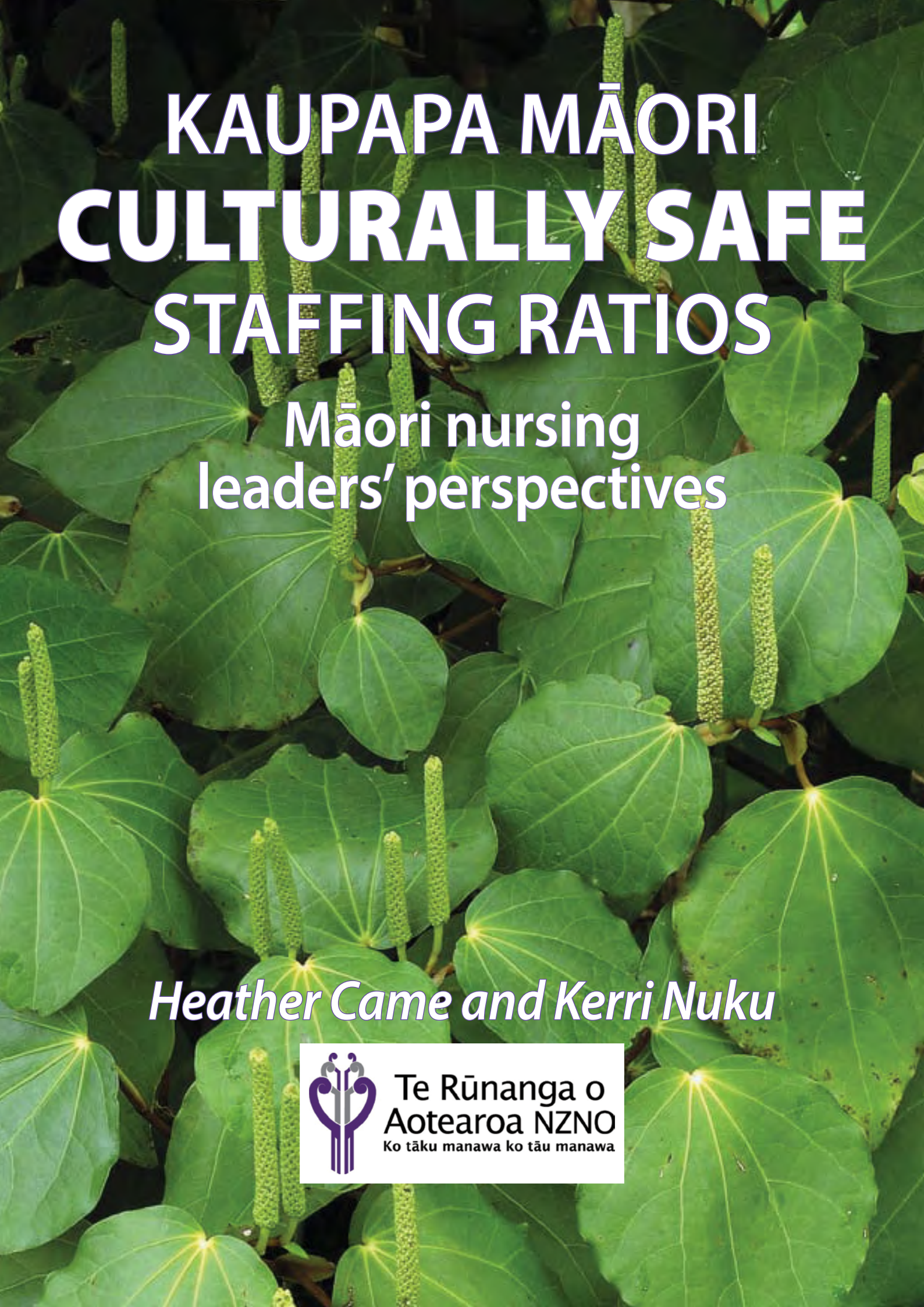

KAUPAPA MĀORI CULTURALLY SAFE STAFFING RATIOS

Māori nursing leaders' perspectives

Heather Came and Kerri Nuku

Te Rūnanga o Aotearoa NZNO
Ko tāku manawa ko tāu manawa

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We acknowledge your collective decades of service to whānau, hapū and iwi.

Ka whaiwhai tonu mātou.

Image from Ngā Mātauranga Taonga – Covid 19 Series, *by Rauawaawa Kaumātua Charitable Trust.*

We acknowledge whaea Hineraumoa Te Apatu, one of the founding members for Te Rūnanga o Aotearoa, who has been our Kaitiaki and supported the aspirations of Maori nurses through her career and personal journey.

We also acknowledge Dr Moana Jackson – his strength and wisdom has guided Māori nursing, and empowered us to be brave and imaginative, to continue to believe in the impossible, and make change possible for the future of our mokopuna.

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Cover image

Kawakawa has been used in rongoā, traditional Māori medicine, for centuries. The leaves chewed by ngā anuhe, caterpillars, indicate those with the most medicinal properties, and they are the first harvested. Image from the *Field Guide to New Zealand Native Trees,* by John Dawson.

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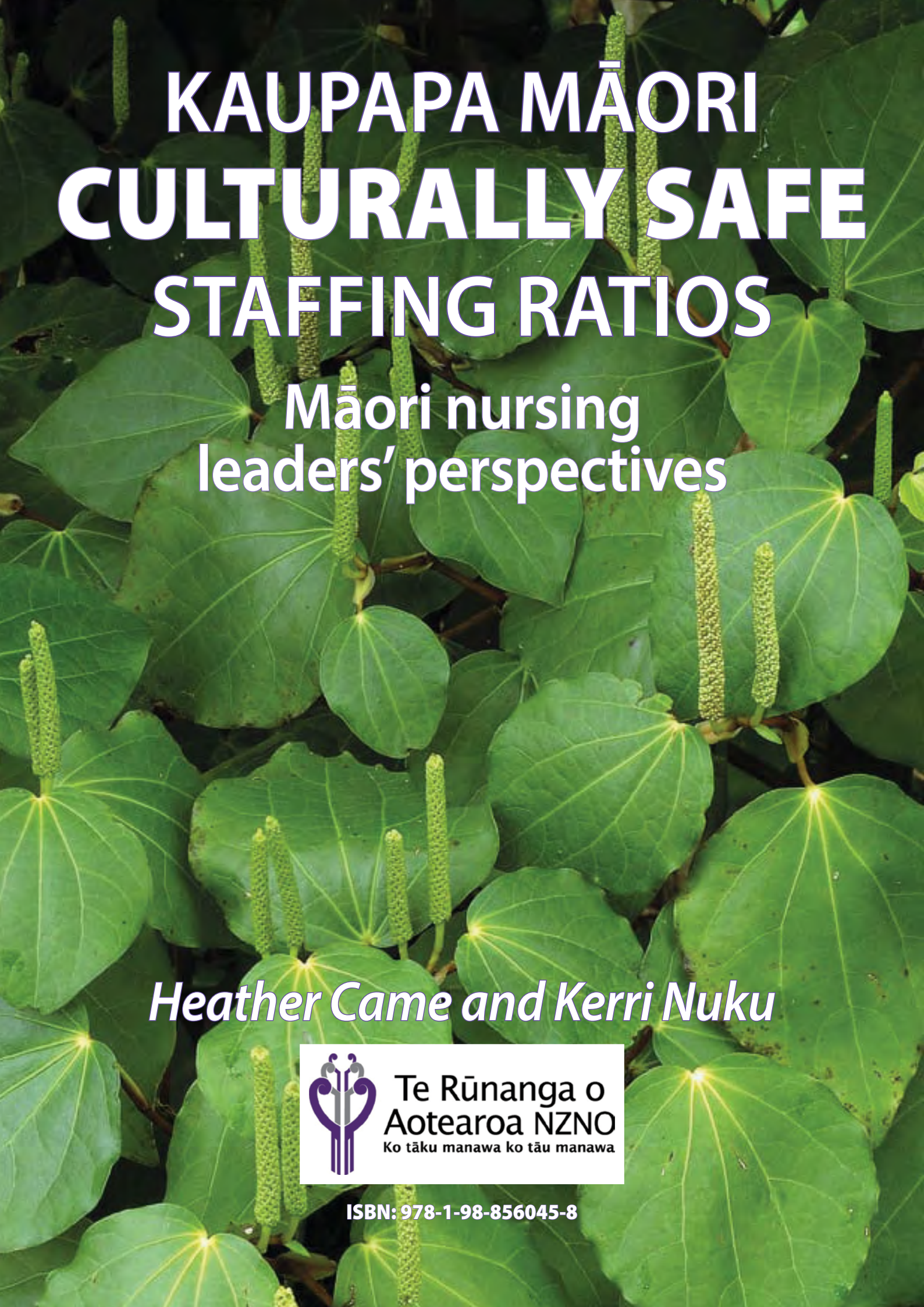

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FOREWORD

SAFE staffing ratios are being developed internationally, in different jurisdictions across the world. These ratios have historically been clinical measures designed from Eurocentric standards and viewpoints. These standards have not integrated cultural dimensions into how to engage safety with whānau.

In this briefing paper, Māori nursing leaders claim a place in the world for Māori nursing. This is not us taking a back seat; this is us leading culture change, influencing the way that care is received or provided to our people.

We believe safe staffing ratios need to centre racial justice and embed cultural responsibilities. This project is an opportunity to do that and to take Dr Irihapeti Ramsden's (2002) pioneering work a step further. Ramsden was adamant that nurses needed to be both clinically and culturally safe in their practice. It is clear nurses need allocated time to achieve this.

We recognise the important recent changes in the competencies and frameworks completed for registered nurses by the Nursing Council. But for these competencies to be realised we need culturally safe staffing ratios.

There is strong international interest in this project, as we have never really told our story through our lens in a way that shows us the impact that culturally unsafe practice has on our people.

This is about us turning ratios on their Eurocentric head, setting the gold standard around cultural responsiveness to Māori and embedding cultural safety into all conversations about staffing levels.

Kerri Nuku
Kaiwhakahaere

As Matua Moana Jackson said:

Be brave – because change requires courage.
Be imaginative – because change only comes with imagination.

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GLOSSARY

Hapū – Kinship group made of related whānau; the primary political unit in traditional Māori society.

Hauora – Health.

Iwi – Extended kinship group, tribe, nation; usually a large group of people descended from a common ancestor and associated with a distinct territory.

Kaitiaki – Guardians, caregivers.

Kapa haka – Cultural performance.

Karakia – Prayers.

