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Whakawhanaungatanga—Building trust and connections: A qualitative study indigenous Māori patients and whānau (extended family network) hospital experiences

Ebony Komene[1] | Bobbie Pene[1,2] (ID) | Debra Gerard[2] | Jenny Parr[2] (ID) |
Cath Aspinall[1,2] (ID) | Denise Wilson[3] (ID)

[1]Faculty of Medical and Health Sciences, University of Auckland, Auckland, New Zealand

[2]Northern Region Te Whatu Ora (Health New Zealand), Auckland, New Zealand

[3]Auckland University of Technology, Auckland, New Zealand

Correspondence
Denise Wilson, Faculty of Health & Environmental Sciences, Auckland University of Technology, 90 Akoranga Drive, Auckland 0627, New Zealand.
Email: denise.wilson@aut.ac.nz

Abstract

Aims: Investigated the experiences of Māori (the Indigenous peoples of Aotearoa, New Zealand) patients and whānau (extended family network) engaging with acute hospital inpatient services and their priorities for a Māori-centred model of relational care.

Design: A qualitative Māori-centred research design using a Thought Space Wānanga (learning through in-depth group discussion, deliberation and consideration) approach.

Methods: Two wānanga were conducted between May 2022 and June 2022, with 13 Māori patients who had been acutely hospitalized within the past 12 months and their whānau members. The first wānanga utilized storytelling and journey mapping to collect data. The second wānanga refined the initial themes. Wānanga were audio-recorded and then inductively coded and developed into themes.

Results: Thirteen patients and whānau attended the first wānanga, while 10 patients and whānau participated in the second wānanga). Four themes were developed: (1) Whakawhanaungatanga (establishing connections and relationships), (2) Whakamana (uplifting the status and esteem of Māori), (3) Whakawhitiwhiti kōrero (the importance of communicating, discussing and deliberating) and (4) Kotahitanga (working together with purpose) all provide insights into the importance of effectively engaging and connecting with Māori patients and whānau when acutely hospitalized.

Conclusions: The experiences and priorities of Māori patients and whānau affirm the international literature, suggesting that Indigenous relational concepts are critical to building relationships, connections and trust. Despite existing healthcare models for working with Indigenous peoples, their poor application contributes to sub-optimal healthcare experiences at all points of their healthcare journey. A relational mode of practice focused on engagement and forming connections better meets the needs of Indigenous peoples engaging with inpatient health services.

Implications for the profession and/or patient care: Despite the existence of Indigenous models of care, Indigenous peoples consistently report a lack of

engagement and connection when accessing inpatient health services. Without establishing relationships, applying models of care is challenging.

Impact (Addressing):

- *What problem did the study address?* Internationally, healthcare systems are consistently ill-equipped to deliver culturally safe care for Indigenous and marginalized peoples, evident in ongoing health inequities. Like other reports of Indigenous experiences of health services, Māori express dissatisfaction with care delivery in an acute inpatient setting. This study investigated Māori patients and whānau experiences engaging with acute hospital inpatient services and their priorities for a Māori-centred model of relational care.
- *What were the main findings?* Māori patients and whānau recounted negative experiences with healthcare professionals lacking effective relationships and trust. Satisfaction occurred when engagement with health care professionals resembled Indigenous cultural rituals of encounter that considered their holistic, collective and dynamic worldviews. Previous models of relational care, while helpful, are not Indigenous and so do not address their needs, such as engagement as a mode of practice (how) to achieve this.
- *Where and on whom will the research have an impact?* This research impacts Indigenous peoples' health outcomes, particularly Māori, and nurses and clinicians working and interacting within acute inpatient and other hospital settings. Indigenous research methods support co-constructing knowledge for translation into practical outcomes through transformational practices, policies and theory development.

Reporting method: We used the Consolidated Criteria for Strengthening the Reporting of Health Research Involving Indigenous Peoples (CONSIDER) statement (see File S2—CONSIDER Checklist) and the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (see File S3—COREQ Checklist).

Patient or public contribution: Māori patients and their whānau interviewed about their experiences were involved in data interpretation.

KEYWORDS

indigenous research, inequity, journey mapping, Māori-centred research, Māori health, modes of care, patient experience, qualitative research, storytelling

INTRODUCTION

Indigenous populations exist throughout the world, including countries such as Australia, Canada, Aotearoa New Zealand and the United States (Mbuzi et al., 2017). Indigenous peoples are failed by health systems that continue to leave their needs and preferences unaddressed (Brockie et al., 2023). Despite national and international efforts to understand better and improve Indigenous patient experiences, there has been a minimal exploration of Māori (the Indigenous peoples of Aotearoa—see File S1—Glossary) and whānau (extended family network) experiences and their priorities for care in acute hospital inpatient services within Aotearoa, New Zealand (Axelsson et al., 2016; Jackson Pulver et al., 2010; Moewaka Barnes

& McCreanor, 2019; Wilson & Barton, 2012). Across acute care services, patients and their whānau (extended family network) will likely encounter clinical and non-clinical health professionals with varying skills and knowledge to meet their health needs. Therefore, effective management is required to meet the fundamental care needs of Māori patients and their whānau across acute hospital inpatient services that improve equity in health outcomes.

Māori, much like other Indigenous populations, had well-established concepts, systems and knowledge to maintain well-being (Boulton & Gifford, 2014; Durie, 2001). Colonization in the form of Euro-Western law, policies and practices eroded Indigenous healthcare practices, reflected in hospitalization and mortality disparities, particularly regarding access, quality of care and health outcomes

(Moewaka Barnes & McCreanor, 2019). Discriminatory practices and racism further perpetuate negative experiences for Māori when they engage with health services (Cormack et al., 2018), something also reported by whānau (Wepa & Wilson, 2019). The reality for Māori is they are more likely to report, among other things, unmet healthcare needs due to cost, unacceptably long wait times for diagnosis and treatment, and access to specialist services (Health Quality & Safety Commission, 2019). Biannual reviews on fundamental care delivery further evidence the dissatisfaction of Māori patients with the care they receive (Pene et al., 2021).

