CASE STUDY

Developing confidence in competence: My experience of the Midwifery First Year of Practice programme

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ABSTRACT

Background: Confidence and competence do not always co-exist in the context of a new graduate midwife. Being competent does not always mean being confident and vice versa. In New Zealand, the Midwifery First Year of Practice (MFYP) programme supports new graduate midwives through their first year of practice.

Aim: This paper examines the concepts of competence and confidence in the context of my experiences as a new graduate midwife in New Zealand, participating in the MFYP programme. The four aspects of the MYFP programme are identified as they relate to my experience. These are: clinical practice, one-to-one mentoring, funded education/professional development and quality assurance, with the focus being on the mentoring aspect of the programme.

Discussion: Using published research about transition programmes alongside my experience of the MFYP programme, I identify my individual challenges during my transition year and how the individualised support available to me through the MFYP programme helped me to meet those challenges.

Conclusion: Whilst there is no clear demarcation point between being a graduate and becoming a confident midwife, my experience suggests that building confidence in the first year of practice is a very individual journey. I believe the MFYP programme successfully supports a graduate's transition from a competent to a confident midwife.

Keywords: competence, confidence, Midwifery First Year of Practice, mentoring, graduate, midwifery practice

INTRODUCTION

Competence comes in various forms and is identified as a core component of professional clinicians (Hodges & Lingard, 2012), with maintaining competence identified as a vital characteristic of the professional midwife (Calvert, Smythe, & McKenzie-Green, 2017). The Midwifery Council of New Zealand (2005) defines competence as, "the ongoing capacity to integrate knowledge, skills, understanding, attitudes, and values within the professional framework of the Midwifery Scope of Practice" (p.6). Within midwifery there is an expectation that midwives can work competently in all areas at all times (Edwards et al., 2016); however, the need and motivation to maintain overall competence depends on the midwife (Calvert et al., 2017).

Confidence is often related to competence; however, they do not always co-exist. Confidence is defined as a feeling of self-assurance arising from an appreciation of a person's own abilities or qualities (Oxford Dictionary of English, 2010). The concept of confidence is an essential part of the transition from undergraduate student to midwife, through gaining confidence in their demonstrated competence. Factors such as the influence of colleagues, perceived autonomy and a sense of familiarity can contribute to enhancing confidence (Bedwell, McGowan, & Lavender, 2015).

Bradshaw, Noonan, Barry and Atkinson (2013), in their descriptive qualitative study of post-registration Irish student midwives' experiences of the competency assessment process, describe competence and confidence in midwifery practice as:

> *. . . involving continual interaction between skills, abilities, and knowledge in a wide variety of maternity settings which attempts to capture concepts of capability, performance, elements of critical thinking and personal attitudes in which a midwife practices. (p.521)*

These findings are congruent with much of the international literature focusing on clinical competency models. The New Zealand College of Midwives (2016) describes a confident midwife as a midwife who is working in partnership with women across the Midwifery Scope of Practice; promoting and facilitating the physiological processes of pregnancy and childbirth; identifying complications in mother or baby and working in collaboration with other health professionals to ensure appropriate care; managing emergency situations; informing and preparing women and their families for pregnancy, birth, breastfeeding and parenthood; facilitating the interface between primary and secondary/tertiary maternity services when necessary; and working autonomously and remaining responsible and accountable for the care provided in all settings. The graduate is expected to be confident and meet the confident midwife profile by the completion of their first year of practice (p.19).

This aim of the article is to examine the concepts of competence and confidence in the context of my experiences as a new graduate midwife in New Zealand who has participated in the Midwifery First Year of Practice (MFYP) programme. I focus predominantly on developing confidence during the first year of practice and the role of the MFYP programme.