Kaumātua – Male elder.

Kaupapa – Policy.

Kāwanatanga, honourable – Government that honours te Tiriti o Waitangi.

Kuia – Female elder.

Mamae – Pain, injury.

Manaaki – Generosity and care.

Mana wāhine – Women of authority, influence and spiritual power.

Maramataka – Monthly almanac, lunar calendar.

Mātauranga Māori – The body of Māori knowledge.

Māuiui – Ill, sick, injured.

Moana – Sea, ocean.

Moko/Mokopuna – Grandchild/ grandchildren.

Moko kauae – Traditional chin tattoo.

Motu – Island, country.

Ngahere – Forest.

Pono – Honest, sincere.

Pūtea – Budget, bank account.

Rangatahi – Young people.

Rongoā – Traditional Māori medicine.

Tamariki – Children.

Tāne – Man.

Tangi – Funeral, usually lasting three days.

Tauiwi – Non-Māori.

Tika – Appropriate, right.

Tikanga – Customary system of Māori values and practices.

Tino rangatiratanga – Absolute authority, sovereignty, self-government.

Wāhine toa – Accomplished women.

Wairua – Spirit.

Wairuatanga – Spirituality.

Whakamā – Ashamed, embarrassed.

Whakapapa – Family history, genealogy; history.

Whakawhiti kōrero – Discussions, deliberations.

Whānau – Extended family.

Whanaungatanga – Establishing relationships.

1 EXECUTIVE SUMMARY

THERE are currently global debates about safe staffing ratios. None of these conversations around the world consider the importance of culture in clinical practice. In Aotearoa/NZ, the omission of culture from the Care Capacity Demand Management (CCDM) is a breach of Te Tiriti o Waitangi.

Whānau deserve culturally and clinically safe healthcare every time they access health services. For this to be achieved we need legislated and funded culturally safe staffing ratios.

The Nursing Council is explicit about the requirement for health practitioners to engage with their Te Tiriti o Waitangi responsibilities as part of ethical practice.

Indigenous peoples have protected collective human rights to the highest attainable standard of health, which is threatened by the existence of monocultural practice and systemic racism.

Cultural safety, as defined by Irihapeti Ramsden, sets clear benchmarks about culturally safe practice to be determined by whānau. To achieve these benchmarks requires us to consider how we can decolonise time and practice within the sector.

Other international evidence suggests staffing ratios are better for patients and staff, save money and produce better health outcomes. The case for legislative ratios has already been argued and won in parts of Australia, Canada and the United States.

Māori nursing leaders interviewed for this report emphasised the centrality of whanaungatanga for cultural safe practice. Honourable kāwanatanga was perceived as aspirational, given the longstanding history of hostility, microaggressions and institutional racism.

We recommend the urgent introduction of culturally safe staffing ratios within nursing.

Māori models of care were seen as a way to enable tino rangatiratanga. Health inequities cause disproportionate harm to whānau, hapū and iwi. Māori nursing leadership was necessary to define equitable outcomes, and to normalise tikanga and wairuatanga.

We recommend the development (and implementation) of culturally safe staffing ratios, led by Māori nurses who have a final overall word on the approach. Kaumātua and kuia need input to ensure tikanga is upheld and that whānau, hapū and iwi, through consumer input, define cultural safe practice.

All decision-making about staffing levels needs to be based on consideration of both clinical and cultural factors. We need to expand the Māori health workforce, particularly nurses, to achieve cultural safe staffing ratios and ensure all nurses, wherever they trained, have baseline cultural and political competencies.

We recommend the urgent introduction of culturally safe staffing ratios within nursing.

2 INTRODUCTION

We have to acknowledge the pioneers who got us here. We have to acknowledge who we can be and where we can stand with strength, conviction and dedication in nursing.

Dr Irihapeti Ramsden ONZM (1946–2003), a pioneer advocate of cultural safety in nursing, at the 2001 launch of The Silent Migration: Ngāti Pōneke Young Māori Club, 1937-1948, *which she co-authored.*

NURSE-to-patient ratios are a critical indicator of quality of clinical care, but impact equally on cultural care for Indigenous peoples.

One of the legacies of Dr Irihapeti Ramsden is the importance of both culturally safe and clinically safe care for whānau. Unrealistic staffing ratios can compromise the ability of nurses to practice safely across both domains.

In pressured healthcare environments, whether in hospital or community settings, staffing ratios have never been more important.

This is particularly true in the face of the current global nursing shortage, through Covid 19, where the wages and conditions of nurses need to be competitive to retain staff in Aotearoa (Tenorio et al., 2021).

Safe staffing ratios are currently optional in New Zealand, although have been regulated in parts of Australia, the United States and Canada.

Concerns about safe staffing levels led NZNO to negotiate for a joint inquiry into acuity-based staffing as part of the 2005 multi-employer collective agreement negotiations.

This inquiry (Safe Staffing/Healthy Workplaces Committee of Inquiry, 2006) led to the establishment of the partnership programme – CCDM.

This programme focussed on improving patient care, making better use of resources and providing a better work environment for frontline staff. It has been rolled out to various degrees across 20 district health boards, but the primary care and Māori health sectors remain outside of its scope.

The programme consists of five standards: governance, validated patient acuity, core data set, staffing methodology and variance response management.

A recent Ministry of Health commissioned review of the programme (Hiliary Graham-Smith cited in 2022, p. 5) found "…the qualitative data and the quantitative data say the same thing – we have not achieved safe staffing or healthy workplaces in our hospitals and we have some way to go".

The report (Ministry of Health, 2022) found CCDM did not recognise Te Tiriti o Waitangi responsibilities towards Māori in its design, implementation or outcomes.

CCDM is based on research that does not recognise Indigenous world views, concepts of care or safety. Tikanga, rongoā and mātauranga Māori are notable omissions from the programme. The reviewers (Ministry of Health, 2022, p. 47) noted:

Our Te Tiriti partnership in Aotearoa New Zealand necessitates that the design, intentions, implementation and outcomes of health sector projects and interventions specifically recognise, honour and uphold the articles … of Te Tiriti.

In its current form, CCDM does not serve the interests of Māori because it does not account for how Māori patients conceive of patient safety and safe care, nor what Māori nurses consider to be safe staffing. There is significant work to be done at both the operational and governance level of CCDM to address this fundamental flaw.

In this briefing paper we make the case for mandatory, fully-funded, legislated (culturally safe) staffing ratios. Our case draws on whakawhiti kōrero (Elder & Kersten, 2015) from mana wāhine nursing leaders from across the motu, and nursing and related literature.

This research was funded by NZNO. In this paper we explore what Māori nurses do over and above the clinical expectations that make a difference for whānau, hapū and iwi, and consider Te Tiriti o Waitangi responsibilities.

We met virtually with ten Māori nursing leaders in April 2024, over the course of two whakawhiti kōrero sessions to unpack what are cultural safe staffing ratios. Leaders were selected through the existing professional networks of the researchers.

As these wāhine toa are experts and were talking about their professional lives, no formal ethical approval was obtained. After seeking expert advice, we shared a participant information sheet (see Appendix one) and secured informed consent. These wāhine, with their consent, are named in the acknowledgements.

After karakia and whanaungatanga, we introduced the project and then explored what were the key elements of cultural safe nursing practice from the various vantage points of the wāhine toa.

During the whakawhiti kōrero we worked through indicative questions adapted from prospective Critical Tiriti Analysis (Came et al., 2023):

- ➔ How could ratios enable whanaungatanga with Māori whānau?
- ➔ What does honourable kāwanatanga look like in the context of ratios?
- ➔ How might ratios advance tino rangatiratanga?
- ➔ How can ratios contribute to equity of outcomes as Māori define them?
- ➔ How can ratios support the normalisation of tikanga and wairuatanga in nursing practice?

In May 2024, Māori nursing leaders were sent a draft of this briefing paper for their review, and invited to provide critical feedback and identify recommendations.

This was discussed collectively at a virtual whakawhiti korero, and in June the briefing paper was peer reviewed by renowned Indigenous nursing scholar Bonnie Castello.

CCDM does not serve the interests of Māori because it does not account for how Māori patients conceive of patient safety and safe care.

3 RATIONALE FOR CULTURALLY SAFE STAFFING RATIOS

Ratios are about being reassured that no matter how many patients come through the door, you have a minimum number of staff available to look after those people…

[Currently] you turn up at work; they might be well staffed today but that is not going to last for the shift as somewhere else isn't, and they get taken away. It is about creating a space where the minimum is always going to be safe.

Once we have ratios correct and we are able to service our community and people, then there are less of them within secondary care, we will be able to educate them; and in primary care they will only be seeking secondary care for elective surgery or something that they want.

FROM relevant literature we identified several key themes relevant to cultural safe staffing ratios. These were Te Tiriti o Waitangi responsibilities; Indigenous rights and the threat of systemic racism; beyond performative cultural safety; decolonising time and practice; and other international rationale.

TE TIRITI O WAITANGI RESPONSIBILITIES

Te Tiriti o Waitangi of 1840 is a key foundational document of the colonial state of New Zealand alongside He Whakaputanga o Te Rangatiratanga o Nū Tīreni (the Declaration of Independence) (Healy et al., 2012; Mutu, 2010). Te Tiriti established the terms and conditions of Tauiwi (non-Māori) settlement. Specifically, it outlined a desire for mutually beneficial relationships.

Within that peacetime negotiation, the British were granted limited governorship responsibilities over Tauiwi, and hapū retained their tino rangatiratanga (unqualified self-determination and authority) as outlined five years earlier in He Whakaputanga. Hapū were granted equal citizenship rights with British subjects, and it was agreed there would be cultural and religious freedom.

Since 1840 the Crown has relentlessly breached Te Tiriti through active policies of colonisation and assimilation, and through inaction in the context of systemic institutional racism within the health sector and other domains (Came et al., 2019; Walker, 1990).

The stage one Wai 2575 Waitangi Tribunal report (2019) showed the failure of the health sector to fulfil Te Tiriti responsibilities over decades.

The Tribunal noted breaches in policy making, investment, service delivery, administration and collaboration. Although Te Tiriti was negotiated

between hapū and the Crown, it remains applicable to all citizens and those who work, live, love and play in Aotearoa (Huygens, 2016; Margaret, 2016).

The British negotiated it for the settlers present in Aotearoa at the time and those yet to come; so it remains directly relevant to Pākehā and Tauiwi nurses alike.