Aotearoa, New Zealand, has recently undergone a significant structural transformation in its national health care system. Significantly, the Pae Ora (Health Futures) Act 2022 establishes Te Aka Whai Ora (the Māori Health Authority) in addition to Te Whatu Ora (Health New Zealand) and a new Public Health Agency. This legislation aspires to healthy futures and eliminating health disparities. The new health system is described as needing to 'protect, promote and improve the health of all New Zealanders' and achieve equity in health outcomes. This transformation follows the Waitangi Tribunal (2019) WAI2575 Hauora, and the Health and Disability System Review (2020) reports that signalled unacceptable Māori health inequities (compared to other population groups) and what is needed to address these. Whakamaua: Māori Health Action Plan 2020–2025 (Ministry of Health, 2020) further identified the need for Māori-led solutions and Māori models of health and wellbeing. Therefore, this study investigated the experiences of Māori patients and whānau engaging with acute hospital inpatient services and their priorities for a Māori-centred model of relational care. Exploring their experiences of acute hospitalization aimed to provide insights into improving the patient and whānau experience and understand their priorities for a Māori-centred model of relational care (Wilson et al., 2022) when accessing inpatient hospital services.

1.1 | Background

Evidence suggests that the multidimensional, holistic and relational underpinnings of health and wellbeing are shared across other Indigenous peoples (Carr & McCormack, 2012). Yet, ongoing inequities and quality of care problems plague health service delivery, differentially affecting population groups like Māori and Pasifika (Health Quality & Safety Commission, 2019; Rumball-Smith et al., 2013). A range of models to improve engagement with Māori exist, such as Te Whare Tapa Wha (Durie, 2001), the Meihana model (Pitama et al., 2007) and the Hui (meeting) Process (Lacey et al., 2011).

Te Kapunga Putohe, the restless hands, provides a Māori-centred model for working in partnership with Māori (Barton & Wilson, 2008). Informed by mātauranga Māori (Māori knowledge), this model is premised on recognizing the person is part of a collective (that is, whānau as an extended family network). The co-existence of Māori values and concepts alongside clinical or nursing practice benefits Māori seeking health care. Care should focus on the person and their whānau while the partnership promotes their

tino rangatiratanga (self-determination, sovereignty, independence, autonomy) and upholds their personal authority and cultural integrity (Barton & Wilson, 2008). Similarly, the Meihana Model brings together the cultural and clinical aspects of working with Māori and is also recommended for use from the first engagement point (Pitama et al., 2007).

Despite these models aiming to improve health practitioners' understanding and engagement with Māori patients and whānau, these problems persist. A common theme in research with Māori patients and whānau highlights issues with their engagement with health practitioners, such as nurses and doctors, commonly reporting not feeling welcome, ineffective interactions, inadequate information sharing and racial discrimination (Anderson & Spray, 2020; Wepa & Wilson, 2019). Nurses and patient describe this as addressing the basics of care delivery to improve patient and whānau satisfaction and quality of care (Parr et al., 2018). However, achieving this in practice is anything but basic and requires skill and expertise on the part of the nurse.

The research site has embedded the Fundamentals of Care (FoC) Framework into its nursing practice. The FoC framework is a point-of-care theoretical framework that captures the complexity of nursing practice, focusing on patients' physical, psychosocial and relational needs (Kitson, 2018). The FoC framework has been criticized for overlooking the importance of Indigenous worldviews that prioritize culturally embedded collective orientations that value reciprocal relationships, family and spirituality in wellbeing (Aspinall et al., 2020). The lack of cultural recognition was also evident in patient and whānau narrative feedback at the research site (Pene et al., 2021). Māori, like other Indigenous peoples, consistently report feeling undervalued, especially when health professionals make little or no attempt to engage with them. Feeling valued and connected are critical for developing trust and engagement in healthcare services and addressing inequity (Mbuzi et al., 2017). The following questions need answering: Why have existing Māori models of care failed to be embedded into practice? What are the priorities for Māori patients and whānau when accessing acute health services? Is a model of care sufficient to change how healthcare professionals engage with patients and whānau?

Wilson et al. (2021) explored the key concepts, principles and values embedded within existing Māori models of health and well-being to determine how they might inform the development of a Māori-centred relational model of care. Their study identified the priorities for effective and meaningful engagement with Māori and their whānau when accessing healthcare services. Māori and whānau priorities included whanaungatanga (connectedness and belonging), whakawhanaungatanga (a process of making connections and relationships) and the socio-political health context (Wilson et al., 2021).

An Indigenous Māori-centred model of relational health care highlights the importance of relationships grounded in a Māori worldview. Fundamental to Indigenous and Māori culture is the value and social process of whanaungatanga—the sense of feeling connected and belonging (Mbuzi et al., 2017). The essence of whanaungatanga (connectedness, belonging) is relationships between Māori and

others, embodied in the Māori worldview. Māori refer to the process of establishing these relationships as whakawhanaungatanga, a cultural imperative that establishes the trust necessary for ongoing engagement with healthcare professionals and healthcare services (Aspinall et al., 2020; Parr et al., 2018; Wilson & Barton, 2012).

1 | THIS STUDY

This paper reports findings from two wānanga (in-depth group discussion, deliberation and consideration) (learning through in-depth group discussion, deliberation and consideration) held with Māori patients and whānau (extended family network) about their experiences of engaging with acute hospital inpatient services, and their priorities for a Māori-centred relational model of care. The research was part of a study that also included Māori nurses and their experiences caring for Māori patients and whānau (Komene et al., 2023).

1.1 | Aim and objectives

The research aimed to investigate Māori experiences of engaging with acute hospital inpatient services patients and whānau and their priorities for a Māori-centred model of relational care. The following research questions informed the exploration:

- What are the experiences of Māori patients and whānau on admission, during and discharge from acute hospital services?
- What is most important when caring for Māori patients and whānau?
- What do Māori patients and whānau think better care looks like in a hospital?

