for their continued professional development, resulting in being able to quickly build skills and gain complex care experience. This was a similar finding to Gilkison et al. (2017), where core midwives built skills, flexibility, and adapted well in complex care situations. Midwives felt an ownership and pride over the culture within their maternity hospital and the team that supported them. Busy complex care units support positive interactions with colleagues working in teams and is instrumental to midwives supporting each other and building knowledge and skills. These findings were reinforced by Macdonald (2019) and Nash (2021) in the study of the A-EQUIP model which sustained midwives who work in maternity units under considerable pressures and contributed to them experiencing self-progression.

The high acuity and diversity of care experienced by midwives working in maternity hospitals has beneficial outcomes for continued professional development, in that, it provides a stimulating and energising workplace where knowledge and skills are developed quickly. This finding was supported by Gilkison et al. (2017) who found that the unpredictability and variety in the day of employed- based midwifery care sustains midwives and prevents them feeling stagnant in their role. However, when midwives felt challenged by the high acuity, important parts of their role were disrupted—the ability to do continuity of care and the holistic parts of the care for women, birthing people, and whānau was lost.

Dream Summary- It's about the Team

When the organisation invests in a positive team culture, early career midwives are supported to build knowledge and skills and feel safe. Investment in a culture of teamwork and mutual trust will foster midwives feeling valued and further support continued professional development through a safe learning environment.

Being Autonomous Within a Maternity Hospital

When early career midwives have mutual trust with colleagues, they feel they can practice autonomously. Other studies have shown that professional development and autonomy are two key indicators for job satisfaction and retention (Dixon et al., 2017; Matthews et al., 2021; Mills et al., 2016). There was division in the findings that autonomy was visible within a tertiary unit. However, participants found they could articulate what autonomous practice was when talking about scope of practice. Feeling autonomous in practice is a key factor and contributes to continued professional development.

Midwifery is unique in that clinical decision making is a shared responsibility with the woman and people. This partnership is the foundation relationship for the midwifery profession in all work environments (Guilliland, 1995; Guilliland & Pairman, 2010). With increased responsibility,and support with complex care, like induction of labour, early career midwives, experience autonomous practise, even when delivering secondary care under the clinical responsibility of obstetric Dr lead care. The Midwives revealed that when their obstetric colleagues were asked to consult in the care and assist with decision making, and they demonstrated they trusted midwifery care, the midwives in turn felt trusted and valued. This was identified as contributing to continued professional development. There was an expectation that in the tertiary hospital, where complex care takes place, that doctors and guidelines have more control over decision making. Midwives felt being autonomous within a tertiary maternity hospital was difficult, some felt that it was impossible. A midwife's place of work can impact on the ability to feel autonomous in practice because of the domination of the medical model and reduced freedom to exercise their own knowledge and decision making (Sonmezer, 2020).

My study found that midwives could be more autonomous in some work settings than in others, especially within primary care environments. Skills such as perineal suturing and induction of labour management were named as opportunities to be autonomous; however, early career midwives needed guidance and support. Midwives revealed

that when pushed to be autonomous, they felt trusted by their colleagues and these became supported learning opportunities in the early years. These findings were supported by Clemons et al. (2020) who noted that job autonomy is not always felt but the nature and culture of the maternity unit can impact autonomous practice and midwifery lead care.

Dream Summary- The Value in Autonomous Practice in Employed Midwifery

Experiencing autonomous midwifery practice within the busy maternity hospital supports continued professional development in early career midwives, the catalyst for this is a trusting workplace culture, teamwork and respecting and acknowledging the skills and experience of a each midwife.

Finding Time for Advocacy and Whānau Care

Midwives value time with women, people, and whānau and see this as being quality time to support the parts of the care, important to being a midwife. This was referred to as working in partnership with the woman/people and whānau, and fundamental to their continued professional development. Sheehy et al.'s (2021) study supported the finding that midwives who have well-developed relationships with women felt sustained and it contributed to job satisfaction. A valued aspect of the partnership is shared decision making and midwives voiced that time was needed to support women/people, and whānau in making informed choices and giving quality care. The decision making support for women/people, and whānau was part of midwives' role and they gained valuable skills in continued professional development. The participants identified that important parts of the role of a midwife as working with women/people and whānau were time for karakia, breastfeeding support, and being an advocate for people and whānau. Clemons et al. (2020) stated that the midwife's ability to be autonomous is impacted by the culture in an organisation and the differences experienced professionally. The New Zealand study concluded that institutional culture and professional differences influenced the ability to give woman/people-centred care.

When midwives experienced continuity of care within a busy tertiary unit, it nurtured a big part of what it was to be a midwife. This was often articulated as the value of being able to care for a woman/person in assessment unit and continuing the care through to the labour and birth. The midwives talked about the benefits and joy in providing all the parts of the care and getting to know the woman and whānau. The midwives felt a strong commitment to continuity of care, even within the hospital

environment, where it is known to be more challenging to achieve. It gave them more confidence to feel autonomous when they had a degree of continuity of care in the way they delivered care. Cull et al. (2020) concurred, contending that autonomy was highly valued, and when midwives felt job satisfaction it positively impacted their ability to develop knowledge and skills and gain confidence, this was another measure of their ability to feel continued professional development.

Within my study it was uncovered that providing whānau centric care, contributed greatly to job satisfaction, as did being with women, people, and their whānau providing holistic care as a health advocate alongside midwifery care. The midwives felt that client care and responsibility was inclusive of whānau and part of being a midwife was to share knowledge. They had a role as a health advocate for the whole whānau and felt that this was sometimes the first time many had accessed health care. Getting to educate and share knowledge and skills to support the whānau felt part of the job, but it was often difficult to find time to do. Sheehy et al. (2021) also found being able to care for the woman and significant others as part of continuity of care within hospital's was a positive contributor to midwives having job satisfaction and as a consequence continued professional development.

Dream Summary- Delivery of care to Women/People and Whānau

Striving for continuity of care within maternity hospitals is beneficial for quality midwifery care and holistic cultural centred care for women/people and whānau. Furthermore, supporting midwives to be more autonomous will facilitate continued professional development and result in improved job satisfaction.

