Full report

Readying nursing students for culturally grounded practice that supports a new vision of older persons' healthcare environments

Judith Honeyfield and Cath Fraser

Ako Aotearoa

TOI-OHOMAI Institute of Technology

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www.ako.ac.nz
0800 MYAKONZ
info@ako.ac.nz

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1 | Executive summary

This report outlines findings and reflections from a year-long, co-funded AARIA project. The purpose of this inquiry was to employ a cultural lens to view the way in which our Bachelor of Nursing (BN) students are preparing, and being prepared to become future leaders in our healthcare sector where older people are highly represented, and hail from an increasingly diverse array of cultural backgrounds. There is a growing literature about the importance of culture in healthcare and education in New Zealand (e.g. Honeyfield et al., 2021; LiLACS NZ, 2015; 2016), although rather less about how this should be supported, or what tools are available. The resources produced as part of this project are intended to contribute to this gap.

Māori and Chinese were selected as specific ethnic groups to consider how well non-western cultures are supported in aged healthcare. Māori as tangata whenua, who still experience inequitable outcomes in many measures of health, and Chinese as the fastest increasing ethnic group in the country. Increasing nursing students' understanding of these cultures, and alignment or variance from Aotearoa 'norms' will help to prepare them for a multicultural workplace.

A mixed method exploratory (descriptive) design combined elements of Kaupapa Māori research, cultural lens theory, narrative inquiry and case study research, and included a number of data sources: (1) an iterative literature review; (2) individual and group semi-structured interviews with four groups of participants (n=46): Older people; BN educators and academic leads/programme managers; preceptors/student nurse educators; and students; (3) Quantitative analysis of clinical placement evaluations; (4) Document analysis of student assessment reports; and (5) Insights and perspectives from cultural engagement/dialogue. Data analysis included both thematic and statistical approaches, and was overseen by Kaupapa Māori cultural advisors as an important element of our responsibility as non-Māori, of conducting researching in a cultural framework (Amundsen, 2018).

Key themes and findings were:

- For older people: (1) Positivity and wellness; (2) Language; (3) Whānau/family; (4) Tikanga/cultural practices; (5) Social justice
- For BN teachers and academic leads: (1) Culture shock; (2) A cultural lens – on students and with clients (including ageism and racism); (3) Anticipatory classroom preparation
- For Preceptors/Student Nurse Educators: (1) Developing a holistic understanding of practice; (2) Valuing professional standards – the role of Nursing Council Standards of Competencies
- For students: (1) A mismatch of expectations and experience; (2) Ageism is real (3) Mixed practice in cultural responsiveness
- From analysis of Quality Improvement assessment projects: (1) A holistic approach to health; (2) Meaningful communication; (3) Client-centred initiatives
- From students' post ARC placement evaluations: Overall, participants were predominantly satisfied with their placement experience, although 24% of respondents would not encourage other students to seek clinical placements at their placement provider, and 17% felt that their overall placement experience was not positive, due to issues such as 1) the lack of useful orientation (30%), the lack of preceptor's support with learning opportunities and limited, if any, opportunities to meet learning objectives (10%).

A discussion of insights from applying cultural lens theory reveals a persistent tension between a traditional biomedical discourse emphasising functional decline of physical and mental capacities (Foster, 2020), in predominantly 'Weird' settings: western, educated, industrialised, rich and democratic (Dik et al., 2019), and a distinctly Aotearoa New Zealand response, emphasising a holistic, hauora-based approach to wellness and positive ageing (e.g. Ministry of Health 2016; 2020).

In response to the above, this project has produced a number of independent outputs to accompany this report:

— A literature review of recent work in the field of supporting cultural identity in aged health care provision
— Teaching resource 1: Narratives. A series of 12 accounts of older adults' experiences of health care and ageing, related to their own cultural identity, and linked to the Nursing Council of New Zealand's six Standards of Competency Pou (NCNZ, 2024).
— Teaching resource 2: Five video clips of some of the project's interviewees talking about their own health and ageing journeys.
— Teaching resource 3: A poster for classroom use: *"What older adults in Aotearoa would like nursing students to know: Findings from the research".*

These outputs have been tested with some of our informants, including Kaupapa Māori advisors, and stakeholders including a visiting delegation of Shenzhen Polytechnic University's nursing and international departments, China, facilitated by Access NZ. Dissemination to date has included two conference presentations and an interview about the project published in December 2024 by national magazine: Hauora Research eNewsletter.

The report concludes with plans for further dissemination, and an acknowledgement of the personal and professional gains and challenges for the research team in undertaking this project.

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And our videographer,

— Oliver Abbott

2 | Introduction

Context and rationale

There is a 'perfect storm' brewing – policy makers, health and higher education practitioners have known about it for some time, but we are still frighteningly unprepared.

First, like most western countries, New Zealand's population is aging, and the effect will accelerate over the next decades. The 2018 Census showed the proportions of our population aged 65 and over at 15 per cent, double what it was in the 1980s (Statistics New Zealand, 2018). According to a recent update, in 2022, "1 in every 6 people in New Zealand were in this older age group. In 2028, 1 in 5 people in the population will be 65+ years. By the 2050s, this group could make up one-quarter of the population". And when it comes to the older, older adult, "Currently 1 in 50 people in the population are aged 85+ years. This could increase to about 1 in 30 during the 2030s, and to about 1 in 20 in the 2040s" (Statistics New Zealand, 2022). Inevitably this rise in longevity will mean a growing demand on public services and resources, and especially the health sector.

Second, we have a critical aged healthcare workforce shortage. Multiple studies in this country and beyond (e. g. Wilkinson et al., 2016) continue to find that student nurses show a persistent disinclination to specialise in this area. The perception is that nurses caring for older people are overworked and undercompensated, and that workplaces are frequently understaffed, with outdated facilities and shoddy equipment (Fisher, 2018; Your turn, 2001). As Parker et al. (2020) noted, despite curricula which support a holistic understanding of aging and a focus on wellbeing (rather than on declining functionality) there has been little impact on the pervasive ageism in aged healthcare – and indeed, across society (Honeyfield et al., 2021). Some of our older adult participants also reported experiencing and/or witnessing examples of ageism firsthand, as described in the Findings section of this report.

Third, we are an increasingly multicultural society, yet our healthcare system and higher education models have been lagging behind. Despite ripples of recent political friction and protest, Aotearoa New Zealand is justly proud of its bicultural heritage and culture; alignment with Te Tiriti o Waitangi is interwoven across all strands of the Bachelor of Nursing (BN) and is highly visible in our public institutions, such as te reo in signage, and kaupapa Māori wards in hospitals. We are less well-schooled when it comes to understanding the rich diversity – and how to respond to the cultural needs – of our 21st Century population.

Statistics NZ's (2019) census data reveals that between 2013 and 2018, our population grew by 10.8 percent, and now has over 200 distinct ethnic communities. Their depiction of New Zealand as a village of 100 people (in which each person represents around 47,000 people) includes the following characteristics:

- 73 were born in New Zealand; 27 were born overseas
- The top 5 overseas birthplaces were: England; People's Republic of China; India; Australia; South Africa.
- 70 were of European ethnicity; 17 were of Māori ethnicity; 15 were of Asian ethnicity; 8 were of Pacific Peoples ethnicity; 1 was of Middle Eastern/Latin American/African ethnicity; 1 was of another ethnic group not listed above.

This means that New Zealand is now one of a small handful of culturally and linguistically 'superdiverse' countries. Amongst OECD countries, New Zealand is the fifth most ethnically diverse, and this trend is forecast to continue: "New Zealand European/Pakeha New Zealanders will not continue to make up the large majority of the population. Growth of our Asian population in particular is forecast to be significant" (Office of Ethnic Communities, 2016). As the Office of Ethnic Communities notes, to optimise the benefits and to minimise potential challenges of superdiversity, we need to be proactive, and create contexts where people are open and engaged with each other and where there is underlying trust. The current project hopes to make a small contribution to this work.

Selection of Māori and Chinese as specific ethnic groups for a cultural lens study

Māori are tangata whenua, people of the land, yet still experience inequitable outcomes in many measures of social-cultural wellbeing, including health. Health NZ (2024) notes that in incidence of almost every serious condition (cancers, stroke, diabetes, heart disease, obesity, chronic pain, arthritis), Māori outnumber non-Māori. Older Māori also experience more difficulty accessing primary care services, with 1.8 times the rate of unmet need for a GP due to cost. Efforts to improve the health system and uplift the health and wellbeing of not only whānau Māori, but of all New Zealanders remains a national priority. One aspect of building trust and responsiveness is strengthening our healthcare workforce – with more Māori nurses, and more nurses who understand the importance of tikanga and practice which affirms cultural identity (Honeyfield et al., 2021).

Including Chinese as a comparison population in order to apply cultural lens theory with Mātauranga Māori approaches and content, recognises that between the 2018 and 2023 census, the Chinese New Zealander population increased about 45% – the fastest increasing ethnic group in the country. Nursing students and graduates are increasingly likely to encounter Chinese clients accessing healthcare services. Enriching students' understanding of Chinese culture, and alignment or variance from Aotearoa 'norms' can only help to prepare them for the workplace. The creation of learning and teaching resources to prompt this understanding is one of the key outcomes from the project described in this report.

Research purpose, aims and guiding research questions

The purpose of this inquiry was to discover and share new learnings and understandings in order to improve student outcomes and produce well-prepared, culturally-confident graduates who will become the future leaders in our healthcare sector where older people are highly represented. This is particularly important given the impending workforce crisis of ageing populations and the need for specialist healthcare practitioners. There is also a growing literature about the importance of culture in healthcare and education in New Zealand (e.g. Honeyfield et al., 2021; LiLACS NZ, 2015; 2016), although rather less about how this should be supported, or what tools are available. The resources produced as part of this project are intended to contribute to this gap.

Key research question

— What do student nurses know, and need to know, about culturally-centred work in older persons' healthcare?

Sub questions

— What is current thinking, in New Zealand and overseas, about how best older persons' cultural identity can be supported in healthcare settings?
— How are cultural identity, ōritetanga (equity), and Te Tiriti o Waitangi-based guidance for practice reflected in both education and healthcare provision that relates to older persons' health and wellbeing?
— What do BN students think about the way they are taught about optimal cultural and environmental factors that promote a sense of positive wellbeing for older people? Were these factors evident during their practicum placements in aged care environments?
— What narratives do students and residents have about specific interventions and initiatives related to culture and a sense of home, that have had positive health and wellbeing outcomes?
— Using cultural lens theory to test transferability of ōritetanga (equity), and Te Tiriti o Waitangi-based guidance for practice, how well-served are Māori and Chinese older people by the prevailing discourse in healthcare literature and policy?
— Incorporating all the above, what are the Hua Akoranga (Learner Outcomes) for student nurses in learning about culturally-grounded older persons' healthcare provision and environments designed to nurture a sense of home? How effective is this learning in preparing and encouraging students to seek a career in older persons' healthcare, and to see themselves as registered practitioners, leaders and managers in this sector?

3 | Literature summary

One of the outputs for this research project is an independent literature review, published as a separate document, and available from the same project webpage as this report (https://ako.ac.nz/knowledge-centre/readying-nursing-students-for-culturally-grounded-practice).

The complete literature review explains the integrated, iterative review methodology including search terms, sources and databases, and the organisational framework provided by adoption of the SPICE tool (NCCMT, 2018), using a series of headings suggested by the acronym: Setting; Perspective; Intervention; Comparison; Evaluation. The review also introduces and outlines four cornerstone sources as the basis for exploring key themes in the literature related to how culture is, or is not, integrated into aged healthcare provision, with particular regard to older Māori and Chinese New Zealanders.

The review acknowledges and outlines the multitude of definitions of what culture is and means, before discussing biculturalism and multiculturalism in this country. Similarly, the many and varied ways older age is defined and discussed in literature and policy is overviewed, including an understanding of ageism and the negative framing this stance entails.

The introduction of cultural lens theory (Hardin et al., 2014) and cultural dimensions theory (Hofstede Insights, n.d.) offers a tool for national cross-cultural comparisons, admittedly in broad brushstrokes. However, what is valuable for this project is the framework for considering how a collective Chinese mindset, for example, differs from a westernised pattern of thinking, and how many of these differences will be evident in the way older people think about, and respond to healthcare services.

In considering the ways Chinese traditions differ from westernised New Zealand societal norms, two key hallmarks of Chinese culture related to ageing and healthcare are discussed: (1) The importance of home and community, and (2) Family and filial responsibility.

A similar analysis of the hallmarks of Māori culture related to ageing and healthcare focus on (1) Two key cultural understandings underpinning the literature related to Māori healthcare (Hauora; Kaupapa and tikanga), and (2) Ageing in place – the role of whānau and community.

A final section of the literature review examines how cultural identity in healthcare provision for older Chinese and Māori can be supported, and again notes two themes in the literature: (1) Acknowledging inequities and reclaiming cultural continuity, and (2) Education and cultural consciousness.

4 | Methodology

Research design

This research employed a mixed method exploratory (descriptive) design to understand the underpinning concepts more thoroughly, and to investigate a relatively new and unexplored field (Swedberg, 2020). Woven into this approach were elements drawn from a number of different epistemologies, that is, philosophies about different sources of knowledge and their validity as a way of understanding the topic. These included:

— **Kaupapa Māori research.** The current project builds on previous work by the project leads (Honeyfield et al., 2021) conducted under this methodology. Both at this time, and earlier in other projects for Ako Aotearoa (e.g. Honeyfield et al., 2016) we have taken part in professional learning opportunities to learn about good practice in researching with Māori. Examples include: attending a two-day wānanga at Awanuiārangi, Whakatane with Distinguished Professor Graham Hingangaroa Smith; regular consultations with Kaupapa Māori cultural advisors at our own organisation and their oversight of our ethics application; marae-based wānanga, conferences and community healthcare events. We understand the responsibility as non-Māori, of conducting researching in a cultural framework (Amundsen, 2018).

  Accordingly, we approached Māori members of the Bachelor of Nursing teaching team and invited them to assist us with this project by forming a 'Komiti Kaupapa Māori research' to advise on tikanga, and especially to support our consultations with Māori participants. Together we held advisory meetings; members also accompanied the researchers to conduct interviews with older Māori people on several occasions. We valued their support and reimbursed them for their time as team members. With one resignation early in the project's timeline, we were glad to have two remaining Komiti members. Their support included: ensuring the research was culturally safe and non-offensive for the participants; ensuring tikanga was recognised and adhered to; consideration of actual or potential implications for Māori, especially with respect to the new Nursing Council Standards of Competence framework which was introduced in October 2024; and respect for intellectual and/or cultural property shared.

  A core position for us was that we understand that Māori participants who shared their experiences with us are gifting us insights that are their own cultural property, and without whom we could not gain this understanding. We ensured that narratives shared by Māori participants were treated with the utmost respect and appreciation, and that those older people who agreed to tell their story to contribute to nurses' education were entirely happy with the way this is presented. This meant both multiple visits to establish relationships of trust and respect, and also including whenever possible, one of the Māori members of the team, along with whānau, to attend the interviews.

  Other relevant aspects of Kaupapa Māori research were: (1) whanaungatanga – for example by ensuring we introduce ourselves properly to the participants and allow time for a sit down discussion to answer any questions and recognising that their perspectives are valid, highly valued, and deserving of a discussion; (2) manaakitanga – for example by upholding integrity, sincerity, and respect throughout the research, making all details of the research transparent, and clarifying responses to check that data collected were reflective of the experience and perspectives the participant

wanted to share. Finally, we have endeavored to ensure that our reporting has privileged Māori cultural norms and presented the lived realities of Māori from a culturally informed position (Mikaere-Hall, 2017).

— **Cultural lens theory.** This methodology helps researchers metaphorically look through different cultural lenses to examine the research subject or context in a different way, while considering congruity or dissonance of experiences and perspectives across targeted cultural groups (Hardin et al., 2014). In our study, we specifically sought to understand how the cultural identity of Māori and Chinese was/was not being addressed in nursing education and healthcare service experiences for older people. Our starting point here was that advocated by Triandis (1996, cited in Hardin et al., 2014, p. 658) who declared "all humans are ethnocentric."

  Culture and related concepts (cultural identity; cultural competence; cultural safety; culturally-responsive etc) are at the heart of this project: as key words in database searches, as questions for participants and focal areas in document analysis. Yet we intentionally chose not to make this methodology our leading framework; we are trying to avoid sweeping ethnic generalisations: we know that just as there are dozens of iwi groups across New Zealand with their own histories, dialects and protocols, so too populations like Chinese New Zealanders are far from homogenous.

— **Narrative inquiry.** This research methodology records an individual's lived experience in a form of oral history. An oft-cited advantage is that the process empowers the teller, and places them at the centre of the data-gathering interview, while criticisms of the method often focus on memory, self-censorship, and its time-consuming nature (Bhattacherjee, 2019). Nonetheless, "indigenous story-telling as research" (Iseke, 2013) is a growing sub-category of this methodology. Iseke describes how elders' stories can inform a range of knowledge-sharing discussions: "(a) storytelling types (mythical, personal, and sacred), (b) storytelling as pedagogical tools for learning about life, (c) storytelling as witnessing and remembering, and (d) sharing stories of spirituality as sources of strength" (p. 559). This approach informed and resonates with our experience of data collection and its influence is clearly evidenced in a number of the project outputs, particularly the videos of Māori kaumatua Tamati in his explanations of the spiritual element to health and his linking of legends to understanding wellbeing and traditional use of medicinal native plants.

— **Case study research design.** One of the most commonly used methodologies of social research (Bhattacherjee, 2019), case study research has been described as "an empirical inquiry that investigates a contemporary phenomenon (the 'case') in depth and within its real-world context" (Yin, 2014, p. 16). In our study, the case, or cases, were the experiences of older people in healthcare, related to their own cultural identity. Some of the tenets of case study methodology that helped us to shape this project were an understanding that cases can be complex and multi-faceted, and that data collection is a "linear but iterative process" (Yin, 2014, p. xxii).

Research methods and procedures

This mixed-methods study employed a number of different data collection tools. All data, including transcriptions and analysis of organisational data (i.e. student post-placement evaluations) was stored on password-protected computers and shared only by the two members of the research team. In keeping with our institution's policy, all raw data and records will be deleted three years' after the project's completion. Data sources were:

1. **An iterative literature review** of published studies from New Zealand and overseas, of culturally grounded practice that supports a new vision of older persons' healthcare environments, and a 'sense of home', and how these concepts are best developed and delivered in nursing education. This review was undertaken across the 12-month project timeline, using a meta-synthesis of literature from a previous project as a starting point (Honeyfield & Fraser, 2021), and adding sources and discussion as reading, searches and conversations occurring during data collection brought new publications to our attention. This review not only informed this final report, it has also been produced as a separate project output, intended as a reference-resource for teachers, learners and other researchers in this field.

   Our approach began with searching databases accessed via the EBSCO Discovery search engine, which includes multiple medical, nursing and health databases and individual e-journal subscriptions. Google Scholar was used to find full-text articles and others were sourced through our organisation's library interloan system. Filters were used to prioritise Aotearoa New Zealand and Australian studies, and those published since 2010. Keywords used in the searches included terms like "culture and aging", "aged health", "positive aging and Māori"; "positive aging and Chinese", and "nurse education and culture". Combinations of these terms were often paired with other keywords, including "multiculturalism," "biculturalism," "kaupapa," "kaumatua" and "qualifications," "nurse graduates" "student nurses," and so on. Sources were logged in an Excel spreadsheet, using a series of headings based on Booth's (2006) SPICE framework: Setting – where? Perspective – for whom? Intervention – what? Comparison – compared with what? Evaluation – with what result?

2. **Individual and group semi-structured interviews.** The main source of our data for this study came from interviews with four groups of participants: Older people; Bachelor of Nursing educators and academic leads/programme managers; preceptors/student nurse educators; and students. Using a minimum of opening questions (see Findings section), this approach allowed us to add in unplanned prompts, ask for examples, and adapt our line of inquiry in response to the story that participants chose to share (Bhattacherjee, 2019; Iseke, 2013). In all cases, we shared a Participant Information Sheet (Appendix A) as part of our contact process, and then took copies, along with a Consent Form to the interview and began each meeting by re-introducing the project and ensuring participants understood the scope, purpose and end uses of their contribution, once agreement to participate is complete. In keeping with our kaupapa Māori research philosophy we provided refreshments for all meetings (Amundsen, 2018). All interviews were audio-recorded, transcribed and where participants were willing, sent to them for verification.

   The setting for interviews was chosen by the participant. For older people, this was generally in their home, although one person preferred to meet in a café, and two

came to our campus. Interviews lasted between 40 minutes and three hours. Many participants met with us on multiple occasions – to check and approve stories, consider or add to what had been covered, or to revisit their story while we video-recorded the session with a contracted videographer (entailing another visit for viewing and final approval). Here, a willingness to meet, build relationships, share kai, and return as often as the participant wished is an important aspect of respectful kaupapa Māori research practice (Amundsen, 2018; Mikaere-Hall, 2017). At the conclusion of the first meeting with each participant we thanked them and offered a card and koha in appreciation for their time (supermarket vouchers).