1.2 | Design

Our Māori-centred qualitative research drew on Kaupapa Māori (Māori philosophy) principles embedded in Thought Space Wānanga (in-depth group discussion, deliberation and consideration; Smith et al., 2019). Such an approach creates a safe space for a group of participants to engage actively with others for collective thinking and problem-solving. Durie (1997) defined Māori-centred research as '…primarily focusing on Māori people, as Māori, and the research methods and practices employed to take full cognisance of Māori culture, Māori knowledge, and contemporary realities' (p. 9). Using a Māori-centred methodology, we intended to produce knowledge from a Māori health care consumer perspective to improve health service delivery. Māori cultural values and concepts, alongside a Māori-centred method, enabled a cross-examination of patient and whānau experiences and identification of common intersecting factors.

This approach assisted in acquiring a more complex and nuanced understanding of the interrelatedness and influence of culture,

worldview, Māori health and well-being when they engaged with healthcare services (Smith, 2012). A Māori-centred approach safeguarded a culturally relevant research process, and the outcome would benefit Māori. Kaupapa Māori values and principles informed participant engagement, data collection and analysis, and dissemination of the findings. These processes complemented research ethics relating to informed consent, confidentiality, data storage and ensuring the safety of all participants throughout the research process.

Four Māori researchers (EK, BP, DG and DW) with varying degrees of research experience planned and conducted the research. In addition, the team collaborated with mana whenua (Māori who tribally belonged to the geographical area of the hospital), the Māori health team and Māori nursing staff (not directly involved as participants in the research). They assisted and advised the research team for participant recruitment and supported participants to engage in the wānanga. These activities involved time and human resources to ensure the research integrity remained Māori-centred.

1.3 | Sample/participants

A purposive sample of 10–15 participants was deemed culturally appropriate and suitable to identify patterns in the data (Braun et al., 2018). We included patients and whānau over 18 years who self-identified as Māori and had an inpatient experience with the acute hospital services within the last 12 months (from January 2021 to January 2022). We excluded patients and whānau who did not identify as Māori, could not give informed consent, or could not communicate verbally. Also excluded were patients and whānau currently receiving care from hospital services. The hospital's patient management system generated a list of patients admitted to acute hospital inpatient services between January 2021 and January 2022. A Māori research assistant, supported by the hospital's Māori cultural support team, phoned patients and their whānau to invite them to participate. The Māori cultural support team also helped recruit participants who had used their cultural service during their inpatient experience.

1.4 | Data collection

The study site was a publicly funded hospital providing acute secondary and tertiary services for its population. While the marae (Māori place for gathering) was the initial setting planned for the wānanga, the COVID-19 pandemic and associated restrictions created logistical difficulties. In consultation with mana whenua (Māori who tribally belonged to the geographical area of the hospital), we used the hospital's improvement and innovation centre as the research site, recognizing that the hospital was also a place of familiarity for both local and non-local Māori.

Wānanga as a Māori relational methodology involves sharing and producing mātauranga (Māori knowledge) in a culturally safe space. Through whakawhitiwhiti kōrero (a process of in-depth

communicating, discussing and deliberating), participants shared and reflected upon their contexts and aspirations for change when they engaged with acute hospital inpatient health services. In this way, they contributed to the co-construction of new knowledge to improve Māori and whānau experiences during hospitalization and understand their priorities for a relational model of care (Smith et al., 2019). Data was collected between May 2022 and June 2022 by the Māori research team members. Two wānanga, each lasting 3 hours, were audio recorded, and the kōrero (discussion) was then transcribed and checked for accuracy. Transcripts were not returned to the participants.

Guided by mana whenua and the Māori cultural support team, the research team followed tikanga Māori (cultural processes and protocols). Each wānanga began with karakia (prayer), mihi (introductions), waiata (song), whakawhanaungatanga (making connections) and koha (gift). Manaakitanga (hospitality and compassionate caring) was crucial in supporting whānau participation and acknowledging their contributions. Therefore, each wānanga required organizing transport, parking and providing kai (food and beverage).

The first wānanga comprised Māori and whānau only and used two methods of data collection: (1) he aha ō hikoi (journey map) spanning admission, inpatient experience and discharge. Patients and their whānau wrote their positive and negative experiences on colour-coded sticky notes, their feelings and suggested improvements. This process got Māori and whānau relaxed and oriented to the research focus. The journey map was then photographed and transcribed. (2) Kōrero mai (Storytelling) enabled every participant to share and further discuss their experiences, prompted when needed by the researchers' open-ended questions. We conducted a similar wānanga with nurses employed at the study site, reported separately (Komene et al., 2023). The second wānanga brought patients, whānau and Māori nurses together to provide feedback on and refine our preliminary findings. Participants explored the alignments and misalignments between their experiences, their priorities for healthcare delivery and the relational model of care (see Wilson et al., 2021).

1.5 | Data analysis

Mahi-a-Rōpū (group work) was used to examine the data collectively and inductively identified initial codes. Upon consensus, we developed the final themes (Braun et al., 2018). As part of maintaining a Māori-centred research process, the values of tika (true, correct and right), pono (honesty), aroha (empathy, compassion and love) and māhaki (humility) ensured critical discussion and debate transpired in developing the themes, Indigenising the data analysis. A strengths-based approach to the data analysis required Māori research expertise to enable a decolonised view of patient and whānau experiences, which is frequently deficit-focused. Instead, we focused on self-determination, validating mātauranga Māori (Māori knowledge) and shifting historically negative,

colonial discourse. Presentation of the thematic analysis back to the patients, whānau and Māori nurses ensured they contributed to and confirmed the data analysis. We invited feedback on whether they felt the themes we presented accurately captured their experiences and priorities for improving healthcare delivery and whether Wilson et al.'s (2021) proposed model aligned (or not) with their priorities. After completing a final analysis, the dissemination of the findings to the mana whenua (Māori who tribally belonged to the geographical area of the hospital) occurred after the study's completion.

1.6 | Ethical considerations

The Auckland Health Research Ethics Committee (AHREC) and the study site approved the research in August 2021. The Te Ara Tika Guidelines for Māori Research Ethics (Hudson et al., 2010) provided the ethical framework for this study. We obtained written and verbal consent from participants after ensuring they understood the research and expectations of their participation. Given the small, ethnic-specific sample, de-identifying data and using secure data storage protected participant confidentiality and was only accessible by the Māori members of the research team. Participants also agreed not to discuss or share information with other participants outside of the wānanga. We used the Consolidated Criteria for Strengthening the Reporting of Health Research Involving Indigenous Peoples (CONSIDER) statement (Huria et al., 2019) to ensure the research praxis would advance Indigenous health outcomes.

