VTE VOCATION, TECHNOLOGY & EDUCATION

ORIGINAL ARTICLE

How a nursing curriculum is responding to societal change: A study from New Zealand

Judith Honeyfield*, Cath Fraser

Department of Nursing and the Research Office, Toi Ohomai Institute of Technology, Tauranga 3112, New Zealand

ABSTRACT

Nursing is a profession that reflects and responds to enormous societal change. This article outlines three key challenges in healthcare around the world and suggests an urgency for nursing curricula and education to revisit some of its fundamental assumptions and messaging for the next generation of graduates. The challenges described here include the way an aging population demographic, a looming health sector workforce shortfall, and an increasingly multicultural population are impacting commentary about the "nurse of the future" in New Zealand. Against this backdrop, we describe a year-long, national, government-funded research project with 46 stakeholder participants to consider how best to prepare nursing students for culturally centered work in older people's healthcare. This mixed-methodology study drew on multiple data sources and particularly valorized narratives offered by 12 participants from a range of ethnicities who shared their experiences of aging, wellness, and healthcare in their later years. Using perspectives from case study design, cultural lens theory, Kaupapa Māori research, and narrative inquiry methodologies, the analysis of our findings revealed five themes related to positivity, language, social justice, cultural practices, and professionalism. The outputs of the project included a number of text and video teaching resources that are currently being disseminated through professional and higher education networks in New Zealand and abroad. While our study is grounded in nursing education, we hope that many of the processes we followed, and the insights gained will be applicable to disciplines outside of healthcare that seek to rethink their development of student thinking and practice.

Key words: nursing education, healthcare, older people, cultural identity

INTRODUCTION

Embedded in nursing education anywhere in the world is the imperative to respond to local, regional, and national healthcare needs. As these needs change and evolve, ongoing investment in curricular renewal is required to prepare nurses for the future. Demographic, technological, resourcing, legal, professional, and policy changes require differing learning, teaching, and assessment responses.

This research project addressed three contemporary challenges that fell into the first demographic category. The population of New Zealand aging. At the same time, it is becoming more multicultural and is facing growing healthcare demands that its current workforce is ill-equipped to meet.

Like many countries, New Zealand is experiencing a rapid shift in demographic structure with increasing growth in the over-65 population—estimated to be one-quarter of our total population by 2050. Similarly, the population of 85+ years will increase to about 1 in 20 in the 2040s (Statistics New Zealand, 2022). Health practitioners, policymakers, and funders recognize that while longevity is a positive societal measure of success and

***Corresponding Author:**
Judith Honeyfield, Department of Nursing, Toi Ohomai Institute of Technology, Windermere Drive, Tauranga 3112, New Zealand. Email: Judith.honeyfield@toiohomai.ac.nz; https://orcid.org/0000-0001-8045-6857
Received: 15 October 2025; Revised: 31 October 2025; Accepted: 10 December 2025
https://doi.org/10.54844/vte.2025.1081

achievement, it is challenging in terms of health, social, and well-being resources. Health needs over a lifetime are impacted by physiological, genetic, lifestyle, psychological, and social determinants, yet almost everybody will need access to high-quality healthcare and highly skilled practitioners at some point.

In addition to an aging population, census data reveals New Zealand today has over 200 distinct ethnic communities, meaning that it is now categorized as culturally and linguistically "superdiverse". In fact, it is the fifth most ethnically diverse of the OECD countries (Bhattacherjee, 2019). The largest ethnic population is European, followed by Māori (Indigenous people), Chinese, Asian, Pacific Islanders, Middle Eastern, Latin American, and African. The top five places of birth after New Zealand are England, the People's Republic of China, India, Australia, and South Africa.

New Zealand is a dual-heritage society founded on the Treaty of Waitangi (Tiriti o Waitangi), signed in 1840 between the British government and Māori leaders and now enshrined in legislation. Yet Māori still experience inequity in many measures of health and well-being with regard to many serious health conditions (cancers, stroke, diabetes, heart disease, obesity, chronic pain, arthritis; Heath *et al.*, 2024). Such inequity requires expert health services, a workforce, and educational responses.

These challenges are exacerbated by New Zealand's current workforce shortages, especially in residential care for the elderly. The shortfall is often made up by internationally qualified nurses (Taylor, 2024). A range of research studies (Guo *et al.*, 2021; Hunt *et al.*, 2020; Lea *et al.*, 2018; Wilkinson *et al.*, 2016) have pointed to a persistent disinclination of student nurses to work with older people in residential care settings. Media and public perceptions of these settings include that they are understaffed, outdated, lack resources, and offer low remuneration (Fisher, 2018; Moquin *et al.*, 2018), regardless of recent progress in increasing salaries and updating facilities to support age-friendly care (Parker *et al.*, 2021). Nursing students frequently display the same deeply rooted bias against specializing in older adult care, with an agist focus on declining functionality, increased frailty, and dementia (Foster, 2020; Honeyfield *et al.*, 2021; McKenzie & Brown, 2014; Wilkinson *et al.*, 2016).

Previous research into students' experiences and intentions of working in elder care settings (Guo *et al.*, 2021; Honeyfield *et al.*, 2020; McKenzie & Brown, 2014) has suggested that further educational responses and curriculum development are required. The current study addresses this gap with an in-depth investigation across a range of culturally representative stakeholders, including older people (European, Māori, Chinese, Asian, and Pacific), student nurses, nurse lecturers, and managers. Our aim was that their feedback would assist with a triangulated approach to developing responsive curricular and learning resources for nursing education.