Having Colleagues Who Check In and Debrief

Approachable, accessible colleagues are essential in feeling supported and trusted to have the knowledge and skills to work as an autonomous practitioner. Matthews et al. (2021) noted that approachable, accessible colleagues, alongside team support, contributes to confidence and midwives feeling supported in practice. Midwives revealed that guidance came from colleagues as words of affirmation. It was often senior colleagues and CCMs who took the time to listen, talk, give second opinions, and guide. My study found that openness to give advice and directed guidance came from colleagues, and mutual trust was a prerequisite to how it was perceived. For early career midwives, reflecting on practice and the day's events with a trusted colleague, especially after an emergency, helped dispel any feelings of isolation. When working in a busy maternity hospital, time to debrief and reflect was infrequently

experienced at work. The midwives felt that debriefing was difficult to do in a busy unit and they often went home with unfinished work issues and unresolved questions. Debriefing with a colleague is a valued part of reflecting on practice to inform learning. However early career midwives, taking time to reflect on practice is invisible, hard to measure and often not acknowledged. Connecting with a colleague to talk about practice is essential collegial care, and results in opportunities to get feedback, reassurance, and guidance for future practice.

The midwives in my study consistently expressed that having time with a trusted colleague to talk about an experience or event in practice was essential to know they were on the right track and gain confidence in their job. There is value in debriefing after an emergency or a difficult day, this was highlighted by many of the participants. Learning that comes from debriefing affirms practice and provides opportunities to make changes in future practice, as a result supports continued professional development. Midwives voiced that when an emergency outcome was successful, it was much less likely to result in a debriefing opportunity and often left the early career midwife with unanswered questions. Being able to debrief was not readily available to all midwives and was often dependent on availability of approachable accessible colleagues. Senior midwives are role models for midwives early in career, offering opportunities to share knowledge and support practice in the early years is invaluable and essential to job satisfaction and continued professional development. However, in a study by Mathews et al., (2021) found that a third of midwives are worried about approaching senior staff for assistance and support. The literature supports my findings that having known a colleague support, like a preceptor in the early years, is crucial and directly contributes to career progression and development as well as supporting the emotional health of the midwife (Coughlan & Patton, 2018; Cull et al., 2020; Matthews et al., 2021; Sheehy et al., 2021).

Dream Summary- Making time for reflecting and debriefing practice experiences

No longer should the benefit of debriefing and reflecting on provision of care be invisible in midwifery practice. Accessible approachable colleagues to connect and debrief with needs to be a valued part of the job and an expectation within the team. This offers opportunities in the early years of midwifery practice for added support and continued professional development for the midwife.

Receiving Feedback to Support Continued Professional Development

Feedback from colleagues, manager, women/people, and whānau was valued and affirming of 'being on the right track' and guiding future practice. Macdonald (2019) found that when midwives feel supported and valued, they were more likely to provide a valuable contribution to the women/people and families for whom they cared. Pride in the job was felt when colleagues took the time to give feedback, and resulted in confidence and feeling acknowledged.

The participants did not define feedback as structured or written but more informal. In a busy high acuity unit where there are critical staff shortages, taking time to support and give feedback to a colleague was not seen as commonplace. However, when they received feedback, the participants felt grateful that their midwifery skills were acknowledged, confidence was felt and they felt valued. Many studies similarly found that being acknowledged from midwives and the women and people, alongside a culture of support, was essential to feeling valued (Clemons et al., 2020; Cull et al., 2020; Gilkison et al., 2017; Manley et al., 2018).

Guidance from a trusted colleague, in the form of words of affirmation, alongside the gift of time, is instrumental to supporting continued professional development. Midwives felt trusted guidance alongside physical support from colleagues assisted in building confidence. When a colleague stood beside the midwife to guide with voice and not take over, this feedback was taken with affirmation of feeling valued and contributed to autonomous practice. However, outside of the first year, when the structured mentorship and preceptorship programmes ceased to exist, midwives did not feel a consistency of access to physical support without the 'graduate title.' This finding is backed up by many studies that show collegial support, preceptorship, and or mentoring is instrumental to the emotional health and continued professional development for all midwives (Coughlan & Patton, 2018; Cull et al., 2020; Macdonald, 2019; Sheehy et al., 2021).

The study further supported that for ongoing skills development there needs to be accessible approachable colleagues known to the midwife to guide outside of the first year of practice. A study by Patterson et al. (2019) found that face to face support was essential for practice knowledge development. Within my study, the access to feedback was inconsistent yet highly valued by the participants. Mathews et al., (2021) study found that nearly half of early career midwives need further support to fulfil their role and for most this was feedback. To ensure consistent support from feedback to invest in the early career midwife's continued professional development,

availability of colleagues is essential. This finding was backed by Mathew's study that approachable accessible senior colleagues was an essential factor for getting feedback in practice.

Words of affirmation from colleagues were like a 'pat on the back;' they were motivating and built confidence in midwives' skills and knowledge. When midwives feel trusted and appreciated, the early career midwife would be more likely to share knowledge and skills and go on to support students, graduates, and other colleagues. The participants felt that when feedback warranted change in practice, it was still affirmative if genuine. This was especially noticed around clinical skills such as perineal suturing. Study findings confirm that feedback from supportive colleagues is protective against stress and burnout and supports midwives early in career to feel autonomous (Cull et al., 2020).

Dream Summary – Feedback supports midwives

Giving of feedback plays an instrumental part in supporting; safe midwifery practice, collegial relationships, emotional care and the sharing of knowledge. Having a cultural norm in a unit of giving feedback ensures that midwives continue to support their colleagues and have a collective responsibility for the safe midwifery practice of the early career midwife.

A Guide Onside

My study revealed that for early career midwives, it was the presence of a colleague beside them while they continued to provide midwifery care, supporting their decision making which developed their midwifery skills and knowledge, building confidence in their professional abilities. When the supported guidance from a clinical charge or senior midwife was trusted, and the midwife got to continue the care or complete the skill, they felt empowered, trusted, and capable. This was most effective for growing confidence and competence in a skill when they guided with voice and did not take over the midwifery skill or management. Guiding skills like IV-line insertion and perineal suturing helped confidence to grow and reduced self-doubt.

