



# Using Cultural Lens Theory to Investigate the Impact of a Nursing Education Practicum in Aged Healthcare: Aotearoa New Zealand's Bi-cultural Framework

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## Abstract

**Aim** The aim of this paper is to apply Cultural Lens Approach theory to data collected from third year nursing students related to an assignment undertaken during their month-long practicum placement in an aged residential care facility. We explore the extent to which a national vision of bi-culturalism and inclusivity is evident in students' quality improvement project topic selection and practice.

**Background** Aotearoa New Zealand is a nation of dual heritage, informed by the cultures of Māori as the indigenous *tangata whenua* (people of the land), and *Pākehā*, (European) settlers. All public sectors, including all higher education providers and the curricula they deliver, are required to incorporate and promote a contemporary, bi-cultural world-view.

**Methods** Stage one of the research reported in this paper involved a) document analysis of 93 students' quality improvement project reports; b) focus groups with 18 students; and c) an online questionnaire for 16 key stakeholders including aged care managers, clinical nurse leaders and student nurse educators. Stage two reviewed the above data through a five-step Cultural Lens Approach process to identify cultural biases and assumptions.

**Results** Qualitative analysis revealed students' increased professional confidence, improving communication and critical thinking skills. Responses as to development of cultural competence and cultural safety were mixed: a key barrier identified was that staff in the placement setting received minimal professional development to ensure appropriate *tikanga* (customary protocols and practice) for Māori residents was in place.

**Conclusion** Viewed through a cultural lens, a westernized concept of aged healthcare provision continues to prevail in most settings. Nursing students noted gaps between cultural learning and practice.

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**Keywords** Aged healthcare · Aotearoa New Zealand · Bi-cultural · Cultural lens · Nursing education · Practicum

## Introduction

### Study Setting: Aotearoa New Zealand

The bi-lingual, full name of our country reflects its dual heritage of indigenous and western cultures, languages and world-views. By placing their language first, we acknowledge Māori as *tangata whenua*, the original people of the land. This respectful recognition is the starting point for New Zealanders' present-day efforts to live in a bi-cultural nation and a multi-cultural society, acknowledging the historical struggles related to colonization by a Eurocentric way of life and value systems. Our national journey of redress began with *He Whakaputanga* (Declaration of Independence) in 1831, instigated by 13 Māori *rangatira* (chiefs) writing to King William IV of the United Kingdom to seek an alliance and protection from other powers. This was then revoked in 1840, so that sovereignty could be transferred to the British crown via *Te Tiriti o Waitangi* (the Treaty of Waitangi), signed by representatives of the British Government, and 46 Māori *rangatira* (Ministry for Culture and Heritage, n.d.). Despite disputed wording and different versions, *Te Tiriti* has become New Zealand's founding document; its signing is commemorated by a public holiday, it is taught in schools and is widely referenced in all spheres of public life. Legislation and government policy emphasize this focus; for example, the Ministry of Health's (2020) website explains how the health and disability system is committed to fulfilling the special relationship between Māori and the Crown under *Te Tiriti o Waitangi*:

- *Mana*<sup>1</sup> *whakahaere*: Effective and appropriate stewardship or *kaitiakitanga* over the health and disability system. This goes beyond the management of assets or resources.
- *Mana motuhake*: Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including *tikanga Māori*.
- *Mana tangata*: Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- *Mana Māori*: Enabling *Ritenga Māori* (Māori customary rituals) which are framed by *te ao Māori* (Māori world view), enacted through *tikanga Māori*

<sup>1</sup> “*Mana*” is a uniquely Māori concept that is complex and covers multiple dimensions. It is a source of both personal and collective strength, pride and identity. In contemporary New Zealand English, the word “mana” refers to a person or organization of people of great personal prestige and character (Kiwi (NZ) to English Dictionary, <http://www.newzealandatoz.com/index.php?pageid=357>).

(Māori customary protocols and practices) and encapsulated within *mātauranga Māori* (Māori knowledge) (p. 1).

In health, as in many other areas, Māori are disadvantaged when compared to *Pākehā* (New Zealanders of European descent), with a lower life expectancy (a gap of approximately 7 years), a higher incidence of smoking, hazardous drinking and obesity. Māori health status is also unequal across almost all chronic and infectious diseases, as well as injuries, including suicide (Health Navigator New Zealand, 2020). The Health Quality and Safety Commission (HQSC) produces an annual review of progress to inform the New Zealand Ministry of Health's planning and decision-making: the fifth "Window on the Quality of Aotearoa New Zealand's Health Care" was published in 2019 (HQSC, 2019). Writing in the foreword, Professor Sir Mason Durie, arguably this country's leading commentator on Māori health management and outcomes, notes that the findings of the report are not new:

Disparities between Māori and non-Māori have been the subject of numerous reports from the 19th century to the present. For 150 years we have known about the higher rates of Māori illness and the lower rates of Māori survival into old age, and from time to time we have sought to remedy the injustices. Some remedies have led to significant improvements...[including] higher life expectancy...But those gains, significant as they are, have not eliminated the gap between the health of Māori and the health of other New Zealanders. Māori are over-represented in almost every type of illness and every known determinant that leads to poor health. (HQSC, 2019, p. 8)

Health equity is therefore an important government focus, and nursing graduates need a clear understanding of historical, political, and structural causes and effects, as they will be required to address this as registered practitioners.

Māori comprise approximately 15% of New Zealand's population, but 43% of our institute's student body; the Bay of Plenty region of New Zealand which is the setting for this study has a rich tradition of Māori culture, and its Māori population ranks 3rd of the 16 regions in New Zealand (Statistics New Zealand, 2014). In the sample of 93 third year nursing students discussed in this paper, 25% identified as Māori.

## **Nursing education**

An undergraduate Bachelor of Nursing qualification is delivered by multiple higher education providers across New Zealand. With minor variations, curricula for this degree—all of which must be approved by the Nursing Council of New Zealand and New Zealand's Qualification Authority—include multiple practicum placements in a range of healthcare settings, increasing in duration and outcome requirements over the three years of study. In their final year, students spend three days a week for four weeks in an aged residential care facility, and are tasked to complete a quality improvement project, using "a range of formal approaches to analyzing the quality of patient care and implementing systematic efforts to improve it" (Djukic

et al., 2013, p. 13). Developing a broad understanding of the importance of quality improvement in pre-registration nursing education unique to the New Zealand context is vital for nursing students in order to meet the requirements of the New Zealand Health Strategy (Ministry of Health, 2016) and *He Korowai Oranga* (Māori Health Strategy) (Ministry of Health, 2014) and be prepared for their future roles as health professionals (Robb et al., 2017). The quality improvement reports also evidence professional competence entry-to-practice requirements (Nursing Council of New Zealand, 2019) which include quality improvement practice skills, cultural safety<sup>2</sup> and working effectively with Māori. Student nurses each develop their own projects in consultation with the placement provider's quality team, manager or clinical nurse supervisor.