1.7 | Rigour and reflexivity

Since the research centred on generating information of relevance and importance to Māori, additional ethical considerations, rigour and reflexivity were essential for conducting culturally safe research. All authors involved in the data analysis (EK, DG, BP, DW) self-identified as Māori and are registered nurses with five or more years of experience, each with different levels of engagement in Kaupapa Māori (Māori philosophy) and Māori-centred research methods from expert to novice. Each researcher recognized the influence of their positionalities and how their ontological and epistemological beliefs could influence the research and its accuracy and trustworthiness. Collective data analysis, member checking and measures to ensure data transparency further strengthened the research's authenticity, reliability and rigour (Haitana et al., 2020).

2 | FINDINGS

Thirteen patients and whānau (extended family network) attended the first wānanga (in-depth group discussion, deliberation and consideration), and 10 patients and whānau participated in the second wānanga along with four nurses. The COVID-19 pandemic

environment contributed to three patients and whānau not participating in the second wānanga). We heard the narratives of Māori and their whānau as a collective. Overwhelmingly, Māori patients and whānau recounted culturally unsafe and racist experiences that began, continued and stayed with them throughout their hospitalization journey. Almost all participants described significant delays in access to care, poor or a lack of communication, not knowing what was happening, and having to draw on their courage to endure these negative experiences until discharge. These experiences evoked many emotions, including feeling lonely, anxious, scared, embarrassed, angry and overwhelmed. They were left traumatized when they did not know what was happening. They waited long hours for attention with little or no communication. For some participants, they smiled to endure the experience but wanted health practitioners 'to be gone'. Four key themes developed: whakawhanaungatanga (process and rules of engagement), mana-enhancing (uplifting the mana of our people), whakawhitiwhiti kōrero (communication, negotiation and deliberation) and Kotahitanga (working together). Māori, like other Indigenous peoples, have a holistic and relational worldview. Whakawhanaungatanga is, therefore, a critical cultural and social value and process that underpins relationship building. Whakawhanaungatanga (making connections) provides the starting point for each theme presented in the findings, denoting the reciprocal rights, responsibilities and expected behaviours between nurses, Māori and their whānau.

2.1 | Whakawhanaungatanga (our process and rules of engagement)

Whakawhanaungatanga refers to connecting and getting to know the people in their health care. Whakawhanaungatanga (making connections) and whānau (extended family network) were integral to the care of patients. Whānau were not necessarily whakapapa (genealogical) whānau but included the 'right' people who shared similar experiences and felt and acted as whānau. When patients were unwell, they needed support and, importantly, to trust those providing care:

> As far as the cultural and the Māori-side of things, I think it really does start with whakawhanaungatanga. Then, we build trust and a relationship between ourselves and the people who care for us.

Whānau listened, shared, laughed and saw what the hospital healthcare providers did not see. They could advocate and speak on the patient's behalf when needed. However, Whakawhanaungatanga often occurred with cleaners and orderlies, people they described as more human than nurses and doctors:

> …one orderly who picked me up, who happened to be Māori, was absolutely beautiful. She didn't just care about how she managed the bed around obstacles,

she actually cared about me, and that transferred to me, and I felt valued.

Healthcare professionals who cared were seen as being genuine. However, participants noted that aroha (empathy, compassion and love) and whakawhanaungatanga were frequently missing in their encounters. When people did not get this right, patients found their experience challenging to understand what was happening and trust those caring for them:

> …the hospice was an even better place for families to go to. The only sad thing about hospice is you can go [to die] … but the whole family can come in and it's like they are in a marae (Māori place for gathering) in the hospital.

Yet when patients and whānau were vulnerable and fearful, they frequently did not know who they were talking to because no one introduced themselves. They felt staff disregarded them and their wairua (spirit) and the importance of knowing who was involved in their care and needing the support of their whānau. Importantly, whānau stressed the need to undertake whakawhanaungatanga before getting down to the business of their health, except in life-threatening situations:

> But when they bring in a team of people and don't explain who they are, you're very vulnerable lying on that bed. Your integrity is gone for a start…. We have to be treated and valued.

Several participants said the hospital was 'an awesome' place years ago compared to now. When we asked them to give an example, one participant replied:

> They attended to you, made a connection before they asked you why you were here.

Within the study context, Whakawhanaungatanga was foundational to supporting participants being Māori, entering an acute inpatient setting and locating each person's responsibility concerning their care. Importantly, those members of their care team who understood and knew themselves culturally and ethnically were better positioned to engage with Māori and their whānau. These health professionals came to understand the patients' and whānau goals. They conveyed a genuine willingness to whakamana (uplift the esteem) patients and their whānau. They were prepared to walk their hospital journey together to optimize their experiences.

2.2 | Whakamana (uplifting the status and esteem of our people)

Whakamana (Uplifting the status and esteem of our people) is critical for Māori patients and whānau (extended family network) to feel

valued and culturally safe. They made it clear that their well-being comprised more than their physical health:

> We need to be provided with a safe environment – emotional, physical and spiritual.

> I feel sad that there is no other Māori on the ward – this affects the hinengaro
> [emotional and psychological wellbeing]

While seeing Māori staff and accessing Māori services made a difference, the cultural intelligence and cultural literacy of staff determined the quality of their interactions and the care they received. Notably, Māori and their whānau (extended family network) observed differences in communication and care that other patients around them received:

> I like hospitals. It's a good place to be. It's a place that I want to be at, but if it's going to happen like this, I don't think I'll come. I'd rather die alone because you aren't getting much help here.

> Communication. Not being able to communicate properly with your nurses because they don't know our culture.

Overwhelmingly, Māori and whānau (extended family network) spoke about the structural racism when engaging with acute inpatient hospital services:

> Protocols that should happen that don't happen.

Patient's experiences speak to the need to include Māori knowledge, practices and values into their healthcare journey as an enactment of Whakamana (uplifting the status and esteem of our people). These practices ensure transparency and support Māori patients to have the capacity to act and share responsibility for their care when entering a hospital. Particularly for Māori, given the unfair history of mortality and morbidity, whakamana (uplifting the status and esteem of our people) opens the space for Māori to feel liberated, conceptualize and kōrero (discuss) how they would define their health and wellbeing when entering hospital services.