Midwives revealed that there was a culture in the first year of practice where it was normal to ask for help and support; something that was less consistent in the following years. This aligns with other studies that recommend preceptorship or mentorship is needed in the early years to support and motivate career advancement (Coughlan & Patton, 2018; Matthews et al., 2021). The participants identified the vast difference

between the first five years with confidence in certain skills and experience. When outside of the first year, midwives still need support and guidance that, for some, it was accepted as normal practice. Midwives identify that there is significant stress within the workplace. My study found similarities to many other studies that the collegial support was instrumental in reducing stress and increasing confidence when transitioning to both the workplace and role of midwife itself in the early years (Coughlan & Patton, 2018; Dixon et al., 2017; Hastie & Barclay, 2021; Hunter & Bick, 2019; Mills et al., 2016; Patterson et al., 2019).

This study revealed that when midwives asked for help and got the support of a guide, they felt more confident in the skill and accepted asking for further support at a later date. My study highlighted for example that it was both their midwifery and medical Dr colleagues who helped teach the skill of perineal suturing, not taking over but guiding by standing beside them. This finding was supported by Hunter and Bick (2019) and Wilson (2012) who found that supporting skill development is dependent on access to colleagues as role models who are willing to provide guidance. My study revealed that collegial support within the classroom or laboratory-based teaching, especially skills such as with perineal suturing and neonatal resuscitation, was helpful for developing confidence in practice and enabled early career midwives to support others. Midwives like one-on-one help in workshops to understand using the equipment, and appreciated the time that their interprofessional colleagues gave in these days. The practical hands-on learning with an experienced colleague or educator was the most beneficial part of study days, alongside the opportunity to connect with colleagues and reflect on experiences.

In the development of skills and knowledge to gain confidence, the organisation needs to be supportive and non-threatening, with a non-punitive approach to practice hands on skills (Bäck et al., 2017). An interesting finding from my study was that skill-based education was an interprofessional responsibility, especially the skill of perineal suturing. One of the skills highlighted in my study that midwives voiced their need for greater confidence with, and had an active curiosity to better themselves in, was perineal suturing. The participants were acutely aware that part of their scope of practice involves being able to diagnose and repair a perineal tear of first or second degree. The participants were aware of the responsibility and future implications of competency in perineal repair. Failure to do this accurately can increase a woman's/person's morbidity and have lifelong effects. However, my study found that perineal suturing was a skill that there was an inexperience and a lack of confidence, as a result of lack of exposure from the undergraduate education alongside the first

year of practice. Indeed, Hunter and Bick (2019) concluded that midwives' pre-registration education in perineal suturing is often inadequate, and there is inconsistency in the support for this skill development. However, when the participants in my study were offered one-to-one support from a colleague who stood beside them to guide them, their confidence in the skill grew exponentially. A study by Gray (2010) also found that professional development opportunities are needed to develop critical thinking and autonomy in the skill of perineal tear diagnosis and repair.

My study highlighted that it was beneficial for the midwife's confidence and skill development when she went on to teach and support the skill of suturing to students and other colleagues. Coughlan and Patton (2018) echoed the understanding that a mentor, or similar, was needed for opportunities for upskilling and shadowing to act in the role, thus offering educational opportunities for self-development and, further, supporting leadership in mentoring others in the skill.

Dream Summary – Colleagues who stand beside to guide

The physical presence of a colleague to offer physical guidance in practice will support skill and knowledge development and confidence to be autonomous. The support from a senior midwife who is approachable and accessible is essential. Identifying the skills that midwives need further support with, like perineal suturing and offering a readily accessible guide that has time to stand alongside, will further enhance professional development in complex skills for early career midwives.

The Role of a Preceptor

Preceptors traditionally were seen more in orientation to the unit role not clinical skills development. The allocated time with a preceptor differed related to workforce issues, not the needs of the midwife. Being supernumerary in the role is important for reliable support for the midwife when orientating to a new environment; yet the inconsistency of availability of the preceptor's time was a problem. When the midwives had not yet built their collegial relationships for support, the lack of a preceptor caused distress. Within my study, senior colleagues and charge midwives who helped the graduate midwife, even if they were not the designated preceptor, were equally as valuable. Many studies support my findings that preceptorship and mentorship assist in retention and sustaining midwives in their first year of practice to grow confidence, even when not formalised (Flinkman & Salanterä, 2015; Lennox & Foureur, 2012; Pairman et al., 2016; Price, 2009; Sullivan et al., 2011). The challenge that the current study highlighted was that availability of support within a high acuity unit with critical

staff shortages, means that accessing support for continued professional development within the workplace is inconsistent and dependant on the day and capacity of the unit and colleagues.

Dream Summary- Preceptors who connect

Preceptorship time needs to be protected and consistent for all midwives to have a safe and supported orientation to a new workplace or transition from student to midwife. Preceptors have an important role in helping the midwife make connections to colleagues to set up support networks for future practice. Having flexibility to meet the needs of the midwife will ensure confidence and competence in practice.

Study Strengths and Limitations

A strength of this study is that it is the first one in Aotearoa New Zealand to look specifically into the experiences of midwives in the early years of practice. Even if small, it will inform the body of literature outside of Aotearoa New Zealand and offers better understanding of what supports professional development in the early years for midwives. A further strength lies in the application of an AI lens, with the findings intended to be empowering and affirmative to maternity hospitals. Dysfunction exists in all organisations. In sharing my findings of what worked well, maternity hospitals can look to improve and promote positive change behaviours in the workplace (Hammond, 1998). Workforce challenges of high acuity and staff shortages are reflective of all maternity hospitals in Aotearoa New Zealand. Bringing one group of early career midwives from one maternity hospital gives the research findings more strength in having similarities of experience and workplace within the participant group.