An additional area of challenge for students must be noted here. With aging populations and a rising demand for gerontology care services, this placement experience is an essential part of the curriculum, but is inevitably constrained by the positions available. As Laugaland et al. (2021) note, low staffing levels of registered nurses (exacerbated by the ongoing Covid-19 pandemic) limit the capacity to effectively host students and can result in variation across a cohort's learning experience, as well as a lack of quality assurance. In New Zealand, entry to aged residential care is available for all people over 65 who are assessed as needing it, on a means-tested, user-pays basis subsidised by public funding. However, while Māori on average have poorer health than the general population, and spend more years of their lives living with disability, they account for only 5.5% of those using aged residential care (Ministry of Health, 2019). As will be discussed in a later section of this paper, this is primarily due to cultural preferences, but nonetheless means that nursing students may well have undertaken their aged care placement in settings with no Māori residents. This does not remove the requirement to practice with a bi-cultural mindset, but its likely impact on student quality improvement topic selection is acknowledged.

## Research Aims

Quality improvement methods to ensure care delivery that is safe, timely, effective, efficient, equitable and cost effective (Huber, 2018) are almost ubiquitous in any contemporary healthcare setting (Djukic et al., 2013). As the *Health Quality and Safety Commission New Zealand* (2019) notes, the approach is at the vanguard of the new focus of healthcare systems from managing and delivering outputs to improving patient experiences and outcomes. Further, the topic has been well studied, both in

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<sup>2</sup> Cultural competence and cultural safety are important concepts worldwide in the effort to eliminate indigenous and ethnic health inequities. The Medical Council of New Zealand (2019) offers a useful distinction in the 'evolution of thinking' away from cultural competence – that is, acquiring skills and knowledge of other cultures – towards self-reflection of personal attitudes and biases that may affect the cultural safety of patients. Curtis et al.'s (2019) review of international definitions and usage supports this position, equating cultural safety with critical consciousness: healthcare organizations and practitioners being prepared to critique the 'taken for granted' power structures and to challenge their own culture and cultural systems. Nursing students in New Zealand encounter learning opportunities to develop their own understanding of cultural safety throughout their degree and are encouraged to embed this concept as part of their own practice philosophy.

New Zealand and internationally, in relation to nursing education programmes, for example, the way in which it is embedded into nursing curricula (Sherwood & Drenkard, 2007), addressing the theory–practice gap (Benner et al., 2009), improving placement experiences (Levett-Jones et al., 2006) and preparedness of new nursing graduates to tackle quality improvement placement experiences (Kovner et al., 2010).

The aim of this paper is therefore to go beyond a simple account of one cohort's experience of implementing a quality improvement project which largely confirms many of the observations already noted in the literature. Instead, a platform from which to consider questions of cultural perspectives, identity, validity and equity is presented. Using a Cultural Lens Approach to review study results allows a discussion of the generalizability of observations and conclusions related to practicum placements in aged care settings and quality improvement interventions. Shifting the cultural lens allows a separate view of culturally-specific assumptions and practices from the underlying theoretical proposition (Hardin et al., 2014). Put differently, looking through different metaphorical lenses facilitates the questioning of whether class-taught principles and values positioned as central to professional nursing practice may or may not be culturally inclusive and transferable in the workplace. In a national setting in which cultural safety is valorized, is this practicum placement experience helping or hindering our student nurses' ability to work effectively with a diverse client base?

## Methodology

### Phase One: The Student Learning Experience Evaluation

The initiating qualitative study of a third year, aged residential healthcare practicum placement in 2018 followed a fairly typical teaching team-led evaluative approach. Following ethics approval (Resolution TRC2019.073), students were first asked for their consent to include their reports in the study via a message on the online learning platform: from a cohort of 104 students, 93 responded affirmatively; one student asked her report not be included, and 10 reports were omitted as incomplete at the time the document analysis was being undertaken. Report topic categories were determined and cross-referenced with student demographics, followed by a thematic analysis informed by the literature.

Second, a short, online questionnaire was used to capture the experiences of key stakeholders in supporting students engage in and reflect on their quality improvement projects. The software platform, *Survey Monkey*, used to format the survey was selected as the organization already held a licence, and the research team were familiar with its use. An email with a link to the online questionnaire inviting participation was sent to 30 potential participants including teaching and clinical staff, local hospital staff, aged residential care managers and nurse leaders. Sixteen responses were received.

Third, smaller focus groups of approximately 45 min were held with 18 students who volunteered to take part as well as sharing their reports, in response to

the earlier learning management system communication. As the students were still studying, in order to avoid perceived coercion or power imbalance, the focus groups were conducted by senior Bachelor of Nursing staff not engaged in the teaching or assessment process in this course. The sessions were recorded and subsequently transcribed, and available for participants to check.

In addition to the usual ethical considerations of transparency of purpose, anonymity and confidentiality, the research team followed our organization's guidelines for culturally safe and respectful research when working with Māori participants and/or Māori intellectual or cultural knowledge. First, our organization's values were woven into our proposal, including our approaches to potential participants, use of *te reo Māori* (Māori language) and partnership orientation to facilitating the focus groups. These values are:

- *Manaakitanga*: 'We uphold and strengthen the *mana* (integrity) of others and our communities'
- *Whanaungatanga*: 'We build and nurture relationships and connections'
- *Toitūtanga*: 'We are courageous and humble in our pursuit of excellence'
- *Kotahitanga*: 'We are united towards our shared purpose' (Toi Ohomai, 2019).

Also, all participants who identified as Māori were offered support from the *Komiti Kaiako Māori* (committee of senior Māori teachers) in the Department of Nursing. This *Komiti* nominated a team member who was fluent in *te reo Māori* and *kaupapa* (protocols) to attend each of the focus group interviews to ensure full participation and accurate representation of Māori voice. Additional Māori student support was available from experienced educators and staff not teaching the course.

Data analysis saw each project's aim, outcomes, reported enabling factors, challenges, and reflections of bi-cultural practices/strategies coded and categorised to identify emerging themes. All thematic analysis was conducted according to the selected Cultural Lens Approach methodology. In order to moderate individual researcher bias and subjectivity, the three members of the research team who undertook this stage of the project independently reviewed and coded each student report. The five-step methodology framework (described in detail in the following section of this paper) guided a grouping of themes and sub-themes under the overarching headings of *concept*, *context*, *operationalization*, *transference/efficacy*, and *gaps/implications*. The same process was then applied to survey and focus group data to triangulate findings. The wider team then compared and finalized theming decisions.