Theoretical approaches

This research used a mixed-method exploratory design (Swedberg, 2020) and different epistemological positions to increase the validity of the outcomes, as described below.

Kaupapa Māori research is often summarized as "for Māori—by Māori" (Smith, 2013) and uses a critical social science perspective to aid research in cultural frameworks (Amundsen, 2018). This was evident in our project, where, to ensure validity and participant safety, a Komiti Kaupapa Māori research group was established with Māori nursing colleagues who reviewed tools and processes, advised on protocols, and supported consultation with Māori participants and their whanau family. A core position in this theoretical approach was respect for cultural knowledge and worldview. For example, after interview sessions, we ensured time for Māori participants and their family to review and approve the way their experiences and feedback were being reported to prioritize Māori cultural norms (Mikahere-Hall, 2017).

Cultural lens theory enables researchers to view diverse cultural representations within the research context in different ways while considering congruity or dissonance in and across cultural groups (Hardin *et al.*, 2014; Hofstede *et al.*, 2010). Through this research, we sought to understand how European, Māori, and Chinese cultural identity was or was not being represented in nursing practice and education.

Narrative inquiry methodology supports the primacy of participant viewpoints, enabling the recording of an oral history with the teller at the center of the data-gathering exchange. While noted as time-consuming and relying on memory (Bhattacherjee, 2019), this methodology includes different types of sacred and mythical storytelling, as well as witnessing; health and well-being are often linked to ancestors, legends, traditional medicines, and treatments (Iseke, 2013). In the current study, an important aspect of this methodology was recognizing the complexity and multi-faceted data arising from interviews that required time for multiple visits and iterative data collection.

Case study research guides empirical inquiry to investigate a contemporary phenomenon (the case) "in depth and within its real-world context" (Yin, 2014). In our

study, the older people participants we interviewed/videoed (or cases) described their own cultural identity, sharing experiences of healthcare, nursing practice experiences, and "things nurses should know" (Nursing Council of New Zealand, 2024). Case study research acknowledges that conclusions will not be representative of the population as a whole; in this research, naturally, not everyone from the same cultural background held or will hold identical views. Therefore, the findings are conversation starters rather than universal truths and are offered to nursing lecturers and students as such.

RESEARCH PURPOSE AND AIM

The overarching purpose of this research was to develop new understandings to improve Bachelor of Nursing (BN) curricula, as well as learning, teaching, and assessment approaches to produce well-prepared, culturally safe nursing graduates in New Zealand. Cultural safety requires nurses to practice in ways that the health consumer determines as being culturally safe (Nursing Council of New Zealand, 2011) thus we wanted to know what a range of stakeholders thought student nurses needed to know about working with older people in healthcare. Our overarching research question was as follows: What do student nurses know and need to know about culturally centered work in older persons' healthcare?

The findings of this research are intended to enable BN curricula development and lecturers' pedagogic resources to prepare graduates to approach client history-taking and lived-experience assessment from a perspective of well-being. The overall goal is for nursing graduates to contribute positively to culturally responsive health outcomes in all care and treatment settings where older people are highly represented. While the literature discusses the importance of culturally responsive nursing education in New Zealand (Honeyfield *et al.*, 2021; LiLACS NZ, 2015, 2016), there is considerably less guidance about how this field should be supported. The research and resources produced as part of this project are intended to contribute to this gap.

Research methods, procedures, and analysis

This mixed-methods study employed different data collection tools. All data, including transcriptions and analysis of organizational data (*i.e.*, student post placement and project evaluations), were stored on password-protected computer files shared only by the research team on servers accessible by key information Technology designated staff. Data collection was underpinned by a literature review of published studies from international and New Zealander authors that supports an approach based on well-being and culturally informed practice for older persons' healthcare, and/or identifies learning resources to improve nursing education curricula. Data sources were listed blow.

Semistructured individual and group interviews

Four participant groups provided key data for this research: (1) Older people; (2) nursing lecturers and academic leads/managers, who are responsible for curricular; (3) nurse educators in the practice setting; and (4) student nurses. Using an ethically approved information and consent process and questions allowed us to include differing lines of inquiry. All interviews were recorded, transcribed, and forwarded to participants for feedback and verification.

The setting for interviews was negotiated with participants; for older people, this was generally in their homes. Some participants consented to a video recording in addition to text. Interviews with nurse educators and clinical workplace-based nurses were conducted at their workplace or online. Interviews with students were held as two lunchtime focus groups when students were already on campus. All interviews lasted 30-45 min. These interviews are the source of all the italicized quotations included below in the Findings and Discussion section. We presented captured text from interview participants to agree or amend prior to analysis.

Analysis of interview transcripts and participant narratives was undertaken using Braun and Clarke's (2006) six-step approach: Familiarization, coding, generating themes, reviewing themes, defining and naming themes, and writing up. In application, we found that the first three phases, as we read and reread participant contributions as researchers separately and together, enabled selecting text for meaning and coding and comparing/agreeing our findings to define and name themes. Videos were edited to accentuate these emerging themes and present the essence of the older participants' stories to complement rather than duplicate the content of the text narratives to expand uses for learning and teaching outcomes. Similarly, revisiting advisors and colleagues, feedback from the Komiti Kaupapa Māori research, our own reflections from attending conferences, and the ongoing review of literature all informed our thinking around coding, theming, and reviewing. In the writing-up phase, we compared the themes identified inductively with those identified in the underlying literature review, ensuring alignment with our research question about what student nurses needed to know for effective practice in culturally centered healthcare of the elderly.