2.3 | Whakawhitiwhiti kōrero (communication, discussion, deliberation and negotiation)

Whakawhitiwhiti Kōrero (communication, discussion, deliberation and negotiation) for whānau (extended family network) was an active discussion, negotiation and oral exchange to bring enlightenment to their situation. Māori patients and whānau wanted health practitioners to ask about their well-being, ask permission, seek clarification about information and share decision-making. These activities created a pathway for communication with Māori and

their whānau at one end and the health professionals at the other. Therefore, Whakawhitiwhiti Kōrero was essential for Māori patients and whānau during their inpatient experience to not only understand whom they were engaging with and understand what was happening but also develop feelings of safety, trust and autonomy while they were unwell:

> Take time to explain things in a way I understand and listen to what I have to say and how I feel … If staff are authentic in their engagement, then patients and whanau will reciprocate.

Command of language, regardless of dialect, was essential for whānau (extended family network) to communicate one's values, beliefs and ideologies while maintaining privacy and participation in their care:

> These doctors don't understand that Māori use their mouths to talk and explain, to tell them things [that is, speak Māori language]. Whether in Māori or not, I could come out with terminology that would totally confuse you, and that's how I felt when the doctor explained my illness to me. Where's the breakdown? Personally, with me, if they spoke our language, which is plain English, really, and if some of them could speak Māori to the people who wanted to speak Māori, that would give them privacy from other people in the room. Even if it's Indian, Pakistani, Punjabi doesn't matter. At least you're communicating and keeping it confidential with that person.

One wāhine (Māori woman) shared her experiences of miscarriage and expressed that despite her health fluency, she felt powerless to advocate for her healthcare needs and that only others sharing the room (her whānau) understood her. She further reiterated the effort and time for active discussion, negotiation and oral exchange with staff required in Whakawhitiwhiti Kōrero to support whānau feeling safe and advocated for:

> I'm educated, and I'm a teacher. But I didn't have the brain capacity to process what was going on. And they didn't listen. They said, "No you have to do this." Nobody would explain or spend time explaining what was happening to me. It wasn't until I got into the ward with the other women that I could start to understand what was happening and I could talk with them. The most terrible thing about trauma is not knowing what was happening, and I didn't feel safe.

Participants described personal strategies to uphold Whakawhitiwhiti Kōrero, such as whānau advocates to convey the support required to meet their clinical and cultural needs:

When you're the patient, you can't really remember all the bad because you're sick. And you need support. Sometimes you don't have support, you don't have a mouth, and you need someone there too. As your whānau member, they need to come in and support you. So, they can speak for you and see what the nurses and doctors otherwise can't see, like seeing if you're clean. And when nobody's done anything, your ring the bell and ask for the nurse, and they don't even understand what we're saying or our cultural beliefs.

One participant described the importance of accessing different services to maintain autonomy over health decisions and communication options during their hospitalization journey. However, the information was withheld:

I don't know if that's withholding or whose responsibility it is to find out what services are available for Māori patients in the hospital during their stay here. Things like availability to chaplaincy services, counselling services, social work services, or just somebody to talk to. Just that company, to keep your mind sane and in the place where it should be and not thinking of the worst things. Cultural integrity and what other people have said about communication, not being able to communicate properly with your nurses because they don't know our culture.

Another participant suggested using virtual communication to connect with whānau, particularly during COVID-19 restrictions. However, many attempts to communicate with staff often failed, and one participant recalled smiling to disengage. Their experiences reiterated how whānau interactions mirrored the staff they felt refused to listen to their needs and further disconnected whānau within the hospital:

All I want to do is smile nicely, say "kei te pai" (I'm fine/good), and away you go because I don't really want to hear or talk to you. I've stopped listening to you. That's what happened to me. They weren't listening.

Participants also touched on the changing workforce with the influx of internationally qualified health professionals. They reiterated the need for a culturally reflective and responsive workforce to communicate better and feel confident that their needs would be met, given their mistrust of current hospital services:

The hospital is not looking after the people. Different nationalities of nurses, how can we change things? Some of the nurses don't know Island languages or, Māori, or different nationalities. How can patients explain themself when they're put in the hospital?

One participant summarized how whānau appreciate staff spending time to laugh and communicate with them during their hospitalization journey. This experience, which is not new, reflects the importance of Whakawhitiwhiti Kōrero for Māori to connect with health professionals and services at a time of unwellness:

I've heard comments about how this place used to be different in the old days. It was beautiful. They [the nurses] would inform you. There's no informed information here. We were treated like humans. They [staff] gave and spent time with us. You felt connected in those first 30 seconds in the door they attended to you, made a connection before they asked you, why are you here? Then you would talk. And the nurses used to laugh. What happened to the laugh?

Participants' reports highlight the importance of verbal and non-verbal engagement from health professionals supporting deeper-level interactions. Health professional attitudes that demonstrated respect, humility, kindness, honesty and generosity helped patients to navigate their healthcare journey. Communication was an essential component of their recovery. They created an environment that upholds Whakawhitiwhiti Kōrero, where Māori patients and their whānau felt safe. Whakawhitiwhiti kōrero is an ethic of care for working with Māori. It requires an intentional practice of supporting kotahitanga (working together).

2.4 | Kotahitanga (working together)

Recognizing the importance of whānau (extended family network) in decision-making and care planning is essential for providing Māori patients opportunities to enhance their health, as they can provide valuable insights, support and advocacy in their care. Kotahitanga (working together) meant opportunities for whānau to be involved and interact with health practitioners authentically to share information, participate in decision-making and uphold their autonomy and agency. Involving whānau in the healthcare process acknowledged their importance and fostered a sense of partnership:

I had these wonderful orderlies. [They would say] "You all right there, mama, oops going over a bump going around the corner coming up," because there's a bump. That's what I call human. That's what I call being in touch.