## Phase Two: Cultural Lens Approach Theory

Culture is learned behaviour, transmitted from one generation to the next (Harris et al., 2016), and is central to our way of life. Unfortunately, comment Hardin et al. (2014), "all humans are ethnocentric" and viewing any issue or offering from the perspective of another can be "profoundly difficult" (p. 658). In many westernized countries with colonial backgrounds, this comes into play when organizations or government policies seek to balance the tension between

the cultural enrichment offered by an indigenous inheritance with more modern, empirical and commercial elements of service provision, including healthcare (Reid et al., 2018). One mechanism for identifying, analyzing, and potentially resolving this tension is the Cultural Lens Approach tool, as an avenue to developing cultural competence (Hardin et al., 2014).

The Cultural Lens Approach hails from the domain of psychology, and offers a way to evaluate how theories, practices or phenomena apply across cultural groups (Hardin et al., 2014). The ‘cultural validity’ of outcomes and/or models is therefore about “the extent to which aspects of theories are generalizable across, equally relevant to, or equally useful to diverse groups” (Hardin et al., 2014, p. 656). Ryan (2017) offers a visual description:

Culture acts like the coloured lens that a photographer uses to see a landscape in a particular way, or the wide-angle lens that both captures and distorts reality. The universal behaviour patterns remain, but they are coloured and bent by the cultural environment. (para. 5).

The five steps of the Cultural Lens Approach are therefore designed to help researchers metaphorically look through different cultural lenses to view the object of their inquiry in a different way. In New Zealand, as in many other western nations, a colonial history of ‘discovery’ and settlement meant that many earlier generations of indigenous people have been subjected to a non-negotiable imposition of a Eurocentric culture (Smith, 2012). In this country, there is a growing acceptance that a loss of cultural identity has led to marginalization and under-performance for Māori people (Apanui, 2015; Bidois, 2011), and a legacy of over representation in negative demographics (such as poor health, low socio-economic status, criminal offending and lower educational achievement) (Durie, 2003, 2011; Marriot & Sim, 2014). Using a cultural lens to consider the impact of policy, practice or curricula is therefore highly relevant to bi-cultural and multi-cultural populations.

The five Cultural Lens Approach steps, paraphrased from the work of Dik et al., (2019) and Hardin et al. (2014), and aligned to this study are:

1. *Articulate how central constructs have been defined (implicitly or explicitly) and thus operationalized in past research.*

This step is about stating and exploring conceptual definitions and processes related to the topic – student nurses’ experiences of implementing quality improvement projects in an aged healthcare setting.

2. *Identify the groups (a) from which these definitions have been derived and (b) to which the constructs have either not been applied or with which surprising results have been found.*

This step identifies the cultural group(s) of interest and the group(s) from which the theory was originally derived. It considers previous studies such as the reviews of quality improvement related to nursing education cited earlier, recognizing that almost all of these have been situated in a western healthcare system. We were not able to find studies which specifically recounted a similar placement experience

while considering its ‘fit’ with the two cultural groups of Māori and non-Māori nursing students.

3. *Identify relevant dimensions underlying cultural variability: What do we know about the cultural contexts of Groups A and B?*

This step begins by acquiring basic cultural knowledge and considers sources of cultural variability without yet making conceptual connections to the theory, avoiding easy, or ‘intuitive’ assumptions. In New Zealand we are fortunate to have a large and growing body of scholarship related to the enactment of bi-culturalism in healthcare provision upon which to draw as we considered how best to explore the gap identified in Step 2, above. It is also important to acknowledge related discussions and recent changes about how these two main cultural groups are defined.<sup>3</sup>

4. *Evaluate the definitions/operationalizations of the central constructs (from Step 1) in the context of broader cultural knowledge about those groups (from Step 3): What do we know about the topic concept within the cultural context of Group B?*

This step entails a synthesis of the previous steps, seeking to connect and explain differences. What do these differences mean? We were able to find several areas in which there appeared to be some tension between the direction offered by a European tradition of aged healthcare, and an indigenous sense of cultural identity. At this point researchers move from knowledge to implications, which in this study, highlighted areas of cultural safety.

5. *Derive research questions and specific hypotheses based on the questions and answers from Step 4.*

This final step seeks to develop directions for new research and/or practice, based on the insights gained from the Cultural Lens Approach process. Directions indicated for this present inquiry include addressing potential areas of cross-cultural misunderstandings with changes in curricula delivery, practicum placement assessment criteria, and targeted professional development initiatives with host placement providers.

Usually, the Cultural Lens Approach is used to allow researchers to examine the cultural biases and assumptions underlying a theory in order to consider what needs

<sup>3</sup> For example, ‘Pākehā’ is usually translated, as in this paper, to mean ‘New Zealanders of European descent’, although it can also be used more generally to mean any ‘non-Māori person’, while some decry the use of a Māori language word at all, to describe those who are not native speakers (<https://thespinoff.co.nz/atea/03-03-2018/a-history-of-outrage-over-the-word-pakeha>). As for determining who is Māori and who is not, collection and classification of ethnicities in official statistics – health and otherwise – is less about racial or biological categories, than “a view of ethnicity as self-identified cultural affiliation” (Cormack & Robson, 2010, p. 8). A third and related issue is the importance of recognising variance and plurality within the Māori population. As Kukutai (2004, p. 1) notes, “High rates of intermarriage and institutional pressures to assimilate mean [Māori] comprise persons with diverse lifestyles, socio-economic circumstances and identities.” Yet, for reasons of history and contemporary politics, including resource allocation and access, public policy tends to treat Māori as a single, homogeneous population. Further, each *iwi* (tribe) will have its own history and *tikanga*, meaning that Māori identities as Indigenous people are much more complex, diverse, and ethnically nuanced than the simple binary of Māori/Pākehā would appear to indicate.

to be changed to achieve a more effective fit in practice (Dik et al., 2019). However, in the current study, we are intentionally re-orienting the approach as a lens by which to consider practice. We ask whether we are, in fact, providing the culturally competent care to reduce racial and ethnic health disparities (Nguyen et al., 2019), to which we aspire.

## Results and Discussion

### The Evaluation

A full account of the quality improvement project evaluation study has been published elsewhere (Honeyfield et al., 2020); the purpose for including key points here is to set the scene for the focus of this paper: an application of Cultural Lens Approach theory to one element of nursing education.