Quantitative analysis of clinical placement evaluations

Nursing programs in New Zealand require evidence of

feedback from practicum experiences (Nursing Council of New Zealand, 2024) and in our program student nurses completed an anonymous evaluation to share learning experiences and challenges after each clinical placement. As a standard clause, completion and submission of these surveys acknowledge consent that data may be used for studies that aim to improve the education experience for future cohorts. For this project, we drew on two years of feedback from year one and year three students after their older persons/aged healthcare placements. We were interested only in the section of the survey about culturally grounded care and its observance, or lack thereof, especially but not only related to Te Tiriti and respecting kaupapa Māori principles. Eliminating incomplete and unapplicable responses resulted in 48 postplacement survey evaluations.

Data were then formatted and exported to SPSS software (https://spssau.net/) for descriptive and inferential analyses. First, the responses to all questions were summarized. The frequencies and proportions of responses in each response category (on a four-point scale: Strongly disagree, disagree, agree, strongly agree), along with corresponding bar charts, were reported. Regression analysis was conducted to establish whether four independent variables (prior to arrival, orientation, and learning resources; support quality, department; area of placement perception; and quality of institutional supervision) predicted the variation of a dependent variable (overall satisfaction).

Responses to three open-ended questions extracted from response forms revealed a somewhat repetitive nature, and the researchers decided that running individual content or thematic analyses for each set of responses would not produce a meaningful outcome. Instead, responses were compiled as a single body of text and analyzed using Leximancer, an exploratory content analysis software (https://www.leximancer.com/). Leximancer automatically detects groups of words (*i.e.*, concepts) that occur together throughout the text, extracting these semantically connected words and then developing categorical dictionaries to code text segments. Researchers used the Leximancer categorization process to further assist the identification of key themes from students clinical practicum evaluations and their experiences.

Document analysis of student assessment reports

An analysis of preexisting text is often used with other types of data for triangulation and to increase the trustworthiness of a study (Morgan, 2022). In this study, we had access to quality improvement (QI) projects focusing on nursing students' work with a client/resident to improve their health and well-being, followed by an assessment report about their project and its outcomes. The 157 reports, most comprising two to three pages, were reviewed to identify the extent to which students were applying their education in cultural safety with older persons in their care. The document analysis followed the same thematic analysis approach undertaken with interview transcripts, although in the interests of practicality, given the volume of material, the first two steps of familiarization and coding occurred simultaneously.

Participants and recruitment

We contacted a range of organizational experts, local multicultural organizations, the New Zealand-China Friendship Society, and local government and volunteer groups to encourage the participation of older people representing a cross-section of backgrounds, ethnicities, and experiences. Furthermore, our Komiti Kaupapa Māori nursing colleagues supported the recruitment of Māori participants, attended some of the interviews, and supported engagement. Thirty interviews were conducted with 16 participants, including family members and partners. Four from this group withdrew from the study, preferring not to have their stories publicly available; however, they consented to contribute excerpts to our final report.

Recruiting nurse lecturers/academic managers, and clinically placed nurse educators was simpler, as these participants held roles that were part of established relationships and education networks. Third-year nursing students were recruited through an in-class invitation from their lecturer on our behalf.

A total of 19 participants were of European descent, 12 Māori, 6 Chinese, 2 Filipino, and 2 Pacific Islanders (Table 1).

FINDINGS AND DISCUSSION

As described, this study drew on multiple sources. Quantitative data came from analysis of students' clinical evaluations, and qualitative data from document analysis of student projects as well as interviews with several stakeholder groups: Older people (participants A-L), lecturers and academic leads, clinically based student nurse educators, and nursing students. Naturally, responses from different data sources ranked items differently or prioritized some issues over others. Consequently, an initial presentation of findings includes a series of themes according to the source (Honeyfield & Fraser, 2025). However, for the purposes of this article, there were sufficient commonalities that these findings could be regrouped and presented thematically under five key banners: Positivity and wellness, thoughtful language, social justice versus agism and bias, cultural

Table 1: Summary and ethnic identity of participants (*n* = 46)

Category	NZ European	Māori	Chinese	Indian	Filipino	Pacific Islander	Total
Older adults	2	4	5	3	1	1	16
Nurse lecturers and leaders/managers	7	3	1	1	-	-	12
Clinically based nurse educators	3	1	-	-	-	-	4
Nursing students	7	4	-	1	1	1	14
All	19	12	6	5	2	2	46

NZ, New Zealand.

practices, and professionalism in practice. Since most of the impactful commentary came from the interviews, the following section may appear to place less weight on survey and student report data. However, we retained the essence of all contributions, unified by the guiding research question about what student nurses need to know to provide positive healthcare experiences for older people and respect cultural identity.

Theme 1. Positivity and wellness

"It's the lucky people in life that get to be old" (Participant G). "You are born, you grow up, you get sick, then you die. All people must walk this four-steps [sic] path. So why should you worry?" (Participant F). "Life has its cycle, and we all live and die. We need to recognize and respect that process, not just attempting [sic] to fix people up" (Participant B).

While numerous studies and statistics about the medical and social determinants of aging include frailty, poor health, loneliness, and depression, this research adopted the position promoted by the New Zealand Ministry of Health's (2016) *Healthy Ageing Strategy* and the United Nations' (2024) *Decade of Healthy Ageing*. As in these reports, it was clear that older participants defined themselves by their enjoyment of life, rather than through what they could not do or no longer had. Participants reported that they had had to overcome significant medical events and make challenging life decisions to reach this positive, thankful place, yet these hurdles had not defined them.