Despite deliberate Crown misinformation and wilful ignorance in relation to the position of Te Tiriti as the authorative treaty text, it remains a key constitutional and public policy document (Cabinet Office, 2019; O'Sullivan et al., 2021). Compelling arguments for the pre-eminence of the Māori text are made elsewhere (Berghan et al., 2017; Healy et al., 2012; Mutu, 2010).

To summarise, the majority of Māori rangatira signed the Māori text; under the international legal doctrine of contra proferentem the Māori text holds eminence; and the Waitangi Tribunal in 2014 found Ngāpuhi (therefore Māori) did not cede their sovereignty when they negotiated Te Tiriti.

The Nursing Council's (2023) website confirms their commitment to ensuring Te Tiriti is fundamental to the way in which the Council undertakes its statutory roles. Engagement with Te Tiriti / the Treaty and the Treaty principles are embedded variously in the nursing code of conduct, scopes of practice, competencies, and guidelines for practice.

The Treaty of Waitangi is a prominent part of the cultural safety and Māori health guidelines (Te Kaunihera Tapuhi o Aotearoa - Nursing Council New Zealand, 2011). To be an enrolled or registered nurse, or indeed a nurse practitioner, and to practice ethically requires nurses to engage meaningfully with Te Tiriti (New Zealand Nurses Organisation, 2019).

INDIGENOUS RIGHTS AND THE THREAT OF SYSTEMIC RACISM

The Declaration on the Rights of Indigenous Peoples (UNDRIP) (United Nations, 2007) guarantees Indigenous people the right to be actively involved in developing and determining health. Under this Declaration, Māori have the right to traditional medicines and protection of medicinal plants, and the right to access social and health services without discrimination. Article 24 (2) (United Nations, 2007, p. 36) notes:

> *Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. [Nation] States shall take the necessary steps with a view to achieving progressively the full realization of this right.*

[Te Tiriti] remains directly relevant to Pākehā and Tauiwi nurses alike.

Evidence shows (Robson & Harris, 2007; Sumibcay, 2024) institutional racism within the health system results in Māori receiving less quality and quantity of care.

According to Paradies et al. (2015), racism is a determinant of health which has been associated with poor mental health, including depression, anxiety, psychological stress, poorer general health and poorer physical health. Over time, exposure to racism can involve premature aging, known as weathering (Geronimus, 1992).

The existence of racism within the health sector (and elsewhere) is a breach of human rights obligations, such as the Convention on the Elimination of All Forms of Discrimination (CERD) and Te Tiriti (United Nations, 1966).

If staffing ratio levels are to be culturally safe, they need to include a consideration of the socio-economic, historical and cultural context in which nursing is occurring. That is, a consideration of the intergenerational impact and trauma associated with settler colonisation (Pihama et al., 2021).

The levels of racism within the health system are such that some whānau choose to stay home rather than engage with monocultural health systems (Graham & Masters-Awatere, 2020).

To establish and maintain the trust of whānau in the health system is highly skilled and important work if we are to address systemic health inequities.

Our whānau do not want to go into hospital; they would rather say home and be māuiui.

BEYOND PERFORMATIVE CULTURAL SAFETY

It is recognised by Indigenous scholars (Hunter & Cook, 2020; Huria et al., 2014; Kidd et al., 2020; Wiapo et al., 2024; Wilson et al., 2022) that "mainstream" nursing has a whakapapa of monocultural practice and systemic racism in settler colonial contexts.

Central to successful therapeutic relationships is being able to establish authentic connections with patients. Healthcare is about being both clinically and culturally responsive to whānau (Health Quality and Safety Commission, 2020).

The health system is not designed for people like me.

My mother [a nurse] was told to leave being Māori at the door. She explained how our stillborn babies would be incinerated and they wouldn't give them back to the parents. She couldn't do it. She would use karakia whenever she was challenged. If you didn't [comply] you were kicked out of nursing.

Since 1992, cultural safety has been a required nursing competency in Aotearoa (Wepa, 2015). Cultural safety recognises the importance of attitude; recognises and understands the, at times, powerlessness of patients; the power of nurses; and the centrality of open mindedness and self-awareness in practice.

It is underpinned by a commitment to anti-racism and to upholding Te Tiriti o Waitangi (Curtis et al., 2019; Heke et al., 2019; Papps & Ramsden, 1996; Ramsden, 2002). Te Kaunihera Tapuhi o Aotearoa - Nursing Council New Zealand (2011) have developed guidelines to ensure nurses practice in a culturally safe manner, as defined by the recipients of their care.

Nursing practice needs to be responsive to Māori worldviews, have understanding of tikanga, and nurses need to be able to communicate effectively with whānau.

Cultural safety is experienced differently for everyone.

For me it's about my upbringing. Where I'm from, what my experiences are; pivotal to that are whānau, hapū and iwi. It doesn't impose on anyone, it is my korowai, and it has always been there throughout my nursing career. Some people say they leave it at the door, but I don't think you can *leave it at the door.*

I was brought up by my grandparents, and their generation were disciplined over the years not to speak Māori, not to show that you are Māori and ingrained in non-Māori society. So cultural safety is acknowledging the hurt and mamae from their generation that was brought onto us.

My view of being safe is being able to walk into a building and no one is going to stare at me for being brown or having a moko kauae. No one is going to be like that "black fella", you don't really need to bring up the colour. Cultural safety is where you can be who you are, who you are born to be, just being you, your authentic self and not being judged for it.

Direct entry into the New Zealand workforce without cultural and Te Tiriti training compromises the right of Māori to receive the highest attainable standard of care.

We need legislative and registration protections to ensure that practicing nurses, managers and teachers have the necessary skills and expertise to work with Māori whānau, as defined by Māori.

As part of those minimum standards, overseas and locally-trained nurses need to be able to pronounce Māori people and place names.

Māori nurses are the vanguard of the cultural safety movement (Roberts, 2019). Flax roots practitioners have embedded it into practice, but there has historically been significantly less uptake from health sector managers, leaders and policy makers (Came & da Silva, 2011).

Workload pressures makes it hard to achieve these minimum standards consistently. Nurses often have limited professional development time to consolidate and extend their cultural practice.

Integrating cultural safety into staffing ratios is a practical way to allow time to normalise cultural safety across the health system, and to move away from performative practice into authentic connection.

Cultural safety has to be right at the forefront in everything we do moving forward. It can't be just: "we will talk about it this session". It has to be every day, from start to finish, so it becomes the norm.

DECOLONISING TIME AND PRACTICE

Adelaide Clocks.

Time is a cultural construct that holds different meanings for different cultural groups (Nanni, 2012). Traditionally, Māori practiced maramataka, often living by a lunar calendar informed by rich mātauranga Māori about the ebb and flow of the moana and the ngahere (Marsden, 2003; Solomon & Peach, 2021). For many, colonisation disrupted this deep connection to the environment.

The clock remains one of the most recognisable symbols of British expansionism and industrialisation (Matamua, 2020). The imposition of Greenwich Mean Time across the globe in 1884 contributed to Indigenous marginalisation, as colonial outposts were integrated into the standard of the metropolis (Nanni, 2012).

Integrating cultural safety into staffing ratios [... allows] time to normalise cultural safety across the health system.

The introduction and normalisation of capitalism within many Eurocentric societies literally, for many, transformed time into money. Marx's (1887/2009) classic text *Das Kapital* talks of workers

selling their labour to make a livelihood for their families, enabling owners of the means of production to maximise profit.

There is clear tension between the neo-liberal quest for efficiency and cost effectiveness and the considered practices of tikanga.

Within the health system, time – in this instance, staffing ratios – has become an ideological frontline between kaupapa Māori and Eurocentric clinical practices and priorities.

There is clear tension between the neo-liberal quest for efficiency and cost effectiveness and the considered practices of tikanga and mātauranga Māori (Bargh, 2007).

This values clash and tension makes it difficult to engage in whanaungatanga and human connection in the clinically allocated times in the New Zealand health system. Clinical care is frequently prioritised over cultural care, rather than both holding weight.

Linda Tuhiwai Smith (2012), in her landmark text *Decolonising Methodologies,* talks about colonisation shifting Māori from being normal and ordinary to being perceived as exotic and other.

Decolonisation in the context of Aotearoa, is therefore the practice of recentring Māori experience, so Māori can be restored to the position of normal and ordinary.

Ramugondo and Emery-Whittington (2022) argued that decolonisation requires a shift towards Indigenous knowledges, recognising that the coloniality of power, knowledge, being and doing are deeply intertwined. They call for:

> *… embodied disobedient praxis within disciplines, with both decoloniality of being and doing as necessary disobedient praxis strengthened by partnerships, alliances and networks of allies and indigenous practitioners.*

(Ramugondo & Emery-Whittington, 2022, p. 209).

OTHER INTERNATIONAL RATIONALES

There is a global trend towards legislating minimum staffing patient ratios, to ensure manageable nursing workloads, and to achieve better patient care and outcomes.

The International Council of Nurses position statement (2009) on evidence-based safe staffing recommended that governments act to ensure safe staffing levels, because it improves patient outcomes and nurse staffing ratios, and yields a good return for investment.

In their review of the academic literature, the NSW Nurses and Midwives Association (2018) identified 20 common adverse patient events related to unsafe levels of nurses (quantity and education; Figure 1, next page).

Studies from the United States show that correcting unrealistic staffing levels can result in significant cost savings and better patient outcomes and mortality.

Needleman et al. (2006), in their study of 799 hospitals, found that increasing staffing levels to the 75th percentile for hospitals could have prevented 6,700 in-patient deaths in those hospitals.

Shamliyan et al. (2009) conducted a meta-analysis of 27 observational studies analysing the savings-cost ratio of increasing registered nurse-to-patient ratios in intensive care units, surgical and medical wards. They found that it could save 300,000+ years of life with a productivity benefit (present value of future earnings) of US$4-5 billion.

Figure 1: Common adverse patient events related to unsafe nursing levels

(NSW Nurses and Midwives Association, 2018)

- ➔ Urinary tract infection
- ➔ Pressure ulcers
- ➔ Hospital-acquired pneumonia
- ➔ Shock or cardiac arrest
- ➔ In-hospital mortality
- ➔ Failure to rescue
- ➔ Upper gastro-intestinal bleeding
- ➔ Hospital acquired sepsis
- ➔ Deep vein thrombosis
- ➔ Central nervous system complications
- ➔ Pulmonary failure post-surgery
- ➔ Metabolic derangement post-surgery
- ➔ In-hospital falls
- ➔ Adverse drug events (missed, delayed or incorrect medication).

