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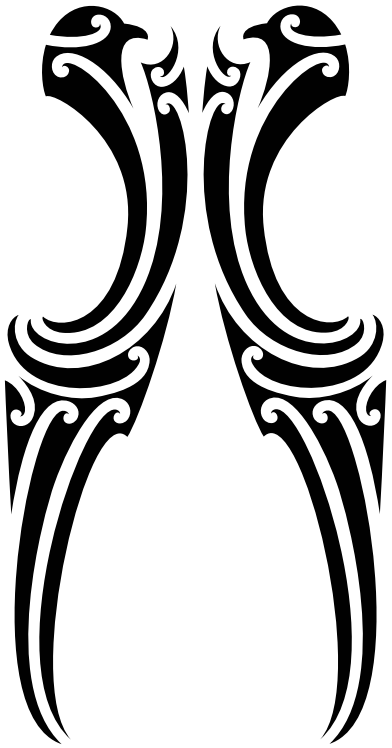
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Whakataukī

Ko te manu e kai ana i te miro, nōna te ngahere.
Engari, ko te manu e kai ana i te mātauranga, nōna te ao.

The one who partakes of the flora and fauna, that will be their domain.
The one who engages in education, opportunities are boundless.



Ākonga

The concepts of Kotahitanga (togetherness, unity and collective action lifting each other up, identifying as one) and Poutama (the pursuit of knowledge) guided the design of the two tohu – 'Kaitiakitanga' and 'Ākonga'. The 'Ākonga' tohu, featured on the front cover of this journal, tells a story about how the kōrari (flower of the harakeke) feeds, sustains, and supports the ākonga – manu. When 'Ākonga' is facing belly to belly, it shows the interaction of ākonga – learning and growing together.



MANUKORIHI WINIATA (Ngāti Raukawa, Te Āti Awa, Ngāti Awa, Ngāti Tūwharetoa) crafted our Tohu and is an established Māori artist.

Visit our website for more information on our tohu, www.whitireiaweltec.ac.nz/our-tohu

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Evidence-Informed Teaching and Learning

EDITORIAL BY CARMEL HAGGERTY & CATHERINE FULLER

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Recently we were asked to identify how research undertaken within the School of Health informs our teaching and learning. This is a valid question, and one that we do not ask ourselves often enough. We might assume that all our teaching and learning is evidence informed. Evidence-informed content is critical to educational practice, and yes, we can confidently say that our research activities are informing our practice as educators. In our mental health and addiction postgraduate team, research has focused on a variety of areas, including moral injury in clinicians (Smith et al., 2025), and professional development to support peer workers entering the mental health and addiction workforce (Ranui et al., 2023).

Another example of how evidence supports teaching is in our recent research, which investigates how Registered Nurses (RNs) support service users with Serious Mental Illness (SMI) (Haggerty et al., 2024). As experienced educators, we regularly explore the need to treat each service user as a 'whole person', more than just a mental health or addiction diagnosis. Especially as the life expectancy of service users with SMI continues to be below expectancy of the general population. The postgraduate team has embedded Te Whare Tapa Whā (Durie, 1984) into the Postgraduate Certificate in Nursing (Mental Health and Addictions) courses (Sculley & Smith, 2023), which ensures the taha tinana (physical health) component is explored extensively along with the other three pou. However, feedback from new graduates enrolled in this programme identified that taha tinana was not always given the attention it deserves in the practice they were observing.

A literature scoping activity (Haggerty et al., 2024) was undertaken to explore RN's support of service users' physical health. The findings clearly identified a role for nurses working alongside services users to assess and manage their physical health. Unfortunately, in mental health and addiction settings there is still some reluctance to accept this as a nursing responsibility. Following the scoping review, new graduate nurses entering mental health and addiction services were surveyed to gather their observations of RN's engagement with service users' physical health. The surveys were replicated from the work of Robson, et al. (2013), slightly modified for the New Zealand context. Interestingly, despite a low return rate, the findings of the survey were consistent with Robson, et al. (2013), proving an ongoing reluctance to incorporate taha tinana into mental health and addiction practices.

With timely assessments and interventions, mental health nurses can help prevent physical health problems before serious symptoms emerge (Erginer & Günüşen, 2018). The inclusion of nurses in programmes that support physical healthcare can provide significant benefits for service users. Some nurses are proactive

in providing physical healthcare, while others view it as less of their responsibility. The disproportionately negative physical health statistics of services users compared to the general population is a growing area of concern within nursing and healthcare services. Publications such as 'Equally Well' by Te Pou o te Whakaaro Nui (2014) provide a strategic framework to assist health providers in improving the assessment and management of the physical health of people accessing mental health and addiction services. Considering that Whitireia and WelTec is supporting new graduate nurses' transitions into mental health and addiction practices, the incorporation of this document into the curriculum was identified as important for teaching and learning. As an endorsing organisation of 'Equally Well' (Te Pou o te Whakaaro Nui, 2014), we commit to supporting organisational change that strengthens nurses' responsibilities to provide holistic care for more equitable health outcomes for service users.

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Understanding the Importance of Trauma-Informed Care & Leadership in Mental Health Nursing

MARION KURESA, WENDY TRIMMER & DE'ARNA RUSH

This integrative literature review explores trauma, trauma-informed care (TIC), and the importance of leadership in mental health nursing practice. Three key themes emerged from the literature sourced: preventing re-traumatisation, organisational culture, and leadership and education. Highlighted in this review are the implications for nursing practice and the importance of organisational culture, leadership, and education when implementing TIC within mental health nursing, to prevent re-traumatisation to tāngata whai ora (people seeking wellness). Despite growing evidence that people accessing mental health services experience re-traumatisation and trauma exposure, mental health acute inpatient services often overlook strategies to prevent this (Barr et al., 2019; Hennessy et al., 2023). Trauma-informed care (TIC) recovery approaches require mental health services to structure tāngata whai ora experiences so they are focused on personalised patient-centred care to support the empowerment of individual choices (Wilson et al., 2017). Significant research emphasises that nurses who are not trained or knowledgeable in TIC approaches can re-traumatise tāngata whai ora, and nurses who do not have the confidence to respond to a disclosure of experienced trauma can compromise patient-centred care (Barr et al., 2019; Goldstein et al., 2024; Maguire & Taylor, 2019).

KEYWORDS: clinical leadership; improving equitable outcomes for tāngata whai ora; reducing restrictive interventions; TIC awareness through education; trauma-informed practice

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BACKGROUND

Trauma is linked to events such as exposure to serious injury, violence, neglect, threatened death, and physical and/or sexual abuse, either indirect or direct (Hennessy et al., 2023; Huo et al., 2023). It is recognised that traumatic experiences can cause dysfunctional impairment that can result in reduced quality of life, poorer health outcomes, and severe mental health issues (Dolezal & Gibson, 2022; Feriante & Sharma, 2023). Both Barr et al. (2019) and Procter et al. (2017) reiterate that when people experience traumatic events that are prolonged, repetitive, and severe, the impacts of trauma can be pervasive. These are described as complex traumatic experiences.

The experience of trauma can significantly affect the lifespan of tāngata whai ora, impacting upon psychopathology, physical health, neurobiological changes, and mental health issues associated with occupational and social adversity (Hennessy et al., 2023; Huo et al., 2023; Maguire & Taylor, 2019). Research indicates that for individuals who have experienced six or more adverse childhood experiences (ACEs), the average life expectancy is 20 years shorter than that of individuals who were not exposed to trauma (Barr et al., 2019; Elders, 2021; Huo et al., 2023). An ACE is defined as a stressful experience that occurs during childhood that directly impacts upon the child, shaping their quality of life as an adult (Barr et al., 2019; Lorenc et al., 2020). Mental health issues that include mood disorders, schizophrenia, and loss of physical function can be directly linked to ACEs (Dolezal & Gibson, 2022; Wilson et al., 2017).

Significant ACE exposure impacts considerably upon brain function, resulting in impairment of behaviour and mood regulation, which leads to the inability to establish healthy interpersonal relationships in adulthood (Barr et al., 2019; Dolezal, & Gibson, 2022). ACEs are a major contributing factor to severe mental health disorders and are associated with poorer quality of life, reduced perceptions of recovery, increased opioid use as a coping strategy, and higher rates of pre-hospitalisation (Barr et al., 2019; Joseph et al., 2020). Examining ACEs through a mental health lens provides evidence that people with an ACE history of physical or sexual abuse are more likely to have earlier admissions to an inpatient mental health service, have lengthier and more frequent hospitalisations, have tendencies to self-harm, be prescribed more psychotropic medication, and have longer durations of time in seclusion (Barr et al., 2019; Elders, 2021; Hennessy et al., 2023; Huo et al., 2023; Riedl et al., 2020).

Increased awareness of trauma has led mental health services to become more comprehensively trained in trauma-informed approaches. They do this by focusing on a paradigm modification within nursing education (Te Pou, 2024). According to Young et al. (2019), an important aspect of TIC is shifting from a diagnostic model of TIC to a trauma-informed psychological approach, with the emphasis on what has happened to the person instead of what is 'wrong' with the person. Mental health services that provide evidence-based TIC approaches can minimise traumatic triggers, reduce the use of seclusion and restraint, stabilise and de-escalate aggressive situations, and prevent potential re-traumatisation (Maguire & Taylor, 2019).

SEARCH STRATEGY

The following question was devised to search the literature – 'What is the effect of nursing leadership in implementing trauma-informed care in forensic practice?' Literature was sourced from CINAHL Ultimate and EBSCOhost databases; limits were literature written in English within the last 10 years, and peer-reviewed articles. Key words were 'forensic or mental health', 'leadership', and 'trauma or trauma-informed'. A total of 63 articles were sourced, and these were reviewed for relevancy to the topic and Aotearoa forensic/mental health practice. Of the 63 articles sourced, 16 articles were identified as relevant, and these articles were analysed using Critical Appraisal Checklists (Critical Appraisal Skills Programme, 2025). Included in this review was grey literature and pertinent information from Te Pou. From the

literature sourced, three key themes emerged: preventing re-traumatisation, organisational culture, and leadership and education. Themes from the literature are discussed below, followed by implications for nursing practice.

PREVENTING RE-TRAUMATISATION

The first theme that emerged strongly within the literature was the need for screening of trauma and the risk of re-traumatisation within mental health settings. Re-traumatisation occurs when a person experiences trauma that is significant to a past traumatic event and repeatedly evokes psychological and emotional responses connected to the original event (Barr et al., 2019). The TIC approach requires staff to validate tāngata whai ora life experiences by asking what has happened to them instead of treating their diagnosis, and to comprehend their behaviours whilst acknowledging that traumatic events have occurred (Barr et al., 2019; Procter et al., 2017). This recognition of the person's trauma assists the health professional to implement the appropriate tools. The findings from various studies suggest that health professionals should deviate from traditional nursing methods and adopt TIC sensitive approaches within the nursing practice (Barr et al., 2019; Procter et al., 2017; Te Pou, 2025).