Participants belonged to community groups, held leadership positions, volunteered, led neighborhood watch, and supported preschool and language development. One participant developed a series of Chinese language resources and books as a legacy for New Zealand. Others provided support and translation services for others of their culture who were undergoing treatment in the healthcare system. The participants' appreciation and pragmatic enjoyment of life were reflected in all cultural groups: They walked, gardened, played cards, and watched television. Mostly, however, they talked about spending time with their family and friends.

Many older participants, particularly Māori, Chinese, and Indian, positively attributed their well-being to close bonds with family. They emphasized how caring for elders is seen as key within their cultures, and many lived together in extended households, assisting with the care of grandchildren and home chores. Family provided transport and help with English; one person told us they didn't know how people managed without daughters. When families lived at a distance, participants told us about the importance of regular visits, Facebook, and communication technology calls. Through a cultural lens, the researchers found extensive congruence in outlook (Hardin *et al.*, 2014), even while different individuals' experiences were dictated by context, especially geographic.

When asked how nurses and the healthcare system could support families, participants shared experiences of how hospital stays had been improved when staff welcomed family. This included stays in intensive care units, traditionally a setting where policy limits access to and number of visitors around patients. They appreciated it when family members could bring in familiar foods, say karakia (prayers), and help nursing staff with traditional knowledge and protocols to make the older family member's stay in the hospital less stressful.

Student nurse educators who were responsible for oversight and assessment of students during clinical placements also described measures such as this, emphasizing a holistic approach to health and recognizing the important role emotional and spiritual elements play in mental and physical healing and well-being. They, too, wanted students to endorse a strengths-based perspective of older people's health and encouraged students to undertake quality improvement projects (an important assessment requirement for students during their Aged Residential Care placement) that focused on wellness initiatives and improvements rather than medical management interventions.

Students were well prepared for this way of thinking about older age, with a curriculum that focused on an appreciative, patient-centered, and holistic understanding of wellness. The shock of caring for older people, for

them, was often when they attended a facility with an almost entirely medical and treatment-oriented approach to care, and the social aspects of care were passed over. Conversely, several students reported formative learning experiences, describing the development of meaningful connections with the older people in their care. Students reported they learned not only about their lives before the medical events for which they were undergoing treatment but about their plans for resuming roles, tasks, and responsibilities once they were discharged. A holistic appreciation that people are multifaceted, more than just their medical status, aligns directly with Kaupapa Māori research principles, as well as the concept that health is affected by the dimensions of family, social connectedness, mental and emotional well-being, physical health, and spirituality (Mikahere-Hall, 2017).

Theme 2. Thoughtful language

"The nurses were good—they mostly called me Mr D_____, so very respectful" (Participant C). "What nurses need to do is to stop doing things, just sit there and be with the patient. Learn their name and use it. Then listen!" (Clinically based nurse educator). "One thing I think is important is language: Training students to say, we 'assist' someone to have a meal. We 'assist' them to take a shower. We don't feed people, or wash people—we're not at a zoo! We don't 'do' things to people" (Lecturer).

Every older adult participant mentioned language and communication and emphasized how important it was to be seen as an individual, to be called by their name, and to have their unique identity recognized. Two things they disliked came up in several interviews. The first was the use of over-simplified, patronizing, or infantilizing language, such as being addressed as "love", "sweetheart", or "dear". This created a sense of being stereotyped, patronized, or coerced into compliant acceptance of a schedule or treatment. Nursing lecturers agreed and said they often raised this concern in the classroom, but with so many international healthcare professionals in New Zealand, this was often a cultural norm from their home countries and needed conscious redirection. Viewing these findings through a cultural lens (Hardin *et al.*, 2014), we interpret the use of terms like "love" or "dear" not merely as linguistic oversights, but as manifestations of a specific, often Western, cultural framework of informal care. When this framework is applied without translation in a superdiverse context like New Zealand, it creates cultural dissonance, stripping patients of their individual identity and reinforcing a power imbalance and the non-transferability of certain caring practices.

A second concern expressed by several older participants was the use of "hospital" language, by which nurses assumed that patients understood rather than taking the time to check and recheck understanding. For example, nurses often assess pain thresholds by asking patients to rate their pain on a scale of 1 to 10. Older people from non-Western cultures want to be helpful, one participant told us, and so rather than asking for an explanation of what healthcare professionals may consider everyday vocabulary through this numerical analysis, they just offer a number arbitrarily to satisfy the questioner.

Clear, kind, simple language is even more important when a patient is speaking their second language. Several second language participants reported the effect of stress, such as unplanned hospitalization, on their ability to understand language, and therefore what was going on around them, making informed consent for procedures problematic for all parties. Nursing students shared some of the strategies that they had learned or seen used in healthcare settings, such as inviting family members to sit in and translate, finding interpreters through the hospital service or local ethnic societies, and using phone translation apps to support both oral and written communication.

Several participants also mentioned the value of using a few words in the patient's language. Language is fundamental to culture and people's identity (Edwards, 2010; Edwards *et al.*, 2018) and knowing that someone has tried to connect in this way can be the first step in establishing trust. In New Zealand, a bicultural and bilingual country, recognition and use of te reo (the Māori language) is supported by the BN curricula, as it shows respect for Māori and helps them feel culturally safe and validated in healthcare settings (Emery & Emery, 2021; Podsiadlowski & Fox, 2011).