Dall et al. (2009), in their analysis of discharge data from 610 hospitals, found that adverse events were associated with 251,000 in-hospital deaths, 22.6 million hospital in-stay days and US $41.8 billion in medical costs.

Unrealistic staffing ratios affect nurse outcomes such as job satisfaction, absence/sickness, emotional exhaustion, burnout and retention (McHugh et al., 2021). The Queensland Nursing and Midwives Union (2017) found that nurses and midwives who work in environments with enough staffing numbers and skill mix to meet demand adequately, are more satisfied and less inclined to leave their employment.

Janellle Taylor, cited in Queensland Nurses and Midwives' Union (2020, p. 2) wrote after the changes:

> *Staff reporting to me that they lost that lump of anxiety in their gut that related to unmanageable workloads, and they finally felt happy to come to work.*

4 TE TIRITI PERSPECTIVES OF MĀORI NURSING LEADERS

Mehemea ka moemoea ahau, ko au anake.
Mehemea ka moemoeā tātou, ka taea e tātou.
If I am to dream, I dream alone.
If we all dream together, then we will achieve.
Te Puea Herangi (1883-1952)

MĀORI nursing leaders are uniquely placed, grounded in te Ao Māori, to provide expert advice around culturally safe staffing levels (Wakefield, 2023). Māori nurses carry dual clinical and cultural competencies and have significant experiences working with Māori whānau (Ratima, N.D.; Te Whata, 2020).

The following whakawhiti kōrero is taken from the focus groups with Māori nursing leaders, and loosely framed around the five provisions of Te Tiriti.

WHANAUNGATANGA IS ESSENTIAL

Whanaungatanga is a critical cultural process of listening and connecting (Carlson, 2016). Irihapeti Ramsden (2002) describes it as a way of disrupting the power imbalances often inherent within clinical relationships.

> *It is important to lay down your clipboard and connect with the person and people you are working with. Care needs to be driven by relationship.*

At a first meeting, explaining who you are is important. Therapeutic relationships need to be flexible, to be fluid, not rigid. *You need to be adaptative to the person or people in front of you.* It is culturally poor manners to start clinically treating someone without whanaungatanga.

> *I know for each and every one of us, whanaungatanga – we practice it, we live it, we breathe it – and there is no way we go into a room and say 'You're up next'. We do whakapapa and whanaungatanga, but is it also our responsibility to teach others to do the same.*

Whanaungatanga can take a couple of hours – sometimes meetings need to be rebooked; sometimes it takes half a day over a cuppa and kai. Other times, for instance in a medically acute crisis, it can be rapid. Connection between nurse and whānau depends on what has historically happened for that whānau in their contact with the health system, and the pressures and complexity of their presenting situation.

Our so called 'soft skills' – whanaungatanga and building trust – are critical to keep Māori whānau engaged in the health system.

Critical care is a lot of emergency situations and whānau who are at their most vulnerable. Emotions are running high, there is fear, there is anger; it is like a living grief they are going through. My ability to connect has to happen to have a therapeutic relationship … my ability to do my job is based on the quick-fire whanaungatanga that we can do.

Notions of professional practice and boundaries within nursing in Aotearoa have historically been Euro-centric and monocultural (Ramsden, 2002). Regulatory policy and practice infrastructure needs to fully recognise te Ao Māori and the cultural practices of whanaungatanga (Te Whata, 2020).

Regional Representatives of Te Poari o Te Rūnanga o Aotearoa NZNO, in 2024.

The Nursing Council can be very rigid around about crossing 'professional boundaries'. They don't seem to recognise whakawhanaungatanga, nor whakapapa.

I always greet people, sometimes with a kiss or hongi. I have written warnings on file, as this was considered inappropriate by some Pākehā colleagues. I don't stop being Māori when I come to work.

Sometimes my patients are literally my whānau, we have shared whakapapa. We need to be able to be our authentic selves as Māori in the workplace.

HONOURABLE KĀWANATANGA

Honourable kāwanatanga was seen by the group as aspirational. It has been missing from the practices of successive coalition governments.

We have had to go through many fights, with Dame Whina Cooper and others leading t o get the rights we have… For us to not have to justify who we are in our own country, and it just feels like that's what we don't want for the future for our tamariki and our moko… we want to choose to be Māori and to do that with equal standing, working side by side.

Investment in Māori health providers ... needs to be urgently and dramatically increased ... to match the proportion of Māori in the population.

It is about being tika and pono, doing the right thing. It is subjective; there are too many people who are wolves in sheep's clothing. They come to the table and their motives aren't honourable.

The current government is systematically dismantling anything that has progressed Māori health in the last 100 years. I cried when I read the 100-day plan of National, I cried in my office because I can't do that anywhere else.

Honourable kāwanatanga requires addressing the mistrust that has been fuelled by relentless Crown policies of colonisation and assimilation. It is about disrupting institutional racism and monoculturalism (Reid, 2021). It is about sharing power and recognising the value and unique dual contributions of Māori nurses (Te Whata, 2020). It's about pay equity, and a safe healthy workplace where Māori nurses can be Māori, and advocate for Māori.

I think I am the pebble in the shoe, I'm the squeaky wheel, I'm the person that will listen then comment on something, and actually encourage my seniors to look a bit further into why this is happening, and often look into themselves as they can't see their own bias.

Enough is enough; we need to come together and start saying that we are no longer going to sit there. When are we really going to take to action and shake it up for once? Because I want to be able to proudly stand and say this is what we have been fighting for … I am strong enough to have all the knowledge and all the research and data to say, 'Actually no, there had been so many promises but not delivered.' And then we get 'I'm sorry', but sorry doesn't cut it anymore.

In the context of staffing ratios, honourable kāwanatanga involves decision-making that invests time and money into Māori nurses to enable the delivery of culturally and clinically safe healthcare, as Māori define it.

With current investment in Māori health providers at 1.91% (Ministry of Health, 2023) of Vote Health, this investment needs to be urgently and dramatically increased.

Investment levels need to match the proportion of Māori in the population, factoring in the complex health needs of whānau, and commitments made under Te Tiriti around equitable citizenship rights and social outcomes.

At a macro level, honourable kāwanatanga involves a brave conversation about whether monetarising health care and allowing for-profit business within the sector is serving the complex healthcare needs and aspirations of Māori whānau.

Māori providers often have a social enterprise model – making a living but also deeply embedded in community, and committed to Māori development.

They have made a significant contribution to Māori outcomes in recent decades (Chant, 2006; Gifford et al., 2018). It is important to note that Māori provider success has occurred despite chronic underfunding of Māori health (Eggleton et al., 2022; Waitangi Tribunal, 2019), and in the context of systemic racism within the administration of the health sector (Came et al., 2017).

Honourable kāwanatanga is creating and maintaining safe workplaces for Māori nurses and whānau. Whānau often have a history of experienced racism within the health system (Cormack et al., 2018; Harris et al., 2024).

Micro (meso and macro) aggressions are widespread in many healthcare settings (Wilson et al., 2022). Whānau don't always trust health practitioners, they can feel whakamā (Graham & Masters-Awatere, 2020; Komene et al., 2024).

> *Sometimes even non-verbal things will put whānau off accessing care. This staff member rang and said 'There are too many people around the bed, there are only supposed to be two'. We asked 'How many are there'? They said 'A whānau', and then we heard someone say 'They are taking up all the oxygen in the room'. It's those sorts of racist comments that our whānau get – it's not like curtains are thick.*

Honourable kāwanatanga is ... maintaining safe workplaces for Māori nurses and whānau.

In emergency situations where emotions are high, Māori nurses often get called to work with Māori whānau. Māori get described as being;

> *'Out of control and they need security'. They don't need security, they need people to understand what is going on for them. Our whānau can pick out fakes, they know who is not genuine or authentic.*

The presence of monoculturalism, racism in any form and micro-aggressions in a workplace is inconsistent with honourable kāwanatanga. Staffing ratios that ignore culture are monocultural.

ENABLING TINO RANGATIRATANGA

> *Our point of difference as Māori nurses is we are not just there for a job; we are there because our whānau have been affected in a way that makes us want to make a difference. It's not just 'come to a new country and get a job' – we are invested in our whānau.*

The colonial health system has a history of white supremacy and institutional racism (Dow, 1995; Lange, 1999). Poor policy and operational decisions have consistently benefited Pākehā, and resulted in Māori receiving lesser quality and quantity of care (Robson & Harris, 2007; Wihongi, 2010).

For Māori nurses, a cultural ... duty of care requires responding to the collective needs of whānau ... this is unpaid, invisible work ... that holds the flawed system together.

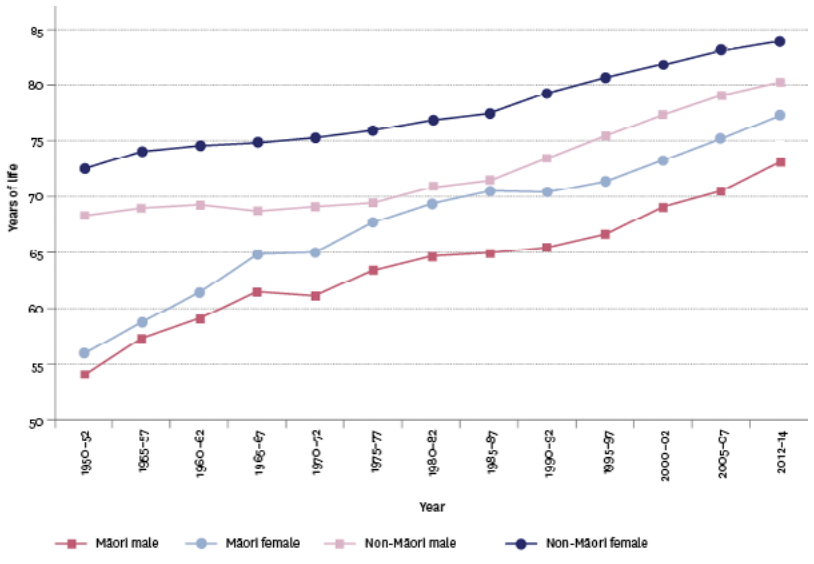
Colonial hierarchies within the health sector serve to disable and obstruct tino rangatiratanga. Māori nurses are often required to navigate complex monocultural and racist environments as they tend to whānau (Huria et al., 2014).