Building relationships based on mutual respect and understanding created a culturally safe environment where patients and whānau could openly express their concerns and feel valued. Kotahitanga for whānau was maintaining their relationship with the hospital to meet

their health needs, and whānau were intrinsically aware of the need to work together towards a shared vision:

> Four percent of our workforce are Māori. So, if you get it right for Māori, you get it right for everyone. That's absolute trust. Because if you don't support your staff, they're not going to be able to support the people.

Māori and whānau recognized that time and staffing often constrained having their health goals met within a hospital system. They also knew services were sometimes disconnected, creating an unsupportive and uncaring environment:

> We are leading patients/whānau to feel health service problems are put before their health… Always follow up afterwards and the staff. You need to ensure you support your staff so that they can do the best job that they can do. Because you don't support your staff, they're not going to be able to support the people. So, I found really good staff who are really understanding. You need to keep those ones and those staff that aren't up to par, you need to put them with the good ones, so they learn how to be better.

Culture is integral to New Zealand's identity, and incorporating Māori values, customs and practices into healthcare is essential for providing culturally responsive care. By working collaboratively with Māori patients and their whānau, healthcare providers can ensure that their care respects and aligns with their cultural beliefs and values. Therefore, kotahitanga was about a workforce that understood the importance of working together and responded to the cultural and clinical needs of whānau as part of their journey:

> For four decades, we've been talking about increasing the Māori nursing workforce, which sits between 6% and 7.5%. Because all the others are from overseas, and it's not that they're bad nurses because they come with good skills. But we don't support them to learn the New Zealand culture and the Māori culture, and that, I think that's where the system fails is that we need the overseas trained nurses because we just don't have enough of our own, but we don't support them well enough so that they can assimilate. Because we're not training them in our culture, all of this happens.

By engaging with Māori patients and whānau, healthcare professionals can better understand their overall health needs and aspirations. One participant reminisced of a time when they felt unified in their hospitalization journey. However, with the onset of COVID-19 and infection control taking precedence over the patient's needs, they preferred to be in a hospice instead of the hospital:

> I remember the time when you could come into the hospital, and you could have your whole family come in with you to share everything with you. That made patients feel better with family and the staff there. But now, especially with COVID, everything is gone to crap. Now I can understand the staff. They've got a hard job with this COVID thing that they've got to put up with. And I also understand they are pushed on patients who have it that families can't go close to. But I think that the hospice is now a better place for families to go because the whole family comes in like a marae (Māori place for gathering).

Kotahitanga, as expressed by one participant in the form of lived experience, was a solution to help identify and overcome barriers for whānau to access and develop culturally appropriate interventions to improve health equity:

> All hospitals in New Zealand need to get their little kaupapa book, burn it and start again. And they need people with lived experience to come in, to help them, show them. We should have 50% professional and 50% lived life experience. But here it's all professional, telling us what we got to do. And if I started telling you what to do would you, would you be happy? Would you sit there and say, "Yeah, kei te pai bro [yes, all good bro]". No. It's all power and control. Once you take that control away from the patient, which we all are when we come here, you haven't got a patient, you've got a body that just wants to get the hell out of here, and they will fight the system until you realise we need lived experience advocating for what whānau need in every ward. If you can change that, then we're 50% healing people because people heal faster when they feel safe and secure.

Through a workforce that can ascribe to Kotahitanga and work by, for and with Māori, hospitals can better deliver culturally responsive, patient-centred care that acknowledges and respects their unique cultural identity, fosters empowerment and engagement, and ultimately leads to improved health outcomes. As said by a participant:

> Find the right people, and make sure we're supported by the community, and that's what whānau are about. Having lots of different people to come in, and if they're not the right people, then get them out and get somebody else in who is the right person. Because that's what you've got to understand, we're diverse and just because we're Māori or whatever, it's not about that. It's about diversity, it's about the skills

that they bring and the knowledge they bring, and it's about the empathy.

Collective work and responsibility must be intentional from the beginning to the end of a patient's hospitalization journey. As an expectation, Kotahitanga ensures all voices are consulted. Only in this way can Māori patients and whānau inform decision-making about their goals. Decision-making must be grounded in the realities, experiences and needs of Māori patients and whāna. In this context, Kotahitanga further recognizes the inherent knowledge and experiences of patients and their whānau, creating a safe space that enhances opportunities for Māori to have positive experiences.

3 | DISCUSSION

Māori face significant health disparities compared to the general population. Working with Māori patients and whānau (extended family network) enables hospitals to address these disparities by tailoring healthcare services to meet their needs. This research contributes a new understanding of the importance of engaging and connecting with Māori patients and their whānau throughout their inpatient hospital journey. Overwhelmingly, in this study, Māori and their whānau reported negative experiences at all stages of their inpatient hospital journey despite the Māori cultural values and models informing care delivery. Undoubtedly, the genesis of these adverse experiences was feeling unwelcome and not knowing the people involved in their care—the outcome involved a lack of trust in healthcare services and the providers of care within them. Compounding these feelings were being talked over, decisions made without their involvement, and not receiving or understanding the information shared. The findings in the study are not isolated to Aotearoa. Internationally, others found unwelcoming and foreign environments, encountering health practitioners that did not respond to their needs, being negatively framed and silenced, and encountering racial discrimination and racism (Anderson & Spray, 2020; Mbuzi et al., 2017; Wepa & Wilson, 2019).

Missing in their experiences was Whakawhanaungatanga (making connections) when they arrived at the hospital or met a new person. Māori, like other Indigenous peoples', worldviews are relational and holistic (Wilson et al., 2021). Whakawhanaungatanga extends beyond the 'good manners' of introducing yourself. Establishing the initial relationship with Māori, their whānau, and health practitioners (nurses, doctors, or allied health professionals) is a cultural imperative and opportunity. Whakawhanaungatanga is the foundation for building a relationship and trust—it can be considered a rule for friendly engagement. Lacey et al. (2011) stressed the importance of clinicians making this connection with Māori patients, indicating it is necessary for building rapport—whakawhanaungatanga is not a one-off event. Such a mode of practice requires clinicians like nurses and doctors to recognize cultural differences and respectfully enable their patients' cultural values, beliefs and practices.