The limitations of my study pose opportunities for further research. The study did not collect data on diversity factors such as ethnicity or gender. Within a bigger study it would be worthwhile to look into how specific target groups behave and interact for continued professional development. Groups such as Māori, rainbow community, disabilities, or other diverse or minority groups working in the midwifery workforce are likely to have common experiences and diverse needs. Including these groups would offer a more informed and accurate look into how the organisation supports continued professional development for those who identify within a minority and/or ethnic group. This would be particularly helpful in addressing inequities that exist within the health system and may be affecting the workforce's ability to progress professionally. The study was conducted in one maternity hospital in Aotearoa New Zealand; therefore,

the findings may not reflect the experiences of working in other maternity hospitals where the workforce and population that they service are different.

Design: What Should Be Ideal for the Organisation? Recommendations for Maternity Hospitals

Maternity hospitals are fraught with staff shortages alongside high acuity. The sustainability of its workforce needs to be addressed. In Aotearoa New Zealand, the unique environment means midwives have a choice to work in a community-based setting or employed in a hospital. This is a challenge for maternity hospitals in sustaining the workforce in both settings as midwives are transient between the two. Exciting and empowering midwives early in career is essential to grow the workforce and see future opportunities and pathways for employed hospital based midwives. Becoming a midwife is a constantly evolving journey, the learning is lifelong; however, the early years are instrumental to sustaining, retaining, and growing the midwifery workforce and inspiring midwives to be part of the long-term plans of the organisation.

My recommendations are:

- Regular opportunities should be provided to connect with the manager within the units [as part of the job description] to check in, debrief, and for joint goal setting and advancement strategies. Meeting yearly for QLP is not frequent enough.
- Midwives need to have time within work to debrief and reflect on the day. Implementation of a coach or supervisor with experience in the hospital, either identified by the early in career midwife or offered, is necessary. This person would work mostly the same shifts or crossover shifts, with work time allocated to debrief and reflect. Ongoing professional support past the first year needs to be strongly considered.
- When skills need further support and development, having a team or colleague that stands beside to guide and debrief, like a clinical coach, is recommended. Perineal suturing and neonatal resuscitation are such skills that are commonly identified and need regular one to one support to ensure ongoing confidence. Such guidance should be available to midwives who require extra support when moving between work places or returning to practice after time away.
- Maternity managers and policy makers should consider the culture of their units and make strategies to enhance and strengthen teamwork alongside professional individual recognition to grow the workforce and reduce attrition.

- Offer a perineal suturing educational practitioner support pathway within the hospital; have ‘specialists’ or coaches that are go to people to have one on one physical support and ongoing continued professional development to further support the skill. Have skill pathways on offer to develop the skill more strategically not by osmosis.
- Identify pathways and navigation for the midwife beyond the immediate unit (e.g., CCM). Make career opportunities visible and easy to access.
- As graduates enter the workforce and midwives transition out of the first year of practice, encourage self-individualised professional development plans and goals that recognise the experience and the diversity of skill and knowledge development.
- Facilitate training around effective functioning teams
- Training and education alongside debriefing and feedback to all preceptors, coaches, managers, and mentors within the organisations. Every staff member has a go to person that they self-identify to support practice. Within some cultures, like Pasifika, “aunties” are support people for students. This could be a similar initiative with a culturally appropriate word to mandate a colleague who is that go to person.
- The role description of a midwife needs to acknowledge time for debriefing, reflection on practice, advocacy, and whānau care.
- All midwives should have access to some form of funded supervision past the first year, with a non-punitive and more therapeutic approach. The Employee Assisted Programme is not appropriate when it cannot appreciate the context of the midwives’ work environment.
- Establish a clinical coach role in every unit, this will ensure added professional midwifery support in readily available to all midwives. A recommended job description has been developed from my study (Appendix K)

Destiny: How to Empower, Learn, and Improvise.

Recommendations for Future Research

- Establish an understanding of the career pathways midwives take into leadership positions from early career.
- Look to grow and provide education around professional support (i.e., coaches, supervisors in midwifery).
- Exploration of culture and ethnicity of midwives, and continued professional development support early in career.

- The implementation of a clinical coach role in Maternity hospitals.
- The experiences of early career midwives transitioning from the MFYP programme.
- Development and mastering the skill of perineal suturing in the early years—a structured skill development based approach.

Conclusion

Professional development is commonly understood to be a more formal and tangible approach that includes study days, workshops, quality leadership programmes, mentorship, and preceptorship. My study challenges this understanding of professional development and reveals that for the early career midwife, continued professional development considers the positive impact of organisations as a whole and the cultural value of trust from the organisation, managers, colleagues and the women, people and whānau. Continued professional development is how people function together to enhance self-progression.

Appreciative inquiry looks to discover what is working and functioning well within an organisation. Under the appreciative lens, my study revealed what is essential to support continued professional development in the early years of midwifery practice. The foundation that supports continued professional development is based on a trusting culture, approachable, trusted colleagues and a team approach to providing cultural safe care to women birthing people and whānau. When midwives see their workplace as positive, with a culture of shared behaviours and norms, like trust, they are likely to have job satisfaction and want to stay in the role (Catling et al., 2020). Continued professional development is multifactorial in the elements required for its success ; however, it is 100% dependent on human interactions and the team for the employed midwife working in a maternity hospital. Words of appreciation from colleagues, women/people and whānau, and actions of acknowledgment and physical support matter, thus making the stressful, challenging, sometimes scary workplaces a place for role progression, exciting professional opportunities, and empowering complex midwifery skill development. Recognising the impact of the interactions of midwives and how they function within a team, needs to be of high priority and acknowledged as a major contributor to sustaining and retaining the midwifery workforce. My study highlights that central to building confidence in skills and knowledge is collegial investment and support. However, with workplace complexities and workforce shortages, reliance on the midwife's collegial connections to access their support network by osmosis is not adequate and needs to be more formalised to

be equitable to all. Formalising the structure of teams and developing a clinical practice coach role will assist in essential professional support within maternity hospitals. It is of priority to sustain and retain highly skilled knowledgeable midwives, who choose a future working in maternity hospitals in Aotearoa New Zealand. To summarise, in the words of a participant:

> *I feel like my DHB (Maternity hospital) has worked exceptionally hard to make the environment positive. There is a kind of expectation that people get along with everyone; it's like a culture. All my feelings of growth and becoming confident are associated with my DHB, my colleagues and my mentors within my DHB.* (Maisy)

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Appendices

Appendix A: Interview Questions

Appendix C

Research Questions for questionnaire

Introduction

- I will explain an overview of my study, what I am doing and why.
- Explain the significance of the Appreciative interview and the fact that it focuses on what is best, not what is broken or not going so well.
- I will invite the participant to share stories and reassure them that all names and places will not be transcribed. The participant will be invited to choose a pseudonym that will be used on the transcription.
- I will explain that the recorded information will be transcribed and that they will get a chance to view, edit or add to the transcription before returning to me within four weeks.