> *We need to move from an illness model to a tino rangatiratanga model… Why would we continue to be part of a system that continues to fail our people? We try and be kaitiaki for any whānau that is hitting the system because we know it is stuffed, so change the system – don't put our people back in that place. Set the bar, lift the bar and then we will all be fine.*

In a Tiriti-honouring health care system, Māori models of care (Wilson et al.) should be commonplace and every day. Whānau ora (Boulton, 2019) has proven to be transformative within the health sector, enabling whānau-centred care and multi-disciplinary teams to address the unique holistic needs of diverse whānau.

From the Social Report, 2016 – Te pūrongo oranga tangata, *Ministry of Social Development.*

Figure 2: Māori and non-Māori life expectancy at birth by sex, 1950–1952 to 2012–2014.



For Māori nurses, a cultural ethic or duty of care requires responding to the collective needs of whānau. It involves ensuring there is a ride home, that medicines can be picked up and relevant referrals are made. Often this is unpaid invisible work within the current health system that holds the flawed system together.

> *Māori deserve to grow old... I sat in a church in Havelock North and there was a sea of [Pākehā] elderly people who would be over 85 years old; and I ... had all the emotions of crying because I will never be able to sit in a space with that many kaumātua.*

When Māori whānau attend health clinics or hospitals, Māori nurses (when available) tend to deal with everything they can at the time, as it may be a long time before the whānau returns. The responsibility for follow-ups, phone calls and other holistic tasks often falls directly to Māori nurses.

> *We help whānau decide what is needed; we are going off their experiences and not dictating what the service expectations are. This can't be done in a 10- or 15-minute appointment … We don't work with individuals, we work with whānau. We check whether they have kai, whether they are vaccinated as well – we are jacks of all trades.*

Māori nurses undertake a significant amount of emotional labour and are frequently called on when someone passes (Hunter & Cook, 2020).

> *We are connectors and facilitators between people. When someone passes, we get called in (regardless of our professional roles) and liaise between the police, whānau and the coroner and make sure there is kai and a cuppa. We buy the kai as there is no budget; it literally takes money from our own families. This is complex work with many stakeholders and*

sometimes there are 30 whānau members to weave together on what is one of the most difficult days of their lives. This is specialised, emotionally charged work.

Māori nurses working within generic providers and/or for the Crown need bespoke leadership, and practice roles and position descriptions that recognise dual clinical and cultural competencies.

These roles need to be appropriately remunerated. Māori nurses need to be involved in service and clinical design and have leadership roles that ensure services are agile and resourced enough to respond to whānau (Moss et al., 2021).

You have a Director of Nursing for Mental Health, and a Director of Nursing for everything else, but ... where is the Director of Māori Nursing so they can speak for us?

We need to find ways and spaces that work for all of us. New graduates need mentoring as they come into practice. It's a huge role in itself that is not funded, and it is all done in our own time.

Tino rangatiratanga is in part about Māori collectively holding power and strength within te Ao Māori. It should be at the core of all service delivery planning.

We all talk about patients being in the centre of care, but not it's policy, it's politics, it's the structures that drive hauora. We need to aim to nurture strong, self-determined people. We have an imbalance of care, power and control.

We have Māori nurses watching people make shit decisions… We are going to take a Waitangi Tribunal case … Māori nurses [have been] powerless to stop it.

There are a lot of non-Māori that would thrive under kaupapa Māori services…. The kaupapa ward is now overloaded, as everyone wants to go there, not just Māori.

Hauora services are driven by kaupapa and are flexible to serve the needs of whānau, hapū and iwi. Māori practice deliberately works to remove power imbalances between whānau and practitioners and aims to work as a multi-disciplinary team. *We are all in this together.*

Effective services for whānau involve entering into relationship, being substitute social workers, and never discharging patients from a service.

Working in a Māori GP practice, we set up satellite clinics and took services to the people. We would go to isolated islands where there might be 30 people; otherwise, they would have no service. We are doing that within the FTE [full time equivalent] *available – it is a huge drain of pūtea with no extra funding… That leadership is tino rangatiratanga. That is about whānau.*

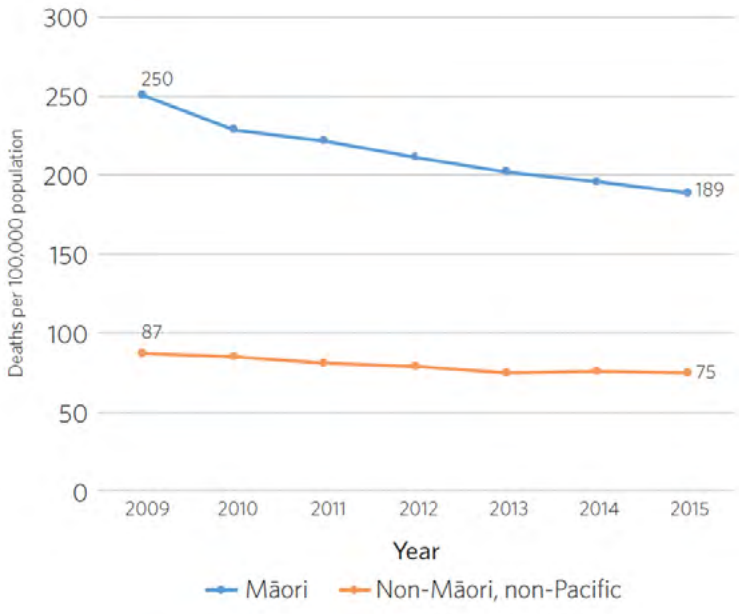
ŌRITETANGA – PURSUING EQUITABLE OUTCOMES

A major driver of the health reforms and the Pae Ora legislation is the pressing need to address inequitable health outcomes.

A conservative estimate from Reid and colleagues (2022) shows that health inequities between Māori and non-Māori adults costs NZ$863.3 million per year. The cost of doing nothing in the face of inequities is predominately borne by Indigenous communities.

Due to complex socio-economic, cultural and historical and political contexts, Māori often present late with multiple, complex medical conditions (Curtis et al., 2023; Marriott & Sim, 2014). This complexity requires both cultural and clinical expertise to achieve positive outcomes for whānau.

Figure 3: Deaths amenable to health care per 100,000 population aged 0–74, 2009–15.



Two and a half times more Māori than non-Māori die from diseases that health care can address. From He matapihi ki te kounga o nga manaakitanga-a-hauora o Aotearoa 2019/A window on the quality of Aotearoa New Zealand's health care 2019, *Health Quality & Safety Commission, Wellington, p.14.*

I remember one young tāne that had mental health issues and he ended up with a stent put into his kidney, which was done acutely. Then he wouldn't come back, as he didn't trust the people looking after him. It took three of us plus his mum co-ordinating to get him to come back in. It took six months to re-engage him with services. He ended up getting his stent re-done and went to the dentist.

There are well researched and documented barriers for whānau accessing health services (Graham & Masters-Awatere, 2020; Jatrana & Crampton, 2021; Jeffreys et al., 2023).

Māori nurses are drawn in by an ethic of manaaki and through whakapapa, to support whānau navigating the health system (Falleni, 2004).

Māori nurses are essential to build and maintain trust with whānau, who often have complex unmet needs (Harris et al., 2019; Hunter, 2019; Ratima, N.D.; Te Whata, 2020).

Our professional and personal networks are really important. It matters who we pass whānau onto. If something goes wrong, they won't come back. We need culturally and clinically safe colleagues, so we have strong networks to enable us to care for whānau.

Māori should be able to see Māori health practitioners when they are accessing treatment. There is a lack of Māori nurses (7%), Māori teachers and Māori mentors across the health system.

The health workforce crisis continues to have a significant impact on whānau. Replacing nurses in health providers with unqualified healthcare assistants reduces the quality of care received by whānau.

Over 30 percent of Māori live in rural or small urban centres (Environmental Health Intelligence New Zealand, 2018), so rural nursing shortages mean whānau are unlikely to be able to access a Māori nurse. Māori nurses reported being run ragged.

I think it is ethically wrong to look at our people as numbers. I know we don't do that, but that is what it is when you are given a contract and you are given numbers, or when you have someone walk in your room and ask, 'How many did you see today?' My people aren't numbers.

We need more enrolled nurses; we need the bridging course so we can get our enrolled nurses up to registered nurses.

It is important that staffing ratios address the inequities in employment conditions between Te Whatu Ora nurses and those working for Māori providers and in primary care.

I see my colleagues in the community absolutely managing on the bare minimum; it has

become the norm. What is the risk to our community – it is huge, not having a safety net.

We are not valuing our Māori nurses, who are so exhausted physically, mentally, in our wairua. If they are not valued through pay equity, how can we pay our bills and look after whānau. The fight for pay equity overlaps with the fight for ratio justice.

We are all nurses, we are all one.

Māori health has traditionally been underfunded by the Crown, which impacts on the investment levels into Māori nursing (Ministry of Health, 2023; Waitangi Tribunal, 2019).

Māori health providers are embedded in community and often come up with innovative strategies to get services to all whānau, through satellite clinics and opportunistic primary care interventions at marae events.

These programmes sometimes attract one-off pilot investment but rarely secure sustainable funding. Research (see Came et al., 2017; Eggleton et al., 2022) shows that Māori providers often have shorter contracts, higher levels of scrutiny, and more challenging relationships with their funders.

Funding formula rarely capture the complexity of Māori whānau, who often have multiple health conditions and are more likely to be living in deprivation.

The funding [time allocated] *doesn't capture the complexity of the patients we look after. They don't capture travel time; we have to travel all around the motu, they don't capture that. We are not just seeing one person but it's a whole whānau, its aunty or uncle or whoever is in the house; they don't capture the phone calls, the referrals…*

We used to have everybody go looking for people, there was no extra money for that to happen, there was no extra money to go and pick Nanny up, to pick those kids up and take them home.

Māori nursing leadership is essential to achieving equity, as Māori define equity.

Māori health has traditionally been underfunded by the Crown, which impacts on the investment levels into Māori nursing.