Interviews with Bachelor of Nursing educators were all during work hours and at their place of work, encompassing Toi Ohomai Windermere and Mokoia campuses, Wintec and Waikato University in Hamilton, AUT and Unitec in Auckland. Duration was generally around 30 minutes for individual interviews; over two hours for one group session with a teaching team from Unitec. Interviews with Student Nurse Educators were through Teams video-conferencing calls, apart from one participant who invited us to her home. These interviews were also around 30-40 minutes.

The interviews with students were scheduled as two focus groups during a lunchtime on a day when students were already on campus, so that the time was limited to 45 minutes. Here we provided lunch, as well as a lucky draw for a supermarket voucher at the conclusion of each meeting.

3. **Quantitative analysis of clinical placement evaluations.** Following practicum placements, student nurses complete an anonymous online evaluation of their learning, experiences and challenges. As a standard clause, completion and submission of these surveys acknowledges that they may be used for studies which aim to improve the education experience for future cohorts. For this project we drew on the surveys which follow first and third year students' older persons/aged healthcare placement experience and reviewed these for responses which related to culturally grounded care, and its observance, or lack thereof, especially (but not only) related to Te Tiriti and Mātauranga Māori. The focus of this evaluation was to address the specific aims and research questions of this project. Once the available survey responses from the past two years were checked for eligibility (i.e. that they were complete, and the student had entered valid responses, rather than opting out of the survey part way through and 'submitting' to escape the online form), there were 48 forms remaining.

4. **Document analysis of student assessment reports.** Analysis of pre-existing text is often used with other types of data for triangulation, a strategy designed to increase the trustworthiness of a study (Morgan, 2021). However, as Morgan notes, there can be concerns about the ethics of using texts as data that the authors may not necessarily see as having been for public readership. In the case of student assessments, part of the academic process includes cross and team marking, and often, external moderation – though usually partially anonymiaed by use of student identification numbers, rather than names. Work submitted for assessment is therefore not "private" in a literal sense. In our approved ethics application, we committed to ensuring that our findings from this analysis were only reported in very general terms, for triangulation purposes, and that any identifying features of student nurse, the client they worked with or the facility which hosted them was removed.

Year three Bachelor of Nursing students undertake a Quality Improvement (QI) project and produce a report about the initiative and its outcomes as part of their assessment. QI is defined as "a range of formal approaches to analyse the quality of patient care and implementing systematic efforts to improve it" (Djukic et al., 2013, as cited in Honeyfield et al., 2022). Students in Aged Care Residential clinical placements working with older adults can choose their own QI intervention. By this stage in their learning students have been exposed to extensive bicultural learning, with Te Tiriti embedded across the curriculum, and extensive reference to He Korowai Oranga (Māori Health Strategy) (Ministry of Health; 2014). The purpose of this document analysis was to identify the extent to which students were applying their training in cultural consciousness into health settings. Specifically we were interested in identifying projects which enhanced a cultural worldview, introduced elements of biculturalism or multiculturalism, or suggested new culturally-safe practices.

5. **Insights and perspectives from cultural engagement/dialogue.** Three important meetings which shaped this project and contributed to the cultural lens through which we considered our data took place during the year-long timeline.

   First, attending a two-day Māori nurse and nurse educators wananga April 22-23: *Te Waka Tūhono ki Tua*, held at Kokohinau Marae, Te Teko in the Eastern Bay of Plenty (https://www.tpoom.co.nz/event/te-waka-tuhono-ki-tua). Jointly hosted with Te Whare Wānanga o Awanuiārangi and Te Kaunihera o Ngā Neehi Māori, this event was attended by approximately 175 support workers, Registered Nurses, Nurse Practitioners, Nursing Tauira and those interested in the field. Speakers included academics, doctors, and Māori media commentators. A whakataukī set by the keynote speaker Associate Professor Haturini McGarvey defined this event:

   Ko taku marae taku whare wananga; ko taku whare wananga taku marae
   My marae is my university; my university is my marae

   A second important meeting was with Tanya Savage from Poutama Pounamu, University of Waikato. Tanya had been one of the contributors to Te Toi Ahorangi2030, the Toi Ora Strategy of Te Rūnanga Hauora Māori o Te Moana a Toi, representing 17 iwi from the central Bay of Plenty and endorsed by the Bay of Plenty District Health Board (Keelan & Porter, 2019). She guided us through the values which underpin this Māori regional health response, and shared how she saw the connection of indigenous (and cultural) rights with Te Tiriti o Waitangi, the United Nations Declaration on the Rights of Indigenous Peoples, and the Mataatua Declaration on Cultural and Intellectual Property Rights of Indigenous Peoples.

   Third, one of the project leaders attended a webinar offered by the organisation Community Research and Inclusive Aotearoa Collective, December 16, 2024, entitled "Ethnic communities, sense of belonging and Te Tiriti: What is the role of Te Tiriti o Waitangi and what does that mean for ethnic communities who call Aotearoa home?" This online conversation about the history of our diverse ethnic communities, the current Treaty context, and visions for the future was facilitated by Bev Tso Hong and featured panelists Anjum Rahman, Ganesh Ahirao (aka Ganesh Nana), and Danny Karatea-Goddard, and Vira Paky (https://communityresearch.org.nz/webinar/ethnic-communities-sense-of-belonging-and-te-tiriti/).

Participants and how they were recruited

When considering potential contributors with lived experience of aging, and who would have a thought-provoking narrative about culture and aging, we aimed for a cross-section of demographics and experience (e.g. Māori, Chinese, recent immigrant) but also noted that older-age across all ethnicities is itself a culture in which people can be seen as 'other'. Talking with Research Office and BN teaching colleagues gave us the name of a local person who was active in the local council and community and as advisor for Kainga Ora housing development. She became our first participant, and quickly passed on contacts for others who met our criteria. Another source of contact were community groups: The Tauranga Ethnic Council, and the Tauranga branch of the -New Zealand-China Friendship Society. We personally knew one of the kaumatua we interviewed, another was a colleague's uncle, others were friends and relatives of friends and relatives. Recruitment was therefore a combination of snowball and convenience sampling (Bhattacherjee, 2019).

Our Participant Information Sheet (Appendix A) and our own preamble to the interview explained that we were seeking to produce narratives of aging and health from a cultural perspective, and the idea of a possible request to film a video record was also introduced. Once we had written up the 'case study' story for participants' approval, the researchers determined our first choice of three video subjects (ageism and social justice, Māori, Chinese), and these participants generously agreed. Prompts based on their life stories were prepared and shared, then videos were taken on the third and fourth visits, using a tripod and a mobile phone. Our kaupapa here was of a partnership process as we discussed what was needed for the teaching resources, and what they would like to share. Further, our Komiti Kaupapa Māori colleagues fed into this process, and attended some of the interviews with Māori participants, contributing to our recruitment and engagement tikanga (Mikaere-Hall, 2017; Olsen et al., 2020). We conducted over 30 interviews with 16 participants, which included two couples and family members. Two from this group preferred not to have their stories presented as publicly available text resources, but were happy to contribute anecdotes and examples for inclusion in our reporting.

Recruiting BN teachers and academic managers, and preceptors/student nurse educators was easy as these were colleagues at our own or other BN providers, and known to us through education networks. Our typical approach was a group email with the Participant information Sheet attached, and an invitation to participate. As shown in Table 1, participants in these groups numbered 12 and 4, respectively.

Recruiting third year BN students was timed to follow their clinical placement in Aged Residential Care and completion of a Quality Improvement assessment project, so that having worked with older people in a setting dedicated to their care and wellbeing would be top-of-mind. Here we asked class teachers to introduce the research, share the Participant information Sheet, and invite students who were interested to attend a lunchtime meeting a few days later. For our first focus group at Mokoia campus in Rotorua, 4 students attended; at Windermere campus in Tauranga, there were 10 participants.

Table 1. Summary of participants (n 46)

Category	NZ European	Māori	Chinese	Indian	Philippino	Pacific	Total
Older adults	2	4	5	3	1	1	16
Teachers & managers	7	3	1	1	–	–	12
Student nurse educators	3	1	–	–	–	–	4
Students	7	4	–	1	1	1	14
All							46

Data analysis

Overall, our approach to data analysis could be described as interpretivist: the social phenomena of ageing experiences intersecting with cultural identity was recounted, observed and reflected on subjectively by our participants. Our rationale and overarching research question(s) for the study are focused on feelings, responses, meaning and motivation and the implications for policy and practice, rather than a more positivist approach to measurements and facts.

In addition, most of the data in this study was qualitative, lending itself to inductive analysis, aiming to build a picture/theory about what culturally grounded practice in older persons/aged healthcare means to different stakeholders (but especially students and educators), how service and practice development is fostered, and how it is evidenced (or not) in specific environments. This means that the data has determined the themes, rather than commencing with pre-determined assumptions (although in many areas our findings did confirm themes described in the literature).

Interview transcripts and participant narratives were considered through thematic analysis using Braun and Clarke's (2006) six step approach: Familiarisation; Coding; Generating themes; Reviewing themes; Defining and naming themes; Writing up. In this project, we found that at least the first three phases outlined above occurred naturalistically, as well as by intention, as we revisited the different contributions and presented them to participants to agree or amend. Videos were edited to accentuate these themes, and present the essence of the older participants' stories while not doubling up on the content of the text narratives.

Similarly, revisiting advisors and colleagues, feedback from the project mentor and our own reflections from conferences and wananga attended, and the ongoing review of literature – all informed our thinking around coding, theming and reviewing. In our 'writing up' phase, we sought to compare the themes identified inductively with those identified in the underpinning literature review – with the aim of answering – or at least addressing, our main, and sub-research questions, as discussed in following sections of this report.

Document analysis of students' Quality Improvement assessments employed the same thematic analysis approach. However, with 157 texts, albeit short (most were 2-3 pages), the first two steps of Familiarisation and Coding occurred simultaneously as a pragmatic selection/exclusion exercise until the nine qualifying projects were identified. The remaining four steps then proceeded as described in the preceding paragraph.

The quantitative survey data collated for this study from organisational data (48 post-placement survey evaluations) was formatted and exported to SPSS for descriptive and inferential analysis. Firstly, responses to all questions were summarised with the help of descriptive statistics. Frequencies and proportions of responses in each category of responses (on four-point scale: strongly disagree, disagree, agree, strongly agree) as well as bar charts were reported. Regression analysis was also run to establish whether four independent variables (*Prior to arrival, orientation and learning resources/ Support quality, department/area of placement perception*, and *Quality of Toi Ohomai supervision*) predicted the variation of a dependent variable (Overall satisfaction).

Responses to qualitative open-ended questions were extracted from response forms and saved as a Word document. Although there were three open-ended questions, responses to some of these questions were either missing or had a repetitive nature. For this reason, running individual content analyses for each set of responses would not produce meaningful outcome. The decision was made to compile all responses together and analyse them as a single text corpus. Leximancer, an exploratory content analysis software (https://www.leximancer.com/), was used to identify key themes in the open-ended responses. Leximancer automatically detects groups of words (i.e., concepts) that travel together throughout the text, extracting these semantically connected words and then developing categorical dictionaries to code text segments. The next step involves the analysis of category frequencies and co-occurrences which leads to the identification of concepts (presented as nodes on a concept map). The implicit relationships between concepts are displayed as a concept map (or a co-occurrence matrix) that reflects semantic connections between concepts.

Ensuring the trustworthiness of findings

This project employed a number of approaches to check the accuracy of our data, and test our thinking:

- First is the nature of the project itself, drawing on data from multiple sources, including evaluations and interviews with a range of stakeholders. This process assisted with triangulation as we searched to identify key teaching points to recommend to educators charged with delivering nursing education related to culturally grounded healthcare practice for older people.
- Primary data, such as narratives and interview transcripts were shared with individual participants to verify our representation of their experiences, reflections and examples. In particular, we aimed to have all our older adults actively agree to the final version of their story; all but two were engaged in this process. However, we were also very aware of not being over-zealous in asking for too much input, understanding that health and energy levels for this participant group could change across the project timespan. We also offered focus group participants, particularly students, the opportunity to view transcripts and final draft findings if they were interested, but no one requested this.
- As part of our data analysis process, the two team leaders undertook the first three steps (Familiarisation; Coding; Generating themes) of the thematic data analysis outlined above (Braun and Clarke, 2006), before comparing notes, to offer two points of view to inform the collaborative phases of Reviewing themes and Defining and naming themes. Consensus and discussion has been shown to improve dependability relating to interpretation of primary data sources (Caulfield, 2023).

— As part of our Kaupapa Māori research process, we held regular check-ins with our Māori team members, as well as external Māori stakeholders (as described in Research Design, above. These hui and kōrero helped our understanding, particularly as we developed the discussion of our findings and moved into the creation of teaching resources and our thinking about how they could be used.
— Peer review of our findings and resources by experts. (1) In October 2024, the project leaders returned to meet again with colleagues from Wintec and AUT Nursing schools, and shared the set of 12 older adult narratives and focus questions as a planned teaching resource, with a positive response. (2) October 2024, presenting our work to Access NZ and a visiting delegation of managers and Heads of the Nursing Department and International Division from Shenzhen Polytechnic University, China. (3) One of our participants, Carole Gordon, is a social scientist and community advocate for positive aging in our region and member of the LiLACs original study team, from The University of Auckland. Carole was awarded the New Zealand Order of Merit for her services to seniors in 2019; she knows this sector well and has been kind enough to support our project with suggestions of literature and initiatives, as well as to review our findings.

Ethics approval

Following advice from Ako Aotearoa that our submission for AARIA funding had been granted, the research team prepared an application for the host institute, Toi Ohomai's Research and Human Ethics Committee. The proposal was reviewed at the November 2023 meeting, and 'approval in principle' gained, asking for some further clarification around budget, timeline and the possible need for translation services. Once these were addressed in a letter to the Committee Chair, full approval to proceed was received in February 2024: resolution number TRC 2024.006; project code #24002.

Limitations – and pivots

— As with most qualitative social science research, this project worked with a smaller sample of size of participants, but aimed for a rich and immersive data set. The intention was to collate individual accounts of lived experience, and related commentary from stakeholder groups to address our research questions. Therefore, the findings and conclusions reported here can only be taken as indicative, rather than representative of a wider population's cultural response to aged healthcare provision in this country.
— Twelve months in tertiary education is a long time in our current environment of political change and sector re-structuring. With the disestablishment of Te Pūkenga came the announcement that development of curricula for the unified Bachelor of Nursing, and Bachelor of Nursing Pacific has been halted and later in 2024 the Bachelor of Nursing Māori was accredited to be offered by NorthTec. At this stage the remaining proposed unified degrees are unlikely to be taught. Original plans agreed in the project approval contract with Ako Aotearoa were to include an analysis of the cultural content of these unified curricula. Instead, we 'pivoted' to include year three nursing students' Quality Improvement projects from their time working with older people, as this is another aspect to identifying their cultural learnings and would, we hoped, support and enrich the data from our student focus groups. A further measure

to address the gap that the cancellation of the unified degree has created in terms of a national view of nursing education directives was addressed by cross-referencing our outputs with the Nursing Council of New Zealand's new *Registered Nurse Standards of Competence*, published in October 2024.

— A second area of political change beyond the control of the research team related to the previous Government's planned social housing building programme. One of our original seven sub-research questions (Taking the example of a planned Kāinga Ora older persons housing as a case study, what are possible student engagement opportunities, related to culture and a sense of home?) was consequently deemed no longer relevant to the study, as Kainga Ora's housing plans were put on hold.

Image next page - project participant Tamati, narrative 9, taken from "Teaching resource: Older adults' narratives of health and wellbeing."


MAORI
TAUPAMEA

5 | Findings and discussion: Key themes from participant interviews and focus groups

5.1 Older people

The following themes were identified through analysis of transcripts from over 30 meetings with 16 participants, which included two couples. Also included in the 16 were two participants who did not want to contribute a personal narrative for our resource outputs section, but still offered examples and anecdotes in the role of a cultural advisor.

The kaupapa of this project was that we facilitated participants to tell their own story in their own words, so that the prompt questions we supplied were only used as a starting point to the conversation; some participants adhered to the outline closely, but others, not at all. Our prompts were:

— What kind of health care/approach helps you retain your wellbeing and sense of cultural identity?
— Thinking about where you are living now, what have been the biggest enablers and challenges to retaining a sense of home and self?
— Can you think of a time when a nurse or student nurse was outstanding or made a positive difference to your health experience?
— What would you want student nurses to know about caring for older people and supporting their cultural identity?

Theme 1. Positivity and wellness

> "It's the lucky people in life that get to be old." (G)

The discussion of this theme must be presaged by the acknowledgement we are only presenting a selected perspective of ageing; naturally there will be a counterweight of stories which highlight illness, frailty, loss of function, dependence, loneliness, despondency…There are plenty of studies, statistics and publicity about the social and medical determinants of such experiences. Instead, this project is modelled on the Ministry of Health's (2016) Healthy Ageing Strategy and the United Nations' (2024) *Decade of Healthy Ageing*. In our choice of narratives to place before nursing and healthcare students, we are deliberately valorizing lived experiences of positive attitudes towards ageing – often, and especially, when the protagonists have had to overcome significant medical events and make challenging life decisions to get there.

Our participants' enjoyment of life and appreciation for some of the advantages of ageing traversed all cultural groups:

> "If I want to stay up all night reading, I can." (B)

> "I go for walks, garden, play cards, read, watch TV". (E)

Participants belonged to community groups like marae and ethnic societies; some took on positions of responsibility and leadership of committees, others did volunteer work such as neighbourhood watch, or supporting kohanga reo. Participant F works diligently at the series of books he is producing as a legacy to his adopted country of New Zealand, offering a practical guide to learning the Chinese language. Participants A and J

supported fellow immigrants in the healthcare system with translation assistance. Several participants embraced the challenge of learning English: Participant L told us about going for walks every day by herself and practicing English by talking to people she saw regularly and finding her place in the local community. Such testimony to the importance of activity and engagement for maintaining a positive attitude towards life in later years aligns closely with Mace et al.'s (2010) report as part of the larger, longitudinal LiLACS NZ study, about countering depressive symptoms, and Edwards' (2010; 2018) finding that active engagement in the business of the marae is linked to positive self-assessment of good health and optimism.

An active lifestyle of leisure and recreation to whatever extent is physiologically possible has also been linked to a positive, but pragmatic philosophy of ageing by international gerontologists such as Gawande (2014). Many of our participants evidenced exactly this matter-of-fact thinking:

> "You are born, you grow up, you get sick, then you die. All people must walk this four-steps path. So why should you worry?" (F)

> "Life has its cycle and we all live and die. We need to recognise and respect that process, not just attempting to fix people up." (B)

> "Of course, not everything went well, and it wasn't all happy, but I forget all that part. I take my medicine and I enjoy my life; I love living in New Zealand." (L)

Participant A's message for nursing students reminds us that we should not be too ready to allow older people to succumb to a sense of futility:

> "Patients need to be encouraged to be in good spirits, for nurses to laugh and joke with them when able. It makes a difference to the level of care you get. It's a win-win. And then you both get blessed." (A)

Theme 2. Language

The importance of language and communication was mentioned, either directly or tangentially, by every participant in this group of informants. No one liked overly-simplified, patronising or infantilised language (Fisher, 2018), such as addressing people as 'love', 'sweetheart' or 'dear.' Another example given was healthcare professionals who come straight to the bedside with little or no eye contact or pleasantries, asking 'How's the leg?'