1. **Stage setting questions**
   - Please tell me how many years you have been in practice post registration?
   - Please tell me what does professional development means to you working in your role?
   - What part of your job do you most enjoy? Why is this?
   - What do you value most about your role as a midwife? What about the people you work with? The DHB you work for?
   - Please describe your peak experience/high point in your career as a midwife?
2. **Topic questions**
   - Describe a time when you felt supported to advance your learning? What did it feel like? What was your contribution to this happening?
   - Tell me about a time that your colleagues contributed to your professional success and fulfilment at work?
   - Please explain to me a successful experience where you took the lead at work or developed a new skill? How were you supported to feel successful at this time? How would your DHB support your development to make this happen more frequently?
   - Your Hospital's core values are stated as ……, How do you see this playing out for you in your development and job satisfaction? Tell me an experience you encountered that demonstrates the core values of your maternity hospital? How do you see your role within the core values the hospital? How does the maternity hospital you work in, help you achieve these core values?

- Please describe to me what helped you transition from the supported structure of the midwifery first year of practice program into your second year and beyond? What is the most valued component you took with you from this program?

- Please tell me about a time when you felt supported to be an autonomous practitioner? What contributed most to this feeling of being autonomous? In an ideal world how would the DHB support you to specialise in an area that you like most about your job?

3. **Concluding Questions**

- Dream into the future, the hospital management has set up a structure to support your professional development and works in partnership with you. What does this look like? What three things have been done to create this healthy partnership between management and the Midwives?

- If you could have 3 wishes granted to support your professional development and enhance your job satisfaction. What would they be?

Or

- You have fallen asleep for a very long time. Ten years have passed. As you awake you discover that everything you have hoped for and dreamed of, for your role as a midwife, in your DHB supporting your growth and development has come true. What do you see?

Extra Question to consider

- Think of a colleague that made a difference to you?
- When you see midwives take the lead role, how is this done positively?

Appendix B: AUTEC Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

29 August 2019

Marion Hunter
Faculty of Health and Environmental Sciences

Dear Marion

Ethics Application: 19/317 **The experiences of early career midwives that supports their professional development while working in maternity hospitals**

I wish to advise you that a subcommittee of the Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application.

This approval is for three years, expiring 27 August 2022.

Non-Standard Conditions of Approval

1. On the Information Sheet please advise that participants may have a support person with them at the interview;
2. On the recruitment advertisement please insert the AUTEC approval wording.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: brigid.beehan@aut.ac.nz; andrea.gilkison@aut.ac.nz

Appendix C: DHB/Hospital Approval Letter

COUNTIES MANUKAU HEALTH

Research & Evaluation Office
Level 1, Ko Awatea, Middlemore Hospital
100 Hospital Road, Otahuhu; Private Bag 93311, Auckland – 1640
cmdhb.org.nz – koawatea.co.nz

11 October 2019

For the attention of: Brigid Beehan and Cate Johns

Thank you for the information you supplied to the CM Health Research Office regarding the following research proposal:

Research Registration Number: 1074

Ethics Reference Number: 19/317

Research Project Title: The experiences of early career midwives that support their professional development while working in maternity hospitals

I am pleased to inform you that the CM Health Research Office has received all the required service lead approvals and the Chief Medical Officer's final sign-off for this research project, which has Brigid Beehan named as the Principal Investigator and Cate Johns named as the CM Health Facilitator.

This CM Health locality approval is valid until 30 June 2021, which is the date specified on your registration information.

All external reporting requirements must be adhered to. Please note that failure to submit amendments and Annual Progress reports may result in the withdrawal of Ethical and CM Health Organisational approval.

FINAL REPORT: It is a requirement of the CM Health Research Policy that all research and audit projects conducted within CM Health should have a written final study report submitted no later than 3 months following completion of the study. This report is to be uploaded to your study file on the Registry and is viewable by CMDHB staff. Contact us for the report template or download it from the Registry.

Yours sincerely

Angela Bennett
Research Coordinator
Counties Manukau Health
Under delegated authority from CM Health Research Committee and the Chief Medical Officer

Appendix D: Verification of Māori Consultation

School of Clinical Sciences
Mātauranga Māori Committee

Verification of Māori Consultation

This document provides verification that the research project named below was discussed with the School of Clinical Sciences Mātauranga Māori Committee, AUT. Specific comments and recommendations are indicated below.

Title of project: The experiences of early career midwives that supports their professional development while working in maternity hospitals.		
Research Team members and affiliations: Brigid Beehan, Marion Hunter, Andrea Gilkison		**Meeting Date:** 04/09/19
Discussion Areas	**Discussed**	**Comments/ Recommendations** (see next page)
Whakapapa: Relationships		
Researcher experience in field	X	
Consultation with local stakeholders	X	R2
Consenting process	X	
Clarity of data usage	X	C1
Dissemination of findings	X	
Benefits to participants	X	C1
Tika: Validity of the research		
Clear purpose of project	X	
Relevance to Māori	X	R1
Likely outcome for participants, communities, other stakeholders	X	R1
Participant recruitment methods	X	C2,3, R1,2
Māori involvement in project (participants, researchers, etc.)	X	C2, R1,2
Manaakitanga: Responsibility and respect		
Participants' access to appropriate advice	X	R4
Participants treated with dignity and respect	X	C4, R3,4
Privacy and confidentiality		
Whānau support	X	C4
Transparency of research process		
Mana tangata: Power & Authority		
Reciprocity (acknowledgements, compensation, gifts)		
Risks of participation identified	X	C4, R3,4
Ownership of outcomes		
Informed consent process	X	R4

Comments from applicant/s

1.	Brigid noted that many people leave the DHB environment, or the profession, due to negative experiences. As such, this research aims to draw on the positive to inform the development of nurturing environments.
2.	She is not specifically targeting Māori per se but is keen to involve Māori.
3.	Intends to recruit via Counties Manukau via the DHB sponsor. Brigid is under the impression that the named DHB sponsor needs to lead recruitment.
4.	Face to face interviews will be carried out in an environment of the participants choosing, with strategies in place to diffuse the inherent power imbalance. Participants may chose to bring a support person.
5.	She aims to do 6-10 interviews (with supervisors suggesting the lower end of that range to be more feasible).