This research offers greater insight into the importance of the first encounters for Māori and their whānau when engaging with

inpatient hospital experiences when they are significantly unwell. However, patients and their whānau commented on staffing and time being issues. Reports of disengagement from nursing staff in this study are reflected in literature elsewhere that signals how stretched the current healthcare system is and the cumulative impacts of unsafe staffing and burnout on patient's hospitalization journeys (Brunetto et al., 2013; Henikx et al., 2022; Komene et al., 2023; Malinen et al., 2020). As highlighted, nursing shortages and a culturally reflective workforce are critical issues that severely impact the available time nurses have with patients to engage clinically and culturally. Nursing shortages also reduce the ability to intervene early should complications arise, thus affecting overall patient safety (Brunetto et al., 2013; Komene et al., 2023). Therefore, these issues will need to be managed for both the long term and in the interim if we are to improve Māori patients' hospitalization journeys.

Patients and whānau also identified the need for internationally qualified nurses (IQNs). Still, participants reported they lack the necessary education and understanding of New Zealand's culture, particularly regarding Māori culture. Given that health is a socio-cultural construction, this is a significant issue, especially as IQNs make up 27% of the nursing workforce in New Zealand (Nursing Council of New Zealand, 2020). While IQNs are a younger but more mid-career workforce than the New Zealand-qualified nursing workforce (Nursing Council of New Zealand, 2020), they are essential to fill the gaps created by attrition, stability in nursing school graduates, and the increasing demand for nurses, their understanding of New Zealand culture is generally lacking (Nursing Council of New Zealand, 2013). The Nursing Council is about to launch new competence assessment requirements from December 2023 for IQNs, which involves completing two online courses that focus on the health and disability service, Te Tiriti o Waitangi (founding treaty between the Crown and Māori), equity, cultural safety and te ao Māori (the Māori world) with a quiz at the end of each (see nursingcouncil.org.nz). However, these changes seem insufficient to develop the knowledge and understanding to work effectively with Māori and their whānau, something found by Clubb (2022). Participants in this study, Māori culture is integral for equitable and culturally responsive care and stressed the need to support better growth in the Māori nursing workforce.

The findings also signal the need to critically call into question the role and utility of organizational values and models of healthcare when not actioned. For healthcare models, such as the FoC Framework, to be optimally realized, the mode or manner of practice needs consideration first and foremost. Given that inequities are both avoidable and unjust, improving the efficacy of interactions with population groups like Māori and other Indigenous peoples is critical to achieving equity in health outcomes (Wilson et al., 2020). A systematic review of models to improve outcomes for people with chronic or complex conditions showed the limited impact of models on outcomes (Mitchell et al., 2015).

We would argue that Māori patients and whānau entering the hospital is like coming onto a marae (Māori place for gathering), a

culturally significant place for Māori to gather. The waharoa or entranceway is where whānau gather in readiness to be welcomed onto the marae, in this case, the hospital (Figure 1). These first encounters of entering the marae are about being welcomed, making connections and knowing the processes or what will happen. Like going onto a marae, this also includes the collective whānau accompanying the patient. Clinicians, like nurses and doctors, can incorporate the concept of whakawhanaungatanga and the discussion and deliberation that ensues in their practice. Hence, it becomes a mode
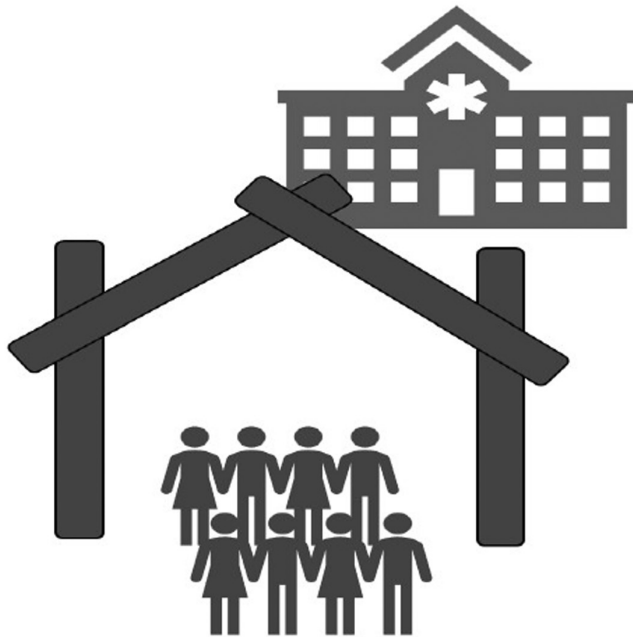
FIGURE 1 The waharoa or entranceway as a place of engagement, welcome and connection.

or way of practice. They can use such a mode of engagement with Māori and potentially other patients.

Whakawhanaungatanga is critical for effective fundamental care for Māori. Participants clarified that well-being is more than their physical health—their wairua or spiritual well-being on entering the hospital setting is contingent on knowing who they are engaging with. Te Whare Tapa Wha (the four-sided house) is a helpful model for understanding the holistic view Māori have of health and well-being—the four sides of the house must be in balance to remain standing. Therefore, ensuring the wairua (spirit) of Māori and their whānau is respected is just as important as having their physical well-being tended to (Durie, 2001). Furthermore, whakawhanaungatanga was also found to be a critical component of a Māori-centred relational model of care (Wilson et al., 2021).

Participants indicated they were often happy they decided to go to the hospital and wanted to be a partner in their care, but often, such an opportunity did not occur. *Kotahitanga* (working together) signals strategies participants suggested to improve their engagement with health practitioners within the hospital setting. *Kotahitanga—working together* (Figure 2), involves health practitioners interacting authentically with Māori and whānau, providing understandable information, including when things will happen and signalling any changes or delays in their care. Their health care experience should whakamana (uplift power and esteem) them and their whānau. Working together requires clinicians like nurses to be authentic and willing to understand the whānau lived realities and how this may inform treatment and care plans. Thus, Māori patients and whānau needed to be actively involved in their care rather than be passive bystanders. At the same time, health practitioners talked over them and made decisions without their input. This research showed that asking Māori and whānau how they are and if they understand information is essential.