Instead, people want to be seen as individuals, called by their name – and they want to know who they are speaking to. Māori participants articulated this from the perspectives of both patient and visitor:

> "The nurses were good – they mostly called me Mr D_____, so very respectful." (C)

> "It starts when I stand at the door. I wait. I'm showing my respect. It's the same as at a marae, you wait to be called to come on." (M)

> "What nurses need to do is to stop doing things, just sit there and be with the patient. Learn their name and use it. Then listen!" (N)

Another point was the use of 'hospital' language – not necessarily technical or highly specialised medicalised jargon, but an assumption that people share an understanding of what healthcare professionals may consider everyday vocabulary. One anecdote shared (admittedly from at least two decades ago, and more related to their work on general wards than with older people, but included as a memorable example), was from a kaupapa Māori support worker:

> "I got a call late at night, from a nurses' station – there's a man here, punching holes in the wall. So I went in, talked to the nurses, then went into the ward. He was upset because his baby had been isolated from the other children in the ward. I'd read the notes, I told him, 'She's isolated because she's got the shits'. He didn't know the word 'diarrhea', and no one had explained. 'Why didn't they tell me?'" (N)

> "Telling a patient 'Nasal medication - three drops a day'. Where? Nose, eyes, ears...?" (N)

Language is also well-recognised as one of the fundamental elements of culture and people's identity (Edwards, 2010; 2018). For older Māori who often come with a lifetime of being embedded in, and interconnected with tikanga, kaupapa and te ao Māori (Emery et al., 2021; Podsiadlowski & Fox, 2011), recognition and use of te reo is an important aspect of making them feel culturally safe, and 'seen' in healthcare settings. This is not just good practice, but a requirement: The Nursing Council of New Zealand's (NCNZ, 2024)

Standards of Competencies include that nurses "must support, respect and protect Māori rights… by addressing power imbalances and working collaboratively with Māori" (p. 5). One of our Māori participants commented:

> "Just hearing te reo, a 'kia ora', a few words, it warms your heart" (O)

Thoughtful, clear communication and the use of simple language is just as important when a patient is a second-language speaker. Several participants alluded to the effect of stress on being able to process language, and the need for nurses to know about various strategies they can use:

> "Older Indians are always surrounded by family. Get an idea from them about the patient's level of English. And if there's trouble understanding, especially with different accents, write it down in English, so the patient can read the question. Sometimes it can help when there's an interpreter, but you need to remember every state in India has its own language, and there are hundreds of dialects too." (H)

> "Aotearoa is increasingly multi-cultural and it won't always be possible for hospitals to find a local interpreter, but there's the telephone services of Interpreting New Zealand, which has been operating for over 30 years and has professional interpreters in over 70 languages." (J)

> "When I had to have an MRI admission, and my daughter couldn't come in, they tried to quickly teach me some short words I would need…And then they found that the machine had a language selection on it and they figured out how to make it work for me." (K)

> "Older Chinese people have worked very hard since they came to New Zealand, no time to learn English. So nurses need to be patient. And kind." (F)

As Chinese participant D's Kiwi husband points out,

> "Surely it is up to the medical fraternity to adapt, in these days of Artificial Intelligence. Like using apps… A patient's NHI should automatically record and refer a need for first language options. Certainly this should be established in admission notes and medical records."

Overall, communication which facilitates ready and full understanding was a key priority for all our participants.

Theme 3. Whānau/family

This was an area that differed widely across our older participants' narratives. Some of our Māori, Chinese and Indian participants directly attributed their wellbeing to the close connections and care provided by family. They also talked about how caring for elders is seen as a filial responsibility within their cultures:

> "...it's nice to be surrounded by family in my own home. I live with my daughter and my health is pretty good...what keeps me well is my whānau." (C)

> "I live with my daughter P_____ and her family; my other daughter lives next door." (H)

> "I play with my grandchildren...I mostly rely on my daughter to translate for me...we all live together; I don't drive." (K)

> "Elderly people all rely on sons and daughters. In our culture, the children look after our elderly people, but in New Zealand, they're different. When they grow up, they're independent by themselves. They don't care about father, mother. When you're getting old you just go to the rest home or retirement home. But our Chinese way is different." (F)

Pakeha New Zealanders also talked about appreciating visits from family living in the same city, one saying she didn't know how people managed without daughters when she talked about the challenges of a limited public transport system; another sharing a code she and her son had worked out if he called by while she was out, with a stone left on the patio table.

Yet for others, living in New Zealand meant accepting a separation from family:

> "I still have a house in the Philippines, and I go back to visit family, but I don't want to live there." (E)

> "We tried to bring out my family too, but we weren't allowed to, so they went to USA with my brother: our family went different ways." (F)

Visits home, Facebook and video calls were the most common responses offered as ways in which participants kept up connections with home and family.

When asked how nurses and the healthcare system could support this important aspect of positive ageing, several participants had stories of how hospital stays had been made far more comfortable when nursing staff allowed free visitation by family – including ICU, when hospital policy is usually to limit access and numbers:

> "They welcomed my family, let my daughter work on her laptop even in ICU, taught her how to read the monitors. No way in China!" (L)

> “I woke up in ICU [after a cardiac arrest] and I knew I must be really ill because they had let all my family come in to sit with me.” (O)

These experiences align closely with the conclusions about the importance of services which sustain whānau, hapū and iwi connections noted by the LiLACS NZ (2015; 2016) longitudinal series of studies. Edwards’ 2010 and 2018 studies go further, stating whānau wellbeing and ageing well for

Māori cannot be separated. He argues that quality relationships, intergenerational relations and regular positive interactions compensate for, and can override the impact of health disparities and enhance quality of life in older age. The inference must be that where whānau and family are able and willing to be part of a recovery/care plan, they become a vital part of a practitioner’s toolkit. An observation like this is really only reflecting the status quo: Brownie’s (2011) study of residential aged care facilities in Australia and New Zealand determined over one-third of the total adult population provides regular informal or unpaid care to older people.

Theme 4. Tikanga/cultural practices

Māori contributors (C, I, M, N, O) all talked about kaupapa and tikanga – either explicitly or through offering examples – at different points in their narratives:

> "...try to be inclusive, so like the Pakeha patient next door, we say, 'Do you want to join in our karakia?'" (C)

> "if I'm asked about how to reflect kaupapa Māori in the health system, I'd say it's defined by the person. Approaching them with respect. Everyone has mauri." (I)

> "One thing I do, is drop in some Māori words – some people won't even notice, some will respond and smile, and some will show curiosity and ask – what does it mean?" (M)

> "For Māori, we have two key principles: tapu and noa....These have to be in balance." (I)

Comments such as this last one closely reflect the overarching guidance provided by the Ministry of Health (2020), in Whakamaua: Māori Health Action Plan 2020-2025 in which a key principle, Wairuatanga; Mana Māori (Spirituality) states that respecting Mātauranga Māori indigenous knowledge and tikanga means recognising the balance between spiritual needs and physical needs by acknowledging the roles of culturally significant people such as tōhunga, kaumātua and church ministry as part of the individual's therapeutic relationships.

There were individual examples of supportive initiatives observed while a patient:

> "I saw good things too – like dinners being brought in. Because there were Māori in the kitchen, if there was a kaumatua in, they'd cook him fish heads, while the others got battered fish. 'We serve moussaka, why not puha and watercress?'" (N)

There were also examples of concern:

> "The cleaners would tell me things too, what's going on with patients, what they saw. Like different whānau coming onto the ward, maybe the patient was being pressured to agree to whatever was going on in their household and lives outside of health and recovery. Like land issues, inheritances. My daughter helps in a cancer clinic, she also sees the same thing, but no one is going to tell a nurse about it. And it's not just Māori, I saw a Pakeha lady being visited by three guys in suits, like a religious cult, they left her in tears. Nurses need to be aware of hospital visitors." (N)

Our older participants from other ethnic backgrounds shared their own cultural insights, often drawing strong contrasts with Kiwi culture. Participant L from China was accompanied by her daughter during our interview, who told us that when L had been diagnosed with bowel cancer, she (the daughter) had been asked to translate and give her the news, but didn't want to: "In Chinese culture we protect our loved ones from bad news if we can". But a health professional helped coach her in what to say, and spent time over a coffee, practicing with her, so that she was able to tell her mother, father, and family in China, in a calm manner. "[The health professional] helped us understand how the New Zealand system is transparent, and now, I think that's much better for everyone"

Other specific examples participants wanted nurses, and student nurses to know about included:

> "We don't drink tap water. In our country you can't be sure it's clean. And we don't drink ice in our water. We drink hot water, rather than English tea or coffee. (L)

> "When you've been sick, we don't eat cold food – like salad, ice cream, yoghurt. We want smooth, soft food that's easy to digest, like congee (rice porridge), fortified with meat broth." (L)

> "Kiwis are used to the system of asking people to talk about pain on a scale of 1 – 10. That's new to many of us – when someone is waiting for a response, it's easy to just choose a random number, trying to be helpful." (H)

A further point of which healthcare professionals need to be aware is the long-term, even inter-generational fear and distrust of hospitals and white coats many older people still hold. Participant I regretted that there was no longer a District Health Nurse calling regularly at the marae and offering free health check-ups: "We used to look forward to seeing her". He shared that more recent hauora community-based and mobile services, such as those offered by diabetes Nurse Practitioners and dementia specialists, have far better uptake by older members of his iwi than those requiring attendance at outpatient clinics in a hospital or medical practice setting. Even Māori who have been a part of health service provision themselves admit to a dislike of hospitals:

> "In my own health journey, I had to go into hospital for a [procedure], but I resisted the surgery for 10 years – even though I knew the system. Common sense goes out the window when it's your own body. How will I feel? What's going to happen?" (N)

Nor is this concern exclusive to Māori:

> "Fiji is a third world country; and even though it might be staffed with Fijian nurses, speaking the Fijian language, being admitted to hospital there is still an alarming experience, especially for older people. This is even more so since the pandemic: you don't go there for them to save your life, you go there to lose your life – there's lots of talk like this on social media." (J)

Theme 5. Social justice

The onus of supporting the older person's entitlement to an equitable health experience is part of the duties of nurses outlined by Nursing Council: "Assist the health consumer to gain appropriate support and representation from those who understand the health consumer's first-language, culture, needs and preferences" (NCNZ, 2024). Achieving equity in health across all population groups is also a core focus of the Ministry of Health's (2016) Healthy Ageing Strategy, was referenced as desirable good practice by Chair of the Health and Disability System Review, Heather Simpson (2019), and is a foundation principle of such advocacy groups as Age Concern (ageconcern.org.nz) and Grey Power (greypower.co.nz).

Participant J, with a professional background encompassing law, immigration advising and tertiary education made particular reference to the diverse populations who live alongside, but are not assimilated into mainstream westernised society. A recent experience had been supporting a horticulture worker temporarily in New Zealand through the Recognised Seasonal Employer (RSE) scheme during an emergency admission:

> "...his English was not good enough to understand the medical procedure the doctors needed to explain to him, so that he could give informed consent. When I arrived, I found him overwhelmed: what had happened, what was needed, how it would work."

As J points out, access to government services, including healthcare, must be available to both English and non-English speakers, and providers need to have strategies, such as a contacts database for translators, ethnic group leaders and English as a Second or Other Language (ESOL) linguistic experts. Other participants (D; F) also mentioned phone apps which offer voice and text translations, and how nurses all needed to know how to use these – rather than letting the burden of cross-cultural communication fall to the unwell person.

For Participant B, the call for social justice extends far beyond the challenges of coping with ethnic and cultural diversity to a concern with ageism in general:

> "I particularly went back to university when I was 60 so that I could do political science and have the right tickets to be able to be heard ... I wanted to honor later life. I found it really sad that people were expected to just disappear and I felt a deep sense of them being missing..."

> ... we have let retirement villages flourish and I do shock people: they don't like it when I call them 'reservations', but I deliberately do that to shock people to think about how we're shutting them away from life."

Participant B is an active political commentator and advocate for older adults' rights, and a regular guest speaker at community groups and local body meetings. She is the local facilitator and has played a key role in ensuring that Tauranga, New Zealand's highest ageing major city, is the first to be backed by the United Nation's *Decade of Healthy Ageing* project (Sunlive, 2023; WHO, 2020). She sees this international initiative as an

important platform to address this country's elder housing and elder care crises, by changing how we think, feel and act towards age and ageing, and ensuring that these perspectives feed into housing, transport, health and social service planning. Citing the WHO's (2023) *Age-Friendly City Guide* to assist local governments and communities progress change, she says:

> "In order for today's generation of elders to stay healthy, independent, purposeful and connected, we need an age-friendly city with hyperlocal communities, accessible and designed for an age-diverse population, inclusion, social cohesion, and care." (B)

Beyond policy and built environments, B argues that change begins by valuing people so that they can have a good life, and as much as possible, stay in their own homes. An active researcher, and reader of research, Participant B champions the 'longevity dividend' concept (Scott, 2021) as healthy older people add value and enrich economic, social, and cultural life through their elder wisdom and knowledge.

5.2 BN teachers and academic leads

Twelve Nursing academic leaders and nurse educators from five BN providers attended interviews and contributed insights to this study. As the original concept behind this inquiry had been to include an analysis of a proposed new unified BN curriculum, we sought perspectives from colleagues at Waikato University, Wintec, AUT and Unitec, as well as our own organisation, Toi Ohomai institute of Technology to ensure a balance of views. While a new political direction in tertiary education has led to a cessation of work on a single, nation-wide BN qualification, much of the information gleaned remains relevant and valuable to our understanding of progress towards culturally-grounded practice in aged healthcare. Guiding questions for these participants were:

- Can you share some thoughts about how well you think current nursing education supports repositioning the perception of older people from a biomedical description of frailty and decline, to one of positive aging and wellbeing?
- Can you comment on the extent to which cultural identity is considered? (Prompts: holistic approach; role of community/connectivity; aging in place)
- What sort of tools or resources do you use to extend students' perceptions of cultural identity when covering older people's health care needs?
- What sorts of tools/resources might be useful? (Prompts: Interactive; media; more representation of diversity; wider range of placement types)
- With so few students choosing to specialise in aged health care following graduation, what do you think nursing education could do better to address the RN workforce shortage? (Prompts: placement roles; increased exposure; positive narratives)
- Can you think of any examples where a student's positive experience related to an older person's care/cultural identity has changed their perception of aged care as a specialism option following graduation?

Theme 1. Culture shock

One of our participants has been a member of a large national research inquiry into education delivery related to older adults' healthcare, funded through an MBIE/Te Apārangi Whitinga Fellowship (Heath et al., 2023; 2024). Originally from the UK, she had done a lot of critical thinking to background her role in this study and shared that she now classified her responses as 'culture shock'. Three examples offered were;

> "I was asked to supervise first year student nurses in west Auckland – I saw RNs with Wellington boots and long white aprons in a room with a naked older gentleman, the look was like an abattoir. I was horrified – why are students even here? Such a lack of dignity. Residents were being treated like a factory line of washes".

> "An older lady who was meant to be being fed, but the nurse left and she choked, arrested, and a student was left doing CPR for 45 minutes – the lady died and the student was traumatised. It was a real shock to me."

> "There was an invisibility of Māori, Pacific, others – it was absolutely Eurocentric. White New Zealanders were favoured. Acute settings were favoured. Rural care services weren't offered as an option."

These examples may now be a number of years old, yet this educator says that there is still reason for concern with the clinical examples some students are encountering especially given that her group's research indicates that placements are the "*shop window*" for students making career decisions about workplace preferences, post-graduation.

Other educators agreed. Several talked about how students get their ideas of what nursing is from fairly glamorised depictions in the media, like *Shortland Street*, *ER* and *Grey's Anatomy.* In reality, when they encountered older people, they were unprepared for grief, loss and loneliness: "*These people aren't going to go home".* In particular, families leaving relatives to be cared for other was a cultural shock for many students. Too, there was the shock of *"old bodies"* and also of menial tasks: "*used as just another pair of hands".*

Several educators/academic lead participants came up independently with the same recommendation to counter, or at least balance the emphasis on using ARCs as clinical placements when giving student experience of working with older adults. One informant suggested that rather than being sent into institutions, students should be in the community, seeing older people in other settings, *"like in the library getting their books. Or in soup kitchens",* even while acknowledging that placements like this would be unlikely to meet the NCNZ's strict frameworks. Other teachers volunteered a successful work-around their team had adopted to support students' interaction with well aged adults: partnering with Communicare (https://www.communicare.org.nz/), who run weekly friendship centres in Auckland:

"Each student went twice, with an RN present. The first session was observing and participating, in the second session students worked in a group to run an activity"

Recording sessions as a future resource added further value. Other suggestions of similar organisations which would offer parallel experiences were: Grey Power, Aged Concern and ethnic societies. Not only would students see examples of positive ageing, such exposure would counter the lack of interactions with older adults of different nationalities, given that

> "New Zealand is not just bi-cultural, it's a multi-cultural society we need to prepare for. We're not connected at all. We could be doing a better job."

Theme 2. A cultural lens – on students and with clients

Ageism

Building on the concept that age is itself a culture (Fraser et al., 2021), viewing the way in which those outside the group talked about older adults, it was clear that the ageism described in the literature (Fisher, 2018; Foster, 2020) was equally evident in practice. Teachers told us about students' comments during placement feedback and coaching conversations which were themselves ageist: 'They're cute and lovely'; 'I absolutely hated working with creepy old men'; 'Older people are racist'. Participants in this group described how comments like this made a good starting point for introducing a holistic view of individuals, for linking to human development theories ("How much is culture, how much is personality?"), and for questioning stereotypes and assumptions as part of cultural competence and cultural safety teaching and learning. Participants also made links to NCNZ competencies, such as showing respect and building therapeutic relationships were also made.

Educators noted too, that students were often upset when they observed examples of ageism perpetuated by ARC staff, including RNs and HCAs. What students see in placement is often not in keeping with what is taught as good practice, and educators told us that students may need to be 'talked down' from wanting to intervene, or counter facility protocols. Educators talked about their professional role here, supporting students:

> "Remember, I tell them, we're not there to intervene, to judge, to advise. We don't need to have confronting conversations. We are there to contribute."

> "What you saw isn't ideal perhaps, but what can you do? How can you work around this? Focus on quality improvement, not blame. Use this in your reflections. Focus on the goal: you can make a difference in a person's day."

Racism

Educators told us that many nursing students initially find it hard to accept that racism and prejudice are a part of everyday reality for many New Zealanders, and that they will encounter this in their healthcare career – often far sooner than they might expect.

> "In class, I ask, who has experienced racism? Every single non-European student put their hand up. The main ethnicity of residents in ARC? NZ European. The main ethnicity of people working with them? Non-NZ European. If you're a Pakeha New Zealander, the world you live in is designed for you. You're unaware of privilege."

Unless we are questioned, we take our culture with us, into our working lives:

> "In NZ, we have our own basic principles and cultural acceptances of what nursing is – we take this wherever we go in the world. And that's what overseas nurses and students bring here – their cultural understanding and expectations of others: family do the care, you check, and that's what nursing is."

Nursing educators agreed that it was very hard to change others' cultural lenses, but that there were two areas of responsibility held towards students. First was the curriculum focus on Te Tiriti, whanaungatanga and cultural sensitivity and ensuring students understood and practised appropriate tikanga. However, one Chinese lecturer felt that there was a huge gap in responding to other cultures' worldviews:

> "Students are not at all exposed to older adults of different nationalities. We ask students to analyse age-related changes and issues – physically, spiritually, psychologically, emotionally. We have just one session on cultural considerations. I haven't seen any culturally-appropriate practice or training in aged care."

A second educator identified their responsibility as a role model. Educators talked about the importance of a strengths-based approach rather than focusing on problems, and modelling different approaches, especially given healthcare staff are multicultural: "making overt what we are doing and why" and using demonstrations to help students remember.

One Indian educator provided examples from her own life she uses with students to make a point:

> "Nothing goes from you to the patient. People see me and assume I'm Muslim or Hindi. In fact, I'm wearing a cross, but I don't volunteer this unless they ask – connections must all be patient led. Another example is that I come from Pakistan where to be gay is illegal and seen as bad. When I first started nursing in NZ I knew I couldn't let any feelings about this show. I tell the students: ward culture, and the classroom – what happens there, leave it there."

Others noted that while there are usually very few older adults of diverse ethnicities in ARCs, when students do encounter them, often their wider family is overseas so they are even more isolated. "For them, their caregivers ARE their family". Just as with Māori, the advice is to know how to listen, to let the client get to know you, and perhaps share a little about themselves. But students are there is a professional role, and educators agreed:

> "...in some countries, people can be caring but they can also be over-involved. I tell them, no touching, no endearments, this is not your grandma."

Academic leads and educators agreed with the position that older people in healthcare settings could be alienated unnecessarily and unintentionally, when their traditions were not being recognised. Some offered examples of cultural norms and customs they share with students, gleaned from their own careers, including:

> "Ask their permission before touching them. Like in India, it is common to hold hands, others won't like this."

> "For some cultures, putting medicine into someone's open palm is very uncomfortable – if you come from a country where beggars hold out their hands, it's ingrained."

Theme 3. Anticipatory classroom preparation

Many participants from this group alluded to the wealth of cultural capital found in the classroom, with students from diverse backgrounds, ethnicities, ages and previous careers. Educators talked about a range of activities and approaches to preparing students for clinical placements, in readiness for working with both older adults and different cultural groups:

- Create scripts and share a 2-minute role play of something inappropriate they've seen, maybe a family member, maybe in placement
- Mātauranga Māori and marae time for familiarity with powhiri protocols, waiata, karakia – encountering values such as respect for elders and traditional knowledge which can carry over into practice
- Case studies to ensure students understand the ethical importance of using translators for clients/residents and patients and learning to use translation phone apps for text and speech
- Learning how to think about how an older adult would feel through simulations and lab exercises, such as wearing simulation suits, using a TENS machine to initiate a tremor, force-feeding a resistant partner, binary reality scenarios with partners to consider the experience of cognitive confusion... "You don't get to choose your chronic illness or what you will be able to do later in life..."