Recommendations made by Committee

1.	We suggest a more active and targeted recruitment strategy to optimise the likelihood of involving Māori e.g. purposefully sample to ensure Māori involvement. This topic has the potential to have significance for Maori and so it will be important to capture culturally-specific perspectives (especially if considering the need to retain Māori midwives in the profession).
2.	Seek out a diversity of recruitment avenues e.g. via DHB Māori services, Māori midwifery teams. It may help to do a presentation to midwifery teams in the DHB to help them put the research into the context, as well as get to know you as a person. The DHB sponsor is only the person who has administrative responsibility for ensuring the research is consistent with what is approved by the DHB and so on. They do not need to be the only person engaged in recruitment. They may be able to help connect you with key people in the DHB however.
3.	The committee queried the context in which some kupu were used in the application and urges caution when using kupu in future – ensuring clarity of understanding re: meaning and context of use. Building on this, we suggest thinking carefully about exactly how you will operationalise some of the key ideas in your study processes e.g. How will you respect tikanga? How will mana be upheld? How will whakapapa be acknowledged and reflected in your approach, interpretation of findings? And so on.
4.	It can sometimes help to have someone present to provide cultural support (to you and for the participant) during the interview, as well as provide support in making sense of kupu and culturally-located concepts in the interpretation and analysis. We would recommend seeing if there is someone who could work with you in this way.

Please contact Gwyn Lewis gwyn.lewis@aut.ac.nz if you have any questions about this feedback.

You may be contacted in 12 months' time for feedback about the process and the usefulness of these comments and recommendations to your project.

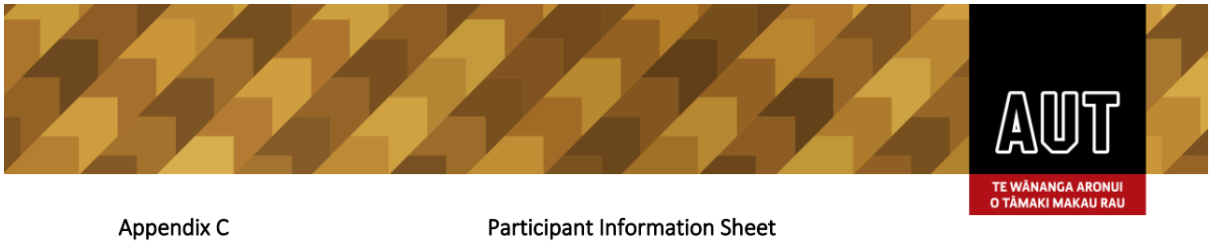
Signature:  Date: 04 September 2019

Nicola Kayes
Mātauranga Māori Consultation Committee

Appendix E: Poster 1

Appendix F: Poster 2

Appendix G: Participant Information Sheet



Appendix C Participant Information Sheet

Date Information Sheet Produced: 19/8/19

Project Title

Experiences of early career midwives working in maternity hospitals that supports their professional development.

Kia Ora,

Thank you for your interest in being a participant in my study.
I currently work as an LMC Midwife, midwifery first year of practice mentor and midwifery educator. I am undertaking this research study as part of the fulfilment of the requirements for a Masters in Health Science in Midwifery at AUT. My interest around my topic has come out of my experience working as a core midwife. I am interested in your experiences of working within a maternity hospital, and what supports your professional development.

What is the purpose of this research?

My research intends to explore the positive experiences that support employed midwives in their role, including aspects that contribute to job satisfaction. This is to answer the research question; 'What are the experiences of early career midwives that support their professional development in maternity hospitals in Auckland'?
It is my desire that the information will help to uncover what supports the professional development of midwives, working in maternity hospitals beyond the first year in practice.
The findings of this research will contribute to data for my masters' thesis and may be used to contribute to academic publications and presentations. It would be my intention to inform participants, managers, midwives and policy makers of findings from my study.
I have developed a keen interest in what supports professional development for early career midwives working in maternity hospitals. My understanding is that maternity hospitals are currently experiencing critical staff shortages and high turnover of staff. Each maternity hospital has a first year practice program for a minimum of 12 months providing support, preceptorship and education. However, what supports midwives after the first year of practice has not been researched in any depth.

The positive focus of this study, in keeping with the research question, allows an affirmative approach to informing midwives, managers and policy makers. The study will highlight positive aspects already in action with recommendations for how to enhance the professional development of midwives in maternity hospitals.

How was I identified and why am I being invited to participate in this research?

Thank you for taking the time to get in contact. As you have received this information sheet, you will ;

- Have spent at least one year in hospital based employed practice

- Be within five years of practising as a midwife
- Work within Auckland area maternity hospitals.
- Have **not** been mentored by me in the Midwifery First Year Practice program

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible. After you have received the information form, if I have not heard back from you within four weeks, I will follow up your interest with a phone call.
Prior to the interview, I will invite you to complete a consent form, to ensure that you understand what you are participating in.

What will happen in this research?

Should you agree to take part in my research study, you will be invited to meet with me for an interview that will last 30- 60 minutes. The interview will be in a private space, either at AUT, your home or a quiet place of your choice, at a time convenient to you. You have the choice to have a support person present at the interview if you wish.
Each interview will be audio-recorded and transcribed, with you choosing a pseudonym in replacement of your own. The Maternity hospital that you work in will remain confidential. I will refer to the hospital as 'the maternity hospital'. I will not reveal the names of participants in this study to any other person. I will always maintain privacy, regarding the identity of all midwife participants. There will be time for any follow-up questions throughout the interview and afterwards.
After the audio- recording has been transcribed you will be provided with a copy of the transcript and given the opportunity to make comments, add or delete parts of the transcription of your interview.
At the completion of my master's thesis, I will provide you with a summary of the research findings and a link to my thesis.