Document analysis of the student reports showed topic selection in order of frequency as: care planning and review; infection prevention and control; wound care/dressings; falls/early alerts; orientation; diabetes management; and physical facilities. Other one-off quality improvement topics included constipation monitoring, managing dementia, manual handling, improving recreational activities, call bells/noise, records confidentiality, medication safety, clothing labelling, restraint practices, secure unit alerts, and client satisfaction recording. Surprisingly, only seven projects addressed *te ao Māori*, cultural values or *Te Tiriti o Waitangi* concepts. Preparation for the practicum-based, aged healthcare quality improvement project in class emphasises the need to respond to individual resident, *whānau* and professional nursing and placement setting demands. Students were free to select their own topic, which was then approved by their placement supervisor and the manager of the placement provider. The only directive was that it aligned with the New Zealand Health Strategy (Ministry of Health, 2016) and *He Korowai Oranga* Māori Health Strategy (Ministry of Health, 2014), including *Te Tiriti o Waitangi* concepts, and would support the student's learning in preparation for sitting State Final examinations, and becoming a registered nurse. Prior to the evaluation, the teaching team had expected that more students would choose to consider how bi-cultural learning covered in three focused papers, and interwoven throughout the curricula, would apply in the workplace. Given that Māori as an ethnicity are over-represented in almost every area of our health system (Ministry of Health, 2016) and preparing our graduates to work effectively with Māori is a vital part of our role as educators, this result was somewhat of a concern.

The online survey and focus group data was highly positive about the overall value of the practicum experience (100% and 86% respectively). Stakeholders attested to the growth in professional confidence they saw in students over the four weeks of placement. Students were able to engage effectively with all members of a healthcare team, including management, at least in part due to having an approved quality improvement initiative in place, some tools to draw on, and the need to lead and champion change. Students talked about the critical thinking required for conceptualisation and planning their projects, as well as gaining problem-solving,

negotiating and group work skills. They generally felt well-prepared for their project task, well supported during implementation, and enjoyed interacting with registered nurses on site (Honeyfield et al., 2020).

Less positive were student nurses' reflections on the challenges they encountered while undertaking their quality improvement projects. Following the almost universal and inevitable issue (e.g. Djukic et al., 2013; Kovner et al., 2010; Robb, et al., 2017; Sherwood & Drenkard, 2007) of time constraints (both of aged care facility staff to engage in the projects, and the students' limited time to achieve these), were issues related to cultural safety and *tikanga*. Of most concern were the 15 project reports identifying that the organizations were not practicing within their own policies. Staffing levels were a concern in a number of these workplaces, as was a lack of staff professional development related to cultural safety. In fact, such training is vital when a feature of New Zealand aged healthcare is the number of migrant workers in the aged care industry, often seen as an avenue to permanent residency (Fonseka, 2019).

## Applying Cultural Lens Approach Theory

*Step 1. Articulate how central constructs have been defined (implicitly or explicitly) and thus operationalized in past research.*

Research and commentary related to nursing education in general, and to quality improvement interventions in particular, are overwhelmingly Western in origin, even when exported to non-Western cultures (Dik et al., 2019). Such studies, note these authors, primarily sample “western, educated, industrialized, rich and democratic (WEIRD) populations” (p, 63), which poorly represent the broader, culturally diverse population. In addition to researcher orientation and non-representative sampling, Western paradigms are still highly influenced by bio-medical models of aging which emphasise growing frailty and loss of physiological and mental function (Foster, 2020).

The concept of age is historically and culturally constructed too (Foster, 2020). In daily life our sense of who is ‘aged’, ‘elderly’, or ‘older’ responds to a Eurocentric view of what we have traditionally known as ‘the age of retirement’; in New Zealand this is 65, the age at which individuals are eligible for the state pension, or the ‘superannuation’ benefit. Political structures, such as government statistics, policies and legislation, also adopt this age determinate, although there are categories within this: the young-old (65–74 years of age), the middle-old (75–84 years of age) and the old-old (85 years plus) (Foster, 2020; Statistics New Zealand, 2014). Indigenous knowledge about aging seldom makes such hard distinctions and considers aging as a lifelong and positive process that begins at the earliest moments of life (Edwards et al., 2018).

*Step 2. Identify the groups (a) from which these definitions have been derived and (b) to which the constructs have either not been applied or with which surprising results have been found.*

Traditionally in Māori culture, the elderly are revered and positioned at the heart of their communities (Marriot & Sim, 2014). A Western construct of aged healthcare views them as a high needs demographic (Ministry of Health, 2016) and problematizes health disparities (Edwards et al., 2018). There is clearly, therefore, a disconnect in which the construct of aging is being applied to the two principal cultural groups in Aotearoa New Zealand. In nursing education the dichotomous account is continued: Māori medical academics like Edwards et al. (2018) note that many recent texts which are making considerable strides in discussing the need to affirm the values and strengthen the capabilities of older Māori and their whānau can still fail to capture a Māori perspective on aging. Others are even more emphatic: a Western approach to quality improvement in aged healthcare, when *Māoritanga* (Māori culture, traditions, and way of life) is not present, will fail to provide practical solutions for healthcare practitioners to demonstrate cultural consciousness in accordance with the Treaty of Waitangi principles (Harris et al., 2016).

*Step 3. Identify relevant dimensions underlying cultural variability: What do we know about the cultural contexts of Groups A and B?*

*Pākehā* (European New Zealanders) culture is predominantly western, with a euro-centric world view. As the majority and mainstream culture, it is easy to take for granted assumptions about the salience of this worldview, and the utility of the constructs which arise from it. Māori, as New Zealand's indigenous people, are still influenced by the historical impacts of colonization resulting in land loss, dislocation and trauma (Edwards et al., 2018).

The Cultural Lens Approach theory builds on multiple antecedents in the field of social psychology; one of the most cited and internationally recognized tools is the Cultural Dimensions Theory (Hofstede et al., 2010) which offers a mechanism for measuring the effects of a society's culture on the values (and hence behaviours) of its members. The model is not intended to suggest everyone in a given society thinks or acts the same way, but the six dimensions nonetheless suggests themes into which generalizations may be grouped.

As a quick precis of the six Hofstede Index dimensions (Hofstede et al., 2010),

(i) *Power Distance* is defined as the extent to which people accept that power is distributed unequally. In pre-European Māori society, for example, subordinate-superior relationships were strictly enforced across three social rankings: the *rangatira* (chiefs), *tūtūā* (commoners), and *mōkai* (slaves) (Taonui, 2005). Rank and leadership were based on seniority of descent from founding ancestors. In contrast, contemporary *Pākehā* society aspires more to egalitarianism.