Another suggestion by a Chinese nurse educator in this group was to introduce students to the idea that health systems varied from country to country. For example:

> "In China, there's lots of preventative training and workshops provide by hospitals, doctors, community nurses. Diabetes, falls prevention, nutrition, how and when to use ambulances. Here, where are they supposed to get advice?

> Doctors in China are practicing disease preventative medicine, whereas here, a minor issue can become severe before you see a doctor."

Some countries, consultations were free, some you had to pay for. In some countries there are long waiting lists, in others, private customers can jump the queue. Some countries have access to a far wider range of medicines than in New Zealand, and sometimes older people will have relatives at home source these for them. Some countries have a complementary system of traditional medicines and treatments, like acupuncture and ayurvedic, that are more accepted by mainstream practitioners than traditional Māori rongoā can be here in New Zealand. No wonder our health system can seem incomprehensible to older immigrant adults.

The academic leaders and nurse educators interviewed for this study generally agreed that there is a strong interface between culture and education, just as there is between culture and concepts of wellness (Fraser et al., 2021). There was acceptance that a multicultural approach to preparing students was a necessary addition to bicultural and Te Tiriti training, yet equally that resources were scant. All this group were supportive of the learning and teaching resources being developed through this project and expressed interest in using them; some offered to review these prior to publication, which has subsequently occurred.

5.3 Preceptors/Student nurse educators

Supporting students prepare for and enter practicum settings is critical to their success and their pathway into the nursing workforce post-registration. Different strategies have been developed to facilitate this support and enhance clinical learning and in New Zealand this is primarily through preceptorship (usually RNs employed by the placement organisation) and on-site clinical coaching and direction provided by Student Nurse Educators (SNEs) who are also members of the BN teaching team (NZNO, 2022). In this study, we interviewed four SNEs who worked with third year BN students during their ARC practicum placements. Our questions for these participants were:

> Can you comment on alignment or mismatch of students' expectations of working with older people when they arrive for placement, compared to their likely experience? (Prompts: tasks, quality improvement projects, understanding of cultural identity and cultural needs)

> How do you create a positive learning environment to ensure students can use a range of holistic health skills while on placement? (e.g. soft skills like communication and empathy, as opposed to clinical skills like wound dressing)

> What more could educators do to prepare students so that they gain a positive experience from working with older people and their health needs? (Do you think they are well-prepared to support cultural identity? Do they respond well to diversity in the health care setting?)

> Can you think of an example when a student on placement was able to support an older person's health and wellbeing in a way which produced a positive outcome? (How did this impact their cultural identity?)

Theme 1. Developing a holistic understanding of practice

SNEs were supportive of a third year ARC placement, commenting that they saw a big difference between first and third year students who had generally moved on from "seeing the entire population as disabled to some degree" to a more personalised understanding and a readiness to form relationships. This is an enactment of the strengths-based, human-centred and inclusive approach to healthcare required nationally by the Ministry of Health (2016) and championed internationally through the United Nations (2024) and World Health Organisation (2020). One SNE described how she reinforced this with students:

> "It starts right from the beginning, like getting informed consent [to conduct as assessment]. I break it down – here's 93-year-old Mabel – you need to remember when you go into her room, that this is her home. That's why we call them RESIDENTS. So how do you do this in someone's home? Not, 'I'm a 3rd year student and I need to do this for my assignment'. Rather, 'I'm a trainee nurse, I want to be a nurse, sitting state finals and getting my medal – the learning I gain from spending time with you can really help me achieve my dream…It's such an honour…etc'. And explain what confidentiality means – that they're not going to stand up in front of a hundred other students and talk about you. Understand that they will have had lives – traumas and successes, family challenges and tragedies. Even questions like how many children they have may be difficult. Students need to allow time. Not to rush someone. Bow out gracefully if they have visitors or need a break – the resident's agenda, not the student's. Pick up their cues."

Other comments related to the importance of language, and the opportunity of working with students towards the end of their education , to influence communication approaches, encourage critical thinking and provide opportunities to gain deeper insights,

> "One thing I think is important is language: training students to say, we 'assist' someone to have a meal. We 'assist' them to take a shower. We don't feed people, or wash people – we're not at a zoo! We don't 'do' things to people."

> "Using language like 'sweetheart, dear, darling'. I think our students, and nurses in general learn this from HCAs – and we have to remember, many are from different ethnic groups and this is much more a norm, and welcomed, in their culture. But we do need to try and correct this – I remember in one clinic, the staff saying to me, 'We just call him 'koru'", as if that was showing the client respect. But I said no, he has a name, please use it. Just because you're using a Māori word, it's still not valid."

One area of growing concern for participants from different groups concerned the growing use of languages other than English. For example, a Radio NZ article from October 15, 2024 "Waikato Hospital staff told to speak English only" quotes a doctor, who says the directive was "clearly aimed at Indian, Filipino and Pasifika nurses, who were healthcare "heroes" but were now being victimised." (https://www.rnz.co.nz/news/national/530752/waikato-hospital-staff-told-to-speak-english-only)

The impact of overseas-trained nurses is also being recognised at regulatory level, with an October 2024 news posting on their website by NCNZ which appears to overrule the Waikato DHB directive:

> "We are aware of the increasingly diverse nursing workforce and the diverse New Zealand population and that there will be times when it is appropriate to communicate in other languages including Te Reo Māori. We support diversity and inclusiveness in the nursing workforce to meet the needs of our diverse population" (https://www.nursingcouncil.org.nz/NCNZ/News-section/news-item/2024/10/Language-in-the-clinical-setting.aspx)

Clearly there remains considerable ambiguity about how and where professional boundaries need to be drawn, and SNEs referenced this in their conversations about culture and ethnicity in the workplace. For example,

> "Students from a patient's culture can use their language, their experience - and it can be a benefit, BUT they must not talk over the top of a client, or to colleagues. In ARC this can be a real barrier. And there are risks with students being called on to translate – especially medical matters – the huge possibility of something going wrong. Given that it's often the nurses who really explain things to the patient, there's a need for some protocols. We encourage student nurses to pause and think: 'How do I know this is OK?'"

Here, two of the SNEs talked about how it was up to the facility to provide translation services, possibly using phone apps as a starting point, but that they were clear it was not acceptable to use students as interpreters; the same principle would apply to newly graduated RNs. Final placements such as this one were opportunities for students to learn about, and practice ethical boundaries and self-protection.

When asked for examples of nursing students evidencing a holistic philosophy of practice, SNEs provided examples from Quality Improvement projects they had overseen as part of the clinical placement assessment. Three of the non-medically focused initiatives which addressed client needs and designed to improve their health outcomes which were described as;

- Supporting memories of home for clients in a dementia ward by using Google Earth on a large communal screen to 'visit' locations and encourage engagement and social interactions
- Re-organising wardrobe and storage for a double amputee resident to improve independent access
- Crafting an artificial ear for a resident with an aggressive tumor requiring heavy bandaging and leaving a formerly active community leader so self-conscious that he barely left his room. "He felt like an alien. The intervention transformed his life."

As one of the SNEs said:

> "You can't guess what will improve someone's qualify of life – you have to ask, and listen..."

(Note: additional examples of students' Quality Improvement projects which specifically supported cultural identity are discussed in the following section 5.2.1.).

Theme 2. Valuing professional standards – the role of Nursing Council Standards of Competencies

The Nursing Council of New Zealand (2024; 2020) is responsible for the registration and regulation of all registered nurses, with mandatory competencies for practice and high-level direction for working with iwi and Māori. At the time of writing, an updated document was being widely shared for consultation: Proposed Registered Nurse Standards of Competencies. The document contains six pou, or domains of competence:

- Pou One: Haora Māori
- Pou Two: Kawa Whakaruruhau and Cultural Safety
- Pou Three: Pūkengatanga and Excellence in Nursing Practice
- Pou Four: Manaakitanga and People Centredness
- Pou Five: Whakawhanaungatanga and Communication
- Pou Six: Rangatiratanga and Leadership

SNEs talked about how students were required to show evidence of working within and towards these competencies, and how they felt this contributes value to the placement experience:

> "We are prompted by the Competencies – cultural safety, therapeutic relationships, partnerships. The Nursing Council Competencies process has made quite a difference to the level of engagement. Students following the RN around, it can be quite a superficial level of nursing, no critical thinking. [The Competencies encourage] students to ask: the background of the person, the social situation, what does the client want? What are their goals? The client is not just someone in the bed they have to do things for/to."

SNEs noted that the Competencies (and similar theoretical frameworks) can seem unrelated to how the students initially think of nursing, and that this is the importance of clinical placements: to apply concepts to practice, and see how enactment makes a difference:

> "We do have students who say, 'Why are you ramming that Treaty and cultural stuff down our throat? It's not what nursing is about!' But then, I have students who tell me, 'All the cultural safety things you taught me, they never made sense until I got into the real world.'"

One SNE shared that she believed the key insight students gained from the personal experience of applying these Competencies to their work with older adults in healthcare setting was self-realisation: *"We are all our own, culturally-created being".* Such an observation aligns with directives in two of the six pou proposed in the new Competencies: Pou Two: "... supports the provision of holistic care, and ensures the nurse reflects on their own values, biases and beliefs, and understands the impact of these on care provision" and Pou Three: "Reflects on own practice, seeks feedback to identify learning needs, and takes responsibility for professional development to maintain and enhance competence".

5.4 Students

Two focus groups with third year students were held midway through the project's timeline, at Toi Ohomai's two main campuses where the BN programme is delivered, and immediately after students had completed a second clinical placement in aged residential care (the first ARC placement occurs in year one). Following an outline of the research, an invitation to students was extended, with 4 students attending at Mokoia, Rotorua; 10 at Windermere, Tauranga. Prompt questions were:

- Reflecting on your nursing education to date, what do you think are the key messages you have received about the care of older people? (Prompt: positive wellbeing? Importance/place of cultural identity? Pros and cons of this area as a specialism following graduation?)
- Throughout the programme, what else could have been interwoven to support your interest in working in this field?
- How did your placement experiences of working with older people align with your prior expectations? (Any comments on holistic approaches, supporting cultural identity, practicing in a culturally safe setting?)
- Can you think of an example from any health care setting, where an older person's health needs were met in a way which supported their cultural identity? Or one where a culturally-led, holistic approach led to a successful outcome? (Or one where cultural needs were not met or supported?)

Theme 1. A mismatch of expectations and experience

Overall, students felt they were well-prepared for their placements:

> "Doing placements with older people, it's not so much what we learn in class beforehand, it's about when we do it. By the second year, for example, we've had more teaching about mental health, so it makes a better link in later placements for working with people with dementia."

However, there were frustrations related to the facilities and staff, with one student saying they felt as if they were considered a "glorified HCA", another that "staff don't know what a Year 3 can, and should be doing", and a third: "The nurses don't always take us seriously". Students found that they were not able to distribute blister pack medications, as most facilities used an online system and students were not given a login – despite having trained for this task. There were similar comments about access to health and safety equipment.

A second area with which students felt that they were not able to engage effectively, and in which observed practice showed considerable variance with what was taught in class was an almost entirely medically and treatment-oriented approach to care, rather than our current, patient-centered and holistic understanding of wellness:

> "Some of the social aspects are harder – when what can be done isn't being done. It can be quite confronting, and every setting is different."

> "Some of those events in the calendar – they are just to look pretty. Not really what the residents want. It can feel rushed, and some places feel very money-driven."

When students were asked about whether there were any areas in which further preparation would have been helpful, students in both focus groups agreed that advocacy and conflict de-escalation training would be useful interpersonal skills, given their challenges in forging collegial relationships with some members of staff, which had the potential to limit the Quality Improvement projects with client-participants that they needed to undertake as part of their practicum requirements.

Theme 2. Ageism is real

Overlapping with a predominantly bio-medical practice, students commented that they observed attitudes in the ARC facilities they worked in that perpetuated assumptions and stereotypical judgements about older adults that students had been taught in class to question:

> "They have the attitude, this is normal for that patient, this is just old age, they are complacent, but actually it's not normal. Not OK."

> "I saw a lot of people talking too fast, where older people couldn't understand. Or assuming they didn't want to join in with activities – have you asked them? More than once?"

> "Sometimes it's their way or no way – not patient-led."

Other examples given related to communication from facility management that was often via notices posted in communal areas, which would exclude those who were visually impaired, immobile, or socially reclusive.

Students also had stories of staff avoiding residents who had a history of aggression or intransigence, but having shown little interest in the individual's psychosocial backstory, such as earlier trauma.

Theme 3. Mixed practice in cultural responsiveness

The 14 students who participated in the two focus groups had a combined experience of clinical placements in 12 ARC facilities, and their perceptions of how well centres catered for cultural inclusivity varied considerably. Similalry students reported ARC centres with no client diversity; others with "lots" of Māori and Pacific residents.

Some positive accounts included:

- Staff and residents appreciating support workers who were Māori, and spoke in te reo
- Alternating church services on Sundays so that as many as possible denominations were catered for
- Celebrating Pacific Island language week with activities and encouraging everyone to use greetings from these languages
- A multi-cultural day with costumes and different foods, supporting sharing and interactions
- The death of a Māori patient: *"staff did karakia, waiata as the hearse drove away, it was moving and humbling."*

More challenging examples:

- One student talked about supporting residents with washing, and how for some older Māori women, it was very important that only a female washes them – they'd rather not have a wash than have a male nurse. Even when a female staff member is available, this needs to be handled sensitively:

> "I was starting to get ready to wash a Māori woman, taking my time, checking in she was OK, trying to preserve her dignity, and it was my first time washing someone like this. Then the HCA came in and the patient started to resist, to hit her, she had hated the way that person had done her care in the past. She didn't want to be rushed and a job ticked off. It took a while to break down the issue, to get them to talk to each other. Take it slower, it'll be faster in the long run. Tinorangitiratanga needs to be respected. More whanaungatanga."

- Another student talked about tokenism and 'virtue-signaling':

> "On the admission board with photos and name cards for all the residents – putting a Māori clip-art border around the Māori patients – why? It's like a tick box – look! We've got 5 Māori patients here! They mightn't even want that special attention. If Māori haven't been exposed to te reo and tikanga as part of their upbringing, it can be overwhelming. You can be re-traumatised by the not knowing."

Suggestions about strategies to address such shortcomings aligned with ideas raised not only by other project informant groups, but also well-traversed in the literature. First was the need for a cultural safety training programme to upskill staff – including fundamental tikanga, such as not putting urinal bottles on tables. The Nursing Council of New Zealand (2024) approaches this by encouraging people to understand how their own culture

impacts on others in their professional role; the Ministry of Health's (2020) Whakamaua: Māori health action plan 2020-2025 extends this by requiring health practitioners to reduce bias and achieve equity within the workforce and working environment in all clinical interactions and service delivery. A second strategy students suggested to support cultural autonomy began with kōrero, just as laid out by Mc-Bride-Henry et al. (2022) and Olsen et al. (2020), asking, Does your resident, …"affiliate to an iwi? What do they like to be called? How should their name be pronounced?"

A final feature of students' experience shared by several participants, was the large number of internationally qualified staff and the impact that this had on ARC facilities' organisational culture. While all noted the skills shortage endemic among gerontology services in general, and ARC in particular, the reality of relying on immigrant nurses and HCAs was at times, difficult:

> "International staff can be confronting, especially when a group are all speaking their own language, giggling, talking to each other over the patient, even while I was there and couldn't understand. Patients can find this very rude; it leads to anger, verbal abuse. These were Indian staff, but in another place, 80% were Philippino – and again, mostly used their own language. And when they spoke to the patient, they were hard to understand, the patient would turn to me, and ask – what did she say? Older people aren't familiar with lots of cultures and accents. It's stressful for them. And it all gets surrounded in busyness – quick come, quick go – hard to get nurses to spend the extra minute."

Given that more than 40% of the New Zealand health service workforce are internationally qualified (Taylor, 2024), cross-cultural workplaces are destined to remain a key part of our environment. Taylor's recent study advises that "to thrive in the workplace, internationally qualified nurses need professional development, protection from bullying and good communication skills". There are clear implications here for better preparing New Zealand nursing students to expect, embrace and positively engage with their overseas colleagues – during placements and following graduation into their nursing careers.

6 | Findings and discussion: Key themes from document analysis

6.1 Quality improvement projects

Quality Improvement (QI) is essential health care business (Hauora Research, 2022; Honeyfield et al., 2020). Student nurses in the final year of their undergraduate programmes undertake a self-selected QI project during clinical placement working with older people in care facilities. Previous research conducted by Honeyfield's team (2020) and reported in Hauora Research (2022) had shown that most students selected medically-oriented aspects of care as a focus: "Care planning and review (20%), infection prevention and control (18%), and wound care (11%) were the three most popular project topics. 'Other' topics (27%) were QI projects that address resources for specific topics/ concerns. Examples QI projects which addressed topics such as constipation monitoring, manual handling, records confidentiality, medication safety, clothing labelling, restraint practices, secure unit alerts, and client satisfaction recording" (Honeyfield, 2020, p. 44). Culture was barely mentioned beyond the requirement to include a passing mention as an indication of including Nursing Council Standards of Competencies.

However, the tertiary reforms which led to the establishment of Te Pūkenga and an initiative to develop a unified BN degree consistent across all providers supported an increased focus on Te Tiriti o Waitangi, and Māori-Crown relationships. While our institution delivers a bi-cultural degree with Te Tiriti o Waitangi, Māori models of health and wellbeing woven across the curriculum, the research team were interested to see the extent to which such heightened awareness might be evident in student nurses' choice of cultural identity and/or Kaupapa Māori holistic approaches to health for their QI assessment project. For this current study, 157 final reports from 2022 (n=81) and 2023 (n=76) were included in the analysis.

Only nine QI projects (5.7 %) which focused on supporting older people's culture and cultural connections were identified:

- **Bible study to increase overall wellbeing.** The student refers to her own, and her ARC participant's "cultural identity as a Christian" as well as the importance of spiritual wellbeing (tapu/noa; 'Te Whare Tapa Whā') as an essential cornerstone of health.
- **Supporting Māori ARC residents' applications for kaumātua/health iwi and hapū grants.** Cultural identity supported access to health and disability products and services.
- **Improvement in weight loss and mobility for John (pseudonym).** Application of the 'Kia Kaha Wheel of Self-Management' to support an older Māori client.
- **Improving Māori Health from within the aged care sector.** Introduced culturally safe resident-centred care with resources in te reo and English ('Ko wai au? Who am I?' based on 'Te Whare Tapa Whā').
- **QI strategy to uphold the Mana (strength) of the resident.** Using 'Te Whare Tapa Whā' to assist a client with understanding her own mental health responses and needs.
- **Honouring cultural identity through Karakia, to empower Māori clients residing in Aged Residential Care.** The participant client was isolating herself from other residents to complete karakia before meals, resulting in anxiety and social exclusion. The student project created laminated placemats with a traditional Māori karakia on the front and an easy-to-follow board game on the back to facilitate community engagement.

— **Bi-lingual Be Active Exercise posters.** Encouraging group involvement to increase a client's mobility where they had previously relied on whānau for motivation (negatively impacted by a sibling's death and decreased family visits).
— **The implementation of music therapy as a non-pharmaceutical alternative to decrease blood pressure.** Using the Māori health model 'Te Wheke' to explore an avenue for social connection for a heavily-medicated Māori client who identified as lonely and depressed.
— **Connecting through first language.** The student project recounts the successes of engaging with an older Fijian client in his own language to complete an advanced care plan which he had previously only provided limited answers to, and a previously unrecognised strong Catholic faith, which lead to visiting a local church for Sunday mass.

Across these nine QI projects in which nursing students had adopted a cultural lens to consider improvements to wellbeing for their older participant-clients, three common elements were noted.

Element 1. A holistic approach to health

Providing culturally responsive care is often described by the interconnected balancing of Durie's (1998) four cornerstones, or walls, of his Te Whare Tapa Whā model: whānau (wider family), whanaungatanga (social connectedness), hinengaro (mental and emotional wellbeing), taha tinana (physical wellbeing) and wairua (spirituality). Wellbeing is defined by the individual, within their own family, culture, socio-political and environmental contexts, meaning people's mental outlook plays a significant role in maintaining wellbeing (McBride-Henry et al., 2022).

When students engaged in projects which considered their participant's needs from a number of perspectives rather than initiating a bio-medical treatment response, they were acknowledging existing cultural and spiritual beliefs and providing resourcing and education to support these. One definition of wellbeing cited by McBride-Henry et al. (2022), is "what individuals intrinsically value" (para. 6). Examples of values which individuals linked to their sense of wellness are easily seen in the nine projects listed above: faith and religiosity; hearing your mother-tongue; community and inclusion; explanations and tools from an indigenous, not westernised perspective.