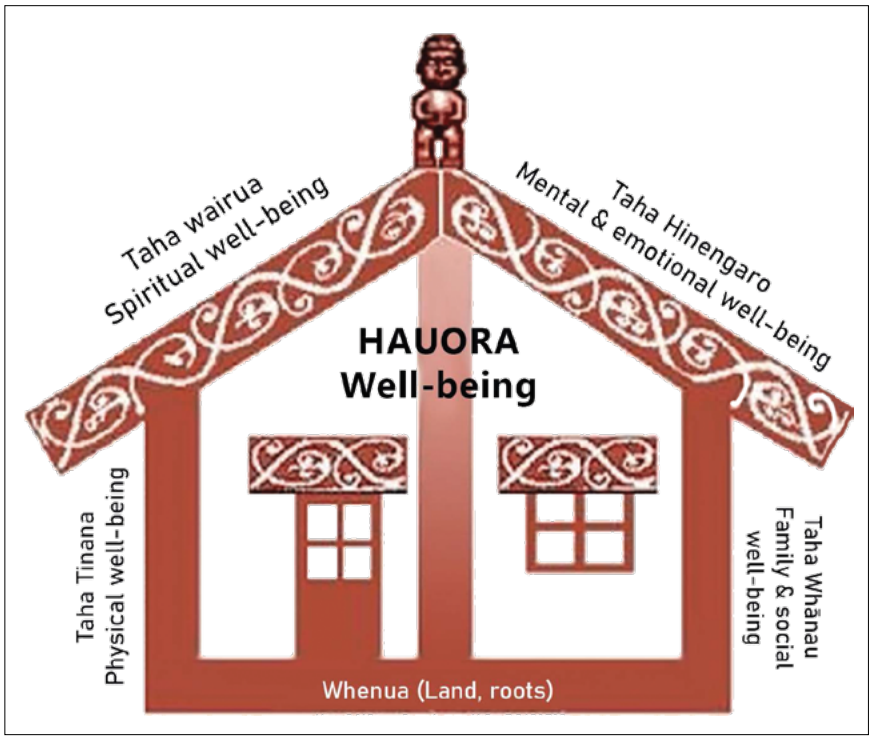
We sit down and ask our whānau what matters to them and what we can help them with, and we should be making sure that everything is sitting there ready for them so they just have to turn up. Not a hard thing: 'You just turn up, or we will come and get you'. That is kind of the point of difference; equity for us is different, Māori health equity is a Tiriti accountability.

One of our young rangatahi tutors for our kapa haka passed away from a cardiac event, because he didn't get the treatment he needed. There are all these massive inequities and then we have our rangatahi transitioning into adult systems that get left behind. It's us walking alongside them at every point of their journey, making sure we can shift and move the system so we can get them the best outcomes or the best care they need at that point in time … we leave the doorway open for them to re-engage.

Whānau need to define equitable outcomes … Nanny might have COPD and can only walk to the letterbox, but her joy is in spending time with her mokopuna. It might not be a disease process that has a cure, but we can definitely design something to enhance that period of her life where her enjoyment of her mokopuna is what will keep her going in every realm of her life.

NORMALISING TIKANGA AND WAIRUATANGA

Tikanga and wairuatanga should be normal in nursing practice in this country. Staffing ratios need to set minimum standards that enable tikanga to flourish and strengthen within nursing practice.



Mason Durie, 1994: Te Whare Tapa Whā model of health.

It will mean that a lot of nurses will not be competent, will not be safe to practice, but we have to set the bar, and then that will bring about change.

Wairuatanga begins with the patient and their whānau and looks different for everyone.

It might be doing painting, it might be weaving harakeke, it might be having a cuddle with their mokopuna.

Māori nurses are regularly drawn into cultural matters across the hospital, over and above our position descriptions. Māori nurses respond to these requests to support whānau. Being a Māori nurse, whether practicing or not, involves being available to our people.

Some [Pākehā] assume our work finishes at the door, but actually it really doesn't finish like that. This patient wanted to have her coffin made of harakeke, she wanted me there at her bedside; she wanted me to be there when the main weaver came to have a meeting with her to talk to her about everything that was going to take place and how it was going to look. This is the patient's tino rangatiratanga. This is her making decisions. This is entwined with wairuatanga because this is what she wanted… When we are Māori nurses the journey goes with her all the way to the tangi day, that is a couple of hours and then I go to the funeral day.

If the kuia rings, I answer. If the duty manager rings and I am off-site I come back to make a difference for our people.

We do all the regular things required of nurses, but then get called on to do more. This cultural loading is often not recognised by our workplaces.

Our cultural work is often invisible.

The monocultural forms don't allow us to report on cultural matters except in mental health, where they literally have a tick box to confirm whether a cultural assessment has been done. Eurocentric ideas around privacy are weaponised in the field, which makes it harder for us to properly care for whānau.

We can be working with a whānau, and they get discharged, and no one tells us. At times, we literally can't locate whānau.

If you are going to take blood, actually acknowledge that blood is our whānau whakapapa and the DNA that you are taking. What are the ethical pieces that surround that?

Eurocentric ideas around privacy are weaponised in the field, which makes it harder for us to properly care for whānau.

Cultural support needs to be available for Māori nurses. Having kaumātua, Māori chaplains, Māori social workers, Māori managers, and Māori receptionists. Māori nurses are currently rare across the system and this needs to change.

We strategise together as Māori nurses, working out collectively how to attain ever-changing key performance indicators. We call it going underground. We have each other's backs, while we stay focussed on supporting whānau to navigate the system.

I managed to un-bundle a Māori chaplain role that worked alongside our team. We knew we couldn't give whānau the extra time for their own wairua, but knew the chaplain could get alongside them and get the kōrero, and then come back to us with what was needed. You don't always have the luxury of doing that yourself.

5 MĀORI FINAL WORD

TE Tiriti o Waitangi is relevant to all major strategic and operational decisions within the health sector. The omission of cultural consideration and Te Tiriti from the CCDM is a clear breach of Te Tiriti. This needs to be urgently remedied to prevent further harm.

Under UNDRIP (the United Nations Declaration on the Rights of Indigenous Peoples) and CERD (the International Convention on the Elimination of All Forms of Racial Discrimination), Māori have a right to determine the highest attainable standard of health free from discrimination.

Staffing ratios therefore need to recognise the cultural needs and preferences of whānau. Likewise, there needs to be a consideration of the socio-economic context for whānau, as a result of the intergenerational trauma of colonisation and systemic institutional racism in the health system.

Cultural safety is deeply embedded within Nursing Council guidelines, scopes of practice, and competencies. Without allocating dedicated time to engage in whanaungatanga and establish connection, talk of cultural safe practice can become performative rhetoric.

Time is a cultural construct, and from a Euro-centric standpoint in the context of settler colonisation and in capitalism, time is money. This construct needs to be decolonised if we are to normalise kaupapa Māori practice.

International evidence shows clearly that regulating minimum staffing levels results in better patient outcomes, happier nurses, and is cost effective. This is why parts of Canada; Australia and the United States have already legislated staffing ratios.

Embedding cultural justice within legislated staffing ratios would honour the legacy of Dr Irihapeti Ramsden and other pioneering Māori nursing leaders, and again put Aotearoa in the forefront of cultural safety and nursing leadership.

Whanaungatanga is not a nice-to-have; it is essential to kaupapa Māori nursing practice. Time for this fundamental cultural process needs to be embedded in culturally safe staffing ratios.

Honourable kāwanatanga was considered aspirational in the context of our current flawed, broken healthcare system – which is littered with racism and mistrust of whānau.

Staffing ratios need intentionally to recognise the time needed by Māori nurses to repair this damage, and support whānau to navigate the often monocultural health system. It is an ethical and cultural imperative for Māori nurses to holistically care for whānau. This often involves considerable cultural and emotional labour for Māori nurses.

Tino rangatiratanga in the health sector has historically been actively resisted by the Crown. In a Tiriti-honouring health system, Māori models of care and practice should be ordinary, and there would be flexibility to respond to the diverse needs of whānau.

Staffing ratios would recognise that kaupapa Māori nursing practice is about the collective – supporting the patient in the context of whānau.

Māori nurses are rare within the health sector, with dual clinical and cultural competencies. This scarcity brings significant demand for additional work to support non-Māori colleagues, and input into projects and advisory roles.

This work needs to be recognised within staffing levels, alongside dedicated time for Māori nurses to collaborate and pursue professional and cultural development as they pursue chosen career pathways.

Māori whānau carry the burden of health inequities, while the country carries the preventable fiscal cost. Inaction on addressing barriers to healthcare – the determinants of health, including racism – enables these inequities to continue.

There needs to be equitable investment in Māori health that recognises the burden of disease, historical underfunding and policy commitments to equitable outcomes and upholding Te Tiriti.

Māori nurses working in by-Māori-for-Māori services (and elsewhere) need to be compensated appropriately for their dual competencies and significant contribution to Māori health.

Tikanga should be normal within the health sector. In many areas of the health sector, it remains exotic and other, and it is rarely a strength of non-Māori nurses.

Mason Durie (1998) has always said wairua is essential to hauora for whānau. The practice of tikanga, often invisible work within a monocultural health system, requires time, thought, and at times, cultural backup.

These considerations arising from our kōrero about Te Tiriti o Waitangi all need to be considered in culturally safe staffing levels.

RECOMMENDATIONS

From our review of the evidence, we recommend the urgent introduction of culturally safe staffing ratios within nursing.

- ➔ Māori nurses need to lead the development (and implementation) of culturally safe staffing ratios, and have an overall final Māori word over the approach.
- ➔ Kaumātua and kuia need to be involved, to ensure tikanga is upheld.
- ➔ Whānau, hapū and iwi need to define what is culturally safe practice.
- ➔ The Māori health workforce, particularly nursing, needs to continue to grow across the entire health system, to enable culturally safe staffing ratios.
- ➔ All nurses need to have base-line cultural and political competencies. To achieve the vision of Irihapeti Ramsden requires nurses proficient in Te Tiriti o Waitangi, antiracism, equity, Māori advancement, and cultural safety.
- ➔ All decision-making about staffing levels needs to be based on consideration of both clinical and cultural factors.

7 REFERENCES

Bargh, M. (2007). *Resistance: An indigenous response to neo-liberalism*. Huia.

Berghan, G., Came, H., Doole, C., Coupe, N., Fay, J., McCreanor, T., & Simpson, T. (2017). *Te Tiriti-based practice in health promotion*. STIR: Stop Institutional Racism.

Boulton, A. (2019, 06//). Whānau Ora: A culturally-informed, social policy innovation [Article]. *New Zealand Sociology, 34*(2), 23-48.

Cabinet Office. (2019). *Te Tiriti o Waitangi/ Treaty of Waitangi guidance*. Author. https://dpmc.govt.nz/sites/default/files/2019-10/CO%2019%20%285%29%20Treaty%20of%20Waitangi%20Guidance%20for%20Agencies.pdf

Came, H., & da Silva, S. (2011). Building political competencies for the transformation of racism in Aotearoa. *Kotuitui, 6*(1-2), 113-123. https://doi.org/10.1080/1177083X.2011.615332

Came, H., Doole, C., McKenna, B., & McCreanor, T. (2017). Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand. *Social Science and Medicine, 199*, 132-139. https://doi.org/10.1016/j.socscimed.2017.06.002

Came, H., McCreanor, T., Manson, L., & Nuku, K. (2019). Upholding Te Tiriti: Ending institutional racism and Crown inaction on health equity. *New Zealand Medical Journal, 132*(1492), 62-66.

Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2023). Critical Tiriti Analysis: A prospective policy making tool from Aotearoa New Zealand. *Ethnicities, 0*(0). https://doi.org/10.1177/14687968231171651

Carlson, T. (2016). Whanaungatanga: A space to be ourselves. *Journal of indigenous wellbeing, 1*(2), 44-59.

Chant, L. (2006). *How Maori health providers created sustainable health delivery models then successfully transistioned them into innovative indigenous health policy.* Forum Ten, Cairo, Egypt.

Cormack, D., Stanley, J., & Harris, R. (2018). Multiple forms of discrimination and relationships with health and wellbeing: Findings from national cross-sectional surveys in Aotearoa/New Zealand. *International Journal for Equity in Health, 17*, 1-1. https://doi.org/10.1186/s12939-018-0735-y

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019, 2019/11/14). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Curtis, E., Jones, R., Willing, E., Anderson, A., Paine, S.-J., Herbert, S., Loring, B., Dalgic, G., & Reid, P. (2023). Indigenous adaptation of a model for understanding the determinants of ethnic health inequities. *Discover Social Science and Health, 3*(1), 10. https://doi.org/10.1007/s44155-023-00040-6

Dall, T. M., Chen, Y. J., Seifert, R. F., Maddox, P. J., & Hogan, P. F. (2009). The economic value of professional nursing. *Medical Care, 47*(1), 97-104. https://doi.org/10.1097/MLR.0b013e3181844da8

Dow, D. (1995). *Safeguarding the public health: A history of the New Zealand Department of Public Health*. Victoria University Press.

Durie, M. (1998). *Whaiora: Māori health development* (2nd ed.). Oxford University Press.

Eggleton, K., Anderson, A., & Harwood, M. (2022). The whitewashing of contracts: Unpacking the discourse within Māori health provider contracts in Aotearoa/New Zealand. *Health & Social Care in the Community, n/a*(n/a). https://doi.org/10.1111/hsc.13691

Elder, H., & Kersten, P. (2015). Whakawhiti kōrero, a method for the development of a cultural assessment tool, Te Waka Kuaka, in Māori traumatic brain injury. *Behavioural Neurology, 2015*. https://doi.org/10.1155/2015/137402

Environmental Health Intelligence New Zealand. (2018). *Urban- rural*. Massey University. Retrieved 1 April from https://www.ehinz.ac.nz/indicators/population-vulnerability/urbanrural-profile/

Falleni, P. (2004). Whakaata ikei runga manaaki - reflection on caring. *International Journal of Palliative Nursing, 10*(8), 390-392. https://doi.org/10.12968/ijpn.2004.10.8.15875

Geronimus, A. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity and Disease, 2*(3), 207-221.

Gifford, H., Batten, L., Boulton, A., M, C., & Cvitanovic, L. (2018). Delivering on outcomes: The experience of Maori health service providers. *Policy Quarterly, 14*(2), 59-64.

Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: A systematic review of two decades of published qualitative research. *Australian and New Zealand Journal of Public Health, 44*(3), 193-200. https://doi.org/10.1111/1753-6405.12971

Harris, R., Cormack, D., Waa, A., Edwards, R., & Stanley, J. (2024). The impact of racism on subsequent healthcare use and experiences for adult New Zealanders: A prospective cohort study. *BMC Public Health, 24*(1), 136. https://doi.org/10.1186/s12889-023-17603-6

Harris, R. B., Cormack, D. M., & Stanley, J. (2019). Experience of racism and associations with unmet need and healthcare satisfaction: The 2011/12 adult New Zealand Health Survey. *Australian & New Zealand Journal of Public Health, 43*(1), 75-80. https://doi.org/10.1111/1753-6405.12835

Health Quality and Safety Commission. (2020). *Ngā taero a Kupe: Ngā wheako pānga kino ki ngā whānau Māori i rō hōhipera 2019 | Whānau Māori experiences of in-hospital adverse events, 2019*. Kupu Taurangi Hauora o Aotearoa | Health Quality and Safety Commission, New Zealand.

Healy, S., Huygens, I., & Murphy, T. (2012). *Ngāpuhi speaks*. Network Waitangi Whangarei, Te Kawariki.

Heke, D., Wilson, D., & Came, H. (2019). Shades of competence? A critical analysis of the cultural competencies of the regulated-health workforce in Aotearoa New Zealand. *International Journal for Quality in Health Care, 31*(8), 606-612. https://doi.org/10.1093/intqhc/mzy227

Hunter, K. (2019). The significant cultural value of our Māori nursing workforce. *Nursing Praxis in New Zealand, 35*(3), 4-6. https://doi.org/10.36951/NgPxNZ.2019.009

Hunter, K., & Cook, C. (2020). Cultural and clinical practice realities of Māori nurses in Aotearoa New Zealand: The emotional labour of Indigenous nurses. *Nursing Praxis in New Zealand, 36*(3), 7-23. https://doi.org/10.36951/27034542.2020.011

Huria, T., Cuddy, J., Lacey, C., & Pitama, S. (2014). Working with racism: A qualitative study of the perpectives of Maori (indigenous peoples of Aotearoa New Zealand) registered nurses on a global phenomenon. *Journal of Transcultural Nursing, 25*(4), 364-372.

Huygens, I. (2016). Pākehā and Tauiwi Treaty education: An unrecognised decolonisation movement? *Kotuitui: New Zealand Journal of Social Sciences, 11*(2), 1-13. https://doi.org/10.1080/1177083X.2016.1148057

International Council of Nurses. (2009). *Evidence-based safe nurse staffing: Position statement*. International Council of Nurses. Retrieved 1 April from https://www.icn.ch/sites/default/files/2023-04/PS_C_%20Evidence%20based%20safe%20nurse%20staffing_1.pdf

Jatrana, S., & Crampton, P. (2021). Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal evidence from New Zealand. *Social Science & Medicine, 288*. https://doi.org/10.1016/j.socscimed.2020.113255

Jeffreys, M., Ellison-Loschmann, L., Irurzun-Lopez, M., Cumming, J., McKenzie, F., & on behalf of the Primary Health Care Programme Grant Team. (2023). Financial barriers to primary health care in Aotearoa New Zealand. *Family Practice*. https://doi.org/10.1093/fampra/cmad096

Kidd, J., Came, H., Herbert, S., & McCreanor, T. (2020). Māori and Tauiwi nurses' perspectives of anti-racism praxis: Findings from a qualitative pilot study [Article]. *AlterNative: An International Journal of Indigenous Peoples, 16*(4), 387-394. https://doi.org/10.1177/1177180120974673

Komene, E., Pene, B., Gerard, D., Parr, J., Aspinall, C., & Wilson, D. (2024). Whakawhanaungatanga—Building trust and connections: A qualitative study of indigenous Māori patients and whānau (extended family network) hospital experiences. *Journal of Advanced Nursing, 80*(4), 1545-1558. https://doi.org/10.1111/jan.15912

Lange, R. (1999). *May the people live: A history of Maori health development 1900-1920*. Auckland University Press.

Margaret, J. (2016). *Ngā rerenga o te Tiriti: Community organisations engaging with the Treaty of Waitangi*. Treaty Resource Centre. https://www.trc.org.nz/treaty-application/nga-rerenga-o-te-tiriti/

Marriott, L., & Sim, D. (2014). *Indicators of inequality for Māori and Pacific people* [Working paper 09/2014]. Victoria University.

Marsden, M. (2003). *The woven universe: Selected writings of Rev Maori Marsden*. Estate of Rev. Maori Marsden.

Marx, K. (1887/2009). *Das kapital: Critique of political economy (S. Moore and E. Aveling Trans.)* (Vol. 1). Progress Publishers.

Matamua, R. (2020). Matariki and the decolonisation of time. In B. Hokowhitu, A. Moreton-Robinson, L. i. Tuhiwai Smith, C. Anderson, & S. Larkin (Eds.), *Routledge Handbook of Critical Indigenous Studies*. Routledge. https://doi.org/https://doi.org/10.4324/9780429440229

McHugh, M. D., Aiken, L. H., Sloane, D. M., Windsor, C., Douglas, C., & Yates, P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: A prospective study in a panel of hospitals. *The Lancet (British edition), 397*(10288), 1905-1913. https://doi.org/10.1016/S0140-6736(21)00768-6

Ministry of Health. (2022). *Nursing safe staffing review: Report on the review of the Care Capacity Demand Management (CCDM) programme*. Ministry of Health.

Ministry of Health. (2023). *Funding to Māori health providers, 2017/18 to 2021/22*. New Zealand Government.

Moss, M., Were, L., & Pipi, K. (2021). Nga Manukura o Apopo: Sustaining kaupapa Maori nurse and midwifery leadership. *Nursing New Zealand, 12*(1), 16.

Mutu, M. (2010). Constitutional intentions: The Treaty of Waitangi texts. In M. Mulholland & V. M. H. Tawhai (Eds.), *Weeping waters: The Treaty of Waitangi and constitutional change*. Huia.

Nanni, G. (2012). *The colonisation of time: Ritual, routine and resistance in the British empire*. Mancester University Press.

Needleman, J., Buerhaus, P., Stewart, M., Zelevinsky, K., & Mattke, S. (2006). Nurse staffing In hospitals: Is there a business case for quality? *Health Affairs, 25*(1), 204-211. https://doi.org/10.1377/hlthaff.25.1.204

New Zealand Nurses Organisation. (2019). *Guideline – Code of Ethics, 2019*. New Zealand Nurses Organisation. https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Code%20of%20Ethics%202019.pdf?ver=2019-06-27-094754-100

NSW Nurses and Midwives Association. (2018). *Ratios save lives*. NSW Nurses and Midwives Association.

O'Sullivan, D., Came, H., McCreanor, T., & Kidd, J. (2021). A critical review of the Cabinet Circular on Te Tiriti o Waitangi and the Treaty of Waitangi advice to ministers. *Ethnicities, 21*(6), 1093-1112. https://doi.org/10.1177/14687968211047902

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal of Quality Health Care, 8*(5), 491-497. https://doi.org/10.1093/intqhc/8.5.491

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., & Pieterse, A. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLOS One, 10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

Pihama, L., Cameron, N., Pitman, M., Te Nana, R., & Smith, L. T. (2021). *Whāia te ara ora: Understanding and healing the impact of historical trauma and sexual violence for Māori*. Māori and Indigenous Analysis Ltd.