(ii) *Individualism* is about people's self-image as 'I' or 'We'. Where mainstream, westernized New Zealand (including higher education) places importance on personal goals, with a self-perception of a separate and distinguishable entity, indigenous Māori are usually characterised as collective in orientation emphasizing the high importance of obligations towards, embeddedness in, and interconnectedness with the *whānau* (extended family) and the *iwi* (tribe) (Podsiadlowski & Fox, 2011).

(iii) *Masculinity* is used to describe societies driven by competition, achievement and success, a value system that starts in school and continues throughout organizational life. Work-life balance may be sacrificed to accomplishments and status. While orientations are different, it is likely that both Māori and non-Māori culture would place similar weightings on this dimension. Most studies which address this characteristic describe the more significant gender-based division of roles in traditional Māori society than is tolerated in 21<sup>st</sup> Century New Zealand culture (e.g. Podsiadlowski & Fox, 2011; Taonui, 2005), although this is not the true intention of Hofstede's descriptor.

(iv) *Uncertainty Avoidance* describes how a society responds to the unknown future. While New Zealand's score as a single nation in the Hofstede Index is neutral, related (according to their notes) to a generally secular worldview and an adaptable and entrepreneurial mindset, traditional Māori society, as with most indigenous cultures, was more spiritual and accepting of 'fate' and their place in the world (Marriott & Sim, 2014).

(v) *Long Term Orientation* is about views of societal change and the importance of tradition. According to the Hofstede Index, contemporary New Zealanders are normative in their thinking: respecting established systems, seeking quick results, and with a relatively low commitment to saving for the future. In contrast, long-term thinking is ingrained in Māori traditions, which value ancestral connections and continue to revere an oral tradition of *whakapapa* (the recitation of genealogy). Few New Zealanders, or visitors to this country, would not have experienced some element of *Pōwhiri* (traditional welcome) or *korero* (formal speech), or *haka* (traditional warrior's challenge) which are a part of our everyday landscape.

(vi) *Indulgence*, the final Hofstede dimension, is "the extent to which people try to control their desires and impulses, based on the way they were raised" (Hofstede Insights, n.d.). Compared to some countries like China, it is likely that both main population groups in Aotearoa New Zealand would describe themselves as a relatively indulgent society: optimistic, focused on enjoying life, having fun, acting as they please and spending money more freely.

*Step 4. Evaluate the definitions/operationalizations of the central constructs (from Step 1) in the context of broader cultural knowledge about those groups (from Step 3): What do we know about the topic concept within the cultural context of Group B?*

Māori have very different health, socioeconomic and other outcomes in later life than non-Māori (Ministry of Health, 2014, 2016). Edwards et al. (2018) summarise the present-day situation: "Health disparities result from differentials in access and exposure to determinants of health, both positive (e.g., good education, employment opportunities, affordable and quality housing, good income) and negative (e.g., racism, exposure to the criminal justice system)" (p. 10). Numerous Māori academics trace these inequitable indices back to the dislocation of a colonial past and cultural marginalization (e.g. Bidois, 2011; Reid et al., 2018; Smith, 2012). Not only do older Māori as a demographic group share these health-related factors and outcomes, but their cultural outlook is also one of *collectivism*, rather than *individualism* (Hofstede

et al., 2010; Podsiadlowski & Fox, 2011), as described above. For these reasons, “interventions to improve Māori aging that focus solely on individuals changing their health behaviours will, therefore, be of limited value” (Edwards et al., 2018, p. 10). What do appear to be working well for Māori are initiatives which start with cultural identity, such as those described by Waldon (2004) and Emery and Emery (2021). Their accounts emphasize that intergenerational interaction between older Māori, their whānau, hapū and iwi, supported by marae participation, the use of Māori language, and access to Māori resources (such as land) are key determinants of wellbeing in old age. Another current example is the National Science Challenge-funded project to develop a *kaumātua* (respected elder) peer-support programme based on *tuakana* (older/experienced *kaumātua*) guiding *teina* (younger/less experienced) *kaumātua* through significant life transitions (Oetzel et al., 2019).

These exemplars provide a context for the first issue related to assessing the operationalization of a quality improvement initiative by student nurses: more than half of the projects reported described work undertaken with an individual client, singled out for special attention. Such an approach is clearly more likely to resonate with a *Pākehā*, rather than a Māori worldview. An ‘exception to prove the rule’ was one of the seven student projects undertaken which did focus on *te ao Māori*, *Te Tiriti O Waitangi* and improving cultural competence and cultural safety for a community. Here the student created a laminated resource with some easy-to-learn cultural activities, *te reo* (language) and *waiata* (song) for Māori and non-Māori residents and staff. The student received positive feedback: “residents learned new words, some had never spoken *te reo*, reduced anxiety, shared own culture” (notes on student report added by placement facility manager). Other student projects which worked with groups of residents outside the domain of culture also noted the value of inclusivity: voicing a concern or possible quality improvement area of focus in group settings allowed other voices to join. Several student nurses noted considerable congruence in shared needs which could be addressed in collective action, rather than isolated interventions.

A second area in which the quality improvement project in aging healthcare settings may not serve both of New Zealand’s main cultural groups equally relates to the dimension Hofstede et al. (2010) label *uncertainty avoidance*. Interventions frequently focus on various medical conditions, and western empirically-based good practice usually suggests these are discussed with the client as a partner in treatment. However, O’Connor (2019) points out that a recent study of Māori views on *mate wareware* (dementia – literally “to be sick” and “to forget, or be forgotten”) determined an overwhelming number of participants found the words “Alzheimer’s” and “dementia” evoked feelings of despair and confusion: “They preferred using Māori words to describe changes in behaviours, such as absent-mindedness and forgetfulness” (p. 11). *Te oranga wairua* (spiritual wellbeing), described as a “deeply spiritual and uniquely Māori experience of connectivity” was the central theme to emerge from the study.

Traditions are important to all peoples, but for indigenous groups, this tangible aspect of culture is critical for self-identity (Apanui, 2015; Bidois, 2011) as well as part of a *long-term orientation* about their people’s place in the land. In Aotearoa New Zealand, recent decades have seen a resurgence of interest in

Māori language, culture, art, knowledge and worldview, sometimes referred to as the ‘Māori renaissance’ (Harris et al., 2016). Students are learning about their dual Māori and Pākehā heritage in school, and higher education qualifications, especially in professions like healthcare, incorporate *Te Tiriti o Waitangi* across the curricula to ensure graduates are able to apply the articles to nursing practice, and to undertake that practice in a manner in which the client feels culturally safe (Nursing Council of New Zealand, 2016). Yet sometimes, knowing how much there is to know can stymie confidence to take this learning beyond the classroom. Student nurses in this study did not as a group exhibit a high level of cultural consciousness or confidence with so few choosing to undertake quality improvement projects in this area, despite many reports noting a need for more bi-cultural initiatives in their placement workplace (Honeyfield et al., 2020).