AUTHENTICITY
- Ensure your engagement is genuine and meaningful
- If you make a mistake, own it and be honest about it
- Treat patients and whānau like people

LANGUAGE
- Use te reo (patient's language) greetings
- Use language patients and whānau can understand
- Try to pronounce names correctly –asking a person is appreciated

INFORMATION
Let patient and whānau know:
- What is happening
- When things will happen
- About any changes or delays

INVOLVE
Include patients and whānau in:
- Conversations
- Decision-making about their care
- This can allay their anxieties and fear

ASK
- Before doing things
- If patients and whānau are okay
- If they understand what is being said, what is being done, and why
- Check that we understand their needs

ASK
Take the time to:
- Explan things
- Ensure patients and whānau understand the information shared by asking them
- Check in with patients and whānau, even if it is for a short amount of time
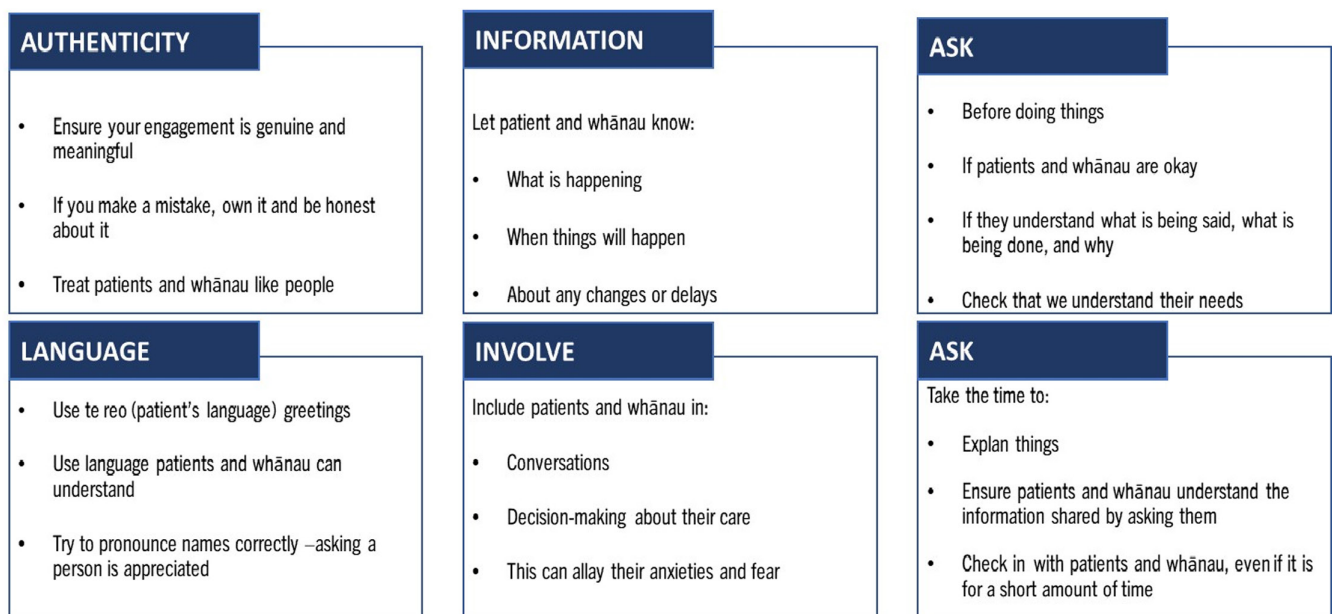
FIGURE 2 Kotahitanga—working together.

Decolonisation and Indigenisation of healthcare is a complex process that is required to address the historical and ongoing disparities faced by Indigenous peoples worldwide when interacting with Western health systems and care delivery models (Reid et al., 2019). Indigenising the healthcare system requires recognizing the historical, socio-economic and cultural context impacting Indigenous health and wellbeing. It also requires creating environments where Indigenous peoples feel respected, supported and empowered. Co-designing healthcare services requires care delivery models tailored to meet the needs and aspirations of Indigenous communities. By understanding these factors, healthcare systems can work towards ensuring equitable, culturally safe and responsive care for Indigenous communities.

No matter what model or concept guides practice, the challenge will be adequate professional development and ongoing support to apply it to practice, something Pitama et al. (2007) also identified. While models of practice can be helpful, these are not well-understood or uniformly applied. We propose focusing on a mode or way of practice for health practitioners begins with whakawhanaungatanga (making connections) and kotahitanga (working together), which Māori patients and whānau indicated they needed but rarely encountered.

3.1 | Limitations

This research involved a relatively small sample of participants. However, participants' stories were overwhelmingly similar. Despite the participant sample size, this study's findings confirm the results of other studies with Māori and whānau (Wepa & Wilson, 2019; Wilson & Barton, 2012) and other Indigenous peoples (Mbuzi et al., 2017). The findings provide valuable insights into areas requiring health practitioners' attention and reflection on incorporating whakawhanaungatanga (and kotahitanga into their practice with patients and whānau. A further limitation was the exclusion of patients and whānau unable to provide informed consent or communicate verbally and those currently receiving care from hospital services.

4 | CONCLUSIONS

The experiences and priorities of Indigenous Māori patients and whānau reinforce the importance of incorporating Indigenous relational concepts such as whakawhanaungatanga (making connections), whakamana (empowerment), kotahitanga (working together) and whakawhitiwhiti kōrero (discussion and contemplation) are critical components of building relationships and trust in inpatient hospital settings. Modes or ways of practice would better meet the needs of Māori and whānau engaging with health services so that fundamental care can proceed. These findings can be translated to other Indigenous peoples with inequities in access to and quality and safety of healthcare services.

CONFLICT OF INTEREST STATEMENT

There are not conflicts of interest.

PEER REVIEW

The peer review history for this article is available at https://www.webof science.com/api/gateway/wos/peer-review/10.1111/jan.15912.

DATA AVAILABILITY STATEMENT

Due to ethical approval and confidentiality of participants, the data is not available.

ORCID

Bobbie Pene https://orcid.org/0000-0002-0264-0074
Jenny Parr https://orcid.org/0000-0003-2365-1394
Cath Aspinall https://orcid.org/0000-0001-6682-7770
Denise Wilson https://orcid.org/0000-0001-9942-3561

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.