Developing midwifery competence to enter the register

The New Zealand midwifery education model prepares students to achieve the four competencies for registration as a midwife that are set out by the Midwifery Council of New Zealand. These competencies encompass the core elements of how "a registered midwife is expected to practise and what she is expected to be capable of doing" (Midwifery Council of New Zealand, 2007, p.1). Gilkison, Pairman, McAra-Couper, Kensington and James (2016), in their review of the New Zealand midwifery education model, believe the model produces "competent, confident midwives able to work across the scope of practice on their own responsibility" (p.33). However, the concepts of competence and confidence are not mutually assured and may vary at the point of graduate registration (Davis, Foureur, Clements, Brodie, & Herbison, 2012).

Graduates must be deemed competent to be entered into the Midwifery Council's Register of Midwives; however, they may not feel confident at that time. While research confirms that the current midwifery education model appears to produce competent midwives, graduates need to gain or increase their confidence in their practice over time (Lennox, Jutel, & Foureur, 2012). Skirton et al. (2012) in their prospective, longitudinal, qualitative study of 35 midwifery graduates in the United Kingdom (UK) discovered there was a perceived lack of confidence in the graduates' abilities to make decisions based on clinical assessment. Whereas, in a survey of New Zealand midwifery graduates, Kensington et al. (2016) found a similar lack of confidence but that it "more frequently stems from a lack of experience rather than a lack of competence or knowledge" (p.20). Clark and Holmes (2007) in a qualitative exploratory study of UK nursing students suggest that competence is linked to confidence in clinical skills and argue that situations which build the graduates' confidence will impact positively on their competence.

I graduated from the new model of midwifery education that Gilkison et al. (2016) discuss and felt I had achieved the competencies needed to be entered into the Register of Midwives; however, my confidence was low when transitioning to a graduate. This was predominately related to clinical skills and autonomous decision making. I felt confident working in partnership with women and knew that I was a competent midwife but lacked the confidence that comes with experience.

Transition to practice programmes

A well-designed transition support programme can play a significant role in assisting graduates to confidently take up their position as registered practitioners (Banks et al., 2011; Clements, Fenwick, & Davis, 2012). Evidence shows that such programmes decrease work stress and anxiety regarding the realities of being a midwife (Chen, Duh, Feng, & Huang, 2011), and improve graduates confidence in their competence due to being supported throughout the first year of practice (Bratt & Felzer, 2011; Kitson-Reynolds, Ferns, & Trenerry, 2015; Park & Jones, 2010). Avis, Mallik and Fraser (2012) researched the transition experiences of UK graduates as recorded by their diary writing and found the "the growth of confidence is linked to support and feedback on acquiring and improving clinical skills, helping them settle into their role" (p.1068). A graduate's ability to successfully transition from undergraduate student to midwife is important from both a personal and professional perspective (Clements et al., 2012).

The challenge for the New Zealand midwifery profession was to develop and provide a transition programme that met the individual needs of graduates within New Zealand's context of maternity care (Kensington et al., 2016). New Zealand's maternity system is designed to provide women-centred continuity of care, regardless of place of birth (Pairman et al., 2016). Graduates may be a hospital- or community-based midwife, choosing the one which best suits them and their lifestyle. Movement between these two roles is fluid, with some midwives working in both roles simultaneously (Grigg & Tracy, 2013).

In many countries hospitals employing graduates, regardless of profession, provide a graduate programme. However, such a hospital-based programme would not work with the self-employed model of community midwifery care that New Zealand's maternity system works on. New Zealand required a transition programme that would work regardless of whether the graduate's choice of workplace was a hospital or the community.

The New Zealand Midwifery First Year of Practice programme

The MFYP programme commenced in 2007 as a fully funded national scheme, aimed at providing a structured yet individualised programme of support to meet the needs of the graduate, wherever they chose to work. Although participation was encouraged, it was not made compulsory until 2015 (Dixon et al., 2015).

The programme has four main components of support. These are: support during clinical practice, ongoing education, formal mentoring, and reflection and review through the Midwifery Standards Review (MSR) process. Essentially, it provides the opportunity for graduates (self-employed or employed) to access funded education, activities and professional development opportunities to consolidate their knowledge, skills and clinical competencies acquired during the undergraduate midwifery education programme, together with a supportive environment through one-to-one mentoring. It concludes with preparation for, and participation in, a MSR at the completion of their first year of practice.