Element 2. Meaningful communication

Communication is more than just semantics. In all but one of the nine QI projects, understanding the English language was not the issue. Yet outcomes from some of these projects indicate that older adults from non-Pakeha cultures gained a higher level of understanding and appreciation of what nursing staff had been asking and advising, when it was presented in language and frameworks which were culturally familiar. A simple example is the use of the *Māori Health Assessment For Care* which begins with a kōrero: Ko wai to ingoa/What is your name? No hea koe/Where are you from? He aha to mahi o mua/What was your past career? Kei te korero Māori koe/Do you speak Te Reo? following the Ministry of Health's (2004) *Guidelines for Cultural Assessment: Māori.*

Several student nurses' reports of these projects described the importance of establishing rapport and building therapeutic relationships as part of supporting wellbeing. Respecting mana was important. Recognising that staff were mostly non-

Māori, and yet needing to work with Māori clients, two students reported asking where the facility's Māori Health Policy was displayed. In one case staff did not know where it was and had never used it; in another the document contained a set of generalised guidelines of care which included such stereotypical and insensitive items as: ' Māori like to use their fingers whilst eating; Always have plenty of food for Māori; Māori people can be reserved; Towels are not to be used on the floor for cleaning up; Ask Māori before removing hair from a comb or brush; and Don't look directly into the Māori resident's eyes'.

Both students noted these examples as not in keeping with the key tenets of Te Tiriti, and as indicative of the need for ongoing, in-service training for healthcare professionals (especially those from overseas jurisdictions, or New Zealanders who have been in the workforce a long time) in cultural safety and cultural assessments.

Element 3. Client-centred initiatives

A third element common to most, if not all the above QI projects – and in all likelihood the majority of the final reports submitted by all other students in these cohorts – was the focus on the older adult, rather than facility imperatives or policies. Initiatives introduced clients to new ways of thinking and new access to funding, demonstrated new documents and approaches to cultural inclusiveness to staff, and socialised important tikanga like karakia for other residents. For some participant-clients, deeply-held values which surfaced through multi-dimensional discussions about wellbeing, like a love of music or a deep Christian faith, were brought to the attention of staff and opportunities for engagement were put in place. Of course, as Olsen et al. (2020) remind us, what matters to the resident now may be different from what matters in six months, but there is considerable potential that the positive impacts of these nursing students' QI projects will last well beyond the term of their clinical placement.

What is distinct to these nine projects is the empowerment and confidence-boost that students gained from advocating for a more holistic, and culturally-oriented approach to supporting clients from non-Pakeha backgrounds. Assessment criteria for students' QI project reports calls for critical reflection, and the document analysis process noted students speaking both for themselves and their clients, of: "cultural reinvigoration"; "pride"; "mana"; "improved quality of care"; "overcoming biases"; "participation"; "confidence with interpersonal skills"; "socialsation"; "better informed"; and "empowered".

6.2 Findings from students' post ARC placement evaluations – quantitative

The survey contained 23 items for which students were asked to select a response from the options: S*trongly Disagree; Disagree; Agree; Strongly Agree.* Please see Appendix B for a complete breakdown for each item, and the results of a regression analysis of the independent and dependent variables.

Overall, participants were predominantly satisfied with their placement experience. The majority of responses to most questions were more positive than negative. However, most participants (78.4%) believed that this positive experience did not make them more likely to apply for a position within this area of nursing after they graduate. It could be also the reason for 24% of respondents not being willing to encourage other students to seek clinical placements at their placement provider.

Although the placement experience could be affected by factors that Toi Ohomai have no control of, there were several important points in student responses suggesting the need for more work to be done regarding the management of placements. Some of the most noticeable factors negatively affecting placement experience were –

1) The lack of useful orientation (according to 30% of respondents)
2) The content of orientation was not useful (according to 28% of respondents)
3) The lack of adequate preparation prior to the practicum (16.7% respondents)
4) The lack of access to a computer (according to 50% of respondents)
5) No staff ID and no communication about residents provided (according to 25% of respondents)
6) No access to relevant resources during the practice (according to 28% of respondents)
7) Limited, if any, opportunities to meet learning objectives (according to 10% of respondents)
8) Not feeling welcome/values (according to 12% of respondents)
9) Not receiving helpful feedback (according to 10.6% of respondents)
10) Having no opportunity to learn useful things from other students (according to 17.5% of respondents)
11) No learning with students from other disciplines (almost 50% of respondents)
12) The lack of preceptor's support with learning opportunities (according to 25% of respondents).

These factors could have played a role in the responses of 17% of respondents who felt that their overall placement experience was not positive.

6.3 Findings from students' post ARC placement evaluations - qualitative

Analysis of 48 surveys using Leximancer software produced a map of concepts (i.e., groups of words appearing in the text in similar places) and themes (i.e., clusters of concepts related to similar topics) presented in Figure 1 below. The map depicts eight themes identified by Leximancer at the theme size fixed at 45%. Table 2 contains the list of themes ranked in accordance with the number of hits (i.e., the number of text blocks in the text corpus linked to a particular theme), and the names of concepts constituting each theme.

The themes are heat-mapped: the light brown/orange and maroon/pink themes are more prominent in the text corpus compared to the "cooler" coloured green, blue and purple themes. Each theme circle includes multiple nodes that represent individual concepts. The node size is commensurate to the number of connections between concepts, and the lines between nodes show connections between concepts. The proximity of coloured bubbles (i.e., themes) and concept nodes reflect their semantic similarity and relatedness.

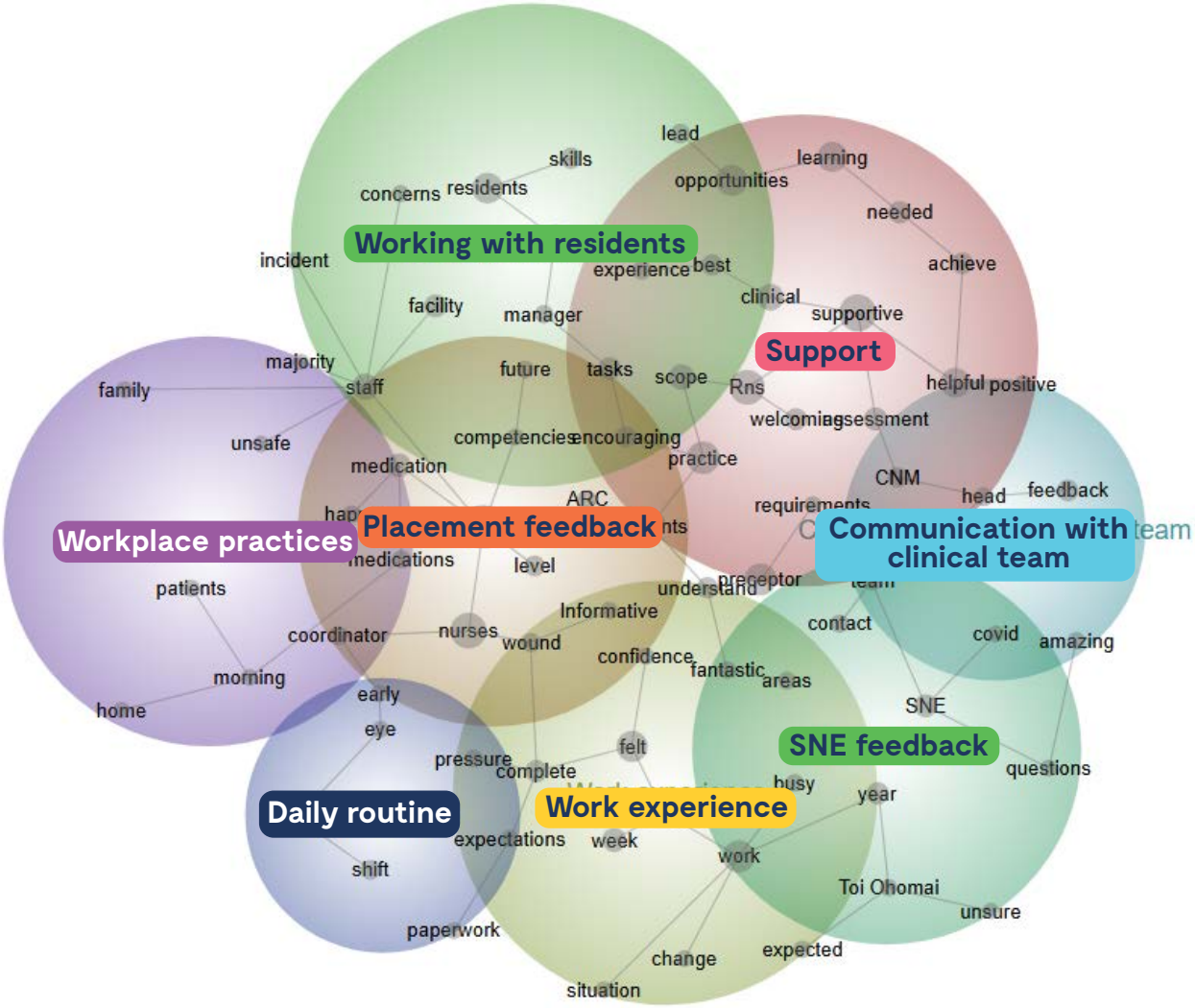


Figure 1: The Map of Themes and Concepts in the Text Corpus

Table 2. Thematic summary

Rank	Theme	Hits	Concepts
1	Support	98	Supportive, RNs, practice, preceptor, opportunities, learning, helpful, clinical, scope, assessment, needed, welcoming, achieve, best, CNM, requirements
2	Placement feedback	95	Placement, nurses, students, staff, medication, encouraging, level, ARC, coordinator, wound, medications, happy, informative, competences
3	Work experience	73	Work, felt, time, week, complete, understand, fantastic, confidence, change, situation
4	Working with residents	61	Residents, care, facility, tasks, skills, lead, experience, manager, future, concerns, incidents
5	SNE feedback	40	SNE, year, contact, areas, busy, Toi Ohomai, questions, unsure
6	Daily routine	28	Day, shift, pressure, expectations, paperwork, early, eye
7	Communication with clinical team	27	Feedback, nice, head, team, amazing, positive, Covid
8	Workplace practices	20	Patents, morning, unsafe, family, home, majority

As Figure 1 and Table 2 suggest, "Support" was the most discussed theme in responses to open-ended questions. It consists of concepts that refer to the quality of support ("welcoming", "best", "needed", "helpful", "supportive") and people providing such support ("RNs", "preceptors", "CNMs). The "supportive" and "RNs" concepts were the most prominent and the most interconnected with other concepts in the theme of "Support". This suggests that RNs' support is essential in the positive placement experience.

Below are some of the respondents' comments about the quality of support.

> My preceptor was very nice and tried to help me as much as possible and RN(CNM) came in to help me do my head-to-toe assessment.

> RN was very helpful, supportive, knowledgeable, and well aware of what I needed to achieve and gave me opportunities to learn and lad care of residents.

However, some respondents had a different experience and were quite disappointed with the lack of support.

> They were not really interested in having a student.

> We didn't have a preceptor and I didn't get to talk with my CNM the whole placement.

Positioning of the CNM concept on the concept map suggests that CNMs were critical for acquiring meaningful and beneficial feedback, though as the above quote shows some participants did not have access to CNMs.

The prominence of the "Support" theme in the narrative of respondents suggests that they needed assistance and encouragement in a new environment. The importance of support was also evident in responses to questions measured with quantitative scales (see Appendix B).

The second-ranked theme "placement feedback" overlapped with the theme of "support", as it is natural to reflect on one's experience in term of how they were treated in a new environment. The "placement feedback" theme consisted of concepts that similarly to the theme of "support" referred to affective appraisal of the placement experience ("encouraging", "happy", and "informative"), people the respondents interacted with during the placement ("nurses", "staff", "coordinators"), and what the placement involved ("wound", "medications", and "ARC"). There were many comments about positive experiences during the placement, for example

> I found other staff helpful and very happy to take me and I was able to meet all competencies.

Other participants were not as happy with their placement due to different factors. Most of them were related to the practicum placement management within the facility:

> There was no orientation which I think future students would benefit from.

> I don't believe that the expectations of my placement were met, I anticipated transition level practice and spent most of my days feeding and showering residents while the nurses completed medication round and the unit coordinator did early-stage pressure scores. They were irritated at me at times because when asked to leave my RN to help move a resident or toilet someone I would decline politely and said I was happy to help afterwards, there was lots of whispering and eye rolling from management to staff around me and it was voiced often how miserable staff felt.

> This placement should be limited to two weeks max or 3rd year students need a wider scope when it comes to medimap and giving medications as it is a huge part of ARC.

The last quote refers to the importance of students' full immersion into the RN role and what is happening within ARCs during the placement.

Similar patterns can be noticed in the concepts belonging to the third-ranked theme "Work experience". The participants discussed the feelings they experienced during their work ("fantastic" and "confident") while also emphasised the demanding work environment by referring to the importance of time management ("time", "week", "complete") and challenging environment ("change" and "situation"). Some respondents felt like their work was not properly managed linked to the RN.

> I did not get to work with an RN for my whole first week, despite me trying to ask the CNM of the facility for time with the RN. I felt this put me behind in the work and it was very difficult to complete all of my [assessment – competency] work within three weeks.

Other participants felt that their practicum was considered as a nuisance by some staff:

> My preceptors were nice but it was remarked that "That's what I was instructed to tell you" when I was asked to follow an HCA for the week.

Nevertheless, some participants were happy with what they experienced during their placement despite certain challenges.

> Considering I had to change placements a week into it, *** was fantastic and I solely appreciate the work he went through to get me another placement.

The theme "Working with residents" consisted of concepts referring to parties involved ("staff", "manager" and "residents"). The concepts "concerns" and "incident" suggest that students experienced some challenges when working in ARCs. For example,

> Another incident where a nurse was interrogated by the facility manager in front of me regarding a medication error. I found this to be very unprofessional because this should have been handled privately.

Some students felt that despite such challenges SNE staff and managers were really supportive and open to the discussion of anything students were not happy about:

> I hope to have her as an SNE in my future placements. Honest and sage to be able to communicate any of my concerns.

> My SNE was very quick to respond and was helpful during the face-to-face visits.

> Toi Ohomai was very supportive to me in my placement as my SNE visited regularly and was always checking my work to see that I was up to date.

While others did not find their SNEs that helpful:

> My SNE was very unsupportive, I never received any complements or positive feedback about any of my work.

In the theme "Daily routine", participants reflected on how their shifts were organised. Some participants were unhappy about the process:

> During the days when I was on AM shifts, I arrived 15-20 minutes early for handover and I would arrive and handover would have already started. On the PM shifts during the handover, I was ignored to the point where the nurses would not even make eye contact with me.

Others felt like their requests about more immersive practicum led to the opposite outcome:

> When I asked to work alongside the caregivers [HCAs] for a day, they were surprised that I wanted to work with them and even asked my nurse on shift if it was alright. I was then only tasked with making two lots of beds before being dismissed.

The theme "Communications with clinical team" mostly consists of positively loaded concepts (e.g., "nice", "amazing", and "positive"). The students' feedback about communications reflects this overall positive sentiment in working with the team that arrange practicum placements with facilities.

> The clinical team had great communication regarding what needed to be done around covid restrictions and had provided good clarity around what I had to do being a household contact.

Some participants were also happy with their SNEs in communications with clinical team:

> My SNE was sick in the last week and contacted the clinical team.

Although the theme "Workplace practices" is ranked lowest in terms of the number of connections to other themes and concepts, it contains a few critical points about practices observed by students at their placement. Some of these observations suggest that Toi Ohomai may need to reconsider their cooperation with certain placement providers:

> This facility has tainted my view of the rest home so much so that I could not put my own family into one if this is how they (residents) are treated.

> I would never recommend this placement to other students due to the skills and practices being used by both nurses and care staff, and the majority of the staff taking a "do what I say not what I do" approach when teaching and demonstrating.

> I was ignored, any input I had about any the residents was disregarded the majority of time. The CSM [clinical services manager]or UC [unit co-ordinator] would speak over me and it felt like I was being shut down.

Nevertheless, there were other students who were very satisfied with the practices they observed:

> Loved the rest home, awesome staff.

7 | Implications, outputs, dissemination

7.1 Insights from applying cultural lens theory

The concept of cultural lens theory (Hardin et al., 2014) has been briefly outlined in the earlier Methodology section of this report, and is covered in more detail in the separate literature review output from this AARIA project. Fundamentally, adopting a cultural lens to examine how aged healthcare is offered to, and received by different cultural groups, throws the assumptions behind central constructs into relief. A broad cultural knowledge about each group, formed through both examining the literature and talking to representatives of the targeted populations, provides a backdrop for identifying gaps and potential solutions.

The setting for this inquiry is tertiary education, and what nurses need to know to prepare them for a career in bicultural, and highly diverse - multicultural New Zealand, with a burgeoning older population. We know that textbooks can still discuss older adults in a biomedical discourse emphasising functional decline of physical and mental capacities (Foster, 2020), and that such medical research and teaching literature is overwhelmingly 'Weird': western, educated, industrialised, rich and democratic (Dik et al., 2019). We also know that in this country, there is a well-recorded history of the impact of colonialism (e.g. Podsiadlowski & Fox), and ample evidence today of inequities in health and other social outcomes for people (e.g. LiLACS, 2015; 2016).

The counter to this failure by medical approaches to always adequately address the cross-culture variability of the broader global population is the holistic, hauora-based approach adopted by Bachelor of Nursing curricula. A tradition of scholarship which understands that Māori and non-Māori have very different world views has delivered a rich suite of cultural tools, such as Te whare tapa whā (the four-sided house), Te Wheke (the octopus) and Te Pae Mahutonga (Southern Cross star constellation) developed by Māori health and education experts Emeritus Professor Sir Mason Durie and Rangimarie Rose Pere (Honeyfield et al., 2021). Bicultural and Te Tiriti o Waitangi positioning is woven across the curriculum, and supported by national policy and guidelines, such as the Nursing Council of New Zealand's (2024) *Registered nurse standards of competence* and the Ministry of Health's (2020) *Whakamaua: Māori health action plan 2020-2025* and (2016) *Healthy ageing strategy.* Many of these documents already include reference to multicultural practice, such as the first's measure that nurses must "ensure that care is inclusive of all identities and backgrounds, upholding the right to self-determination" (NCNZ, 2024, p. 3).

In order that students meet these competencies, especially as they relate to non-dominant cultures, it is up to academic leaders and nurse educators to provide appropriate models and frameworks for students to filter and test their conclusions in alternative contexts (Dik et al., 2019). Thus cultural lens theory supports the conceptual understanding of cultural consciousness – understanding our own culture in order to develop deeper cultural knowledge about other individuals and contexts (Podsiadlowski & Fox). In both education and healthcare, the process of cultural consciousness is a fundamental step in the preparation for multicultural learning, teaching and research (Heath et al., 2023).

We hope that the poster teaching resource produced as one of the outputs from this project will offer one possible tool for educators moving students from personal

reflection, to application of cultural consciousness with real-life examples. The poster *"What older adults in Aotearoa would like nursing students to know"* contains dozens of verbatim quotes gleaned from the multiple engagements undertaken as background preparation, or data collection. We acknowledge that these statements offer a snapshot of what individual participants wanted to share, although of course not everyone from the same cultural background will hold identical views. Nonetheless, the comments can be used as conversation starters, or possible role-plays, or as a basis for written scenarios.

7.2 Project outputs

From inception, this project has been designed to contribute to both the theory and practice of nursing education related to healthcare provision for older adults in Aotearoa New Zealand. As a first deliverable, we hope that the data and discussion in this report will directly feed into our own delivery of the Bachelor of Nursing, and more widely across the sector. Understanding the ako practices that work for students will support educators to strengthen professional teaching and learning practice and ultimately improve health care outcomes for Māori and all peoples. We also intend that our own learning and critical reflection will inform future academic presentations and publications and contribute to the literature in the field.

In addition to both short and long versions of the report, further outputs include:

- A stand-alone literature review to collate and synthesise recent work in the field of supporting cultural identity in aged health care provision.
- Teaching resource 1: Narratives and lesson plan example. A series of 12 real-life case studies of older adults' experiences of health care and ageing, related to their own cultural identity, and linked to the Nursing Council of New Zealand's six Standards of Competency Pou (NCNZ, 2024). As these competencies have only recently been published we anticipate that this will be one of the first purposely-linked learning and teaching resources and so of immediate use for nurse educators. Each narrative has been developed from a series of interviews with the participant, and approved for classroom use by the subject. Each includes optional focus questions, and an example lesson plan written in consultation with BN teaching team members is provided as a possible guide for practitioners.
- Teaching resource 2: Video clips of some of the project's interviewees talking about their own health and ageing journeys. Four of our participants from different ethnicities (Carole, John and Nellie, and Tamati) assisted us to make five short clips related to different aspects of living in the community as an older person, and making the link between health and their own cultural traditions. These have been carefully edited to avoid repeating the content shared in Teaching Resource 1. The clips are between 4 and 8 minutes, and could be used with students in a range of contexts, covering topics such as the migrant experience, PTSD, political advocacy, kaupapa Māori medicine, intergenerational learning, using legends as metaphors for traditional wisdom and service development as well as many more.
- Teaching resource 3: A poster for classroom use: "What older adults in Aotearoa would like nursing students to know: Findings from the research". The poster is intended as a conversation-starter about cultural consciousness and contains numerous examples that participants shared with us during interviews and focus groups. A possible use here might be as a template for students to develop their own record of cultural practices/expectations/preferences that they observe during clinical placements, throughout their BN study.