One inhibiting factor already noted was that some placement workplaces were not practicing within their own policies. For example, one of the seven Māori *tikanga*—focussed projects noted that the aged care provider’s policy documents referenced *Te Whare Tapu Whā* (a holistic Māori health model using the metaphor of a four-walled house to illustrate dimensions of wellbeing), (Durie, 2003; Ministry of Health, 2014), but that most staff were unaware of what this meant, and were not modelling the approach in their practice. The student’s report stated that discussing the model with residents reduced anxiety and helped develop social interactions. Here, as in numerous reports, a need was noted for professional development for staff, especially, but not only, for migrant staff with overseas qualifications and little first-hand experience of *Te Ao Māori*. A logical progression is the need for nurses, and nurse educators to advocate for this to be mandated, through engaging with public policy, and even political action (Wilson et al., 2020) to lead and shape change (Hunter, 2020).

*Step 5. Derive research questions and specific hypotheses based on the questions and answers from Step 4.*

The above steps recognize the cultural characteristics of Māori and non-Māori European peoples in New Zealand, and some of the key areas in which these differences became apparent in a nursing education aged healthcare placement, through analysis of reports and feedback from study participants. A number of implications for programme development, educator delivery, higher education-industry partnerships, and further research arise.

First, there appears to be a disconnect for student nurses between the various units of study. All papers in the Bachelor of Nursing curriculum address bi-culturalism, cultural competence and safety and *Te Tiriti o Waitangi* related to that topic. This inclusion is intended to provide a grounding for professional healthcare practice as a Registered Nurse in Aotearoa New Zealand, in *all* settings, and across *all* client groups. Instead, it seems that student nurses have viewed bi-cultural and *te ao Māori* learning as a discrete subject area – which most chose not to address. Avoidance of confronting and often uncomfortable topics is not limited to this study, or this education programme either. Reid et al. (2018) from

the Faculty of Medical and Health Sciences in New Zealand's largest university, write,

In our experience students are able, and usually willing, to comprehend the relationship between the illegal confiscation of land and natural resources with subsequent lower socioeconomic status and poverty even after so many generations. However, most students struggle with these deeper understandings of coloniality at an ideological level and how racism underpins it (p. 3).

A future focus for education providers could therefore be (1) to extend the way in which bi-cultural concepts are embedded and discussed as integral to practice across the whole curriculum (Hunter, 2020), and (2) to build confidence in Pākehā students to address and lead bi-cultural quality improvement projects to benefit Māori and whole-community client groups. This is a significant challenge for many educators: as Hunter (2020) notes, non-members of an indigenous group seeking to apply new models of a different cultural identity can lay themselves open to charges of cultural appropriation. Curtis et al.'s (2019) advocacy for teaching approaches which build student nurses' self-efficacy and provide opportunities to analyse and deconstruct clinical placement experiences may help students to reconcile this tension.

Outside the scope of this paper is extensive literature which would support classroom conversations about cultural specificity, but a starting point is Hunter's direction to student nurses working with cultural knowledge and models not their own: "Be deeply curious about what these concepts mean in the embodied, lived experience of the person in front of you." (p. 25).

Addressing the need to include additional bi-cultural – and by extension, multi-cultural and marginalized demographic groups – dimensions of study is as necessary in the workplace as it is in the classroom. Healthcare providers – and arguably, most especially aged residential facilities – have high staff turnover (Kovner et al., 2010). In New Zealand, their workforce at different times has large numbers of nurses returning to work after an absence, nurses who prefer part-time shift work or on-call relief to support other roles, or as a move towards retirement, and nurses from overseas (Sherwood & Drenkard, 2007). Many of these nurses will have received little, if any training in ensuring cultural safety for their clients; some may not be fully aware of the 'Nursing Competence 1.2' related to the application of *Te Tiriti o Waitangi* (Nursing Council of New Zealand, 2016). Here then, is a place for education providers to partner with healthcare facilities and offer professional development to staff, to ensure currency and clarity regarding cultural safety guidelines and good practice.

The need for ongoing professional development – including attending conferences and symposia, and keeping up-to-date with recent literature—is also essential to ensure the positive work being undertaken to reduce health inequities reaches the current and future healthcare workforce. A current and leading example in this country is LiLACS (Life and Living in Advanced Age, a Cohort Study in New Zealand) a longitudinal cohort study begun in 2010, by the School of Population Health at the University of Auckland. Aiming to determine the predictors of successful advanced ageing and understand the trajectories of health and wellbeing in advanced age, this is the first such study in the world of an indigenous population (LiLACS, 2015, 2016). The study has generated dozens of long

**Table 1** Summary of Cultural Lens Approach steps applied to a nursing education practicum in aged healthcare

Step 1. Articulate definitions and operationalizations	
• What is the central construct?	Aged health care
• How has it been operationalised?	Quality improvement projects undertaken during student nurses' practicum placements
Step 2. Identify the groups (a) from which these definitions have been derived and (b) to which the constructs have either not been applied or with which surprising results have been found	
With what groups were these constructs developed?	Western countries, including New Zealand
What groups have the constructs been applied to with unsatisfactory results?	Indigenous populations, in this case Māori
Step 3. Identify relevant dimensions underlying cultural variability: What do we know about the cultural contexts of Groups A and B?	
What cultural dimensions could impact the validity of conducting quality improvement projects in aged health care settings?	Differences in <i>power distance</i> (fixed social rankings and rigidity of power structures, unquestioning acceptance of authority) Differences in <i>collectivist / individualistic</i> mindsets Differences in <i>uncertainty avoidance</i> (acceptance of fate) and <i>long-term orientation</i> and the importance of tradition
Step 4. Evaluate the definitions/operationalizations of the central constructs (from Step 1) in the context of broader cultural knowledge about those groups (from Step 3): What do we know about the topic concept within the cultural context of Group B?	
What do we know about bi-culturalism in New Zealand in the context of:	Outcomes appeared to focus more on professional skill development than improving cultural competence and cultural safety
• Quality improvement projects	Topics with a cultural safety focus were under-represented in the study sample
• Nurse education practicum placements	Operate within a mainstream, westernized worldview, even where organizational policies state otherwise. Staff would benefit from professional development related to <i>Te Tiriti</i> and bi-cultural practice
• Aged healthcare	
Step 5. Derive research questions and specific hypotheses based on the questions and answers from Step 4	
How do Māori and non-Māori aged health care residents perceive the cultural environment and its 'fit'?	
Is the New Zealand Māori experience in aged health care settings comparable to other indigenous groups?	
What interventions can lead to a shift in cultural lens – for students? For aged care staff and managers?	
In what other nursing areas could the Cultural lens Approach be employed to identify gaps / anomalies / inequities?	