One area in which both lecturers and students agreed that effective communication was essential was taking a patient history. This is not just about getting accurate medical information but is the start of the patient-caregiver relationship and a chance to practice human-centered care. Older people wanted nurses to know that they were people, just like those caring for them. Older adults have a full and rich psychosocial backstory, they have likely experienced love and loss and had families, careers, and public and private lives. As Kaupapa Māori theory reminds us, all people are connected—to their ancestors and descendants, their rivers and mountains, and their faith and beliefs (Mikahere-Hall, 2017; Podsiadlowski & Fox, 2011). Active listening and checking reciprocal understanding are therefore integral to meaningful communication and comprise some of the skills nursing students need to learn and practice to engage effectively with those they are caring for, whether they share a common cultural background.

Theme 3. Social justice versus ageism and bias

"I particularly went back to university when I was 60 so that I could do political science and have the right tickets to be able to be heard … I wanted to honor later life. I found it really sad that people were expected to just disappear, and I felt a deep sense of them being missing…" (Participant A). "They have the attitude, this is normal for that patient, this is just old age, they are complacent, but actually it's not normal. Not ok" (Student nurse). "What you saw isn't ideal perhaps, but what can you do? How can you work around this? Focus on quality improvement, not blame. Use this in your reflections. Focus on the goal: You can make a difference in a person's day" (Clinically based nurse educator).

While New Zealand has a superdiverse population, many of our institutional policies and public service practices have been designed to meet the needs of European New Zealanders, followed by Māori and Pacific Islanders. We already have well documented gaps in health outcomes for these three groups; what now of the other diverse populations who live alongside us but are marginalized from mainstream, Westernized society.

One participant from a law, immigration advising, and education background referred to the way in which such people can "fall through the cracks" when they encounter systems with which they have no prior experience. Now a New Zealand resident, he is often called in by the local hospital to assist when someone from his own, third-world home country is admitted for care. He shared a story of supporting a seasonal horticultural worker temporarily in New Zealand who needed emergency hospital care and who was completely overwhelmed by needing to understand his condition and consent to surgery. As he related to us, had he not been available, the nursing staff would have struggled to accommodate the man's needs, and yet, legally, both English and non-English speakers are equally entitled to government services. It is the providers' responsibility to have care strategies and resources available for the entire population they serve, this participant told us, including translators, ethnic group leaders, and linguistic experts.

Equity is not just about ethnicity. Student nurse participants talked to us about how practices they encountered during clinical placements in residential care facilities for older people were highly indicative of a bio medicalized approach to care, an approach they were being taught in class was outdated and disempowering. Students noted assumptions that all residents conformed to the same pattern of increasing debility and frailty, evident in limited recreation and mobility options, inflexible scheduling, and staff avoidance of "troublesome" patients. Another example was communication from facility management via notices posted in communal areas, automatically excluding the visually impaired, immobile, or socially reclusive from taking part, or being advised of planned changes to routine. These comments from interviews were also borne out by the Leximancer concept map from the document analysis of student projects, in which "work experience" and "working with residents" appeared in the top four causes of impact that influenced students' overall experience, often detrimentally, of clinical placement in aged residential facilities.

Agism, stereotyping, and unconscious bias education must be combatted in class, healthcare settings, and the wider community. Lecturers told us that the first step they believed students needed to take was to recognize their own cultural identity and its holistic nature, and how they thought about differences in world views between their culture group and those of others. Lecturers also stressed that students were undertaking clinical placement to learn and contribute but that it was not their role to challenge and confront behaviors they felt were demeaning. What they could do was model more respectful conversation or undertake quality improvement projects that would allow them to make a small but major difference to one client's quality of life.

Theme 4. Cultural practices

"New Zealand is not just bi-cultural, it's a multicultural society we need to prepare for. We're not connected at all. We could be doing a better job" (Nursing academic manager). "In some countries, people can be caring but they can also be over-involved. I tell them, no touching, no endearments, this is not your grandma" (Lecturer). "In Chinese culture, we protect our loved ones from bad news if we can. Mum's own mother died of a tumor, and all the family knew, including Mum's sister who is a doctor, but no one ever told her it was anything but an infection" (Participant K).

The key tenets of cultural lens theory are observation and critical inquiry (Hardin *et al.*, 2014). In our study, the academic leads and lecturers recognized that older people accessing care in any health setting could be alienated unnecessarily and unintentionally when their traditions were not recognized. They talked about how many nursing students struggled to think that racism might be prevalent in our society, how, for any ethnic national majority group, the world has been designed for them, and how privilege is hard to see (Amundsen, 2018).

It can be hard to change another's cultural lens, but lecturers also agreed that this was the role of education. Alongside the mandated bicultural and Te Tiriti training, a multicultural approach to preparing students was necessary. One strategy this participant group identified

was the rich cultural capital found in increasingly diverse student nursing classroom groups. Ideas for activities to prepare students for working with both older adults and different cultural groups included scripts for role-playing as laboratory exercises that demonstrate a challenging cross-cultural event: A family member's report of a relative's treatment experience, enacting Māori values such as respect for elders and traditional knowledge, practicing prayer and singing as part of preparation for cultural events, unpacking case studies of ethical practice/breaches, hearing from medically trained translators and using translation phone apps for text and speech, and simulating aging issues the older person might be dealing with such as force-feeding, tremors, cognitive confusion, and sight and hearing impairments.