Screening of ACEs within the admission process can improve nursing practice through enhancing tāngata whai ora recovery and therapeutic alliance, while creating a safer environment for tāngata whai ora and staff (Hennessy et al., 2023). Failure to address the significance of abuse and trauma can have long-term effects in adulthood and is one of the most important moral and clinical deficits of current mental health approaches (Procter et al., 2017; Seitanidou et al., 2024; Te Pou, 2024).

Mental health services are becoming increasingly responsive to how interactions with consumers can exacerbate negative effects, which leads to re-traumatisation and can even create trauma for those admitted without previous trauma (Barr et al., 2019; Wilson et al., 2017). Coercive practices such as involuntary detention, seclusion, restraint, forced medication, and exposure to physical or verbal aggression, remain prevalent in inpatient mental health settings. These practices may contribute to re-traumatisation, particularly when healthcare professionals lack education in TIC, potentially causing distress and negatively affecting therapeutic engagement (Barr et al., 2019; Wilson et al., 2017).

A review completed by Barr et al. (2019) provides insight into participants accessing acute mental health inpatient services that faced challenging experiences with nurses' behaviours and interventions that caused re-traumatisation. These challenges consisted of not being asked about their previous traumatic history during the admission process, lack of consideration of past trauma during nursing interventions, and staff interactions that triggered a trauma response (Barr et al., 2019). Despite increasing awareness of ACE, pre-admission screening is not a routine aspect within mental health services (Barr et al., 2019; Joseph et al., 2020). Hennessy et al. (2023) highlight that not screening tāngata whai ora for previous traumatic history during the admission process poses a significant challenge to providing the appropriate care. Pre-screening for trauma can significantly reduce the risk of re-traumatisation during nursing interventions such as restraints, seclusion, and medication treatment (Barr et al., 2019; Hennessy et al., 2023).

ORGANISATIONAL CULTURE

The second theme that emerged in the literature related to leadership and TIC was the importance of ensuring that the organisation has a culture that positively impacts patient safety and healthcare (Aydoğdu, 2023; Goldstein et al., 2024). Organisational culture moulds organisational behaviours and delivers insight into the service development needed to achieve job satisfaction and effective patient care (Aydoğdu, 2023; Goldstein et al., 2024). According to Goldstein et al. (2024), nurses are the leading representative role in change, and it is imperative as a leader to understand how organisational culture affects healthcare professionals. An organisational culture change

is required to establish TIC education as a part of the annual nurse core competency requirements. This would enhance decision making and develop clinical skills (Elsheikh et al., 2023; Goldstein et al., 2024). Aydoğdu (2023) emphasises the importance of organisations adopting a supportive culture with the main focus on promoting a healthy, collaborative working environment – specifically by incorporating transparent communication, placing significant value upon teamwork, and creating a cohesive professional environment. Hult et al. (2023) states that nurses within leadership roles would benefit from leadership training that delivers empowerment and provides supportive and rational leadership skills.

As inpatient mental health services progressively abandon institutionalised care and foster a person-centred approach, it is paramount that organisational change occurs to support service care delivery (Elsheikh et al., 2023). Trauma-informed care is achieved when organisations develop the necessary steps in conjunction with changes to policies, procedures, leadership styles, and avoidance of autocratic nurse–patient relationships in delivery of nursing care (King et al., 2021). According to Cannon et al. (2020), while TIC education and training are pivotal to improving the delivery of mental health care, TIC approaches require service-wide approval, key performance indicators being implemented around non-coercive recovery, and trauma-informed practices being successfully delivered. Promoting effective delivery of TIC in nursing practice requires organisational interventions that will reduce the use of restraints and seclusion, and decrease the occurrence of re-traumatisation, and improve staff awareness and skill (Huo et al., 2023). Both Huo et al. (2023) and Maguire and Taylor (2019) agree that without organisational change, staff find themselves unable to improve care and make positive change because of the organisation's bureaucracy and insufficient resources.

Promoting organisational change to enhance TIC approaches will endorse consumer safety, prevent re-traumatisation, enhance recovery, and promote therapeutic relationships within the delivery of nursing care (Elsheikh et al., 2023). The role of nurses is fundamentally critical, yet in today's healthcare setting, it is often seen as highly competitive and complex, with organisational culture impacting on a nurse's job satisfaction and quality of healthcare (Aydoğdu, 2023). Increasingly high levels of inpatient acuity combined with high occupancy make it challenging to provide basic, safe care, let alone enact the cultural change required to apply TIC approaches effectively (Allison et al., 2015). Implementing TIC approaches within healthcare culture will require acknowledging the inadequacy of current approaches (Huo et al., 2023; Wilson et al. 2017). An essential aspect in the provision of healthcare is an organisational culture that supports the retention of health professionals by providing growth opportunities, valuing their staff, and having strong organisational values (Aydoğdu, 2023). In addition, an organisational culture that promotes innovation, continuous learning, and collaboration is fundamental to ensure job satisfaction (Aydoğdu, 2023).

LEADERSHIP AND EDUCATION

The third theme that emerged was the importance of leadership and education in the implementation of TIC in order to reduce re-traumatisation and promote organisational change. Te Pou (2024) highlights the importance of TIC training so that staff know how to screen for trauma and how to prevent re-traumatisation. It is essential that, through staff training and inductions, mental health professionals are assisted to become more competent and confident in using TIC approaches (Hennessy et al., 2023). This TIC training ensures nurses can identify and assess the history of trauma to improve the delivery of post-disclosure support and avoid potentially re-traumatising their patients (Hennessy et al., 2023).

Evidence-based practice (EBP) is defined as an amalgamation of personal expertise, current research, and patient preference to provide tāngata whai ora with successful

healthcare experiences (Elsheikh et al., 2023). Providing EBP education is an essential aspect of effective clinical leadership that is underpinned by the attributes of approachability, honesty, professionalism, and willingness to share knowledge (Mrayyan et al., 2023). It is paramount that nurse leadership roles value the necessary skills and knowledge to advocate for the implementation of evidenced-based TIC approaches while supporting nurses during crisis situations to influence change in clinical practice (Elsheikh et al., 2023). As stated by Elsheikh et al. (2023), an important aspect of a leadership role, as responsibilities and areas of expertise increase, is to make informed decisions, to provide staff with clinically sound guidance and delegation to deliver quality healthcare.

An essential component of nurses working in leadership roles should be to seek TIC educational programmes by accessing EBP to enhance knowledge and promote relevant clinical skills in practice, which is critical for quality of care, consumer safety, and job satisfaction (Elsheikh et al., 2023). As supported by Mehta et al. (2023), expanding awareness of trauma and improving knowledge of TIC approaches within nursing delivery can assist in preventing re-traumatisation. While doing so it is essential for nursing leadership to provide educational support to nurses, through EBP. This will enhance their clinical skills and alter traditional practices, promoting effective interventions that enhance recovery and wellbeing for consumers (Elsheikh et al., 2023; Mehta et al., 2023).

IMPLICATIONS FOR NURSING PRACTICE

Goldstein et al. (2024) emphasise that due to the ubiquity of exposure to traumatic experiences and the profound impact on health, it is critical that mental health services implement tools to apply a TIC approach to promote patient safety and prevent re-traumatisation. Applying TIC considerations within nursing frameworks enhances the delivery of healthcare based on the understanding of how trauma impacts people's lives, thus enhancing tāngata whai ora mental health recovery (Goldstein et al., 2024; Procter et al., 2017).

A barrier to developing TIC approaches is changing current practice. This requires education in TIC, beginning with nurses who are willing to adapt their personal practice to train and support colleagues (Maguire & Taylor, 2019). A strategy to mitigate barriers, improve outcomes, and promote service provider behaviour is implementing clinical champions that can adapt their practice to better service tāngata whai ora (Morena et al., 2022). Clinical champions are individuals dedicated to implementing initiative change and overcoming resistance that may occur within organisations (Morena et al., 2022). Clinical champions play a critical role in introducing and advocating change within nursing practice and are effective at promoting provider behaviour change and addressing provider-level barriers (Morena et al., 2022).

The 'Keeping it real' framework outlines seven essential capabilities that underpin effective mental health and addiction practice by promoting the attitudes, values, knowledge, and skills required to deliver safe, person-centred, and recovery-oriented care (Te Pou, 2025). These capabilities include working collaboratively with people experiencing addiction and mental health challenges, engaging effectively with Māori, whānau, and communities, challenging stigma and discrimination, demonstrating professional responsibility through policy implementation, and maintaining ongoing professional development (Te Pou, 2024). Acknowledging these components improves people's experiences while accessing healthcare that includes TIC approaches (Te Pou, 2024).

CONCLUSION

It is evident from the literature that implementing a trauma-informed approach in mental health settings can promote healing and post-traumatic growth while also improving therapeutic relationships, and fostering empowerment and hope for tāngata whai ora. Key factors in this review highlighted that achieving a trauma-informed approach requires organisational change through a restructure

of existing policies and procedures to core competencies within training. Furthermore, the admission process should be restructured to involve trauma pre-screening, which can be assessed and used to help determine the best TIC for the individual. Therefore, pre-screening is the basis of providing holistic care while enhancing therapeutic alliances with staff and tāngata whai ora to ensure quality healthcare is achieved. Evidence has suggested that screening the history of trauma during the admission process and implementing it within a TIC nursing approach reduces and prevents the use of seclusion and restraints, resulting in prevention of re-traumatisation. TIC clinical champions play a critical role in applying initiative changes to promote a trauma-informed approach and overcome resistance within service provider culture. It is also evident that nursing leadership roles should be guided by EBP to enhance the decision-making process to collaboratively add value and influence others to adhere to professional standards while implementing TIC. Optimising professional development in TIC will sustain competence, enhance strong self-motivational leadership values, and promote a positive organisational culture while scaffolding TIC approaches.

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MARION KURESA, RN, BN, PG Cert (Mental Health) is an after-hours coordinator and senior registered nurse with the Mental Health, Addiction and Intellectual Disability Service (MHAIDS).

WENDY TRIMMER, RN, MA (Applied) Nursing has worked as a mental health nurse and nurse educator for over 30 years. She is currently General Manager of Te Whare Mahana Trust in Mohua Golden Bay.

DE'ARNA RUSH, RN, BA, MProfPrac, PG Cert (Nursing and Specialty Care) (Waikato Tainui, Ngāti Apa, Ngāti Pākehā) is a Senior Nurse Academic at Whitireia and Weltec.

Māori Oral Health Across the Lifespan: A Literature Review

LEE SMITH, JEANETTE GRACE, KURAMAIKI LACEY, SHAYOLA KOPERU, JODI BISHOP & TE KAUNIHERA KAUMĀTUA O NGĀTI TOA RANGATIRA

Māori experience inequities in oral health, oral health outcomes, and access to oral health/dental care; however, this has not always been the case. Prior to the arrival of colonisers in the 1800s, Māori traditionally had good oral health due to a healthy diet – e.g., kaimoana (seafood), birds, and crops (Broughton et al., 2021; Schmidt & Moffat, 2011). Māori also chewed on tough foods such as fern roots, which eventually resulted in their teeth being ground to the gum line (Schmidt & Moffat, 2011). Colonisers brought with them Western diets which featured sugar and refined grains that Māori consumed and incorporated into their diets (Broughton et al., 2021). By the mid-nineteenth century, it was observed that Māori had the same levels of toothache and tooth decay as colonising Europeans (Broughton et al., 2021; Schmidt & Moffat, 2011).