Element one: consolidating midwifery clinical practice

Consolidation of skills and knowledge forms an integral part of the transitional journey for graduates during their first year of practice. The transition from being an undergraduate student to a confident midwife can be challenging. Adapting to new environments, changing dynamics in existing professional relationships and differing expectations within their role can cause insecurity, fear and stress (Dixon et al., 2015; Wain, 2017). Choosing the work setting that suits graduates' individual circumstances is an important part of consolidating and developing midwifery practice (Pairman et al., 2016).

My experience

For me, working in the hospital suited my personal circumstances, and the small rural secondary unit where I was employed, which was midwifery led, aligned with my midwifery philosophy. However, this was in a region new to me. I had no history and no existing professional relationships there.

Starting as a graduate in a new environment meant that I had to adapt, whilst simultaneously establishing professional relationships with both midwifery and medical colleagues, understanding the dynamics of the unit, its unfamiliar policies and guidelines, and

the culture of a rural secondary unit. During this time, I also had to prove my knowledge and skills to my colleagues to build their confidence in my abilities, whilst also consolidating my practice skills and identifying opportunities for further skill development.

In many ways this felt like an initiation rite which I had to pass before being accepted by my more experienced midwifery and medical colleagues. This process took approximately six months and within those six months I took every opportunity available to understand the culture of the unit and forge professional relationships. This included attending social events, professional events, journal clubs and in-service education. I often volunteered to be the second midwife at births, which provided the community-based midwives with the opportunity to get to know me and my practice and build professional trust. Despite the challenges involved in this "initiation period", I still felt supported by the midwifery and maternity community. My manager and educator gave me opportunities to attend meetings and workshops to further develop knowledge and skills alongside other clinicians such as obstetricians, paediatricians, anaesthetists, lactation consultants, pharmacists and social workers; all of who helped me to develop inter-professional communication and collaboration skills and enabled opportunities for referral and multi-disciplinary care experience.

Towards the end of my first year of practice, I was given the opportunity by my manager to do shifts in a nearby tertiary hospital's birthing suite. The aim was to consolidate my secondary and tertiary knowledge and skills. This clinical experience was a major influence on my practice because it helped me to realise that I preferred to work in a lower level care environment. It also helped me to understand that I had increased my confidence in my existing skills and developed a stronger midwifery philosophy. This meant that, in practice, I looked for opportunities to support the woman's physiology and work in ways that support the woman to birth normally where possible.

Element two: Funded education & professional development

Continuing professional development is vital to maintain competence and confidence (Hundley et al., 2007). However, rural midwifery brings with it its own challenges to accessing education. Crowther (2016), in a qualitative study exploring rural and remote rural midwifery in New Zealand, found these to be or include "geographic location, on-call demands, travel, accommodation, course costs, poor local resources (libraries, broadband access) and lack of provision of locum cover for mandatory and elective educational days" (p.30).

Within the MFYP programme all graduate midwives are required to undertake elective and compulsory education. The focus of the education component is on consolidation of the knowledge, skills and experience acquired in the midwife's undergraduate programme, with up to 80 hours of funded education. All graduates are required to have a written professional development plan that includes well-defined goals and specific education outcomes.

My experience

I identified the need to increase my knowledge and skills related to various practical skills such as IV cannulation, suturing, labour and birth, and complicated postnatal care. I dutifully made my way to workshops and study days, completing requirements and reaching the goals that I had set.

The MFYP funding for elective and compulsory education was important because often the workshops and courses that I needed to attend were held in cities or towns outside of the region. The funding allowed me to access these courses when I would not have been able to financially afford to attend otherwise. Attending the elective and compulsory courses increased my confidence in my clinical skills and decision-making, especially regarding physiological labour and birth, emergency management, suturing, IV cannulation, prescribing and documentation. This in turn increased my confidence to take future opportunities to continue developing these skills.