Finally, students can be introduced to very specific examples of cultural dissonance. One memorable example offered by one of our older participants was that, in their culture, health recovery means eating simple foods at room temperature so as not to shock the body—so, never jelly or ice cream, which are staples in New Zealand recovery wards. Some cultures do not like raw foods, such as salads or sushi, or being offered unboiled water. For some New Zealand Māori, native plant remedies and traditional treatment knowledge are highly respected, and the concepts of Tapu (sacred, prohibited, restricted) and Noa (ordinary, unrestricted) are aligned with the spiritual aspects of holistic health and whole person well-being. In kaupapa Māori theory and practice, healing depends on the correct protocols to balance these life elements and restrictions (Edwards, 2010; Edwards *et al.*, 2018).

Medical systems are also different. A Chinese nurse lecturer suggested introducing students to the notion that health systems varied across countries, saying, for example, that in China, there is a good deal of preventative training and workshops provided by hospitals, doctors, and community nurses, whereas in New Zealand, the expectation is that you see a doctor after you are sick, not before. Another difference is that our Westernized model of practicing medicine means that primary communication is with the patient, who must be kept fully informed about their condition and treatment; in other cultures, it is seen as more beneficial to protect the sufferer from unwelcome news and stress.

Analysis of both student evaluations following their clinical placement and quality improvement project reports demonstrated that students were seeing positive examples of cultural responsiveness, such as the following: (1) Staff and residents appreciating support workers who were Māori, and spoke in te reo. (2) Holding church services on a rotating worship day and Sunday schedules so that as many denominations as possible were catered to. (3) Celebrating Pacific Island Language Week with activities and encouraging everyone to use greetings from these languages. (4) Holding a multicultural day with costumes and different foods, supporting sharing and interactions. (5) The death of a Māori patient was followed by staff who performed karakia and waiata as the hearse holding the body drove away.

The core values illustrated here and endorsed by all participant groups as supporting cultural responsiveness were faith and religiosity, hearing your first language, community and inclusion, and explanations and tools from an Indigenous, not a Westernized, perspective. These findings are also well supported by the literature (Guo *et al.*, 2021; Olsen *et al.*, 2020).

Theme 5. Professionalism in practice

"The Competencies encourage students to ask: The background of the person, the social situation, what does the client want? What are their goals? The client is not just someone in the bed they have to do things for/to" (Academic manager). "I have students who tell me, 'All the cultural safety things you taught me, they never made sense until I got into the real world'" (Lecturer).

The Nursing Council of New Zealand registers and regulates registered nurses and approves and accredits all nursing education organizations to deliver programs that meet both educational program standards and *Registered nurse standards of competence* (Nursing Council of New Zealand, 2024). This document lays out a high-level direction for nurses working with Māori and other cultures. Evidence of working within and toward these competencies is required by students and nurse educators in theory and practice as formal assessments and following all clinical placements.

Nursing students and nursing lecturers are therefore highly focused on ensuring that placement experiences provide quality learning opportunities, and it is clear that findings from students' post-residential care facilities placement evaluations were predominantly ranked as positive (83.0%). However, while the students might have liked the setting and the older residents with whom they interacted, most participants (78.4%) felt that this did not make them more likely to apply for a position within this area of nursing after they graduated. Some of the most noticeable factors negatively affecting student nurses' placement experience were: (1) The lack of useful orientation (30.0%). (2) The lack of adequate preparation prior to the clinical practicum placement (16.7%). (3) No staff ID and little communication about residents were provided (25.0%). (4) No access to relevant resources (28.0%). (5) The lack of preceptors' (registered nurse in practice) support with learning opportunities (25.0%).

Student nurses wanted to be treated professionally, to contribute, and to be guided by a knowledgeable and experienced preceptor; however, they reported inconsistent and variable support and feedback. Yet, clinical placement in residential care for older people is a requirement in all nursing programs, and there are calls for this requirement to be reconsidered. Several nurse lecturers and leaders suggested that students should be in the community, working with healthy older people in other settings and one participant suggested settings such as, "like in the library getting their books. Or helping in soup kitchens, playing cards". This participant continued, "If we want nursing graduates who understand and support cultural identity and positive aging, we need to send them to practice in settings where these features of societal change are already happening".

CONCLUSION

This research centered on BN nursing education and considered what student, and graduate nurses need to know for a healthcare career in an increasingly older, multicultural New Zealand. Participants confirmed that nursing graduates continue to be disinclined to work in older persons' residential care environments and continue to report agist attitudes, as reported in the literature. Yet, some reports of perception change were also apparent, with nursing students creating culturally responsive initiatives when working with older people. Lecturers and clinically placed staff also concurred with the literature regarding the paucity of learning resources and pedagogical approaches to fostering positive aging concepts and cultural responsiveness.

The methodology, including older people, students, and nurse lecturer participants, led to thoughtful and naturally occurring testimonies that were developed into a range of interactive and visual resources as key research outputs. When asking older people what messages they wanted to pass on to the future generation of nurses, their "direct voice" provided meaningful authentic and heartfelt feedback. This unscripted, natural narration provided interpersonal communication starters for nurses to consider the messages conveyed in each case study.

In presenting the resources developed as outcomes from our findings, especially the personal stories as evidence for practice, we confirmed previous research stressing the urgent need to improve BN curricula and learning, teaching, and assessment resources as essential preparation for clinical practice.

The following learning and teaching resources were developed as outcomes of this research.

Teaching resource 1: A series of 12 written narratives with participants' photos, describing their experiences of healthcare and aging related to their own cultural identity and linked to the Nursing Council of New Zealand's Standards of Competency for registered nurses (Nursing Council of New Zealand, 2025). Each narrative includes suggested questions and an example teaching plan as a guide for use.