and short reports, factsheets, journal articles, conference presentations and keynote addresses – nationally and internationally. Findings have been reported in broad trends across the years of the study, as well as by topic, such as dementia, income, independence in daily activities, relationships and emotional support,

alcohol use, oral health, medication, and participation in Māori society. Supporting the work of Waldon (2004), Emery and Emery (2021) and Edwards et al. (2018), the LiLACS study has also evidenced the importance of culture to older Māori, as holders of heritage, knowledge and *tikanga* (2015).

Clearly there is significant research already underway regarding the delivery of culturally-informed healthcare. The present application of Cultural Lens Approach theory to one aspect of nursing education summarised in Table 1 also suggests a number of topics for further research. The study which underpins this review (Honeyfield et al., 2020) includes student, teacher and healthcare managers' voice. The most impacted group – the aged care residents themselves – have yet to tell their story. How congruent would both Māori and non-Māori residents' narratives of cultural inclusivity or exclusion be – with one another and with the results of this review? How transferable are these findings and experiences across other indigenous groups in colonised, westernized settings? What interventions and longer-term strategies make the most impact and lead to an enduring shift in perception paradigms? And, where else might the Cultural Lens Approach be useful to interrogate cultural clarity, and cultural equity?

## Conclusions and Implications for Nursing Student Preparation

As described above, the Cultural Lens Approach is a relevant and useful tool for examining the cultural validity of an aspect of both nursing education, and professional healthcare practice in aged care facilities. The quality improvement projects student nurses undertook while in their practicum placement yielded positive professional gains in skills and confidence; it would be hard to argue against the value of this experience as a preparation for sitting State Final exams and commencing a career as a Registered Nurse. Yet re-examining the projects and resultant reports through a bi-cultural lens readily highlights areas where outcomes could be further enhanced – through action in the classroom, the workplace, and at a national, political level (Wilson et al., 2020). Work for teaching teams to locate placement positions in aged care facilities with both Māori and non-Māori residents must also be a continued focus if students are to develop confidence in delivering cultural safe care (Curtis et al., 2019; Ministry of Health, 2019).

The steps of the Cultural Lens Approach provide a clear framework for researchers and practitioners to use in engaging in cultural safety work. The steps provide a structure for examining cultural assumptions and considering differences, such as Hofstede et al.'s (2010) six dimensions of cultural identity. By integrating this knowledge and sharing new understandings with our students and wider network of healthcare providers and stakeholder groups, we are taking a few more steps on the path towards becoming a culturally-enlightened profession.

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## Declarations

### Conflicts of Interest/Competing Interests

- The authors have no relevant financial or non-financial interests to disclose.
- The authors have no conflicts of interest to declare that are relevant to the content of this article.
- All authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.
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## References

- Apanui, N. (2015). *Hei took i te tukunga: Enabling Māori tertiary learner success*. [Keynote address to the National Tertiary Learning and Teaching conference, Tauranga: Bay of Plenty Polytechnic, 30 September – 2 October 2015]. <http://nltconference.ac.nz/>. Accessed November 2020.
- Benner, P., Sutphen, M., Leonard, V., & Day, L. (2009). *Educating nurses: A call for radical transformation*. Jossey-Bass.
- Bidois, V. (2011). *Māori student engagement: Voices from the margins*. [Unpublished report]. Toi Ohomai Institute of Technology.
- Cormack, D., Robson, C. (2010). *Classification and output of multiple ethnicities: Issues for monitoring Māori health*. Wellington, NZ: Te Rōpū Rangahau Hauora a Eru Pōmare (Wellington School of Medicine and Health Sciences).
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*, 18(174). <https://doi.org/10.1186/s12939-019-1082-3>
- Dik, B. J., Canning, B. A., & Marsh, D. R. (2019). A cultural lens approach to promoting work as a calling. In L. E. Van Zyl & S. Rothmann Sr. (Eds.), *Positive Psychological intervention design and protocols for multi-cultural contexts*. Springer.
- Djukic, M., Kovner, C., Brewer, C., Fatehi, F., & Seltzer, J. (2013). A multi-state assessment of employer-sponsored quality improvement education for early-career registered nurses. *The Journal of Continuing Education in Nursing*, 44(1), 12–19.
- Durie, M. (2003). *Whāiora: Māori health development*. Oxford University Press.
- Durie, M. (2011). *Ngā tini whetū: Navigating Māori futures*. Huia.
- Edwards, W., Theodore, R., Ratima, M., & Reddy, R. (2018). Māori positive ageing. *New Zealand Medical Association Journal*, 131(1484), 1–12.
- Emery, W., & Emery, T. (2021). *Koeke a ko ake nei: Towards intergenerational positive ageing for Ngati Pīkiao*. Health Research Council of New Zealand.
- Fonseka, D. (2019). Immigration move a 'game-changer' for aged care workers. *Newsroom*. <https://www.newsroom.co.nz/immigration-game-changer-for-aged-care-industry-and-others>. Accessed November 2020.
- Foster, P. (2020). *What undergraduate nurse education actually teaches student nurses about people named as older: A Foucauldian discourse analysis* [Thesis]. <https://openrepository.aut.ac.nz/bitstream/handle/10292/13298/FosterP.pdf?sequence=3&isAllowed=y>. Accessed November 2020.
- Hardin, E. E., Robitschek, C., Flores, L. Y., Navarro, R. L., & Ashton, M. W. (2014). The cultural lens approach to evaluating cultural validity of psychological theory. *American Psychologist*, 69(7), 656–668. <https://doi.org/10.1037/a0036532>