In developing all three teaching resources, our common theme was to ask our participants, what messages would they want to pass on to the future generation of nurses? We hope that hearing a 'direct voice' will be highly impactful for learners – and perhaps contribute to their better understanding and more empathetic practice when working with older people in-course, and following graduation.

7.3 Dissemination

We have already begun to socialise our findings and present some of our learning around the research process with both various stakeholder groups. To date:

- **Return visits to informants** (BN teachers and managers) at Wintec and AUT to share progress and discuss the teaching resources that were being developed.
- **Presentation of resources to delegation from Shenzhen Polytechnic's nursing and international departments**, China, facilitated by Access NZ.

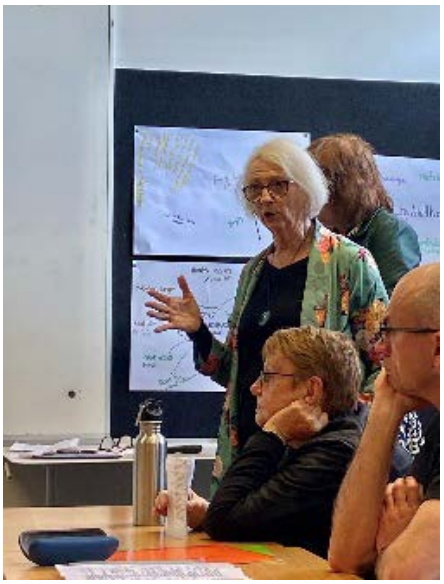


Cath and Judi with Jenny Song, Nursing lecturer, Wintec; at AUT with Kay (in grey jacket), Shenzhen visitors and Dr Walley Qiu (far left); workshopping our resources with Shenzhen's aged healthcare and nursing representatives.

- **Conference presentations – Rotorua and Christchurch.**

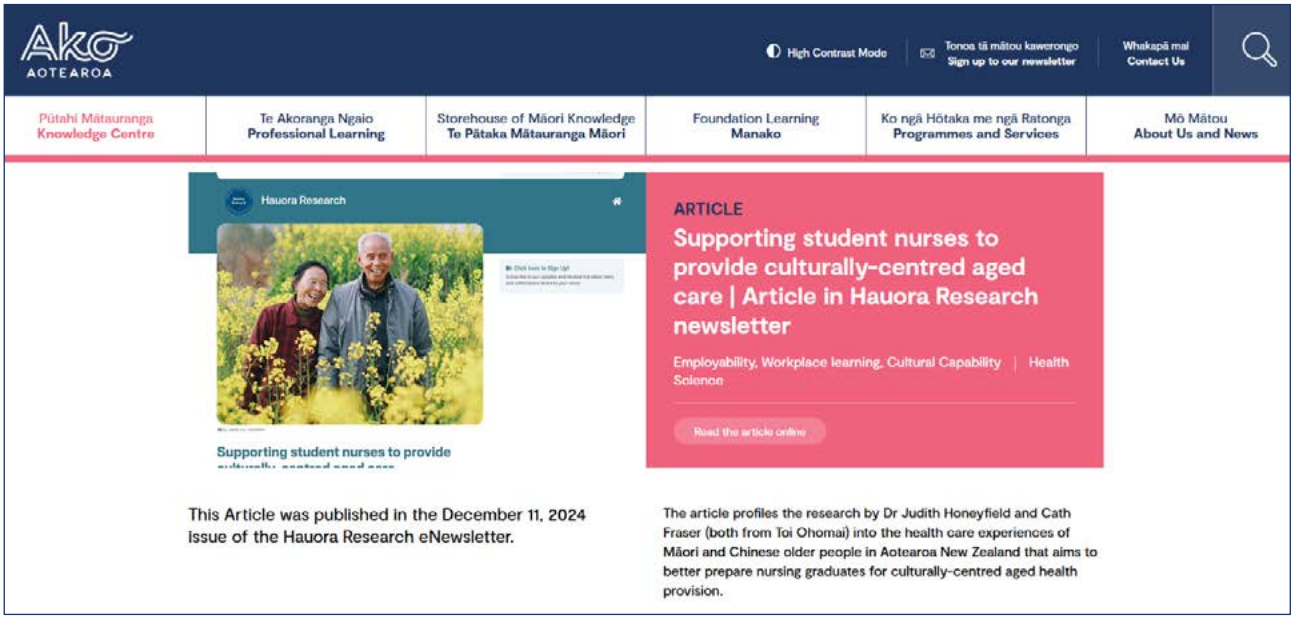
  Fraser, C., Honeyfield, J., & Peterson, R. (2024, September 19). Mentoring, championing and stepping up: A case study of a 15 year research partnership [Symposium presentation]. Te Manawa Reka Curiosity Research Symposium, Toi Ohomai Institute of Technology, Rotorua, New Zealand.

  Fraser, C., & Honeyfield, J. (2024, December 6). Winning, doing, finishing: An account of externally funded research, with some pointers for colleagues [Symposium presentation]. OPSITARA Research Symposium, Ara Institute of Canterbury, Christchurch, New Zealand.

Cath, Judi and Ruth presenting the research process and AARIA model at Rotorua

— **Interview and article in national magazine: Hauora Research eNewsletter,** December 11, 2024 issue. https://hail.to/hauora-research/article/gSvX3iL



https://ako.ac.nz/knowledge-centre/readying-nursing-students-for-culturally-grounded-practice/supporting-student-nurses-to-provide-culturally-centred-aged-care

8 | Wrap up and future plans

This year-long, co-funded project has been satisfying and successful, from the perspective of the project leads and authors of this report. We are deeply grateful for the outputs achieved to date and the wisdom of the participant, colleagues, managers, students, and nurses, and Ako Aotearoa and Toi Ohomai that have assisted these– the teaching resources and research presentations - and look forward to extending their use and dissemination throughout 2025 and beyond.

— **Internationally:** A key focus will be a poster and a paper presentation at the Nursing Asia Pacific Conference 2025 in June, with the theme "Advancing Nursing Excellence: Leadership, Innovation, and Patient Centered Care Through Education, Research, and Technology Integration" (https://nursing.conferencesedition.com/). We have two abstracts accepted and included in the programme:
    1. "Planning for effective nurse education: Preparing the next generation of nurses for the societal changes happening today."
    2. "Indigenous and migrant experiences of a predominantly western model of healthcare in Aotearoa New Zealand."

— **Regionally:** We continue to work closely with Ruth Peterson and Ako Aotearoa and are keen to attend the 2025 Northern Sector Colloquium and spread the word about the AARIA funding scheme. We are always ready to assist others with the application process and some of the things we have learned – what helped, what to watch out for, recovery and leveraging strategies.

— **Internally:** Once Ako Aotearoa has completed the review and publishing of this project and its outputs through their website, we plan to workshop the text and video narratives with our colleagues and support their use of the resources with nursing students – pointing out a number of curriculum areas in which their inclusion might add to teaching and learning – such as preparation for ARC clinical placements, understanding Te Ao Māori and indigenous health/medicinal knowledge.

The project has entailed a lot of personal and professional development – some foreseen and planned for, but more often as a response to issues beyond our control. We had expected to need to learn more about mixed method research, digital recording and editing, and software analysis tools. We had included subcontractor hours in our budget to assist with these elements of the research, which largely proceeded as planned. We also anticipated the need for multiple visits to build relationships and establish trust with our older participants, and this was certainly the case. We started by bringing morning tea and offering vouchers to thank people for their time, and ended up invited for lunch, being sent home with baking, walking round gardens, being photographed for family, and exchanging pictures and emails while one or other party was on holiday. These encounters have been a highlight of our study!

Unexpected challenges included:

— A change in the political landscape and ensuing policy reversals. An initial intention with the cultural lens approach was to analyse the proposed unified Bachelor of Nursing degree's to assess coverage of diversity and inclusion from a multicultural perspective – and to consider alignment with themes and concerns disclosed by our participants in our primary data collection. However, with the new National-Act-NZ First Coalition Government the announcement was made that Te Pūkenga – NZ Institute of Skills and Technology would be dis-established and that the workstream

would be halted. Our correction was to pivot the document analysis element of the project to a deeper review of two existing collections of programme data: students' Quality Improvement Project Reports, completed as an assessment, and Post-ARC Placement Evaluations, completed as part of the programme's standard review and monitoring practice. These changes were accepted by Ako Aotearoa as part of our first Milestone Report.

— Health issues and two resignations impacted availability at times of all three members of our advisory Komiti Kaupapa Māori team members. One resignation occurred before the project even commenced; our other two colleagues had contracts to support the project outside of their regular work hours. We are grateful for the assistance from one original team member who attended multiple interviews with two of our Māori participants as tikanga support, and the second, who offered an alternative contribution and reviewed, then aligned the 12 text narratives and focus questions against the Nursing Council of New Zealand's new registered nurse Standards of Competence framework. The sample Lesson Plan included in this teaching resource was also her idea. To acknowledge their assistance, we negotiated with our Research Office to use some of the funds to provide vouchers for them, as non-monetary koha.
— Our older participants were also affected by health issues – a significant surgery, and a death. This was a sad time as we had learned about their stories and come to know them a little as wonderful individuals with rich backgrounds and insights. Both these Rangatira were Māori, and significantly important for the direction of this dual-population focused project. The first was a Rangatira we had met with five times – one was a visit to our organisation so she could meet up with other members of the team, but with a date for a major surgery, as is her right, she chose to withdraw and we negotiated to also withdraw her narrative from the project documents. The second Rangatira died suddenly after we had completed his story and had his and whānau approval. We sought permission through a colleague and whānau member to facilitated our meetings with her uncle and his whānau. With her liaison support the family have generously allowed us to retain his story, so that the thoughts he wanted to share with student nurses have not been lost.

Overall, we could sum up by saying: Our ageing and increasingly culturally diverse population will be a feature of our social and healthcare landscape for years (decades) to come – as will be our need for skilled practitioners to provide care and services. When we prepare our students for the world of work, we need to balance the contributions of classroom approaches – textbooks, lectures, labs, simulations, avatars, role play – with authentic voices from real life. We hope that this project offers a possible starting point for teaching and learning discussions which ready our nursing students for culturally grounded practice that supports a new vision of older persons' healthcare provision.

Image next page - project participant Lydia, narrative 5, taken from "Teaching resource: Older adults' narratives of health and wellbeing."

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Image next page - project participant Ying, narrative 12, taken from "Teaching resource: Older adults' narratives of health and wellbeing."

Appendices

Appendix A: Participant information sheet

Research project: **Readying nursing students for culturally grounded practice that supports a new vision of older persons' healthcare environments**
Name of Researchers: Judi Honeyfield and Cath Fraser
Researcher Contact details: Email ID: cath.fraser@toiohomai.ac.nz

You are invited to participate in a research project focused on the Bachelor of Nursing (BN) programme, and how well it is preparing graduates for culturally-centred care provision working with older people, in a range of healthcare and community settings. This study has received ethics approval from the host organisation, Toi Ohomai Institute of Technology's Research Committee (#24002, March 2024), and is jointly funded by Toi Ohomai and Ako Aotearoa – New Zealand's Centre for Tertiary Teaching Excellence. We will be speaking to several groups of informants:

— Bachelor of Nursing teaching team members
— Managers of aged healthcare facilities
— Preceptors
— Bachelor of Nursing students
— Older people from a range of health care and residency providers

We are inviting you to participate in an interview, and would like your permission to make an audio/video recording of our conversation – Cath and/or Judi will explain to you which recording method will apply to your interview. You will have the opportunity to read the transcript of the recording (or review the video, if relevant) to confirm your responses, prior to publication.

For most of our participants, we will ensure anonymity in our reporting by not including names or identifying details.

For a small number of older people who are being asked about their experiences of ageing and health care from a cultural perspective, we will ask whether we can re-visit them to film them telling their story directly to camera, in their own words. If you are one of these participants, we will ask you to sign a special consent form allowing public viewing, and will discuss this with you more fully at that time.

The findings from this research will be used for educational purposes in the Bachelor of Nursing programme, and may also be used for conference presentations, and as part of the project report on the Ako Aotearoa website.

We are happy to discuss this research at any time – please contact us through Cath's email address above. Thank you for considering this invitation.

Cath Fraser and Judith Honeyfield

Appendix B. Descriptive statistics and regression analysis for student surveys

Descriptive statistics

Table 1. *Responses to "The teaching provided during classroom time prepared me well for the clinical placement."*

	N	%
Disagree	7	21.2%
Agree	21	63.6%
Strongly agree	5	15.2%

Most participants felt to be prepared (63.64%) or very prepared (15.5%) for the clinical placement, while 21.21% did not think they were prepared.

Figure 1. Proportion of Responses to "The teaching provided during classroom time prepared me well for the clinical placement."

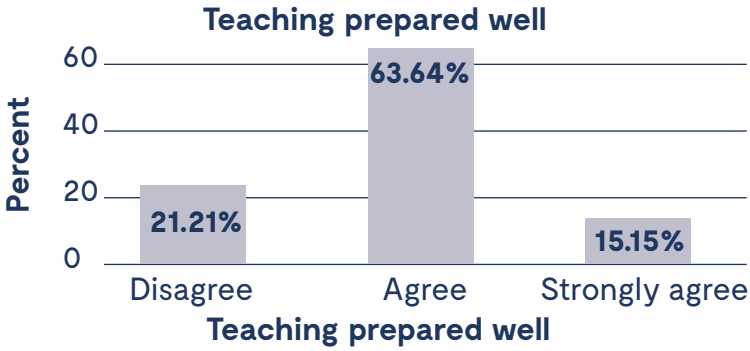


Table 2. *"The information I received from Toi Ohomai Institute of Technology about my placement was accurate and timely."*

	N	%
Disagree	4	8.3%
Agree	31	64.6%
Strongly agree	13	27.1%

Most participants agreed that they received accurate and timely information about the placement (64.6%) or strongly agreed (27.1%) for the clinical placement, while 8.3% did not think they received such information.

Figure 2. Proportion of Responses to "The information I received from Toi Ohomai Institute of Technology about my placement was accurate and timely."

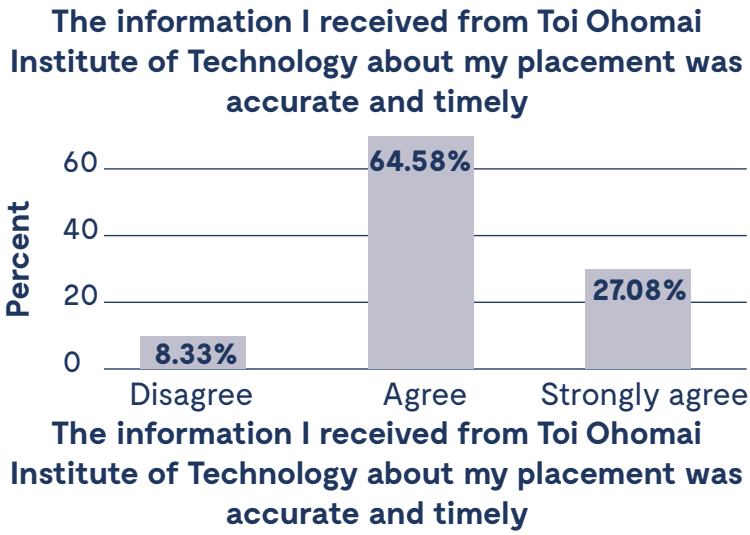


Table 3. "*I felt Toi Ohomai Institute of Technology prepared me adequately prior to the practicum.*"

	N	%
Disagree	8	16.7%
Agree	29	60.4%
Strongly agree	11	22.9%

Most participants agreed that Toi Ohomai prepared them adequately prior to the practicum (60.42%) or strongly agreed (22.9%) for the clinical placement, while 16.7% did not think they were adequately prepared.

Figure 3. Proportion of responses to "I felt Toi Ohomai Institute of Technology prepared me adequately prior to the practicum"

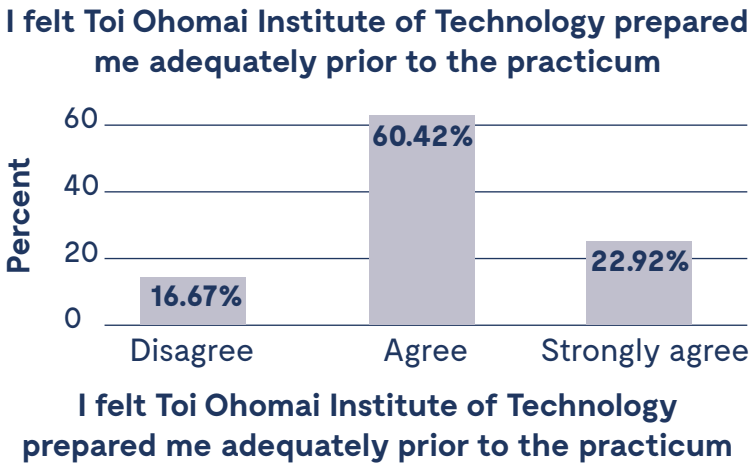


Table 4. "*I understood the professional approach and behaviour I was to demonstrate prior to my practicum.*"

	N	%
Agree	12	36.36%
Strongly agree	21	63.64%

The majority of participants (63.64%) agreed that they understood the professional approach and behaviour they were to demonstrate prior to their practicum, while 36.36% strongly agreed with this statement.

Figure 4. Responses to I understood the professional approach and behaviour I was to demonstrate prior to my practicum

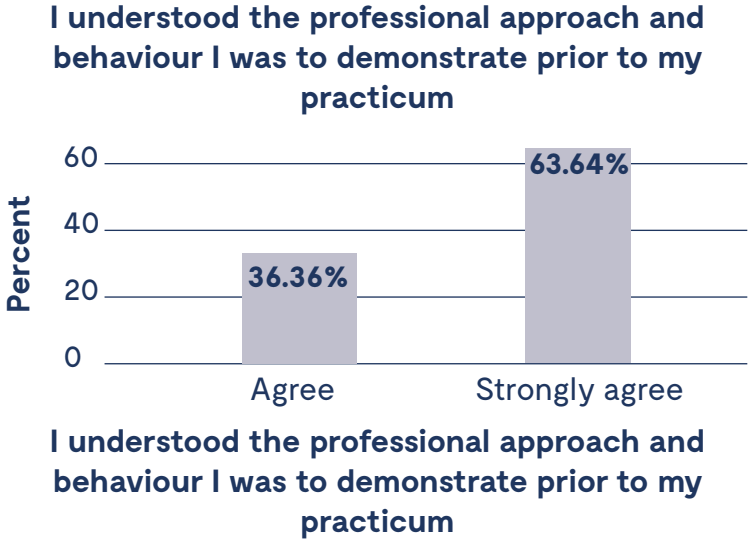


Table 5. "*On the first day of my placement, I received a useful orientation to my placement.*"

	N	%
Strongly disagree	4	8.7%
Disagree	10	21.74%
Agree	20	43.5%
Strongly agree	12	26.1%

As the above results suggest, there were participants who strongly disagreed (8.7%) and disagreed (21.74%) that they received a useful orientation on the first day of their placement. However, the remaining participants agreed (43.5%) or strongly agreed (26.1%) that they received a useful orientation.

Figure 5. Responses to "On the first day of my placement, I received a useful orientation to my placement."

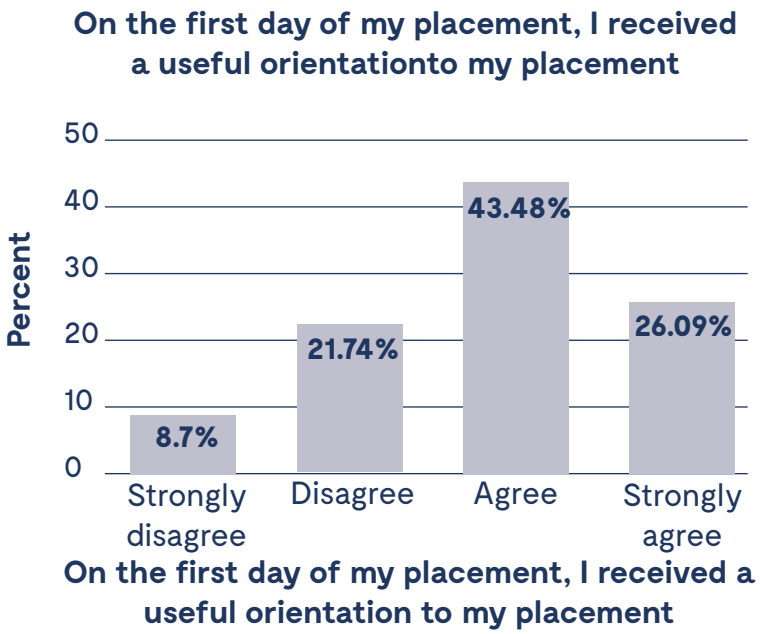


Table 6. "*The content of the orientation day was appropriate and helpful.*"

	N	%
Strongly disagree	2	4.65%
Disagree	10	23.26%
Agree	23	53.5%
Strongly agree	8	18.6%

As the above results suggest, there were participants who strongly disagreed (4.65%) and disagreed (23.26%) that the content of the orientation day was appropriate and helpful. However, the remaining participants agreed (53.5%) or strongly agreed (18.6%) that the orientation day was appropriate and helpful.