What are the discomforts and risks and how can they be alleviated?

While midwifery experiences have the potential to cause discomfort, the methodology chosen for this study focuses on positive experiences encountered by you. This approach minimises risk of discomfort or embarrassment, if for any reason you feel this way we can stop the interview, reschedule or give you the time to talk about this if you wish.

What are the benefits?

This research hopes to explore the positive experiences that impact on your professional development as a midwife working in the maternity unit.
The projected benefits are;

- You will have an opportunity to talk about positive experiences that support you in practice.
- District Health board employed midwives, managers and policy makers will have knowledge about what is currently working and what positively supports early career midwives staying in their hospital-based midwifery role.

- As a consequence of this study and the methodology chosen, I will be providing recommendations that are affirming, energising and appreciative for early career midwives and managers.
- Your participation assists me in the completion of my Masters of Health Science in Midwifery.

How will my privacy be protected?

Protecting your privacy and maintaining confidentiality is of upmost importance for me. The pseudonym that you choose will be used in the transcription in replacement of your own name. I will not identify your workplace within the data.
Confidentiality will be assured throughout this study and beyond. I will not identify that you have participated in my study. A transcriber will type up the interview data; she has signed a confidentiality agreement.
The consent form you sign will be stored separate from the transcriptions and locked in the supervisor's office.

What are the costs of participating in this research?

The research interview will require 30-60 minutes of your time; alongside potential travel time should you wish to travel to a quiet venue for the interview.

What opportunity do I have to consider this invitation?

Your participation in this study requires you to contact the researcher to express your interest. If after reading the information sheet and agreeing to be part of the study, the interview would take place within one month, at a time suitable to you.
If you are interested in participating in the study, we will plan a time to meet, at a place convenient and comfortable for you to conduct the interview.

Will I receive feedback on the results of this research?

Yes. I will send you a condensed summary of the findings and a link to my thesis. Results of this project may be published in midwifery related journals and presented at midwifery related conferences.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Marion Hunter *mhunter@aut.ac.nz* ph. 09 921 9999 ext. 7365
Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 09 921 9999 Ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:
Brigid Beehan *brigid.beehan@aut.ac.nz* *021 718 617*

Project Supervisor Contact Details:

Marion Hunter *mhunter@aut.ac.nz* 09 921 9999 Ext 6038.

Approved by the Auckland University of Technology Ethics Committee on *29 August 2019*, AUTEC Reference number *19/317*.

Appendix H: Consent Form

Consent Form

Project title:

The experiences of early career midwives that supports their professional development while working in maternity hospitals.

Project Supervisor: Marion Hunter

Researcher: Brigid Beehan

- ○ I have read and understood the information sheet provided by Brigid Beehan about this research project in theInformation Sheet dated_____.
- ○ Brigid has given me an opportunity to ask questions and to have them answered.
- ○ I understand Brigid will that notes during the interviews and that it will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings havebeen produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 29 August 2019 AUTEC Reference number 19/317

Note: The Participant should retain a copy of this form.

Appendix I: Safety Protocol

AUCKLAND UNIVERSITY OF TECHNOLOGY ETHICS COMMITTEE (AUTEC)

Guide for drafting a Researcher Safety Protocol

DEFINITION & PURPOSE:

This is a guide to drafting a Researcher Safety Protocol and needs to be adapted for each research project.

Researchers need to assure their own safety as well as that of their participants and research assistants. The main purpose of a researcher safety protocol is to assess the level and likelihood of risk and to provide appropriate arrangements to minimise and manage those risks.

Situations in which researcher safety is likely to be at risk may include times when:

- *researchers are visiting the homes of others;*
- *researchers are undertaking sensitive research in a manner that puts them at personal risk;*
- *researchers are undertaking research in hazardous conditions;*
- *researchers are undertaking their research in a social or cultural setting with which they have minimal familiarity;*
- *researchers are involving people who pose a higher risk than would normally be the case (e.g. people with a known propensity for violence);*
- *the study impinges on the vested interests of powerful persons;*
- *the study is subject to the exercise of coercion or domination (e.g. where the research is about social conflict or where participants may face political threat, discrimination or stigma);*
- *there is an increased exposure to everyday risks (e.g. accidents, illness).*

Researchers may find it useful to read this research about levels of violence towards researchers in the field (QUALITI (NCRM) COMMISSIONED INQUIRY INTO THE RISK TO WELL-BEING OF RESEARCHERS IN QUALITATIVE RESEARCH by Bloor, M., Fincham, B., and Sampson, H.)

The following questions may be used to help write a protocol that is relevant to the context of the research.

Project title and brief description:

The experiences of early career midwives that supports their professional development while working in maternity hospitals.

This research will ask the question "What are the experiences of early career midwives that support their professional development in maternity hospitals in Auckland?" The research aims to assist in understanding of what sustains early career midwives and supports their professional development, contributing to job satisfaction and future careers in the DHB. The Research participants are early career midwives who; have spent at least one year in hospital practice, are within five years of practising as a midwife and work within Auckland area maternity hospital. Data will be collected, through face-to-face semi-structured interviews, which will take approximately 30- 60 minutes. The methodology is appreciative inquiry so the focus is on what the successes and positive experiences are for the midwife. Research findings will be presented to the midwife participants, maternity managers and leaders, as well as the wider national and international midwifery community.

Applicant

Marion Hunter

Primary Researcher

Brigid Beehan

Where is the research being undertaken?

The research will take place at an agreed place, either in the participants home, AUT or workplace. The researcher has her own car, and will use this to travel to the interview location. The participant will be invited to have any support people or whanau at the interview.

Who will be collecting the data and interacting with participants?

The researcher will be collecting the data and interacting with the participant during the interview. There is no other people attending with the researcher.

How familiar is the researcher with the social or cultural context of the research ?