Teaching resource 2: Video clips of some of the older interviewees talking about their aging and health experiences. Four participants from different ethnicities spoke about aspects of living as older people in the community and making links between their cultural traditions and health. The videos ranged between four and eight minutes, covering topics such as the migrant experience, Māori medicine, political advocacy, intergenerational learning, the impact of using legends to share traditional wisdom, and more.

Teaching resource 3: A poster entitled "What older adults in Aotearoa would like nursing students to know: Findings from the research". This resource is designed to foster conversations with and between students about cultural consciousness and is useful for reflecting on and preparing for clinical practice.

Naturally, the development of curricula and learning resources is only part of the picture. To create culturally safe, competent, and skilled graduates to support optimal health outcomes for older people, more interrelated health and education sector actions are required. Specific recommendations include: (1) Improve nurse lecturer professional development by tracking learning initiatives across the three years of the nursing program to embed culturally relevant, positive aging, and well-being approaches to advance health outcomes in all clinical settings with older people. (2) Create structural change in the mentoring and supervision of both lecturers and students to foster confidence in developing culturally safe care initiatives. (3) Increase opportunities for students to work with healthy older people to gain insights into inspiring career choices and specialty practice in older people's healthcare. (4) Create dedicated education units (education and health service provider partnerships) to mentor and support student learning in clinical practice with older people in residential settings.

Growing older means a cultural shift in and of itself. In both education and healthcare, the process of learning about cultural consciousness and unconscious bias education is a fundamental step in preparation for multicultural learning, teaching, and research. Opportunities for students to recognize their own and others' agist attitudes is important, as is understanding the worldviews and different lenses of others. Supporting student rethink the language they use about aging that reduces a

deficit approach, such as older people "thriving in later life", "aging well", and "healthy aging", and continue to develop deep curiosity about the nature of health and well-being in all assessment and care activities with older people.

The recommendations offered above are intended to address our guiding research purpose: Understanding how best to prepare student nurses for culturally centered work in older persons' healthcare. We asked people with different vested interests in the outcome about what they thought and then extrapolated actionable strategies. While our work reflects a small, localized data platform, our findings echo the challenges across international nursing literature to foster nursing curricular changes and nursing education towards improved care and outcomes for older people's health and well-being. We look forward to the next phase of the project, implementing and evaluating these ideas, along with further research to expand our platform and address the scale limitations of this initial inquiry.

Limitations

This project included a comparatively small number of participants, so the findings cannot be said to be generalizable across nursing education in the tertiary sector. It would be interesting for future research to survey larger numbers from all stakeholder groups to verify the findings and suggestions offered here. We also acknowledge the cultural specificity of the findings. Our study focused on European New Zealanders, Māori New Zealanders, and Chinese New Zealanders in one region of this country. Further research to extend the number of cultures included would also be desirable.

DECLARATIONS

Acknowledgement

None.

Author contributions

Honeyfield J: Conceptualizations, data collection, writing, review, and submission. Fraser C: Conceptualization, data collection and analysis, original writing, editing. All authors have read and approved the final version.

Source of funding

This study was supported by Toi Ohomai Institute of Technology and Ako Aotearoa New Zealand Center for Tertiary Teaching Excellence (# TRC 2024.006; Date 28 February 2024).

Ethical approval

This project was approved by the host institute's Research and Human Ethics Committee (# TRC 2024.006; Date 28 February 2024).

Informed consent

Informed consent was obtained from all participants.

Conflict of interest

The authors have no conflicts of interest to declare.

Use of large language models, AI and machine learning tools

None.

Data availability statement

Data used to support the findings of this study are available from the corresponding author upon request. Glossary of Māori terms used in this paper is provided in the supplementary materials.

REFERENCES

Amundsen, D. (2018). Decolonisation through reconciliation: the role of Pākehā identity. *MAI Journal: A New Zealand Journal of Indigenous Scholarship*, *7*(2), 140-154. https://doi.org/10.20507/maijournal.2018.7.2.3

Bhattacherjee, A. (2019). *Social science research: principles, methods, and practices*. University of Southern Queensland.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Edwards, W. J. W. (2010). Taupaenui: Maori positive ageing: a thesis presented in fulfilment of the requirements for the degree of Doctor of Philosophy in Public Health at Massey University, Palmerston North, New Zealand. Retrieved November 19, 2025, from http://hdl.handle.net/10179/1331

Edwards, W., Theodore, R., Ratima, M., & Reddy, R. (2018). Māori positive ageing. *New Zealand Medical Association Journal*, *131*(1484), 1-12.

Emery, W., & Emery, T. (2021). *Koeke a ko ake nei: Towards intergenerational positive ageing for Ngati Pikiao*. Health Research Council of New Zealand.

Fisher, S. Factors that influence nurses" attitudes towards working with older adults: A qualitative descriptive study. Auckland University of Technology (Unpublished Master's thesis). 2018.

Foster, P. M. (2020). What undergraduate nurse education actually teaches student nurses about people named as older: A Foucauldian discourse analysis. Retrieved November 19, 2025, from https://hdl.handle.net/10292/13298

Guo, Y., Yang, L., Zhu, L., Wan, Y., Zhang, S., & Zhang, J. (2021). Willingness and associated factors of working with older people among undergraduate nursing students in China: a cross-sectional study. *BMC Nursing, 20*(1), 113. https://doi.org/10.1186/s12912-021-00639-7

Hardin, E. E., Robitschek, C., Flores, L. Y., Navarro, R. L., & Ashton, M. W. (2014). The cultural lens approach to evaluating cultural validity of psychological theory. *American Psychologist*, *69*(7), 656-668. https://doi.org/10.1037/a0036532

Heath, S., Hudson, S., Abd Aziz, N., Crawford, R., Taylor, P., Kabbar, E., Solomon, B., Foster, P., Munro, V., Page, M., Rogalin-Henderson, M., Mall, R., Johnson, S., Groube, J., Grogan, A., Adesina, C., Soper, F., Eleno, M., Phillips, J., & Topp, M. (2024). *Research Report Series: Aotearoa New Zealand student nurses" perceptions of working in aged care: August 2024*. Unitec ePress. https://doi.org/10.34074/rsrp.110

Hofstede, G., Hofstede, G., Minkov, M., & New, M. H. (2010). *Cultures and organizations: software of the mind* (3rd ed). McGraw Hill Professional.