Figure 6. Responses to "The content of the orientation day was appropriate and helpful."

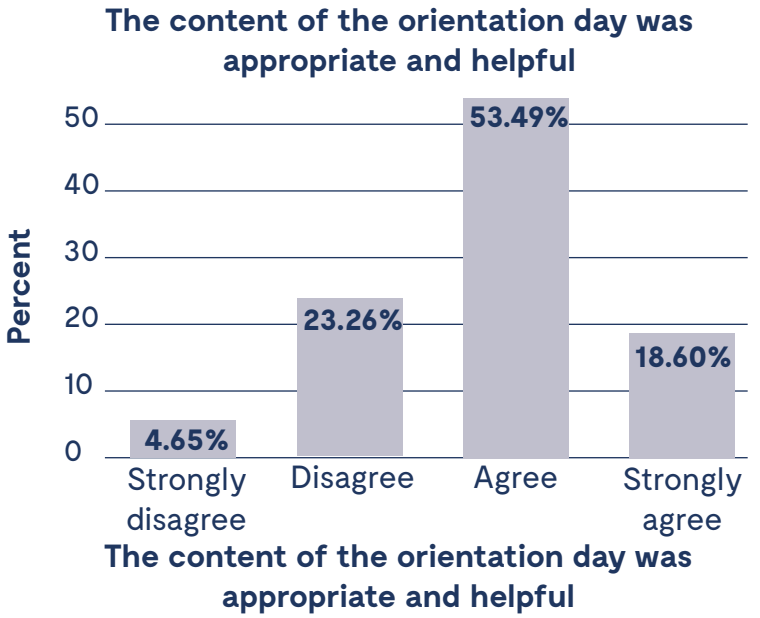


Table 7. *"I was provided with appropriate identification, access and communications devices (e.g., ID card, swipe card, keys, pager, computer login details)."*

	N	%
Strongly disagree	1	2.4%
Disagree	9	22%
Agree	20	48.8%
Strongly agree	11	26.8%

As the above results suggest, there were participants who strongly disagreed (2.4%) and disagreed (22%) that they were provided with appropriate identification, access and communications devices. However, the remaining participants agreed (48.8%) or strongly agreed (26.8%) that they were provided with these items.

Figure 7. Responses to "I was provided with appropriate identification, access and communications devices (e.g., ID card, swipe card, keys, pager, computer login details)."

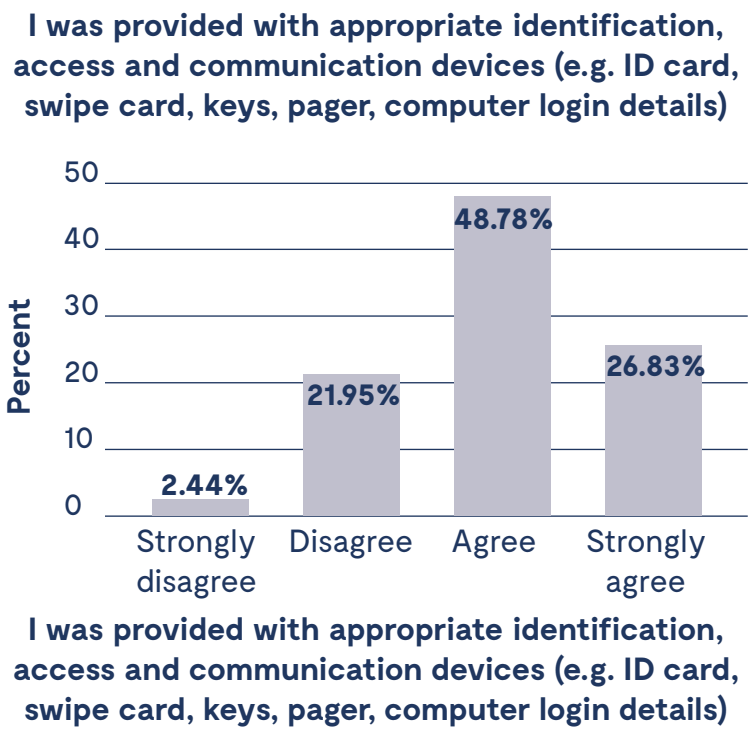


Table 8. *"I could access a computer when I needed to."*

	N	%
Strongly disagree	5	17.24%
Disagree	9	31%
Agree	10	34.5%
Strongly agree	5	17.24%

The above results show that a considerable proportion of participants did not have access to a computer when they needed to (17.24% were very confident in this and 31% were confident). The remaining participants either agreed (34.5%) or strongly agreed (17.24%) that they had access to a computer when they needed to.

Figure 8. Responses to "I could access a computer when I needed to."

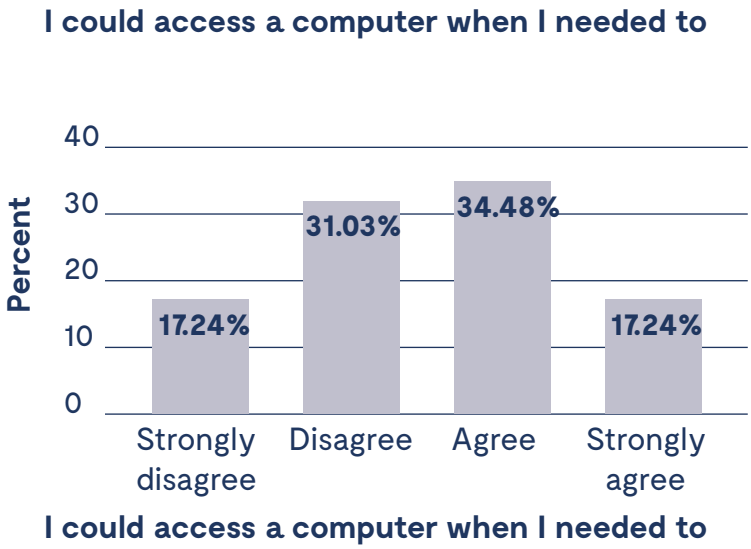


Table 9. *"I was able to access resources relevant to the practicum and my assessment points during the placement."*

	N	%
Strongly disagree	2	4.26%
Disagree	5	10.64%
Agree	30	63.8%
Strongly agree	10	21.26%

Most participants (63.8%) agreed or strongly agreed (21.26%) that they were able to access resources relevant to the practicum and assessment points during the placement. Only a few participants (4.26% - strongly disagree and 10.64% - disagree) believed that they did not have access to resources to the practicum and assessment points.

Figure 9. Responses to "I was able to access resources relevant to the practicum and my assessment points during the placement."

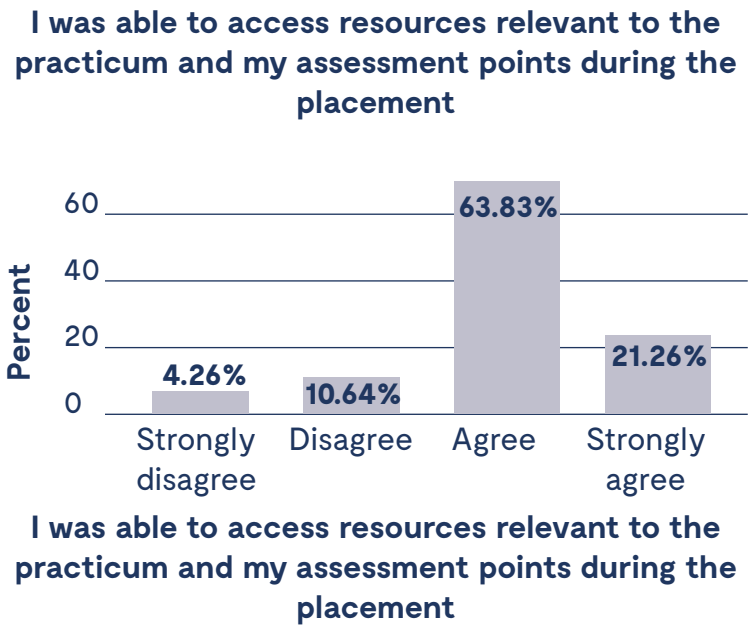


Table 10. *"The placement provider gave me opportunity to meet my learning objectives during the practicum."*

	N	%
Disagree	4	10.26%
Agree	16	41%
Strongly Agree	19	48.7%

Most participants (41%) agreed or strongly agreed (48.7%) that the placement provider gave them opportunity to meet their learning objectives during the practicum. Only a few participants (10.2% - disagree) believed that they did not have such an opportunity.

Figure 10. Responses to "The placement provider gave me opportunity to meet my learning objectives during the practicum."

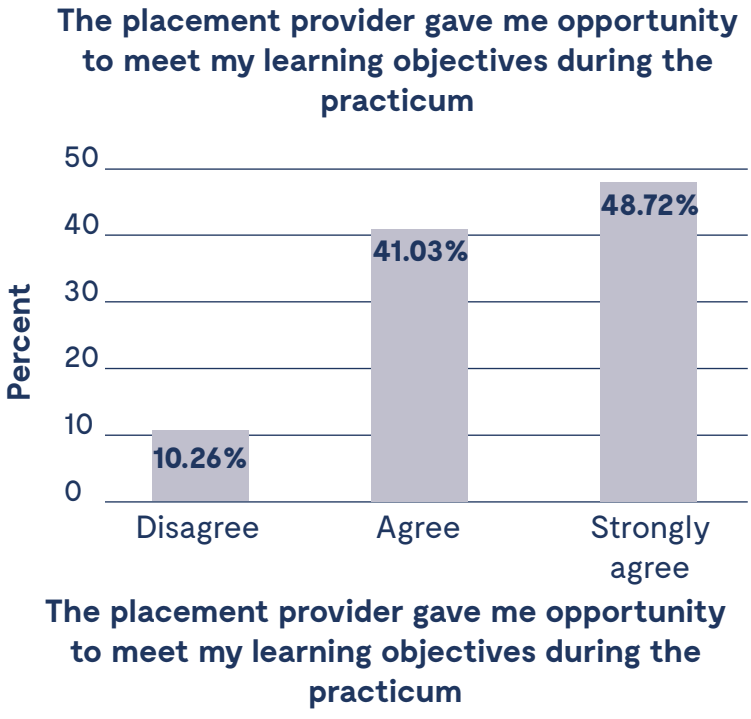


Table 11. *"The staff in the department/service area where I was working made me feel welcome, valued and part of the team."*

	N	%
Strongly disagree	1	2.1%
Disagree	5	10.4%
Agree	17	35.4%
Strongly agree	25	52.1%

Most participants (35.42%) agreed or strongly agreed (58.1%) that the staff in the department/service area where they were working made them feel welcome, valued and part of the team. Only a few participants (10.4% disagree and 2.1% strongly disagree) believed that they were not welcome and valued.

Figure 11. Responses to "The staff in the department/service area where I was working made me feel welcome, valued and part of the team."

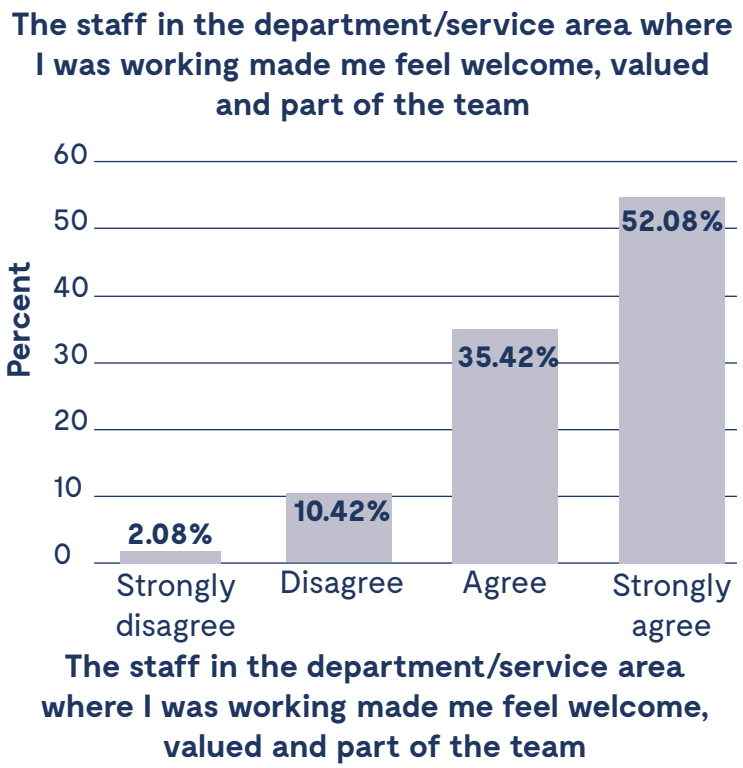


Table 12. *"I had access to the medical equipment and tools I needed for my placement."*

	N	%
Disagree	1	3.1%
Agree	19	59.4%
Strongly agree	12	37.5%

Most participants (59.4%) agreed or strongly agreed (37.5%) that they had access to the medical equipment and tools they needed for my placement. Only a few participants (3.1 % – disagree) believed that they did not have such access.

Figure 12. Responses to "I had access to the medical equipment and tools I needed for my placement."

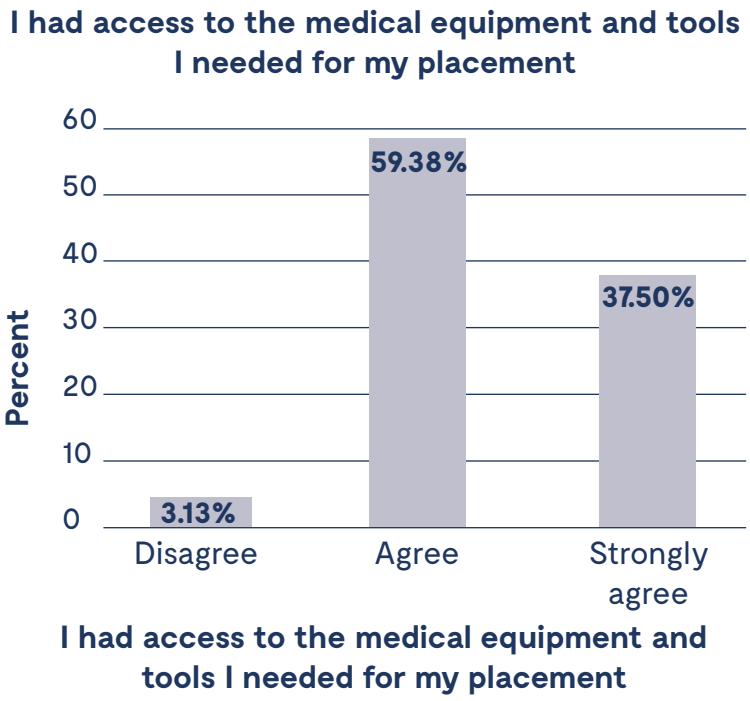


Table 13. "*The staff I worked with were professional and helpful.*"

	N	%
Strongly disagree	1	2.1%
Disagree	2	4.2%
Agree	22	45.8%
Strongly agree	23	47.9%

Most participants (45.83%) agreed or strongly agreed (47.92.1%) that the staff they worked with were professional and helpful. Only a few participants (4.17% disagree and 2.1% strongly disagree) believed that the staff were not professional and helpful.

Figure 13. Responses to "The staff I worked with were professional and helpful."

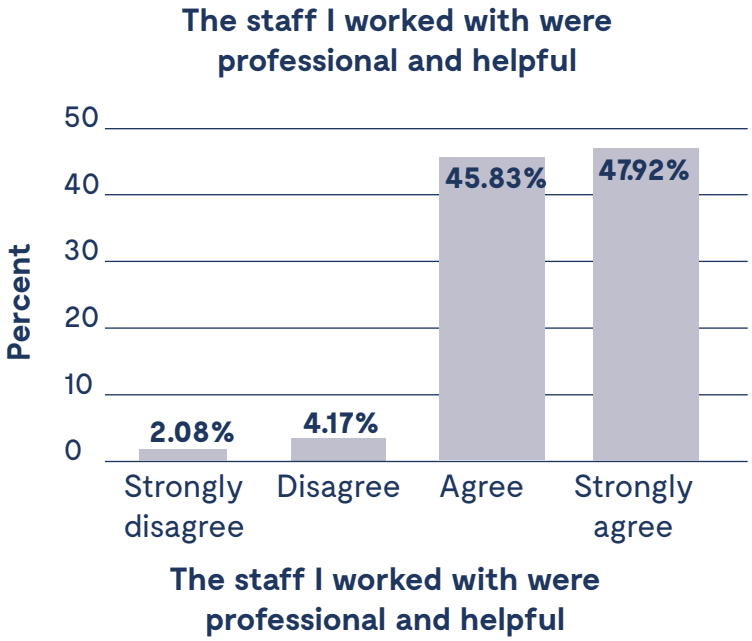


Table 14. "*The number and types of patients I saw were sufficient to promote my learning.*"

	N	%
Disagree	3	6.3%
Agree	27	56.3%
Strongly agree	18	37.5%

As the above results suggest, most participants (56.25%) agreed or strongly agreed (37.5%) that the number and types of patients they saw were sufficient to promote their learning. Only a few participants (6.25% disagree) did not think that the number and types of patients they saw were sufficient to promote their learning.

Figure 14. Responses to "The number and types of patients I saw were sufficient to promote my learning."

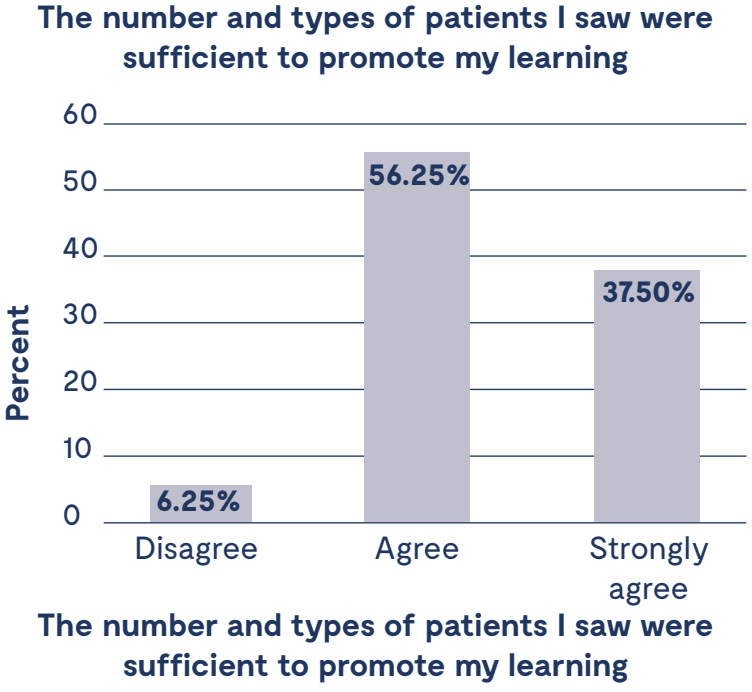


Table 15. *"My placement supervising lecturer/SNE facilitated my learning well."*

	N	%
Strongly disagree	1	2.1%
Disagree	3	6.3%
Agree	21	43.8%
Strongly agree	23	47.9%

As the above results suggest, most participants (43.75%) agreed or strongly agreed (47.92%) that their placement supervising lecturer/SNE facilitated their learning well. Only a few participants (6.25% disagree and 2.1% strongly disagree) did not think that their supervisor facilitated their placement well.

Figure 15. Responses to "My placement supervising lecturer/SNE facilitated my learning well."