Māori experience significant oral health inequities across the lifespan, including higher rates of decayed, missing, or filled teeth (abbreviated as DMFT for permanent dentition or adult teeth, and dmft for deciduous dentition or baby teeth) as well as more frequent periodontal pocketing compared with all non-Māori except Pacific peoples (Broughton, 2010; Broughton et al., 2021; Ministry of Health, 2006). Reasons for this disparity have been cited as these structural barriers:

- Overrepresentation of Māori in the statistics for financial hardship
- Cultural barriers and/or racism experienced by Māori when they visit their oral health providers (Jackson et al., 2025; Koopu & Boyd, 2009)
- Differing cultural understandings of oral health (holistic versus individualistic)
- Underrepresentation of Māori in the nation's oral health workforce.

The high cost of private oral care can make it inaccessible for Māori and can lead to individuals attempting self-extraction. For individuals living rurally, it can be challenging to book, and travel to, an appointment with the public health system (Dental Council, 2021; Lacey et al., 2025). Kaumātua (esteemed Māori elders) may also have previous experiences of oral health care when it was provided with little pain relief, which may have put them off regular oral health visits (Stuart et al., 2011). Individualist models of health are also generally perpetuated in the nation's health systems, which, in turn, fail to cater to holistic Māori understandings of health and well-being, and ignore the important role of whānau in health (Stuart et al., 2011).

KEYWORDS: inequity in oral health; kaumātua; Māori; oral health; Te Tiriti o Waitangi

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THE LITERATURE REVIEW

This literature review will provide a synopsis of literature reporting on the oral health status and oral health service utilisation rates of Māori across the lifespan. It should be noted, however, that as Lacey et al. (2021) explain, there are no clinical surveillance and monitoring mechanisms for the oral health status of Māori adults. To date, there have been three national oral health surveys that reported on oral health status of adults and their patterns of accessing oral health services. These studies included clinical examinations and reported data on clinical findings, such as the number of decayed, missing, or filled teeth (DMFT for permanent dentition or adult teeth, and dmft for deciduous dentition or baby teeth); periodontal pocketing; and the statistics for oral health visits of Māori compared with non-Māori. Nationally, self-reported oral health data is collected from adults through the *New Zealand Health Survey* (Ministry of Health, n.d.).

A significant gap in the literature is the lack of in-depth qualitative and kaupapa Māori studies reporting Māori adults' perspectives on oral health, as well as the barriers to, and enablers for accessing dental/oral health care. Specific studies on kaumātua understandings and experiences of oral health are vital given the ageing population of Aotearoa and the fact that more older people are remaining dentate (meaning they have at least one natural tooth) into the third age. Reports of oral health experiences of kaumātua are also needed as kaumātua play a crucial role in passing on cultural knowledge, which includes traditional oral hygiene and health care practices (Stuart et al., 2011).

This literature review will inform the design of a future research project that will explore kaumātua perspectives on oral health, their experiences of oral health care, and their access to oral health services. It will also explore the barriers to, and enablers for, good oral health and hygiene amongst kaumātua. This future study will partially fill a research gap on kaumātua accounts of oral health care.

LOCATING THE LITERATURE

A narrative literature review was selected for this study and the subsequent study as it draws on the available evidence to formulate a research question, making it appropriate for this purpose (Ahmad, 2025). It was also selected because it enables more flexibility in the literature synthesis and write-up than the rigidity of a systematic literature review or meta-analysis, as well as being particularly suited to a qualitative research approach or, alternatively, narrative research (Ahmad, 2025; Sukhera, 2022).

Locating specific research studies on kaumātua oral health proved to be difficult. Initially, a general internet search was conducted using the search terms 'kaumātua', 'oral health', 'dentistry', and 'dental clinics', which resulted in no studies being identified. Another set of search terms was then selected, including 'Māori', 'older people', 'elderly', 'oral health care access', and 'dental visits', which led to a study on older New Zealander's oral health being located. The study had a specific section on Māori elders (CBG Health Research, 2015). Both sets of search terms were then used to search in Google Scholar and the 'search everything' function on the Whitireia and WelTec library site (which links to all databases that the polytechnic subscribes to). Unfortunately, no further studies were identified.

Given the scarcity of literature, an AI search was undertaken using Microsoft Copilot, which did not result in any published literature being located, however, it did link to websites such as Te Ao Mārama: Aotearoa Māori Dental Association (2022) and the University of Otago, where specific priorities for Māori oral health were reported. On the webpage for Te Ao Mārama, some links to published studies on

Māori oral health were listed, but none of these related to kaumātua. A decision was therefore made to explore the wider literature on the oral health of Māori and clinic access across life stages. The research team were also aware that Emeritus Professor John Broughton (formerly of the University of Otago Faculty of Dentistry), had researched extensively on Māori oral health, so his name was utilised as a search term to locate further literature. Literature was located, albeit mostly relating to the oral health of tamariki Māori.

Research has a limited lifespan so, ideally, the literature included in this review would have been published in the last five years. Due to the lack of research available on Māori adults and kaumātua, however, some dated studies have been included. Only literature that was available in full text, in English, and published in the twenty-first century was reviewed. The next section reports literature according to specific life stages.

TAMARIKI MĀORI

Under the Community Oral Health Service (COHS) scheme, basic oral health care is free (subsidised by the government) until year 8 of schooling (around 12 years of age). Given the COHS collects and publishes data on children's oral health, there is a plethora of information on tamariki oral health. This COHS data set for children aged 5 and children in year 8 is published annually. Data is available on the oral health of some tamariki Māori because it is collected yearly and published as part of the scheme. Unfortunately, the way oral health services are rolled out often means that Māori are less able to access this care than their non-Māori counterparts (Boyd et al., 2022; Tustin et al., 2024). For instance, Māori parents residing in rural locations have reported being less able to access the COHS as they have to take time off work to travel to appointments, while cultural dissonance associated with western models of health embedded in public health services, including the COHS (explained in more depth below) are also likely to be barriers to some Māori parents accessing this scheme (Āti Awa Toa Hauora Māori Partnership Board, 2025).

A somewhat outdated study undertaken in 2009 with 5- to 6-year-old children in Northland found that dental caries (decay) was higher amongst tamariki Māori who attended lower decile schools, while tamariki Māori also had higher rates of tooth loss (due to caries) and untreated tooth surfaces than the Pākehā/other group (Gowda et al., 2009). Later studies have found that, by the age of 5, nearly twice as many tamariki Māori (60%) as non-Māori children (33.3%) had dental caries (Boyd et al., 2022; Tustin et al., 2024). In 2022, at age 5, tamariki Māori had an average of 3.1 dmft compared with 1.4 for 'other' children. In year 8, tamariki Māori had an average of 1.2 DMFT compared with 0.6 of 'other' children (Environment Health Intelligence New Zealand, 2025). Not only is dental caries more pervasive in tamariki Māori, it is also more severe when accounting for economic deprivation, and even occurs in locations with fluoridated water (Boyd et al., 2022; Tustin et al., 2024).

Compared with non-Māori children, tamariki Māori are also more likely to undergo a hospital dental procedure (Tustin et al., 2024). A secondary analysis of hospital data from 2000 to 2020 showed that tamariki Māori aged 5 and in year 8 were both less likely to be seen by the COHS (Cure Kids, 2024). Since 2018, the rate of children accessing hospital dental care has generally decreased, but hospitalisation for dental caries among tamariki Māori (and Pacific children) has been double that of non-Māori.

The Āti Awa Toa Hauora Māori Partnership Board (2025) reported that, in 2021, 80.8% of tamariki Māori aged up to 4 years were enrolled in the COHS, compared with 94% of non-Māori children. They undertook research with whānau groupings and discussed oral health, amongst other topics (please note that the total number of participants is listed as 108, but the number of whānau groupings and people in those groupings is not discussed). Half the whānau groups considered oral health care to be inaccessible in their rural localities, and long wait times

and inhospitable clinic hours were barriers to accessing oral health services. Other barriers included a lack of cultural safety, few Māori dentists and other oral health professionals, and a lack of practitioners who could speak te reo Māori and employ kaupapa Māori and mātauranga Māori approaches.

Some whānau groups also shared their positive experiences with oral health care, especially when it was provided through kura kaupapa and Kōhanga Reo. They recommended that kura kaupapa and Kōhanga Reo connect with oral health professionals to bolster the attendance of tamariki Māori and their whānau. They also recommended that oral health education should be provided to Māori households (as many do not understand the link between oral and general health), oral health subsidies should be provided for low-income households, and "Māori-led oral health initiatives, including mobile dental clinics and culturally safe services" should also be provided (Āti Awa Toa Hauora Māori Partnership Board, 2025, p. 26).

RANGATAHI MĀORI

Under the Adolescent Oral Health scheme (AOH), basic adolescent oral health care is free to young people from year 9 of schooling until their 18th birthday (although many dentists do not participate in this scheme as the remuneration from the government is perceived as relatively low). Research has consistently shown that Māori are less likely to access this free care than their non-Māori counterparts (Broughton et al., 2021; Pledger et al., 2024). Specifically, a study on the oral health of adolescents residing in the Canterbury region showed that rangatahi Māori were 37% less likely to access this care than non-Māori (Lee et al., 2023).

PAKEKE MĀORI

The most recent national study that included a specific section on Māori adults' oral health care was the *New Zealand Oral Health Survey* (Ministry of Health, 2010). This reported inequities in oral health care access by younger adults (25 to 34), Māori, Pacific peoples, and those residing in areas of high socio-economic deprivation. Māori adults (aged 18 to 75 plus) had twice the rate of edentulism and were 1.1 times more likely to have one or more missing teeth than non-Māori. Māori were also more likely to have a non-functioning dentition and fewer 'sound' teeth than non-Māori. As part of the oral health assessment, Māori participants were also found to be 1.5 times more likely to have untreated decay, while the number of untreated teeth with decay was 1.9 times higher. Māori adults had a greater DMFT score than non-Māori and had 1.5 times more periodontal pocketing than non-Māori. They were also found to be 1.3 times more likely to have some periodontal loss of attachment, 1.4 times more likely to have *moderate* periodontal loss of attachment, and 1.9 times more likely to have *severe* periodontal loss of attachment, compared with non-Māori.