Element Three: One-to-one mentoring

A formal mentoring structure is one of the crucial characteristics of a successful transition support programme identified by Ulrich et al. (2010) in their 10-year longitudinal study of nursing graduates in a resident programme in the United States. Within midwifery the concept of mentoring has been well established for centuries through the historic apprentice-style training (Stojanovic, 2008). The MFYP mentoring is a partnership established with an end purpose and is defined by the New Zealand College of Midwives (2000) as "one of negotiated partnership between two registered midwives. Its purpose is to enable and develop professional confidence" (p.1). Both parties are engaged in the process which resonates with the partnership model of midwifery care in New Zealand. Pairman et al. (2016) and Dixon et al. (2015), in their evaluations of the MFYP programme, both concluded that finding the right mentor was vital to a successful mentoring relationship and supportive of a positive transition.

My experience

I found this important element of the programme initially problematic because I had moved into a new area and therefore did not know any of the available mentors. Usually, students can identify who they would like as their mentors during their undergraduate programme. I was unable to do this so had to put my trust in a mentor that I did not know. However, once I got to know her philosophy and teaching style, it was soon apparent that she was an experienced mentor with a lot to offer and the ability to provide the support and encouragement that I needed.

Mentors have a responsibility to listen, challenge, support and critique graduates to empower and encourage them to research, explore and reflect on their own practice (New Zealand College of Midwives, 2000). The mentoring relationship lasts 12 months and is focused on planned goals and expectations that are defined by graduates based on their unique learning needs (Kensington, 2006). Mentors also play a significant role in assisting the graduate in setting goals, debriefing and identifying areas for further learning.

The importance and value of the mentor became clear for me at the six-month mark when I hit a confidence roadblock and a make-or-break point professionally. I had, up to this point, had very limited exposure to labour and birth post registration, whereas my confidence in antenatal and postnatal care was high. It was then that my mentor became my biggest advocate and a plan was put in place to help me move past this roadblock. A great deal of time was spent discussing ways and means of how to get involved in care and not just feel like the ward cleaner or the postnatal midwife caring for the new mother and baby on the ward. I needed to put myself out there, work on relationships with the community-based midwives, gain their trust in my abilities and feel worthy of my role and connected to my scope of practice in the midwifery world.

With the support of my manager, my mentor approached a lead maternity carer (LMC) midwife, and encouraged her to invite me to gain experience from the consenting woman, by helping her midwife. After this, invitations came from other community midwives to help them care for women having inductions or to cover for short spells with women who required secondary care, if

these women had given consent for my involvement. Having this experience increased my confidence and was the turning point I needed. This was thanks to the support of not just the mentor, but also my midwifery colleagues, and it opened more opportunities for me to continue to develop my clinical practice.

Having a mentor who was there no matter what, someone who encouraged, supported, challenged and advised me during this first year as a midwife was invaluable. Being able to challenge her back (the mentor), as well as be challenged, gave me confidence in my knowledge, decision making and professional interactions.

In 2015 Midwifery Practice Support was introduced to provide all graduates with the opportunity for clinical support whether or not the mentor is available when needed ((New Zealand College of Midwives, 2016). This had not been available during my MFYP year.

Element Four: Midwifery Standards Review

New Zealand College of Midwives (2016) describes a Midwifery Standards Review (MSR) as:

> *A process of reflection, assessment and education . . . and reflects the midwifery profession's partnership with women as well as the requirement for the midwife to be professionally accountable to herself, the women for whom she cares, the profession and the wider community (p.37).*

All graduates are given the opportunity to self-reflect and explore their midwifery practice, identify their strengths and weaknesses, and advance their professional development plan to help achieve their goals. Takase, Yamamoto, Sato, Niitani and Uemura (2015) found, in their cross-sectional survey of the relationship between workplace learning and self-reported competence of nurses and midwives in Japan, that confidence may impact on midwives' self-evaluation of their competence and that learning from reflection may be useful through acknowledging a positive view of one's own competence. The MSR attended during the first year of practice is funded as part of the MFYP programme. The mentor assists in preparing the graduate for her review and attends in support of the graduate.