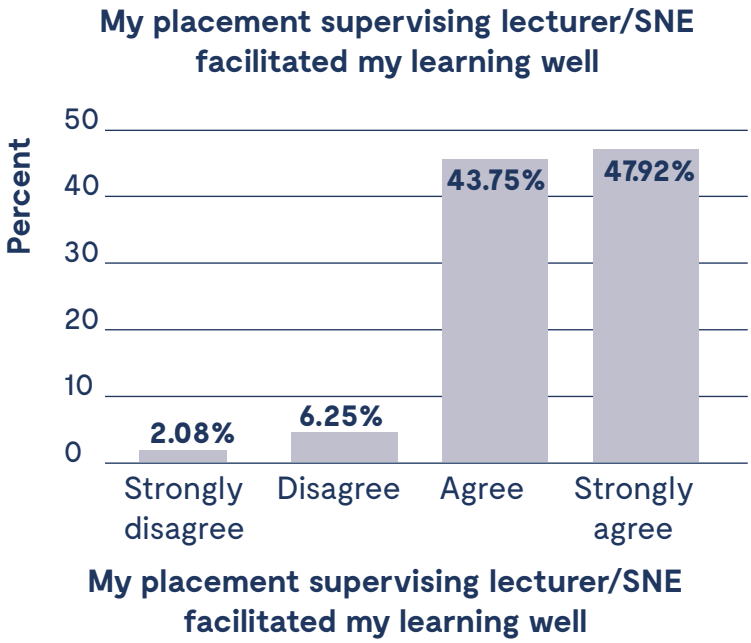


Figure 16. *My placement supervising lecturer/SNE visited regularly*

	N	%
Strongly disagree	1	2.1%
Disagree	2	4.2%
Agree	23	47.9%
Strongly Agree	22	45.8%

Most participants (47.92%) agreed or strongly agreed (45.83%) that their placement supervising lecturer/SNE visited them regularly. Only a few participants (4.17% disagree and 2.1% strongly disagree) did not think that their supervisor visited them regularly.

Figure 16. Responses to "My placement supervising lecturer/SNE visited regularly."

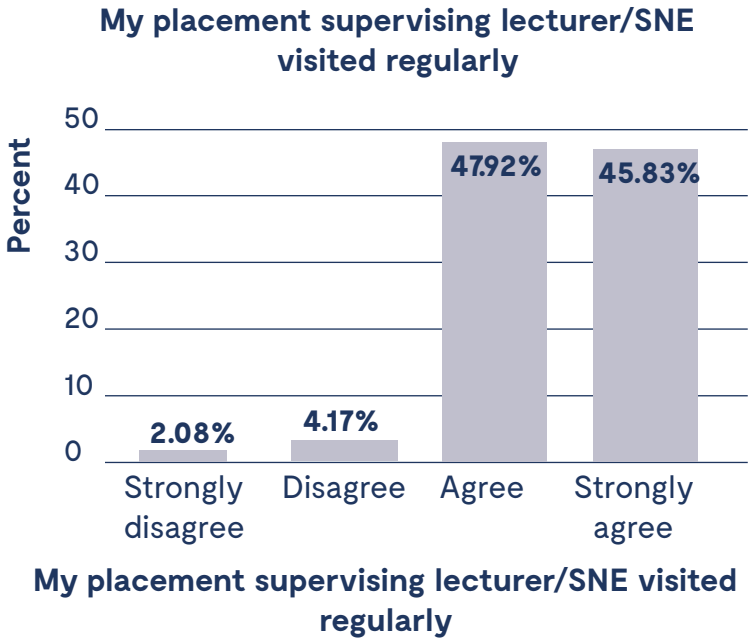


Table 17. *"The feedback I received from staff (positive and negative) helped my learning."*

	N	%
Disagree	5	10.6%
Agree	21	44.7%
Strongly agree	21	44.7%

Most participants (44.7%) agreed or strongly agreed (44.7%) that the feedback they received from staff helped their learning. Only a few participants (10.6% disagree) did not think that the feedback received was helpful in their learning.

Figure 17. Responses to "The feedback I received from staff (positive and negative) helped my learning."

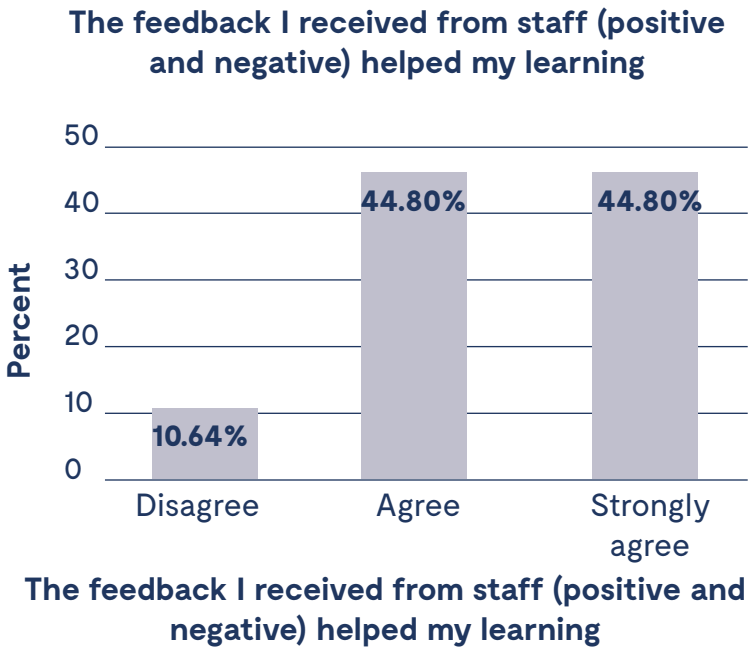


Table 18. *"I learnt useful things from other students on placement at the same time as me."*

	N	%
Disagree	7	17.5%
Agree	23	57.5%
Strongly Agree	10	25%

Most participants (57.5%) agreed or strongly agreed (25%) that they learnt useful things from other students on placement. Only a few participants (17.5% disagree) did not think that they learnt useful things from other students.

Figure 18. Responses to "I learnt useful things from other students on placement at the same time as me."

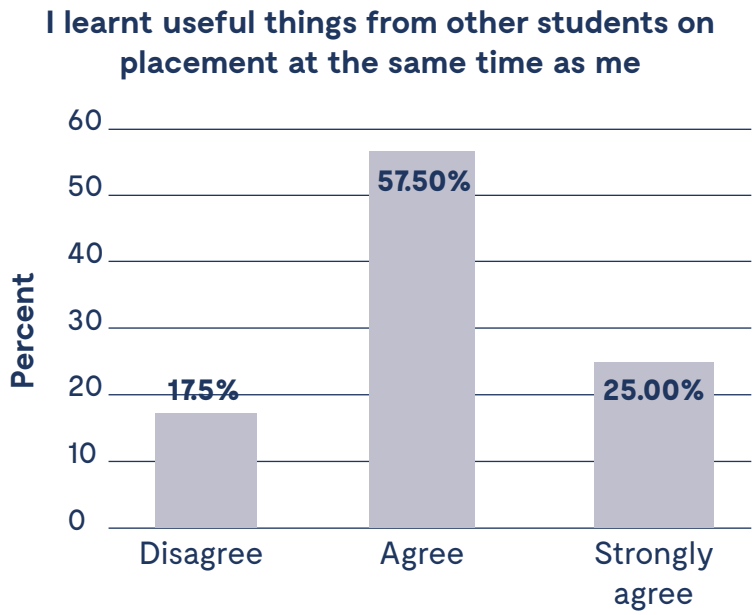


Table 19. "*Some of my learning was with students from other disciplines (eg medicine, nursing, physiotherapy).*"

	N	%
Strongly disagree	3	9.4%
Disagree	12	37.5%
Agree	13	40.63%
Strongly agree	4	12.5%

Significant proportion of students (9.4% strongly disagree and 37.5% disagree) did not think that their learning was with students from other disciplines. Nevertheless, the remaining students (40.63% agree and 12.5% strongly agree) had an opportunity to study with students from other disciplines.

Figure 19. Responses to "Some of my learning was with students from other disciplines (eg medicine, nursing, physiotherapy."

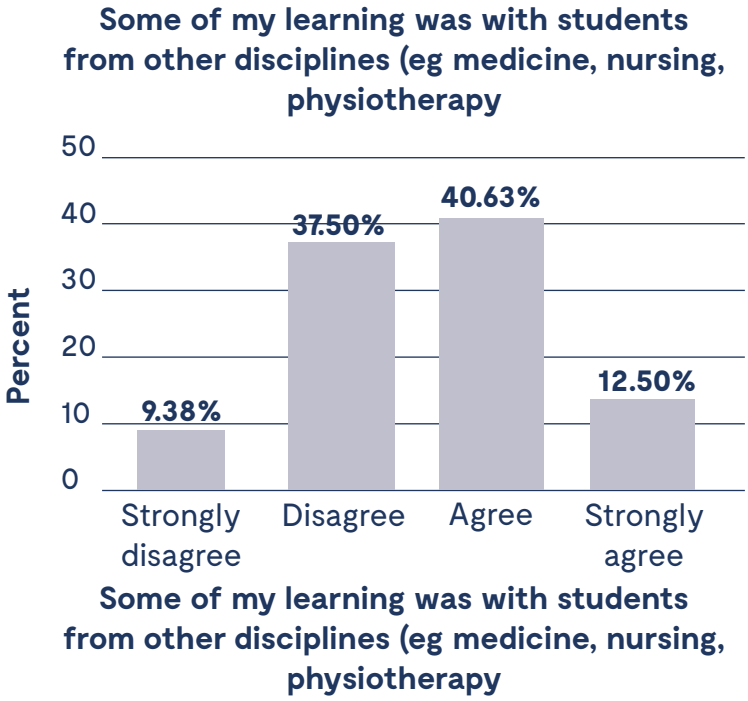


Figure 20. *"My clinical preceptor actively sought learning opportunities for me to encourage my learning experience."*

	N	%
Strongly disagree	3	9.38%
Disagree	5	15.63%
Agree	16	50%
Strongly agree	8	25%

75% of respondents (50% agree and 25% strongly agree) believed that their clinical preceptor actively sought learning opportunities for them to encourage their learning experience. The remaining 25% either disagreed (15.63%) or strongly disagreed (9.38%) with this statement.

Figure 20. Responses to "My clinical preceptor actively sought learning opportunities for me to encourage my learning experience."

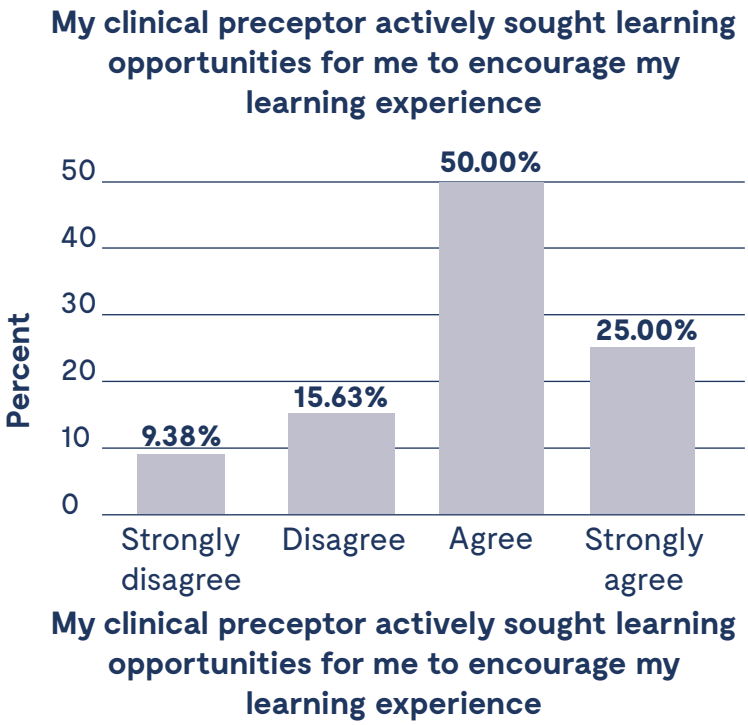


Table 21. *"Overall, my placement experience was a positive one."*

	N	%
Strongly disagree	2	4.26%
Disagree	6	12.77%
Agree	26	55.32%
Strongly agree	13	27.66%

The majority of respondents (55.32% agree and 27.66% strongly agree) agreed that their overall placement experience was positive. The remaining participants either disagreed (13%) or strongly disagreed (4.26%) with this statement.

Figure 21. Responses to "Overall, my placement experience was a positive one."

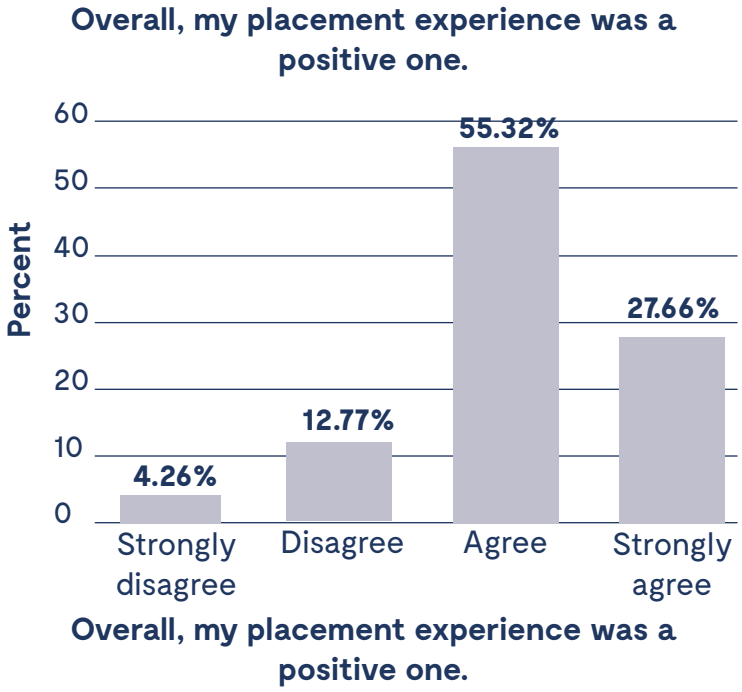


Table 22. *"As a result of my placement experience, I am more likely to apply for a position within this area of nursing after I graduate."*

	N	%
Strongly disagree	8	17.4%
Disagree	28	61%
Agree	4	8.7%
Strongly agree	6	13%

The majority of participants (61% disagree and 17.4% strongly disagree) did not think that the placement made them more likely to apply for a position within this area of nursing after graduation. Only 21.7% of respondents (8.7% agree and 13% strongly agree) believed that their placement had such effect on their plans after the graduation.

Figure 22. Responses to "As a result of my placement experience, I am more likely to apply for a position within this area of nursing after I graduate."

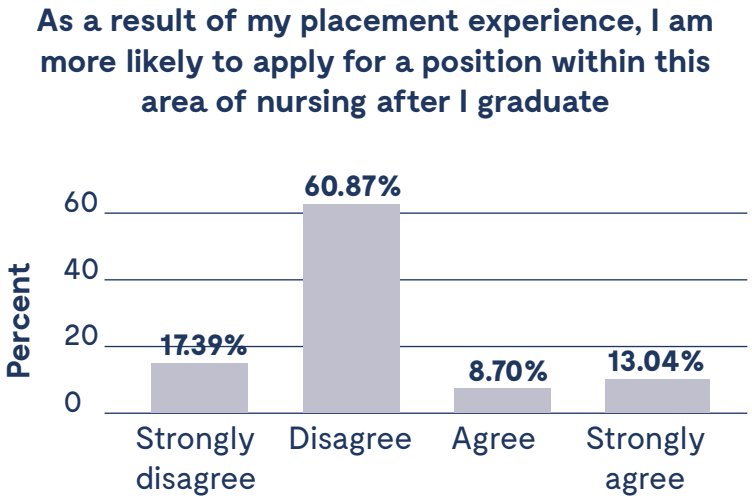
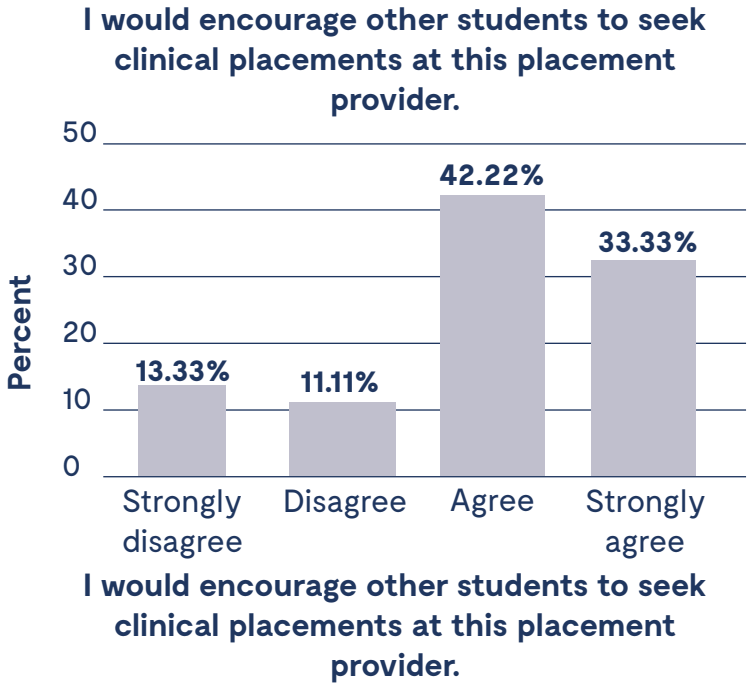


Table 23. *"I would encourage other students to seek clinical placements at this placement provider."*

	N	%
Strongly disagree	6	13.3%
Disagree	5	11.1%
Agree	19	42.2%
Strongly agree	15	33.3%

The majority of respondents (42.2% agree and 33.3% strongly agree) agreed that would encourage other students to seek clinical placements at this placement provider. The remaining participants either disagreed (11.1%) or strongly disagreed (13.3%) with this statement.

Figure 23. Responses to "I would encourage other students to seek clinical placements at this placement provider."



Regression results

The questionnaire consists of five sections:

— Prior to arrival (IV)
— Orientation and learning resources/Support Quality (IV)
— Department/Area of Placement perception (IV)
— Toi Ohomai supervision (IV)
— Overall (DV)

Each of these sections consists of several questions which can be considered as dimensions of each variable (section). The section 'Overall' constitutes a variable that reflect satisfaction with the placement. This variable can be considered as a dependent variable (DV). All other variables represent factors that may impact DV (Overall Satisfaction) and are treated as independent variables (IV). The relationships between these variables can be described with the help of this formula:

$$OS = \beta_0 + \beta_{pa}\, PA + \beta_{sppt}\, SPPT + \beta_{plcm}\, PLCM + \beta_{super}\, SUPER$$

Where *OS* is the predicted value of Overall Satisfaction; β_0 is the *Y* intercept (the value of OS when IVs = 0); *PA* the score for Prior to Arrival; *SPPT* is the score for Orientation and learning resources/Support Quality; *PLCM* is the score for Department/Area of Placement; *SUPER* is the score for the quality of the Toi Ohomai supervision, and the *Bs* are coefficients assigned to each of the IVs during regression.

IVs and DV were created by collapsing means of questions included in each section of IVs and DV. For example, Overall Satisfaction (DV) represents mean scores for means of three questions included in the 'Overall Satisfaction' section.

Reliability of IV and DV scales was evaluated with the help of Chronbach's alpha coefficient. Ideally, it should be above .7 to keep an item in the scale.

The Chronbach's alpha coefficient for the question *'As a result of my placement experience I am more likely to apply for a position within this area of nursing after I graduate'* was below .7 which necessitated its removal from the OS scale. The total number of items for this scale was reduced to two.

In the 'Supervision' scale, this question *'I learnt useful things from other students on placement at the same time as me'* also had the Chronbach's alpha coefficient below .7 and had to be removed. The total number of items for this scale was reduced to three.

Scales for PA, SPPT and PLCM did not contain any items with the Chronbach's alpha coefficient below .7 which allowed to keep all items. PA consisted of two items, SPPT of five items, and PLCM included three items.

A multiple regression was run to predict Overall Satisfaction with the Placement from Prior Arrival experience, Support quality, Placement Perception, and Supervision Quality. This model was significant *F (34.686), p <.001, R Square (adjusted) = .818.* The individual predictors were examined further and indicated that Support Quality *(t = 3.380, p =* .002*)* and Placement perception *(t = 2.64, p =* .014) were significant predictors, but Prior Arrival experience (*t = -.353, p =* .727) and Supervision Quality (*t = -.543, p =* .592) were not significant. Below is the SPSS-generated output for regression coefficients.

In other words, findings suggest that Support Quality and Placement Perception can contribute to overall satisfactions with the placement. Support Quality explains 6% and Placement Perception 4% of the variance (calculated by squaring values of partial correlation coefficients) in Overall Satisfaction score. These are unique contributions of support quality and placement perception IVs, with any overlap or shared variance removed. The remaining 71% of variance (the model explains 81% of the variance) is due to overlap and shared variance.

Table Regression Coefficients

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
		β	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	Constant	-.856	.388		-2.208	.036	-1.654	-.059					
	Prior Arrival	-.073	.206	-.051	-.353	.727	-.495	.350	.754	-.069	-.027	.290	3.448
	Support Quality	.741	.219	.563	3.380	.002	.290	1.191	.891	.552	.263	.219	4.574
	Placement perception	.624	.236	.484	2.640	.014	.138	1.109	.872	.460	.206	.181	5.536
	Supervision	-.088	.163	-.067	-.543	.592	-.423	.246	.644	-.106	-.042	.399	2.504

a. Dependent Variable: Overall Satisfaction

Ako AOTEAROA

TOI-OHOMAI Institute of Technology