There have also been several smaller studies conducted with specific groups of Māori adults (e.g., Broughton & Anderson, 2013; Reid et al., 2020). A study with 41 tāngata whai ora (mental health service consumers) was conducted in Western Tauranga Moana (Bay of Plenty), although only 13 tāngata whai ora participated in both the pre- and post-dental intervention interviews. The participants reported experiencing oral pain, toothache, infection, and halitosis (bad breath), while all had unmet dental needs including failed restorations, gum disease, dental caries, missing teeth, and edentulism without dentures. Their oral health was found to impact on their tinana (body), hinengaro (mind), whānau, and wairua (spirit) (Broughton & Anderson, 2013). Oral health care received as a component of the study had a positive impact on the participants' mental and social well-being, relationships, oral functioning, and self-perception. They also stated that they would take a more proactive approach to maintaining their oral health and hygiene, as well as the oral hygiene of their whānau.

Another study was undertaken on the oral health of 33 Māori participants with diabetes mellitus (aged 29 to 80) who attended a primary care clinic in Northland with high socio-economic deprivation levels, overcrowding,

and a non-fluoridated water supply (Reid et al., 2020). Cost was the greatest barrier to accessing oral health care and determined whether the participants visited their general practitioner (for interim care) and hospitals (for extraction). Bureaucratic errors from ACC, as well as Work and Income refusing to pay for costly restorations, led to tooth extraction for some participants. Some perceived edentulism as inevitable, while others considered edentulism something that could free them from pain and financial burden; however, they failed to account for the cost and discomfort of ill-fitting dentures and the subsequent impact of their dentures on mastication.

Given that diabetes and periodontal disease disproportionately affect Māori, a second kaupapa Māori study was carried out. It focused on the same intersecting health concerns with 26 Ngāti Toa Rangatira adults (Lacey et al., 2025). Two wānanga were conducted with those diagnosed with diabetes and their whānau. The barriers to accessing oral health services reported by the participants included cost, long wait times (even when in pain), and having to take time off work to attend an appointment. The participants said that oral health was seldom discussed with their medical practitioners in appointments, and they wanted more integrated healthcare and knowledge of what dental support was available. They stated that the link between oral health and diabetes needs to be discussed by their health providers in the first instance at the prediabetes stage. They also recommended that information (such as pamphlets) should be centred in te ao Māori. The results highlighted how Māori value oral health as well as access to resources and support services.

KAUMĀTUA MĀORI

It should be noted that all studies reviewed in the above adult Māori section have included kaumātua, but data has not been reported separately (e.g., 18 to 80 years and above). Despite the abundance of studies focusing on the oral health of older New Zealanders (e.g., CBG Health Research, 2015; Smith et al., 2020; Smith & Thomson, 2017; Thomson, 2024), specific information on kaumātua oral health is limited (Stuart et al., 2011). Stuart et al. (2011) maintain that, given that Aotearoa has an ageing population and that there is an increasing number of older people remaining dentate into the third age, more information needs to be collected on kaumātua oral health care, their access to oral health care, and their oral hygiene beliefs and values. This study was written prior to the 2012 *New Zealand Older People's Oral Health Survey* (*OPOHS*), which was the most recent national study on older people's oral health (CBG Health Research, 2015).

As part of the *OPOHS*, 2,218 people aged 65 and over participated in individual interviews, and 1,882 participated in oral examinations. The study also included 226 kaumātua; the results for this group were reported in a separate section. Kaumātua were found to have higher rates of tooth loss and edentulism, but they were also less likely to replace their missing teeth with dentures compared with non-Māori. Dentate kaumātua were less likely to report a fully functioning dentition and were less likely to use a fluoride toothpaste than non-Māori. The kaumātua were less likely to have visited a dental professional in the last 12 months as well as "half as likely to have visited at that time for a check-up; only one-fifth as likely as non-Māori to usually attend for a check-up; and half as likely to visit the same dental professional for dental care and advice" (CBG Health Research, 2015, p. xvii). The kaumātua who did access dental care were less likely to report feeling as though the dental professional had listened attentively to their concerns (CBG Health Research, 2015). The main barrier for kaumātua accessing oral health care was the perceived cost.

Unfortunately, the *OPOHS* also found that older people in general who reside in rest homes, those who need daily living assistance, those aged 85 years and above, and those who are men, experience oral health inequities (CBG Health Research, 2015). Those with dementia had significantly worse oral health, which may be because their carers do not see it as

a priority. Age-related mobility issues, health conditions, and the low remuneration received on the national pension were all cited as barriers to accessing oral health care. One study with older people who resided in their own homes and needed living assistance also cited embarrassment and not wanting to make a fuss as additional barriers to accessing care (Smith et al., 2020). These issues may also be experienced by kaumātua and thus need further exploration.

DISCUSSION

At all life stages, Māori experience inequities in oral health, access to oral health care, and oral health outcomes. This is even the case for tamariki and rangatahi Māori when basic oral health care is free. There is a large body of literature reporting on the oral health of tamariki Māori, but the oral health status and oral health care access of Māori in other life stages is significantly underexplored. For this reason, some of the literature reviewed can be considered dated, and some studies have been discussed consecutively rather than as an overall group. Lacey et al. (2021) explain that there is a pervasive gap in literature reporting on the oral health status of Māori adults and kaumātua. The researchers of this literature review support this assertion.

Utilising evidence from *the New Zealand Oral Health Survey* (Ministry of Health, 2010), Lacey et al. (2021) explore Māori oral health inequities through the lens of Te Tiriti o Waitangi. Under article 1, Kāwanatanga, the Crown must provide equitable health policy and outcomes for Māori. Successive governments have been, and remain, in breach of this responsibility. Lacey et al. (2021) explain that, traditionally, governmental health policy has failed to include any mention of Te Tiriti o Waitangi and/or Māori health. This is seen in the current strategy, *Good Oral Health for All, for Life* (Ministry of Health, 2006), which sets the nation's key strategic direction for oral health without any reference to Te Tiriti o Waitangi. The *Good Oral Health for All, for Life* strategy remains the nation's key oral health strategic document, despite it being 20 years old.

Under article 2, Tino Rangatiratanga, the Crown must provide Māori with opportunities to exercise their control and authority. In oral health, this opportunity can be met by working with Māori health providers to develop kaupapa Māori and mātauranga Māori oral health services (Lacey et al. 2021). To achieve this, the number of Māori oral health professionals must be consistent with the percentage of Māori in the general population and sufficient to meet Māori oral health needs. In 2022, Māori made up 4.1% of the nation's dentists, 10.1% of oral health therapists, and 12.5% of dental therapists, compared with 19.6% of Aotearoa's general population who identified as Māori (StatsNZ, 2024). If the government is to meet its responsibilities under article 2, and help address bias and prejudice in the present system, then boosting the number of Māori oral health professionals and kaupapa Māori oral health services is necessary.

In their research with whānau groupings, Āti Awa Toa Hauora Māori Partnership Board (2025) explained that they had positive experiences when visiting Ora Toa, which is a health service owned and operated by Te Rūnanga o Toa Rangatira Inc. It provides a broad range of health services including oral health, GP access, diabetes clinics, breast screening, injury prevention, and other services based on their 'mauri ora' model and approach. Āti Awa Toa Hauora Māori Partnership Board (2025) call for more accessible, holistic, and Māori-led oral health initiatives if the oral and general health inequities experienced by Māori are to be addressed. They maintain that "investment is also needed in public health messaging and education around prevention, especially about how oral health links to wider Hauora" (Āti Awa Toa Hauora Māori Partnership Board, 2025, p.46). Such suggestions help to ensure tino rangatiratanga is embedded in oral health care services.

Lacey et al. (2021) also maintain that the Crown is breaching Māori rights to Ōritetanga (equity) as per article 3 of Te Tiriti o Waitangi, which is evidenced by Māori inequities in oral health, oral health care access, and outcomes. It is also in breach because it fails to collect regular

data on the oral health status of Māori adults, which could lead to greater insights that could inform policy development aimed at addressing the oral health inequities experienced by Māori.

It is beyond the scope of this literature review to hold the government accountable for its Te Tiriti o Waitangi breaches and address the ongoing impacts of colonisation. It is also beyond the researchers' control and capabilities to implement a nationwide oral health care system where inequities experienced by Māori (as well as Pacific and low-income populations) can be potentially remedied. However, the literature review highlights the pervasive gap in research studies reporting on the oral health of rangatahi Māori, Māori adults, and kaumātua Māori. The future research study, which is informed by this literature review, will explore the oral health of a group of kaumātua from Ngāti Toa Rangatira in the Porirua region, which will partially fill a research gap. It will also document traditional Māori perspectives on oral health, which poses a counterpoint to most oral health studies that report statistical data on rates of edentulism, dmft/DMFT, dental caries, and periodontal disease amongst other oral health conditions.

In many published oral health surveys and research, Māori data is also included in a separate section, which may lead to unfavourable attitudes and comparisons with Pākehā. For instance, higher rates of dental caries or tooth extraction may frame Māori as less interested in maintaining their oral health, which is inaccurate (Āti Awa Toa Hauora Māori Partnership Board, 2025). Questions also remain around data sovereignty when Māori data is collected for national surveys; Māori should have control of the collection, ownership, and application of Māori data for research purposes (Lilley et al., 2024).

The kaupapa Māori research currently being designed by the research team (the authors) will provide greater insight into how kaumātua view oral health, its importance, and the specific cultural and age-related factors that impact on kaumātua oral health care service attendance. Ideally, such detailed data may lead New Zealand dental/oral health professionals to practise in a culturally safe manner, which is mandated by their profession (Dental Council, 2022). Findings may also be used to leverage change and advocate for an oral health system where all its citizens have good oral health across all stages of life.

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LEE SMITH, PhD, MA, PGDip(Arts), BTchg, BA is a senior research advisor at Whitireia and WelTec New Zealand.

JEANETTE GRACE, BEd(AdultEd), PGDip(Rehabilitation), MProf (Ngāti Tuwharetoa, Ngāti Toa, Ngāti Koata) is the Dean of Te Wānanga Māori at Whitireia and WelTec.

KURAMAIKI LACEY, MComDent, BDS (Te Arawa, Ngāruahine) is a Senior Lecturer at the Hauora Māori Faculty of Dentistry, University of Otago.

SHAYOLA KOPERU, MEd, RN, BN (Ngāti Porou, Ngāti Kahungunu, Te Ātiawa) is the Kaiwhakaruruhau Programme Manager for Bachelor of Nursing Māori at Whitireia and WelTec.

JODI BISHOP, BNM (Ngāti Toa, Ngāti Kuia, Ngāti Koata, Ngāti Maniapoto) is a Kaiako for Bachelor of Nursing Māori at Whitireia and WelTec.

TE KAUNIHERA KAUMĀTUA O NGĀTI TOA RANGATIRA meet monthly to discuss matters of importance and any other business that whānau or the community seek to raise. Dr Te Taku Parai chairs the kōmiti and attendance ranges between 40 and 60 people. The kaumātua are looking forward to participating in the oral health project later this year.