Honeyfield, J., Sims, D., Proverbs, A., & Rowe, W. (2020). Fostering quality improvement educational outcomes in undergraduate nursing curricula:

Graduates" perceptions of their practices for change. *International Journal of Business Tourism and Applied Sciences, 8*(1), 41-50.

Honeyfield, J., Fraser, C., & White, M. (2021). *What is good practice in aged healthcare provision A literature review of international studies informed by cultural context: The Aotearoa New Zealand perspective*. Te Pūkenga/Toi Ohomai Institute of Technology.

Honeyfield, J., & Fraser, C. (2025). *Readying nursing students for culturally grounded practice that supports a new vision of older persons" healthcare environments*. Ako Aotearoa.

Hunt, G., Verstappen, A., Stewart, L., Kool, B., & Slark, J. (2020). Career interests of undergraduate nursing students: a ten-year longitudinal study. *Nurse Education in Practice*, *43*, 102702. https://doi.org/10.1016/j.nepr.2020.102702

Iseke, J. (2013). Indigenous storytelling as research. *International Review of Qualitative Research*, *6*(4), 559-577. https://doi.org/10.1525/irqr.2013.6.4.559

Lea, E., Marlow, A., Altmann, E., & Courtney-Pratt, H. (2018). Nursing students' preferences for clinical placements in the residential aged care setting. *Journal of Clinical Nursing*, *27*(1-2), 143-152. https://doi.org/10.1111/jocn.13859

LiLACS NZ. (2015). *Participation in Māori society in advanced age: Findings from LiLACS NZ*. University of Auckland.

LiLACS NZ. (2016). [Life and living in advanced age: A cohort study in New Zealand]. University of Auckland.

McKenzie, E. L., & Brown, P. M. (2014). Nursing students' intentions to work in dementia care: influence of age, ageism, and perceived barriers. *Educational Gerontology*, *40*(8), 618-633. https://doi.org/10.1080/03601277.2013.863545

Mikahere-Hall, A. (2017). Constructing research from an indigenous kaupapa māori perspective: an example of decolonising research. *Psychotherapy and Politics International*, *15*(3), e1428. https://doi.org/10.1002/ppi.1428

Ministry of Health NZ. (2016). *Healthy ageing strategy*. Ministry of Health-NZ.

Moquin, H., Seneviratne, C., & Venturato, L. (2018). From apprehension to advocacy: a qualitative study of undergraduate nursing student experience in clinical placement in residential aged care. *BMC Nursing*, *17*(8),1-13. https://doi.org/10.1186/s12912-018-0277-z

Morgan, H. (2022). Conducting a qualitative document analysis. *The Qualitative Report*, *27*(1), 64-77. https://doi.org/10.46743/2160-3715/2022.5044

Nursing Council of New Zealand. (2011). *Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice*. Nursing Council of New Zealand.

Nursing Council of New Zealand. (2024). *Nursing education programme standards*. Nursing Council of New Zealand.

Nursing Council of New Zealand. (2024). *Registered nurse standards of competence*. Nursing Council of New Zealand.

Olsen, C. F., Debesay, J., Bergland, A., Bye, A., & Langaas, A. G. (2020). What matters when asking, "what matters to you?" - perceptions and experiences of health care providers on involving older people in transitional care. *BMC Health Services Research*, *20*(1), 317. https://doi.org/10.1186/s12913-020-05150-4

Parker, C. N., Harvey, T., Johnston, S., & MacAndrew, M. (2021). An exploration of knowledge of students and staff at residential aged care facilities and implications for nursing education. *Nurse Education Today*, *96*, 104639. https://doi.org/10.1016/j.nedt.2020.104639

Podsiadlowski, A., & Fox, S. (2011). Collectivist value orientations among four ethnic groups: Collectivism in the New Zealand context. *New Zealand Journal of Psychology*, *40*(1), E5-18.

Smith, L. (2013). *Decolonizing methodologies: Research and indigenous peoples* (2nd ed.). Zed Books.

Statistics New Zealand. (2022). *One million people aged 65+ by 2028*. Statistics New Zealand.

Swedberg, R. (2020). Exploratory research. In C. Elman, J. Gerring, & J. Mahoney (Eds.), *The production of knowledge: Enhancing progress in social science*. Cambridge University Press.

Taylor, D. (2024). Migrant nurses" experiences in the workplace—what support do they need to thrive *Kaitiaki Nursing New Zealand, 26*(10), 35.

United Nations. (2024). *UN Decade of Healthy Ageing's database of promising interventions to prevent and respond to abuse of older people*. United Nations.

Wilkinson, J., Neville, S., Huntington, A., & Watson, P. (2016). Factors that influence new graduates" preferences for specialty areas. *Nursing Praxis in New Zealand*, *32*(1), 8-19.

Yin, R. K. (2014). *Case study research design and methods* (5th ed.). Sage.