- Harris, F., Macfarlane, S., Macfarlane, A., & Jolly, M. (2016). Māori values in the workplace. *MAI Journal*, 5(1). <https://doi.org/10.20507/MAIJournal.2016.5.1.4>
- Health Quality and Safety Commission of New Zealand (HQSC). (2019). *A window on the quality of Aotearoa New Zealand's health care 2019 – a view on Māori health equity*. HQSCNZ.
- Health Navigator New Zealand. (2020). *Māori health overview*. <https://www.healthnavigator.org.nz/healthy-living/m/m%C4%81ori-health-overview/>. Accessed November 2020.
- Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations: Software of the mind* (3rd ed.). McGraw Hill Professional.
- Honeyfield, J., Sims, D., Proverb, A., Rowe, W. (2020). Fostering quality improvement educational outcomes in undergraduate nursing curricula: Graduates' perceptions of their preparation for practice change. In K. Heuer, C. Kerdpitak, N.P Mahalik, B. Barrett, & V. Nadda (Eds.), *Conference proceedings of international conference business education social sciences tourism and technology* (pp. 224–231). <http://icbtsproceeding.ssr.u.ac.th/index.php/ICBTSMALTA2020/issue/view/14>. Accessed November 2020.
- Huber, D. (2018). *Leadership and nursing care management* (6th ed.). Elsevier.
- Hunter, K. (2020). Cultural safety or cultural appropriation? *Kai Tiaki Nursing New Zealand*, 26(1), 24–25.
- Kovner, C., Brewer, C., Yingrengreung, S., & Fairchild, S. (2010). New nurses' view of quality improvement education. *The Joint Commission Journal on Quality and Patient Safety*, 36(1), 29–35.
- Kukutai, T. (2004). The problem of defining an ethnic group for public policy: Who is Māori and why does it matter? *Social Policy Journal of New Zealand*, 23.
- Laugaland, K., Billett, S., Akerjordet, K., Frøiland, C., Grealish, L., & Aase, I. (2021). Enhancing student nurses' clinical education in aged care homes: A qualitative study of challenges perceived by faculty staff. *BMC Nursing*, 20, 111. <https://doi.org/10.1186/s12912-021-00632-0>
- Levet-Jones, T., Fahy, K., Parsons, K., & Mitchell, A. (2006). Enhancing nursing students' clinical placement experiences: A quality improvement project. *Contemporary Nurse*, 23(1), 58–71.
- LiLACS, N. Z. (2015). *Participation in Māori society in advanced age: Findings from LiLACS NZ*. Ministry of Health.
- LiLACS NZ. (2016). *Health, independence and caregiving in advanced age: 2016 findings from LiLACS NZ*. Ministry of Health.
- Marriott, L., & Sim, D. (2014). *Indicators of inequality for Māori and pacific people*. University of Victoria.
- Medical council of New Zealand. (2019). *Statement on cultural safety*. <https://www.mcnz.org.nz/assets/standards/b71d139dca/Statement-on-cultural-safety.pdf>. Accessed November 2020.
- Ministry for Culture and Heritage. (n.d.). *He whakaputanga - Declaration of independence*. <https://nzhistory.govt.nz/culture/declaration-of-independence-taming-the-frontier>. Accessed November 2020.
- Ministry of Health. (2014). *The guide to He Korowai Oranga: Māori Health Strategy 2014*. Author.
- Ministry of Health. (2016). *The New Zealand Health strategy: Future directions*. Author. <http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-roadmapofactions-2016-apr16.pdf>. Accessed November 2020.
- Ministry of Health. (2019). Annual data explorer 2017/18: New Zealand health survey [data file]. <https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer>. Accessed November 2020.
- Ministry of Health. (2020). *Te Tiriti o Waitangi*. <https://www.health.govt.nz/our-work/populations/Māori-health/te-tiriti-o-waitangi>. Accessed November 2020.
- Nguyen, K. H., Seaman, K., Saunders, R., Williams, E., Harrup-Gregory, J., & Comans, T. (2019). Benefit–cost analysis of an interprofessional education program within a residential aged care facility in Western Australia. *Journal of Interprofessional Care*, 33(6), 619–627. <https://doi.org/10.1080/13561820.2019.1577808>
- Nursing Council of New Zealand. (2016). *Competencies for registered nurses*. Author.
- O'Connor, T. (2019). Māori views on mate wareware (dementia). *Kai Tiaki Nursing New Zealand*, 25(10), 11–12.
- Oetzel, J. G., Hokowhitu, B., Simpson, M., Reddy, R., Cameron, M. P., Meha, P., Johnston, K., Nock, S., Greensill, H., Harding, T., Shelford, P., & Tuhiwai Smith, L. (2019). Correlates of health-related quality of life for Māori elders involved in a peer education intervention. *Journal of Health Communication*, 24(5), 559–569. <https://doi.org/10.1080/10810730.2019.1637483>
- Podsiadlowski, A., & Fox, S. (2011). Collectivist value orientations among four ethnic groups: Collectivism in the New Zealand context. *New Zealand Journal of Psychology*, 40(1), E5–18.

- Reid, P., Cormack, D., & Paine, S.-J. (2018). Colonial histories, racism and inequity – the experience of Māori in Aotearoa New Zealand. *The European Journal of Public Health*, 28(1), 3–205.
- Robb, G., Stolarek, I., Wells, S., & Bohm, G. (2017). The state of quality improvement and patient safety teaching in health professional education in New Zealand. *NZ Medical Journal*, 130(1464), 13–24.
- Ryan, C. (2017). *Through the looking glass: a cultural lens on behaviour change*. StopPress, ICG Media. Retrieved from <https://stoppress.co.nz/opinion/through-looking-glass-cultural-lens-behaviour-change/>. Accessed November 2020.
- Sherwood, G., & Drenkard, K. (2007). Quality and safety curricular in nursing education: Matching practice realities. *Nursing Outlook*, 55, 151–155. <https://doi.org/10.1016/j.outlook.2007.02.004>
- Smith, G. (2012). Kaupapa Māori: The dangers of domestication. *New Zealand Journal of Educational Studies*, 47(2), 10–20.
- Statistics New Zealand. (2014). *2013 Census QuickStats about a place: Bay of Plenty Region*. <http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/>. Accessed November 2020.
- Taonui, R. (2005). Tribal organisation - Social rank. *Te Ara - the Encyclopedia of New Zealand*. <http://www.TeAra.govt.nz/en/tribal-organisation/page-5>. Accessed November 2020.
- Toi Ohomai Institute of Technology. (2019). *Strategic framework*. Author.
- Waldon, J. (2004). *Oranga Kaumatua: Perceptions of Health in Older Māori People*. Ministry of Social Development.
- Wilson, D. M., Anafi, F., Kusi-Appiah, E., Darko, E. M., Deck, K., & Errasti-Ibarrondo, B. (2020). Determining if nurses are involved in political action or politics: A scoping literature review. *Applied Nursing Research*, 54, 1–10. <https://doi.org/10.1016/j.apnr.2020.151279>

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