Patient Rights Breaches by Aotearoa New Zealand Paramedics and Nurses: An Exploratory Study

YOURI WIJLAND, CANDECE BROADBRIDGE, VICKY FIELD, PHIL HAWES, CARMEL HAGGERTY, DR AIMEE PACKER & DR LEE SMITH

Background: Due to high-pressure, stressful, and challenging work environments, paramedics and nurses may make errors in patient care which may lead to patient harm. Fear, as well as punitive and hierarchical organisational structures, are proven factors that discourage error reporting. All healthcare service provision in Aotearoa New Zealand must be consistent with the Code of Health and Disability Services Consumers' Rights, which outlines ten rights that health consumers are entitled to when receiving healthcare. Breaches of the code are published on the Health and Disability Commissioner (HDC) website. In 2024, an exploratory study was designed that aimed to quantify and compare the number of reported breaches between paramedics and nurses. Method: A subsequent descriptive statistical analysis of HDC breach decisions (published 2014–2024 inclusive) across both professions was undertaken. The severity of the breaches was also assessed using HDC severity assessment codes (SAC) scores based on the resulting patient harm. Results: Nine paramedics and 100 nurses were found to have breached the code; however, per 1,000 practitioners, paramedics were three times more likely to breach the code than nurses and were also more likely to breach the code at a higher severity rate than nurses. Across both professions, the most prevalent breach was of right 4, the right to receive services of an appropriate standard. Study findings support those of international studies whereby healthcare errors go underreported; however, study results add nuance to the body of literature that does exist by adding literature from an Aotearoa context and by comparison between professions. Implications: Findings are valuable in that they may be used to raise awareness of professional healthcare errors, as well as inform potential interventions aimed at reporting and reducing these mistakes.

KEYWORDS: health error; near-miss healthcare; nursing care; paramedics; patient safety

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BACKGROUND

Aotearoa New Zealand's population of approximately 5.3 million people (Stats NZ, 2025) is serviced by two ambulance providers: Wellington Free Ambulance and Hato Hone St John. At the end of 2024, there were 2,627 registered paramedics in Aotearoa, which is roughly 1% of the health workforce (Kaunihera Manapou Paramedic Council, n.d.). For the same period, there were 78,700 registered nurses, constituting slightly over 50% of the nation's healthcare workforce (Te Whatu Ora, 2024). The nursing workforce is made up of enrolled nurses (18 months' training), registered nurses with bachelor's degrees (three years' training), and nurse practitioners who have prescribing rights (master's degree and extensive training). Nurses must be registered with Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand (NCNZ) to practice, while paramedics must also be registered with Te Kaunihera Manapou Paramedic Council (Te Kaunihera Manapou) to be able to practice.

Paramedicine and nursing share several commonalities. Both can provide primary healthcare, in pre-hospital and hospital settings respectively (noting that not all nurses are employed in public hospitals). In Aotearoa, paramedics and nurses often train in the same tertiary education institution, while in Australia and some European countries, there are paramedic nurses who graduate with the skills and competencies of both professions (Australian Catholic University, n.d.; Metropolia, n.d.). Like all healthcare professionals in Aotearoa, paramedics and nurses must provide a standard of care that meets the Code of Health and Disability Services Consumers' Rights (Code of Rights). The Code of Rights lists 10 rights that all consumers of health are entitled to, one of which is the right to receive services of an appropriate standard. However, given paramedicine and nursing are high-pressure occupations, errors do occur, which are usually a result of a combination of personal (e.g., fatigue), organisational (e.g., understaffing), and design flaws (e.g., equipment malfunctions and other material factors) (Brabcová et al., 2023).

Given the professional backgrounds of the research team (paramedics and nurses), a small exploratory study was designed that aimed to investigate and compare the number of proven breaches of the Code of Rights, published by the Health and Disability Commissioner (an independent organisation whose role is to uphold and protect the rights of all consumers, and to investigate and resolve complaints). The research question guiding the study was how the breaches of the Code of Rights by paramedics and nurses compare.

LITERATURE REVIEW

Paramedic errors

International studies maintain that because of the high-stress, acute, unpredictable, and challenging pre-hospital environment, paramedics can make errors with medication, patient assessments, reporting, communications, and driving (Poranen et al., 2025; Williams et al., 2021). Medication errors include giving the wrong dose, administering a drug that causes an adverse or allergic reaction, incorrect timing of a drug dosage, and administering a drug incorrectly (e.g., via the wrong route) (Walker et al., 2023). In a systematic review of research on paramedics and patient safety, Strandås et al. (2024) report that "role ambiguity, role conflict, role overload, role identity, and role insufficiency in the dynamic nature of prehospital care" (p. 1,385) also result in paramedic errors. Studies focusing on paramedic errors generally centre on their mistakes with medication, while other forms of paramedic errors are scarcely reported (Meadley et al., 2023). See Williams et al. (2017) for an exception.

International research also maintains that instances of paramedics reporting errors are low. For example, a study conducted in the United States found that of 352 anonymous paramedic respondents to a survey, 9% indicated that they had made a medication error, yet only 4% reported their mistake (Meadley et al., 2023). Meadley et al. (2023) maintain that in the United States, paramedics are reluctant to report errors for fear of negative repercussions.

In an Irish study, the number of self-reported errors by paramedic participants was far less than what was expected. This is evident in the statistics of the one ambulance service studied, which attended over 300,000 people, yet only 11 medication errors were reported (Byrne & Bury, 2018). The identified barriers to reporting incidents included fear of negative repercussions and mockery; perceived legal, professional, and financial repercussions; and "procedural ambiguity, lack of feedback, and a perceived lack of both consistency and confidentiality" (Byrne & Bury, 2018, p. 867). In a separate United Kingdom study of ambulance employees, including paramedics and others, over half the survey respondents (the number of respondents was not reported) felt unable to raise incidents of concern due to perceived cliques, bullying, discrimination, a lack of confidentiality, and a culture of distrust in their workplace (National Guardian, 2023).

A systematic review of international research on patient safety incident reporting in pre-hospital settings found an average of 5.9 patient safety incidents per 100 patients (O'Connor et al., 2021). In 2022, one Aotearoa ambulance service attended 498,605 patients (Hato Hone St John, 2023) and reported four paramedic clinical errors, a rate of 0.0014 incidents per 100 patients (Te Whatu Ora, 2022). In 2024, there were seven incidents and near-miss incidents reported per 539,732 patients treated or transported by the same ambulance service—0.0013 incidents per 100 patients (Hato Hone St John, 2023).

Nursing errors

In a systematic literature review of 31 international research studies that focus on nurses' error reporting, Woo and Avery (2021) found that like their paramedic counterparts, nurses' errors were significantly underreported. Factors that led to this underreporting included a fear of being blamed and distrusted, a shaming organisational culture, lack of managerial support, and unfavourable reporting systems. Personal qualities (e.g., dis/honesty) and level of experience (novice and beginning nurses are less likely to report errors than more experienced nurses) are also factors that have been identified as impacting nurses' error reporting (Braiki et al., 2024).

The most commonly identified nursing errors include misdiagnosis, incorrect treatment, preventable patient falls, needle stick injuries, and charting and medication errors (Rodziewicz et al., 2024). Factors leading to these errors include burnout, stress, and overwork due to inadequate nurse/patient ratios (Pappa et al., 2023; Leaf & Murray, 2023). Some errors may go unnoticed by nurses and paramedics alike; other errors can cause severe harm including death (Meadley et al., 2023). Nurses who have made errors can also suffer poor mental health (anxiety, depression, and suicidality) and consequently exit the profession, adding to the global nursing shortage (Pappa et al., 2023).

There is no recent easily accessible nationwide Te Whatu Ora Health New Zealand data that reports errors across the national healthcare sector, likely due to the sensitive nature of this data (Macdonald, 2025). Older data from 2009/2010 reports that there were 374 hospital patients involved in serious or sentinel events, of which 127 died as a result (New Zealand Nurses Organisation [NZNO], n.d.). A serious event is not life-threatening or leads to ongoing reduced function but involves medical care (NZNO, 2023). A sentinel event is where death or severe loss of function has resulted from an error (NZNO, 2023). The Capital, Coast, and Hutt Valley region of Te Whatu Ora released regional data reporting that 104 serious adverse events (SAE) had occurred in their region in 2024 (Te Whatu Ora, 2025). The percentage of SAEs involving nursing errors cannot be determined; however, it is likely that a number involved nursing errors, given that nurses comprise over half of the nation's healthcare workforce.

The NCNZ mandates several competencies that nurses must embody in their practice. One of these competencies includes engaging in evidence-informed practice to "diagnose, plan care, identify appropriate interventions,

lead the implementation, and evaluate care provision and outcomes" (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand [NCNZ], 2025, p. 4). Nurses must also show leadership and proactively initiate change as needed in patient care, and "intervene, speak out, and advocate to escalate concerns on behalf of colleagues or recipients of care" (NCNZ, 2025, p. 4). Paramedics also have a professional Code of Conduct, which they must employ in their practice. Within this code they must "maintain consumer trust by providing safe and competent care" (p. 4). Paramedics and nurses, like pilots, teachers, and farmers, are fallible human beings and make mistakes (Meadley et al., 2023). Reporting errors is necessary because it leads to improved patient care and better health processes, systems, and practices (Kumah, 2025; Meadley et al., 2023).

The Code of Rights and complaints

As stated, all patient healthcare provision in Aotearoa must comply with the Code of Rights (Table 1). Under right 10 of the Code of Rights, all health consumers, their families and friends, staff providing or witnessing care, or anyone more generally, have the right to make a complaint (Health & Disability Commissioner, n.d.). They can complain to the healthcare provider, e.g., aged-care residence, GP clinic, or Te Whatu Ora (any of whom must assist the consumer); the healthcare provider's employer or the regulatory body; or the Health & Disability Commissioner, who must, as soon as practically possible, make a decision regarding how to deal with the complaint. Under section 33 of the Health and Disability Commissioner Act 1994, the commissioner will decide whether to take no action; to refer the complaint to an agency, person, or an advocate; to call a conference with parties concerned; or to investigate the complaint personally (Health and Disability Commissioner Act 1994, s. 33).

Investigations where health practitioners have been found to have breached the Code of Rights are published (with names redacted) on the HDC website. It should be noted that few of the complaints reported to the HDC result in a breach finding. In 2024, the HDC received 3,148 complaints, of which only 127 (4%) were found to be breaches (Health & Disability Commissioner, 2024). Consequently, results should be viewed as a small fraction of the errors that paramedics and nurses may make in providing care.

RESEARCH DESIGN

Accessing the data

As Code of Rights breach decisions are publicly available on the HDC website, ethics approval was not required. However, institutional departmental approval was sought. Given the exploratory nature of the study, descriptive statistics were employed, and data was presented in tables and graphical formats for ease of interpretation (Divecha et al., 2023). Descriptive statistical data analysis was chosen so that findings would be accessible to a wide audience, given patterns are easier to visualise and understand than complex inferential statistics (Cooksey, 2020).