What language support is needed? None

What local tensions are there? None known , unlikely to be

How strongly active are any cultural, religious or racial divisions? Not likely

What do local sources, such as the police or local leaders, say about risks in the research area? Unknown at this stage

Which local 'community leaders' have been spoken with to explain the research and gain their endorsement? None

The researcher is a midwife herself and is very familiar with the social context of her participants and colleagues. The researcher has worked alongside midwives for 20 years and has familiarity with a wide range of cultural contexts of midwives. Consultation will be with, AUT Ethics committee, DHB Ethics (pending on AUT ethics approval) and *Mātauranga Māori Committee (planned 4/9/19).*

How safe are the activities in which the researcher is taking part?

Does the research involve sports or activities that may be hazardous in nature? No

What safety protocols are in place? This one only

Will sufficient qualified personnel be in attendance to supervise the activity or respond swiftly to any emergency? Not needed

There are no safety issues anticipated by the researcher other than that of attending the home of the participant.

What level of access to support is available?

Who will be available to provide assistance should it be required? Not needed

How will the researcher ensure that those providing support will be aware of any need that arises?

What will those providing support do if it is needed?

The researcher does not anticipate that support will be needed. The researchers partner will be notified in the case of a safety issue and academic support will be given by the named supervisors. If support at the home is needed the police will be notified to assist.

What emergency plans are in place? Who can help?

What training or support is needed and how will it be accessed? Not needed

What University policies are relevant to your project? Have you read and understood them? Not needed

How have significant local actors, such as statutory and community organisations been contacted? Not needed

Who has been in touch with potential participants and what advice have they given?

Who else is aware of the researcher's itinerary and research schedule? The researcher's partner

How will the researcher keep key support people informed of what is happening?

How will key support people react if the agreed contact protocols are not followed?

The participants have contacted the researcher after seeing a poster in their workplace. The participant has been emailed an information sheet and a consent form prior to committing to the research, with the opportunity to contact the researcher with any further questions or to organise the interview. Contact from the researcher will be by phone or email. As the interviews may take place in the home, this exposes me with some degree of unknown risk. I will text my partner prior to the interview and after. My phone has a find my iphone app and I am connected to life 360 so my where about is identifiable by this.

Don't forget to update your safety protocol regularly:

Date for next review

20 Nov 2019

Appendix J: Transcriber Confidentiality Agreement

Confidentiality Agreement

Project title

The experiences of early career midwives that supports their professional development while working in maternity hospitals.

Project Supervisor: Marion Hunter

Researcher: Brigid Beehan

√ I understand that all the material I will be asked to transcribe is confidential.

√ I understand that the contents of the tapes or recordings can only be discussed with the researchers.

√ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....Shoba Nayar .....

Transcriber's Contact Details (if appropriate):

Email: snayar19@gmail.com.....

.....

.....

Date: 19th August 2019

Project Supervisor's Contact Details (if appropriate):

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Approved by the Auckland University of Technology Ethics Committee on 29 August 2019 AUTEC Reference number 19/317

Note: The Transcriber should retain a copy of this form.

Appendix K: Clinical Practice Coach Job Description

Midwifery Clinical Practice Coach - Job Description

The successful Midwife will have a kind, enthusiastic, positive attitude and a commitment to supporting and guiding midwives in clinical practice. The Clinical Practice Coach role will support midwife practitioners to work effectively and inclusively as part of the team, feeling confident and competent with clinical skills and knowledge working in the Maternity unit.

There will be a specific focus in the support role in advising, assisting, and guiding midwives (employed and LMC midwives) with clinical skills and knowledge development to work within the team who are.

- Transitioning from the first year of practice programme
- Within the first five years of practice
- Transitioning between clinical areas
- Returning to practice after time out of the midwifery workforce
- Developing an individualised professional development plan to support role advancement and specialisation.
- Needing guidance and support following an unexpected event/outcome

The role will involve supporting one-to-one skill development, debriefing, and guiding practice, to build confidence and competence in individual midwifery knowledge and skills. The clinical practice coach will have a close working relationship with the Maternity manager, educators, and preceptors. They will work alongside the midwife to develop an individualised continued professional development plan with joint goals and advancement strategies.

The Clinical Practice Coach will have well developed, positive communication skills and confidence in debriefing and reflecting with colleagues. They will work effectively and safely within a team, supporting diversity from all ethnic and minority groups inclusive of Māori, Pacifica and the rainbow community.

The clinical practice coach role will be supernumerary to the allocation for the unit, to work with midwives and teams in the clinical practice environment. The role requires the specialist midwife to be responsible for supporting midwives with their

knowledge and skills development to reduce stress and increase retention in the workplace. The clinical practice coach will strengthen and support effective teamwork alongside midwives' individualised continued professional development.

As the Clinical Practice Coach you will;

- Have a current annual practising certificate [APC] with no restrictions
- Engage in all the mandatory requirements set out by the Te Tatau o te Whare Kahu- Midwifery Council as part of the requirements to maintain an APC
- Have 5+ years in practice, with experience and expertise in midwifery skills and knowledge
- Show well-developed clinical and cultural competence.
- Be flexible with work shifts aligned to the needs of the workforce.
- Be culturally safe and competent in practice, practice and respect the principles of Tūranga Kaupapa and the organisations values.
- Uphold te Tiriti o Waitangi practice, having an understanding and commitment to the delivery high, quality, cultural safe and equitable care for the interprofessional team, women, people and whānau
- Be experienced in and committed to collaborative team-based leadership.
- Have experience in preceptorship and/or mentoring and/or as a reviewer.
- Knowledge and/or training in debriefing and giving effective, culturally safe feedback.
- Have experience working with individualised professional development plans with engagement in and/or completion of postgraduate qualification.

It would also greatly benefit the role if you have;

- Annual NZRC NLS course completed in last 2 years or NZRC NLS Instructor qualification
- Perineal suturing education within the last two years
- Annual cultural safety education engagement
- Completion or currently engaged in Postgraduate qualification in midwifery education or supervision.

The Clinical Practice Coach will be working in a team with other Clinical Practice Coaches and will meet on a regular basis to identify and support the needs of the preceptors, educators, and the wider midwifery teams. Being able to work well on a one-to-one basis and as part of a team, with confidence in giving guidance and feedback that is empowering and supportive to ongoing practice development is essential.