Queensland Nurses and Midwives' Union. (2020). *Ratios save lives and money: Phase 3 Strengthening and expanding the care guarantee*. Queensland Nurses and Midwives' Union.

Queensland Nurses and Midwives Union. (2017). *Ratios save lives: Phase 2 Extending the care guarantee*. Queensland Nurses and Midwives Union. Retrieved 1 April from https://www.qnmu.org.au/DocumentsFolder/Ratios%20website/Phase%202/Ratios%20Save%20Lives%20Phase%202%201017%20FINAL.pdf

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* [Unpublished doctorate, Victoria University]. Wellington, NZ.

Ramugondo, E. L., & Emery-Whittington, I. (2022). A decolonising approach to health promotion. In S. Kessi, S. Suffla, & M. Seedat (Eds.), *Decolonial enactments in community psychology* (pp. 191-211). Springer International Publishing. https://doi.org/10.1007/978-3-030-75201-9_10

Ratima, C. (N.D.). *Understanding cultural safety: How are nurses using cultural safety to engage effectively with patients in clinical settings*. Eastern Institute of Technology].

Reid, P. (2021). Structural reform or a cultural reform? Moving the health and disability sector to be pro-equity, culturally safe, Tiriti compliant and anti-racist (Editorial). *New Zealand Medical Journal, 134*(1535). https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=edsinz&AN=edsinz.999093342802837

Reid, P., Paine, S.-J., Ao, B. T., Willing, E. J., Wyeth, E., Vaithianathan, R., & Loring, B. (2022). Estimating the economic costs of Indigenous health inequities in New Zealand: A retrospective cohort analysis. *BMJ Open, 12*(10), e065430. https://doi.org/10.1136/bmjopen-2022-065430

Roberts, J. (2019). Kawa Whakaruruhau – has its intent been lost? *Nursing New Zealand (Wellington, N.Z.: 1995), 25*(11), 14-15.

Robson, B., & Harris, R. (Eds.). (2007). *Hauora: Māori standards of health IV. A study of the years 2000-2005*. Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago. http://www.otago.ac.nz/wellington/research/erupomare/projects/otago019494.html

Safe Staffing/Healthy Workplaces Committee of Inquiry. (2006). *Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry*.

Shamliyan, T. A., Kane, R. L., Mueller, C., Duval, S., & Wilt, T. J. (2009). Cost savings associated with increased RN staffing in acute care hospitals: Simulation exercise. *Nursing Economics, 27*(5), 302-331.

Smith, L. (2012). *Decolonising methodologies: Research and indigenous peoples* (2nd ed.). Zed Books.

Solomon, R., & Peach, M. (2021). Nga kitenga o te maramataka: The insights into the Maori lunar calendars. *International Journal of Integrated Care, 20*. https://doi.org/10.5334/ijic.s4211

Sumibcay, J. R. C. (2024). Examining structural racism as the fundamental cause of health inequities among the Indigenous Māori, Native Hawaiian, and Pacific Island peoples in the U.S. and Aotearoa New Zealand: Perspectives from key informant community leaders. *SSM. Qualitative research in health, 5*, 100379. https://doi.org/10.1016/j.ssmqr.2023.100379

Te Kaunihera Tapuhi o Aotearoa | Nursing Council New Zealand. (2011). *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice*. Te Kaunihera Tapuhi o Aotearoa | Nursing Council New Zealand.

Te Kaunihera Tapuhi o Aotearoa | Nursing Council New Zealand. (2023). *Te Tiriti o Waitangi policy*. Retrieved 6 Feb from https://www.nursingcouncil.org.nz/Public/Treaty_of_Waitangi/NCNZ/About-section/Te_Tiriti_o_Waitangi.aspx

Te Whata, T. (2020). *Determining the value of Maori nurses in Aotearoa*. [MBs thesis, Massey University]. Palmerston North, NZ. https://mro.massey.ac.nz/items/21d7c84a-42fa-4c58-b694-952acd297c4e

Tenorio, M., Aletreby, W., Al Shammari, B., Almuabbadi, B., Mwawish, H., & Montegrico, J. (2021). The Interrelation between nurse-to-patient ratio, nurse engagement, and missed nursing care in King Saud Medical City: Basis for development of nurse-patient quality of care. *Saudi Journal for Health Sciences, 10*(2), 116-124. https://doi.org/10.4103/sjhs.sjhs_74_21

United Nations. (1966). *International Convention on the Elimination of all Forms of Racial Discrimination*. Author. http://www2.ohchr.org/english/law/cerd.htm

United Nations. (2007). *Declaration on the Rights of Indigenous Peoples*. Author. http://iwgia.synkron.com/graphics/Synkron-Library/Documents/InternationalProcesses/DraftDeclaration/07-09-13ResolutiontextDeclaration.pdf

Waitangi Tribunal. (2014). *He Whakaputanga me te Tiriti – The Declaration and the Treaty* [WAI 1040]. Author.

Waitangi Tribunal. (2019). *Hauora report on stage one of the health services and outcomes inquiry*. Author.

Wakefield, S. (2023). *Investigating Māori nurse leaders' experiences within nursing*. [MNS thesis, Te Herenga Waka | Victoria University of Wellington]. https://openaccess.wgtn.ac.nz/articles/thesis/Investigating_M_ori_nurse_leaders_experiences_within_nursing/24160812?file=42392238

Walker, R. (1990). *Ka whawhai tonu mātou: Struggle without end*. Penguin Books.

Wepa, D. (2015). *Cultural safety in Aotearoa New Zealand* (2nd ed.). Cambridge University Press.

Wiapo, C., Adams, S., Komene, E., Davis, J., & Clark, T. (2024). An integrative review of racism in nursing to inform anti-racist nursing praxis in Aotearoa New Zealand. *Journal of Clinical Nursing, 1-13*. https://doi.org/10.1111/jocn.17205

Wihongi, H. (2010). *Tino rangatiratanga in health policies and practices: A kaupapa Māori analysis of the 1996 national cervical screening programmes's policy document – the years 1990 to 2000* [Doctoral dissertation, Waikato University]. Hamilton, New Zealand).

Wilson, D., Barton, P., & Tipa, Z. (2022). Rhetoric, racism, and the reality for the Indigenous Māori nursing workforce in Aotearoa New Zealand. *Online Journal of Issues in Nursing, 27*(1), 1-13. https://doi.org/10.3912/OJIN.Vol27No01Man02

Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing, n/a*(n/a). https://doi.org/https://doi.org/10.1111/jocn.15859

APPENDIX 1: PARTICIPANT INFORMATION SHEET

18 March 2024

Project Title: Culturally safe nursing staffing levels

An invitation

Kia ora, Mairi Lucus (NZNO) and Heather Came (Heather Came & Associates) are passionate about culturally safety, Māori health and ending inequities. We are inviting you to participate in a targeted research study.

What is the purpose of this research?

We are pulling together a briefing paper &/or academic paper examining cultural safe nursing staffing levels. This will be used by NZNO to advocate for culturally safe staffing levels to improve quality and quantity of care for Māori whānau.

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

You were identified as a Māori nursing leader by Kerri Nuku or Mairi Lucas. You meet our selection criteria as Māori nurses with expertise in cultural safety and nursing staffing levels. Your contact details were secured through existing professional networks.

How do I agree to participate in this research?

If you agree to participate in this research, you will need to complete a consent form. This can be done via email for you to sign, scan and return. Your participation in this research is voluntary (it is your choice), and whether or not you choose to participate will neither advantage nor disadvantage you.

You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed, or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This research will involve you participating in up to two whakawhiti kōrero over the course of the next six months. Each whakawhiti kōrero will take up to two hours. The following is a broad outline of what might be covered.

1. **Whakawhanaungatanga**; who we are; purpose of the study; who you are; your understanding of culturally safety and culturally safe staffing levels.

2. We will present a draft briefing paper from the international literature review and whakawhiti kōrero with Māori nursing leaders. We will collectively critically review the work with a view to strengthening the draft

The whakawhiti kōrero will be done online using a platform such as Zoom or MS Teams. The whakawhiti kōrero will be recorded and transcribed by the researchers or a colleague who has signed a confidentiality agreement. If you want, a copy of the transcript these can be sent to you after whakawhiti kōrero and you can edit as you wish.

After the whakawhiti kōrero has been completed and the initial findings generated, a further kōrero with all participants will be held to discuss the significance and accuracy of the findings.

What are the discomforts and risks?

It may be uncomfortable describing and discussing culturally safe staffing levels.

How will these discomforts and risks be alleviated?

The focus of the discussion will be on building an evidence base to prevent future harm and culturally unsafe and clinically unsafe staffing levels. No identifying details of people or organisations will be published in any of the study outputs. You are able to step out of the whakawhiti kōrero at any time, and you don't have to answer a question should you wish not to.

What are the benefits?

It is hoped that you will find participating in the whakawhiti kōrero an opportunity to consider and reflect upon, and potentially lead to, a refinement and development of your understanding of cultural safety. The aim of the study is to build an evidence base about what is cultural safety, clinically safe staffing levels to inform future advocacy efforts.

How will my privacy be protected?

It is your decision whether to be identified in this study. Your names will be known to the research team and the transcriber. If you choose to be identified, a short biography (approved by you) will be included in the briefing paper. You can also choose to have no identifying details published in the study reports and a pseudonym could be used.

At the whakawhiti kōrero you will meet other Māori nursing leaders (that are likely to be already known to you) and they will know you are a participant.

What are the costs of participating in this research?

Participating in this study will take some time – between two to four hours.

What opportunity do I have to consider this invitation?

It would be appreciated if you could respond to me within two weeks.

Will I receive feedback on the results of this research?

You will be invited to a whakawhiti kōrero to discuss our findings and be provided with a copy of the final briefing paper.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Kerri Nuku; Kerri.Nuku@nzno.org.nz

Whom do I contact for further information about this research?

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

Researcher contacts:

Mairi Lucas – Mairi.Lucas@nzno.org.nz

Heather Came – dr.heather.came@gmail.com

Project Sponsor contact:

Kerri Nuku – Kerri.Nuku@nzno.org.nz.

Some of the nurse claimants to the Waitangi Tribunal Health Service and Outcomes Inquiry (Wai 2575).

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