Published Code of Rights breaches on the HDC website date back to 1998; however, to reflect current practices this research is limited to the 10-year period of January 2014 to September 2024 inclusive. Each HDC decision is made up of multiple pages outlining the background of the complaint, the investigation, breached rights, and recommendations. Decisions were filtered by the terms 'paramedic' and 'nurse', which resulted in 98 decisions for 'paramedic' and 1,226 for 'nurse'. Decisions focused on organisations and non-clinical staff (e.g., ambulance dispatchers) were excluded from the analysis. Each of the ten rights has multiple clauses, so for ease of analysis they were grouped under the primary right.

Data analysis

The Health Quality & Safety Commission utilises Severity Assessment Codes (SACs) to indicate the harm experienced by a patient due to clinical error (Te Tāhū Hauora Health Quality & Safety Commission, 2024). SAC1 is the most severe harm, which results in death, loss of function, or the

need for lifesaving interventions. SAC2 is major harm, including major permanent or temporary loss of function, where significant intervention is needed. SAC3 is moderate harm, including temporary loss of function, where moderate intervention is required. SAC4 is minor harm resulting in little or no amount of function loss, where minimal or no intervention is required. SACs are employed by national health providers to categorise errors and are likely familiar to healthcare providers, which is a reason they are employed in this study (Te Whatu Ora, 2025).

Two members of the research team read each full decision on the HDC website and separately assigned SAC scores depending on the severity of harm resulting from the error. Individual results were subsequently compared, with most SAC scores being found to be consistent. When SACs were inconsistent, a third member of the research team acted as an intermediary, and scores were discussed until a consensus was reached.

Descriptive statistics (small data summaries) were compiled that included the sum of published breach findings against paramedics and nurses, and the total number of breached rights per profession. The percentage of rights breaches per 1,000 registered paramedics and nurses was also calculated. Given that in Aotearoa there are more registered nurses than paramedics, this allows for more accurate comparison. Finally, a tally of the range of SAC scores per 1,000 nationally registered paramedics and nurses was undertaken with results presented in the following section.

FINDINGS

Table 1

Frequency of rights breached by paramedics and nurses

Right	Paramedic (n = 9)	Nurse (n = 100)
1. Right to be treated with respect	0	2
2. Right to freedom from discrimination, coercion, harassment, and exploitation	0	4
3. Right to dignity and independence	0	1
4. Right to services of an appropriate standard	8	124
5. Right to effective communication	0	1
6. Right to be fully informed	1	7
7. Right to make an informed choice and give informed consent	0	9
8. Right to support	0	0
9. Rights in respect of teaching or research	0	0
10. Right to complain	0	1
Total	**9**	**149**

From 2014 to 2024, nine paramedics and 100 nurses were found in breach of the Code of Rights. Nine paramedics were found to have breached nine times, while 100 nurses were found to have breached the Code 149 times. A single HDC decision may result in multiple rights breaches by the same practitioner. On average, for each HDC decision, there were 1.49 breaches per nurse; in contrast a 1:1 ratio is observed for paramedics. Based on the number of registered professionals, this equates to 3.67 breaches per 1,000 registered paramedics, and 1.22 breaches per 1,000 registered nurses. In other words, paramedics were found to be in breach of the Code of Rights three times more often than nurses, on a per-1,000-registered-practitioner basis. Table 1 highlights that right 4 was the most frequently breached right for both paramedics (88.9%, n = 8) and nurses (83.2%, n = 124). This equates to 3.26 per 1,000 registered paramedics and 1.51 per 1,000 registered nurses, as seen in Figure 1. Rights 1, 2, 5, 7, and 10 were breached in a small number of decisions regarding nurses but were absent from paramedic breaches. No paramedics or nurses were found to have breached right 8 (the right to support) or right 9 (rights in respect of teaching and research).

Figure 1

HDC breaches by paramedics and nurses per 1,000 practitioners

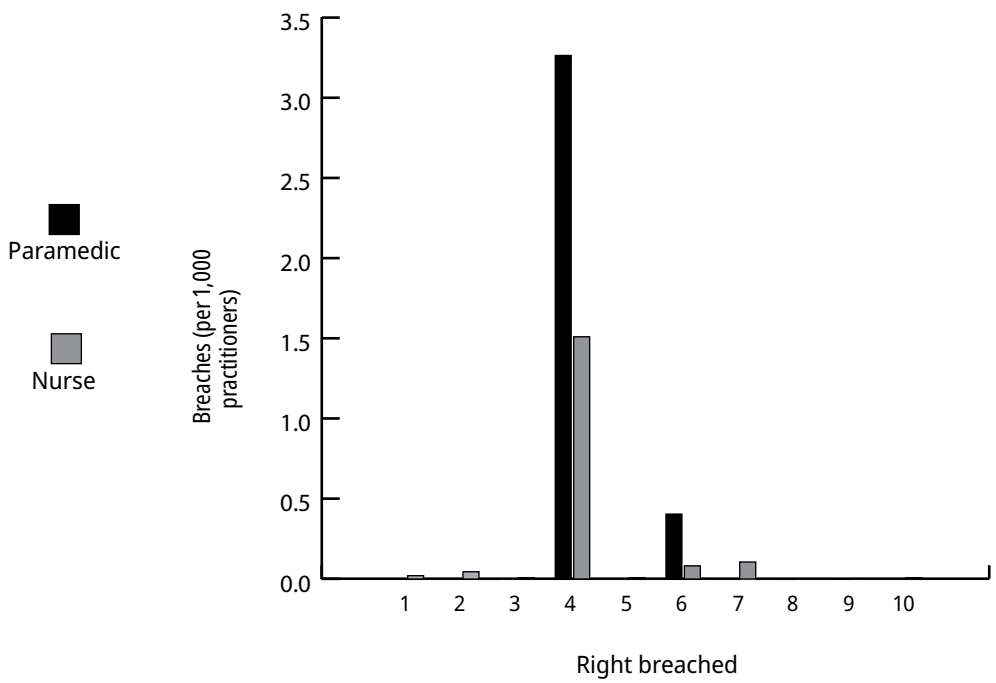


Figure 2 reports the distribution of SAC scores assigned to paramedics and nurses per 1,000 practitioners. Amongst paramedics, the SAC1 category had the most breaches (2.44), followed by SAC2 (0.81), then SAC4 (0.41). Paramedics had no breach at SAC3 severity. Nurses had breached the range of SACs at SAC1 0.54, SA2 0.09, SAC3 0.22, and SAC4 0.35 breaches.

Figure 2

Severity of rights breaches by paramedics and nurses per 1,000 practitioners

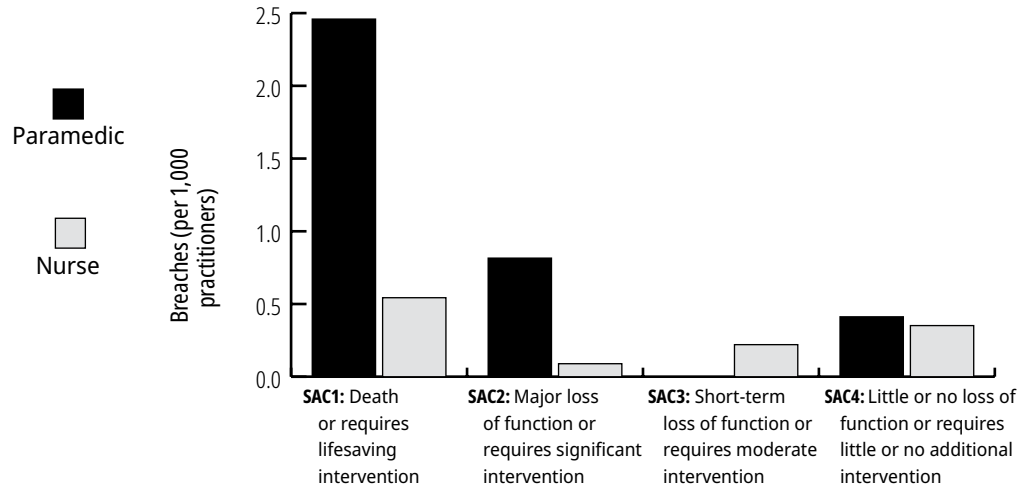
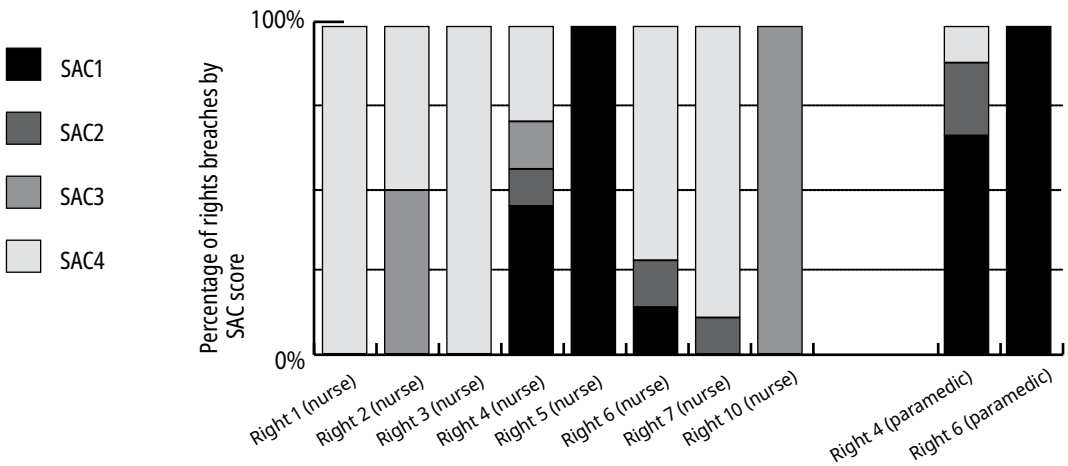


Figure 3 highlights that nurses had more low-acuity (referring to the level of severity of a patient's unwellness) breaches at SAC3 and SAC4 across a broader range of rights than paramedics. For both nurses and paramedics, the high harm incidents, at SAC1 and SAC2 level, predominantly occurred in right 4, the right to services of an appropriate standard, and right 6, the right to be informed. A single nurse was found in breach of right 5 at a SAC1 level also. A breach of the Code of Rights resulting in the most serious levels of harm (SAC1) occurred more frequently in paramedics (n = 6, 66.67%) than nurses (n = 45, 45%).