My experience

The MSR process enabled me to reflect on my year as a graduate and see the progress in my knowledge, skills, confidence and experience. It empowered me to reflect on the difference in confidence at the beginning of the MFYP programme and then at its completion. The opportunity to look in hindsight at the challenges, successes, support and collaboration that shaped my first year of practice was invaluable.

The feedback provided by both midwifery colleagues and consumers was positive and further bolstered my confidence. I went into my MSR with the confidence and knowledge that, having completed the MFYP transitional journey, I was now a competent and confident midwife.

DISCUSSION

The realities of everyday practice can often be challenging for graduates as they work to develop confidence in their practice. Confidence has been found to be the key to successful adaptation into their new role as an autonomous midwife (Kensington et al., 2016; Skirton et al., 2012). Davis et al. (2012) believe that the responsibility to support graduates to become confident is not just laid at the feet of other midwives but belongs equally to all healthcare professionals they encounter who contribute to the graduates' consolidation of skills and continuation of their learning.

Fenwick et al. (2012) suggest a "theory-practice gap" exists where graduates doubt their skills and decision-making ability following registration, due to their limited clinical experience. The theory-practice gap links the concept of confidence and competence, with research revealing a conflict between the taught midwifery practice and the reality of day-to-day practice in contemporary maternity wards (Reynolds, Cluett, & Le-May, 2014; Wain, 2017). It is essential to provide learning opportunities to link theory and practice, and role modelling, and to encourage occupational socialisation in order to develop confidence in graduates (Licqurish, Seibold, & McInerney, 2013).

When measuring confidence in UK graduates, Donovan (2008) emphasised the vital role that mentorship played in developing midwives, identifying that their experience of mentorship impacted on their confidence as a midwife. This is supported by Hughes and Fraser's (2011) qualitative, longitudinal cohort UK study and Cummins, Denney-Wilson and Homer's (2017) qualitative, descriptive study of Australian graduates. The presence of a mentoring relationship has a significant effect on how graduates work, and on their confidence in their skills.

The MFYP programme provides all-encompassing support to graduates and is critical to the development of their confidence. It provides links between theory and practice through all four elements and individualised assistance for graduates to consolidate knowledge and skills through gaining practical experience in their chosen workplace. It also enables gaps in knowledge to be identified and filled through funded education and professional development exercises and creates self-reflective opportunities on the progress of their year's practice through MSR. Kensington et al. (2016) in their thematic analysis of the MFYP programme found each element contributed to building graduates' confidence, with an emphasis on the importance of support from their mentor and the wider midwifery community. This is supported by Pairman et al. (2016) who identified the most important elements of building confidence were "financial support for education", "support from a mentor", and "clinical practice support from colleagues".

In my experience, I found that each of the four elements of the programme was essential and contributed to my confidence; each element complementing and often overlapping the others. I transitioned from being competent at the point of registration to being a confident midwife, according to the Confident Midwife Profile, at the end of the MFYP programme. This achievement was echoed through the MSR process.

CONCLUSION

There is no clear demarcation point at which graduates become confident midwives (Lennox et al., 2012). Graduates are considered competent to provide safe midwifery care at the point of registration but often lack confidence at the beginning of their first year of practice. Graduates' transition journeys require time and support to build confidence (Avis et al., 2012).

My experience attests that building confidence in the first year of practice is a very individual journey and supports the fact that competence and confidence do not always co-exist. I believe the MFYP programme successfully supports a graduate's transition to a competent midwife with a confidence that continues to grow. This not only benefits the graduate, but also the profession as a whole.

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The author declares that there are no conflicts of interest.

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