Figure 3

Relationship between SAC score and rights breached by nurses and paramedics

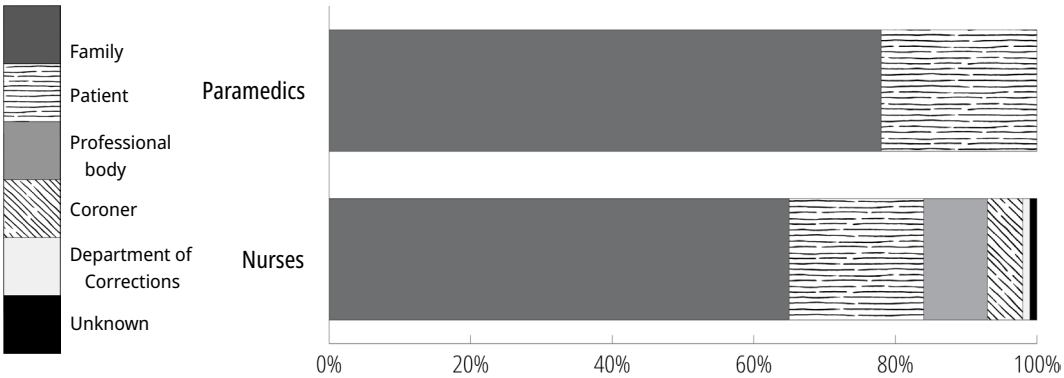


All complaints against paramedics were from patients (n = 2, 22%) or their families (n = 7, 78%). Of the 100 complaints against nurses, 19 (19%) were from patients and 65 (65%) from patients' families.

Additional complaints were from the NCNZ (n = 9, 9%), coroners (n = 5, 5%), the Department of Corrections (n = 1, 1%), and one unknown source (n = 1, 1%) (see Figure 4).

Figure 4

Origin of complaints against paramedics and nurses



DISCUSSION

This study aimed to provide an overview and comparison of breaches of the Code of Rights by paramedics and nurses, over the 10-year period of 2014 to 2024 inclusive. During this period nine paramedics were found to have breached the Code of Rights (nine rights breaches), while 100 nurses were determined to have breached the Code of Rights (149 rights breaches). This appears to be relatively few breaches compared with the number of patient interactions that occurred over the same period. During 2023–2024, 21.3% of Aotearoa children and 17.8% of the adult population visited an emergency department, where they likely interacted with a nurse (Manatū Hauora Ministry of Health, 2024). In 2024, Hato Hone St John (2025) and Wellington Free Ambulance (n.d.) had 905,201 call outs where paramedics likely treated patients. Given that O'Connor et al. (2021) found an average of 5.9 patient safety incidents per 100 patients, then breaches of patients' rights associated with paramedic and nursing errors should be much higher than reported. Although O'Connor et al.'s (2021) ratio was formulated in the absence of Aotearoa studies, it is unlikely that Aotearoa health practitioners make fewer errors than their international counterparts.

Paramedics

Although the number of breaches by paramedics was relatively low, compared to nurses on a per-1,000-practitioner basis, paramedics were three times more likely to be found in breach of the Code of Rights, and at a higher SAC severity level than nurses. This finding is consistent with a United Kingdom study, which found that compared to other health professionals a disproportionate number of patient complaints made to the Health and Care Professions Council were about paramedics and social workers (Lucas et al., 2023). Our study's findings were consistent with another national study where complainants were statistically more likely to complain if they or their family member had experienced severe or major harm from an error (Bismark et al., 2006).

All but one breach of the Code of Rights found against paramedics related to the right to services of an appropriate standard. This finding

contrasts Mehtonen et al.'s (2025) Finnish study, where complaints about paramedics centred on inappropriate behaviour (such as not listening and dismissive attitude), lack of timely care, and non-conveyance of patients to hospital when the complainant deemed it necessary. Statistics from 2015–2017 also report that most complaints made to Hato Hone St John and Wellington Free Ambulance were about the attitude and communication style of paramedics (Manatū Hauora Ministry of Health, 2020). Given that 85% of Aotearoa ambulance responses are to low-acuity patients (Todd et al., 2022), then it is somewhat surprising that no breaches by paramedics were in relation to right 5, centred on effective communication. Perhaps these complaints were dealt with through the ambulance service provider's internal complaints processes. However, it is also possible that right 5 is generally breached less often, as only one nurse was found in breach of right 5 in ten years of published breach decisions.

Another reason to explain the narrow range of reported rights breaches by paramedics may be because they are viewed as heroic, since they provide emergency lifesaving care (Lucas et al., 2023). This elevated status may cause a reluctance to report perceived instances of low-acuity breaches.

In Aotearoa, ambulances are frequently called for coughs, colds, sprains, and other minor ailments not requiring emergency care (Lotter, 2009). Paramedics also experience violence or objects being thrown at them while attending emergency call outs (Otago Daily Times, 2019), all while there is a high demand for their services. Given the stress of the profession, often combined with a dysfunctional, high-blame culture (Lucas et al., 2023), it was surprising that paramedics were not found as being in breach of the Code of Rights more often.

International research has reported that near-miss and error reporting amongst paramedics is low (O'Connor et al., 2021; Vilke et al., 2006). The findings of this study suggest that this is also the case in Aotearoa. Nevertheless, paramedics were three times more likely to have breached the Code of Rights on a per-1,000-registered-professional basis than nurses. If all errors were to be reported, it is possible that the number of paramedic breaches of the code could be higher.

Nurses

Perhaps because nursing is a more established profession, an abundance of literature acknowledges that nurses are human beings and may make mistakes (Koehn et al., 2016). Many articles also list prevention strategies for reducing these errors (e.g., Coelho et al., 2024; Heydarikhayat et al., 2024; Raines, 2000). Yet Raines (2000) reports that a professional culture of blaming, shaming, disapproval, and ostracism means that these errors remain underreported. Nursing errors are exacerbated by chronic understaffing (NZNO, 2024), which leads to "higher mortality rates, morbidities, [and] adverse advents" (Henderson, 2013, para. 1). Chronic understaffing must be addressed so nursing errors can be reduced and a better standard of patient healthcare can be provided.

Nurses, like paramedics, were found to have breached right 4 more often than other rights. However, they breached a wider range of rights than paramedics, albeit in small numbers. This may be because nurses generally have more ongoing contact with patients than paramedics (Bouchrika, 2025). For instance, they may work in oncology, mental health, or geriatrics, as well as hospitals, aged care, and GP clinics, amongst other settings. Nurses also act as liaisons with the wider healthcare team on the patient's behalf and are often a patient's first point of contact in a health setting (Ohri et al., 2022). Nurses therefore may commit breaches across the range of patient rights, compared to paramedics, who may deliver short-term emergency interventions (Bouchrika, 2025).

The diversity of nursing workplaces and specialities may also account for why there were less SAC1 and SAC2 acuity breaches by nurses than paramedics. For example, a breach by a nurse working in a smoking cessation health programme is probably less likely to lead to serious harm than a paramedic making an error

in delivering rapid lifesaving care. Though, if a nurse made an error in the emergency department or surgery, then it could lead to severe patient harm including death.

Some reported breaches of the Code of Rights by nurses can also be considered problematic, and in some instances illegal, rather than errors per se. For instance, one breach details how a nurse sexually assaulted two patients (breaching rights 3, 4, 6, and 7) and another breach details how a nurse attempted to groom a former mental health patient (breaching right 4). These acts cannot be described as errors in healthcare provision but as illegal and abuses of power by health professionals. Given these proven incidences of Code of Rights breaches were reported on the HDC website, then they are included here. It is unclear whether these behaviours resulted in criminal prosecution.

Complaints

Most complaints about a health professional are made by the patient or their family (Bismark et al., 2006). Although 84% of the complaints against nurses originated from patients and their families, it is interesting to note that 9% originated from the NCNZ. Te Kaunihera Manapou made no complaints against paramedics. This may be because many of the breaches predate the establishment of Te Kaunihera Manapou in 2020. Perhaps because of this relative newness, patients and their families may have been unaware of the professional body's existence. At the same time, no paramedic providers were the originators of complaints against those found to be in breach of the Code of Rights. This finding is interesting given these services are required to report SAC1 and SAC2 incidents by law, which all paramedic breaches were found to be (Manatū Hauora Ministry of Health, 2020). It is also possible that Te Kaunihera Manapou, Hato Hone Saint John, and Wellington Free Ambulance did bring or refer complaints to the HDC, and that these complaints did not result in a breach finding.

Five percent of complainants against nurses were coroners. Coroners can undertake their own investigations of unexplained or unexpected deaths (Te Whatu Ora, 2025). A prison and another unreported source were also complainants against nurses, which highlights the diversity of settings in which nurses are employed, unlike paramedics.

In summary, this study has reported several similarities and differences in the breach findings for paramedics and nurses. Firstly, the most common right breach by both professions was right 4, the right to healthcare of an appropriate standard. Nurses were found to have breaches across all but two rights, while paramedics in contrast, were only found in breach of two. Although the reasons for this disparity in the number of rights breached cannot be ascertained, it is perhaps because of the differences in nurse specialities and their ongoing involvement in patient care across diverse healthcare settings. Paramedics' primary role is to provide pre-hospital emergency care, which is also likely why paramedics were found to have higher acuity breaches than nurses. The high stress of both health professions means that both paramedics and nurses may make mistakes and may be fearful of reporting them given their punitive working environments and fear of judgement. International research highlights how fear of repercussions and hostile working environments may lead to underreporting, although no national literature exists to support this finding. However, a recent national study reported that in paramedicine, women were discouraged from reporting sexism, homophobia, and harassment by their senior colleagues and managers (Wynch, 2025). Such a culture is unlikely to result in an environment where paramedics feel safe enough to report errors that can lead to improved care.

Evaluating the research

This study has several strengths and limitations. Firstly, published research studies specifically exploring breaches of patient rights by nurses and paramedics are not currently available. This study helps bridge this research gap by exploring the total of patient rights breaches reported on the HDC website. It also provides data on

the severity of the impacts of these errors on patients, which allows comparison across professions. This is an important foundation for future inquiry into an area that remains significantly underexplored in the Aotearoa context.

Complaints in this study are from patients, their families, the NCNZ, and external parties, rather than paramedics and nurses themselves. Many errors are unlikely to be reported to healthcare providers, professional registration bodies, or the HDC, leaving the true scale of error and clinical risk impossible to estimate. Consequently, breach findings reported on the HDC website are likely to be 'the tip of the iceberg' when it comes to health practitioner errors.

The relatively low number of paramedics found to have breached the code means some statistics can be misread. For instance, the one paramedic's breach of right 6 corresponded with a SAC1 score, although this is reported as 100% of paramedics who breached right 6. Reported statistics must be examined with caution, and findings cannot be generalised to the wider population of registered nurses and paramedics.

Since published HDC decisions do not include formal SAC ratings, scores were assigned by the research team based on their interpretation of the events described in the reports, involving subjective interpretation. The reason SACs were initially established was to reduce inconsistencies in classifying, reporting, and learning from adverse health events that cause patient harms (Te Tāhū Hauora Health Quality & Safety Commission, 2024). Arguably, the HDC should include a SAC rating in their breach findings so that future researchers can gain a better insight into the severity of patient harm resulting from health professional errors.

CONCLUSION

This study has provided information on published breaches of the Code of Health and Disability Services Consumers' Rights and errors in healthcare provided by paramedics and nurses, while exploring the patient harm resulting from these errors. The study is exploratory in scope and was undertaken to partially address the relative lack of Aotearoa literature exploring and comparing paramedic and nursing errors.

Aotearoa healthcare providers, Te Kaunihera Manapou, and the NCNZ should ensure there is a culture where paramedics and nurses are able to safely report errors in their practice. As employers and licensing bodies, these organisations have a responsibility to provide competent health professionals who need support to improve their practice, rather than reprimand their employees if they make mistakes in high-pressure situations. Many errors reported in this study have resulted in proven publicly published breaches; however, it is likely that many others may go unnoticed and unreported. Uncovering the reasons for these errors, learning from them, and developing solutions for overcoming them in future healthcare services is more important than blame. Having a formalised pathway for reporting errors is one way.

DECLARATIONS

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YOURI WIJLAND BPharm, BHSc (Paramedic), PG Cert (Pain and Pain Management) is an independent researcher.

CANDECE BROADBRIDGE BHSc (Paramedic) is a paramedic kaiako.

VICKY FIELD NZCATT, BHSc (Paramedic), BA, Cert Introduction to Funeral Services is a paramedic kaiako.

PHILIP HAWES MHR is the Programme Manager for Simulation and Post-grad, Whitireia and WelTec Aotearoa New Zealand.

CARMEL HAGGERTY RN, MA (Nursing), MEd is the Head of the School of Health at Te Kura Hauora School of Health & Wellbeing, Whitireia and WelTec Aotearoa New Zealand.

AIMEE PACKER PhD, BHSc, BSc is a Registered Paramedic.

LEE SMITH PhD, MA, PGDip(Arts), BTchg, BA is a senior research advisor at Whitireia and WelTec Aotearoa New Zealand.

Abstract

Strategies Non-Pacific Tutors Can Use in Their Teaching to Engage Pacific Nursing Students

RACHAEL BOWEN

Abstract for a project presented in partial fulfilment of the requirements for the degree of Master of Professional Practice

This professional practice project developed, facilitated, and reviewed a Community of Practice (CoP) designed to enhance the cultural capability of, and provide support for, non-Pacific nursing kaiako. It sought to provide support for these kaiako in strengthening the success of Pacific ākonga in Aotearoa New Zealand. Grounded in a commitment to Te Tiriti o Waitangi and the use of culturally responsive language and practice, the CoP created a collaborative space for reflection, knowledge sharing, and professional growth. Guided by *The Kato Toolkit. From Good to Great: The 10 Habits of phenomenal educators for Pacific learners in New Zealand tertiary education,* the project emphasised the integration of Pacific values and liaison, relational pedagogy, and culturally sustaining teaching approaches.

Kaiako reflected on their teaching practices through a series of structured online sessions incorporating Talanoa methodology and situated learning. They explored Pacific worldviews and examined personal biases. The inclusion of Pacific cultural liaison input further strengthened understanding of culturally safe practices and challenged dominant Western pedagogical norms. Informal feedback gathered indicated increased confidence, cultur al responsiveness, and motivation among participants to adapt their teaching to better meet the needs of Pacific ākonga.

Despite challenges with online delivery and competing workloads, intentional facilitation and clear structure supported sustained engagement. As an ongoing initiative, this CoP provides a sustainable platform for continued collaboration, reflection, and professional development. Overall, the CoP demonstrated effectiveness as a professional learning approach. It reinforced the importance of relational practice, ongoing critical reflection, and cultural mentorship in advancing equitable educational outcomes for Pacific nursing ākonga.

RACHAEL BOWEN MPP, RN is a nurse lecturer for the Bachelor of Nursing Pacific Programme at Whitireia and WelTec.

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Abstract

The Double-Edged Sword of Pacific Nursing and Trade Students

FUIAVAILILI WINDY ALISI SIONE-TUISILA

Abstract for a Master of Professional Practice research thesis

This thesis examines the lived experiences of Pacific students enrolled in trades and nursing programmes at Whitireia and WelTec. The study focuses on how Pacific students balance the demands of academic study with their cultural, family, and community responsibilities. While institutional support structures exist, Pacific learners continue to face systemic challenges, including financial pressures, limited culturally relevant support, and the need to uphold family obligations, which shape their academic engagement and outcomes.

A qualitative research design was adopted, incorporating the Talanoa methodology to ensure cultural safety and authenticity. Four Talanoa sessions were conducted: one with Pacific nursing students (n = 4), one with Pacific trades students (n = 7), and two with Pacific tutors (nursing, n = 3; trades, n = 11). Each Talanoa session lasted 40–60 minutes in culturally respectful settings. The data were analysed thematically, guided by the Pacific relational philosophy of Teu le Vā – which emphasises nurturing and maintaining respectful relationships throughout the research process.

Five interrelated themes emerged from the analysis of the data:

1. Family and Cultural Expectations, which serves as both a motivating force, and a source of pressure. Students' academic efforts are tied to collective pride, but the weight of expectation often creates emotional and financial strain.
2. Balancing Commitments and Financial Pressures, as students frequently juggle study, work, and family responsibilities, leaving them stretched and fatigued.
3. Institutional Support and Flexibility, which highlights the pivotal role of empathetic, culturally responsive tutors who create safe spaces for learning, in contrast to rigid institutional frameworks, which often leave students feeling marginalised.
4. Identity, Belonging, and Representation, which reveals how cultural visibility within the institution sustains motivation, while its absence deepens feelings of isolation.
5. Personal Growth and Resilience, which illustrates how Pacific students turn challenges into strengths, developing adaptability, perseverance, and leadership, even at a personal cost.

This research contributes to the growing body of work on Pacific education by amplifying the voices of students and tutors, and demonstrating how success is shaped not only by individual effort, but also by cultural values, family ties, and institutional responsiveness. These findings support more flexible, relational, and culturally sustaining approaches in higher education that honour the holistic realities of Pacific learners. By recognising and valuing students' identities, educational institutions can move beyond tokenistic inclusion toward genuine equity and belonging.

FUIAVAILILI WINDY ALISI SIONE-TUISILA, MPP (Leadership), is a Pacific Lead Engagement Advisor and Student Mentor at WelTec, supporting Māori and Pacific learners in their education, wellbeing, retention, and success. She has over 15 years' experience across tertiary education, student development, youth development, and community leadership. Her work is grounded in Pacific values, relationships, and a commitment to improving educational outcomes and opportunities for Pacific learners and communities.

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Abstract

Between Worlds: Fuata Niue Explore Their Multiple Ethnicities and Connection to Their Niue Cultural Identity in the Aotearoa New Zealand Context

LEISHA LORRAINE WILLIAMS

Abstract for a Master of Professional Practice research thesis

This research study investigated how young people born in Aotearoa New Zealand who self-identify as having multiple ethnicities connect with their Niue cultural identity and heritage. It aimed to explore the experiences of fuata Niue (young Niue people) with multiple ethnicities who reside in Aotearoa. The research considered how participants develop a strong sense of identity in their cultural background, with particular focus on their Niue identity. The motivation for this research stemmed from the migration story of Niue people who came to Niu Silani (Aotearoa New Zealand) for a better life, more opportunities, and a better financial status. Aotearoa was considered as 'the land of milk and honey' with unlimited potential.

The process of making the bright and distinctive yellow kahoa hihi (Niue neck garland) guided this research, recognising it as a significant ethnic marker for tagata Niue in the diaspora of Aotearoa. Within this population, around 40% report belonging to at least two ethnic groups, while 27% of tagata Niue are aged 15–29 years (Stats NZ, 2023). The research explored how six fuata Niue navigated their multiple ethnicities within a North Island centre in Aotearoa.

A qualitative research approach was employed to investigate the experiences of Aotearoa-born fuata Niue who identify as having multiple ethnicities. The research design provided a platform for participants to share their knowledge, voices, and experiences of having mixed heritage. Talanoa methodology was chosen to ensure that the interviewing process was culturally aligned with the selected participants' backgrounds.

Participants were recruited via Niue community networks, social media platforms, and word of mouth. Six fifine Niue (young female) aged 18–25 years participated in two fono fuata (youth meetings) or focus groups facilitated by the researcher. The fono fuata were audio recorded and transcribed verbatim by the researcher. An inductive thematic analysis of the transcripts identified three key themes: Niue Ki Luga (Niue Pride), Hiki e fakahihiga (Code switching), and Tuaga He Niue Mooli (Justifying a position in society).

All participants prioritised their Niue cultural identity over their other ethnicities while sharing the intricacies of managing their multiple ethnicities in different contexts. The fuata Niue had both diverging knowledge of Niue cultural practice and Vagahau Niue (Niue language), which led to discussions about the need to bridge the space between their Niue and their other ethnic identities.

This thesis gives a voice to a small group of fuata Niue, capturing a snapshot of the phenomena of tagata Niue with multiple ethnicities in Aotearoa.

KEYWORDS: Mixed ethnicity; Niue identity; Pacific youth; Vagahau Niue

LEISHA LORRAINE WILLIAMS MPP is a Pacific Engagement Advisor at Whitireia and WelTec. She is proud of her Niue heritage, with ancestral ties to the villages of Alofi and Hakupu.

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Abstract

Beyond the Sirens: The Impact of Gender on Women's Experience of Being a Paramedic in Aotearoa New Zealand

EMILY WYNCH

Abstract for a thesis presented in partial fulfilment of the requirements for the degree of Master of Professional Practice

This study explores the impact of gender on women's experiences as paramedics in the near gender-balanced workforce of Aotearoa New Zealand. Whilst the existing knowledge base highlights predominantly negative experiences shaped by sex and gender—like those faced by women in other historically male-dominated professions—the topic remains under-researched, with no studies specific to Aotearoa identified.

This research aimed to raise awareness of the impact that cisgender female physiology has on the experience of being a paramedic. It looked to deepen understanding of how work-life integration, career progression, and workplace interactions affect women's experience of working as paramedics. Data was collected from 148 respondents through an anonymous online survey, combining quantitative responses from Likert-style questions with qualitative insights using reflexive thematic analysis. Applying concepts of Appreciative Inquiry, a novel approach in this field, the study identified opportunities and possibilities for improving women's experiences.

The findings reveal the profound influence of female-sex physiology, work-life integration, career progression, and workplace interactions on women's experiences of being a paramedic. These experiences are captured in the themes: blood, sweat, and tears: cisgender women on the frontline; finding equilibrium: balancing the highs and lows; the career progression paradox: equity in theory, barriers in practice; and negative interactions: positive feedback loop. Notable contributions include insights specific to Aotearoa and the impact of menstruation on cisgender women paramedics. While challenges are evident, positive experiences highlight opportunities for meaningful change.

The study offers evidence-based recommendations for gender-informed, inclusive policies and procedures to support women's physiology. Following these suggestions can improve workplace interactions and build a safe, equitable, and productive environment. These recommendations underscore the potential for paramedicine to lead by example, setting a benchmark for other industries. The outcomes of this study move towards driving systemic change and contributing to societal progress.

EMILY WYNCH MPP (Clinical Leadership), PGDip Primary Health, BHSc (Emergency Care Practitioner) is a Senior Degree Lecturer at Whitireia and WelTec. She is registered as an Extended Care Paramedic with Te Kaunihera Manapou | Paramedic Council and practises as a clinician for Wellington Free Ambulance.

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