How can Nursing Education and Development Strengthen Operational and Clinical Practice to Enhance Quality Outcomes within Te Whatu Ora, Health New Zealand, Waikato District?

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ABSTRACT

Aotearoa New Zealand's health system requires a well-equipped nursing workforce capable of delivering effective care to the population it serves. To progress this aim, the Professional Development Unit within Health New Zealand (Te Whatu Ora) Waikato District, provides a comprehensive range of post-registration education and development opportunities. An earlier project examined the integration and streamlining of education and development functions resulting in development opportunities. Building on that foundation, the present research explored how nursing education and development can more effectively support operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District.

A single embedded case study design, informed by bicultural approaches and critical appreciative processes, was used. The study was situated within a critical interpretive paradigm and underpinned by critical social theory. Two units of analysis guided the inquiry: strategic intentions identified through document review, and stakeholder perspectives gathered via focus groups and individual interviews. Data were analysed using Braun and Clarke's (2022) reflexive thematic analysis

The strategic intentions units of analysis evidenced that the Waikato DHB Strategic Plan (2016) and the Nursing at Waikato Strategy (Waikato DHB, 2017) positioned education as central to achieving effective health service delivery. However, the intent was not consistently reflected in other documents and organisational structures. The stakeholder perspectives units of analysis confirmed the presence of a learning culture in parts of the organisation, while revealing gaps between operational efficiency and aspirations for quality outcomes for patients/tāngata whaiora.

Three interconnected themes were identified. The first theme, 'impact and influence', highlighted the reactive nature of practice environments; the significance of nurses' presence in care delivery; and tensions between clinical and management priorities, workforce composition, and siloed structures. The second theme, 'safe, shared practice growth', drew attention to the need to equip nurses with essential skills, the value of mentoring for individual and team development, and the importance of interprofessional collaboration. The final theme, 'embedding identity, equity, and Te Tiriti o Waitangi in practice', emphasised Kawa whakaruruhau, cultural safety, Te Ao Maori worldviews, identity, and Tuakana–Teina relationships. Together, these findings demonstrate that strengthening education within governance and leadership structures, integrated learning cultures, and bicultural practice are foundational to operational and clinical practice to enhance quality outcomes.

The study proposes several actions to strengthen education within governance and leadership structures, and facilitate learning cultures and bicultural practice. Recommendations include embedding strategic priorities across operational management, clinical practice, and education and development; integrating education and development leaders within governance at organisational and service levels; involving education and development teams early in service planning; and developing culturally grounded indicators of quality that reflect Te Ao Māori values, equity, and relational care.

This case study contributes insights into how integrated educational, clinical, and operational systems can strengthen practice and enhance quality outcomes. The findings provide a foundation for broader application across comparable health districts.

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ACKNOWLEDGEMENTS

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools (unless it is clearly stated and referenced, along with the purpose of use) nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university of other institution of higher learning.

I have used Grammarly, MS Copilot, and ChatGPT for editing as per the guidance of my supervisors and the AUT Post Graduate Handbook.

Signed

Cheryl Atherfold

Date 2 February 2026

DEDICATION

“In every conceivable manner, whānau is the link to our past and the bridge to our future”

This work is dedicated to our daughter Brooke Jessie Atherfold

– he Wahine Toa nana i whiriwhiri te ora i roto i nga raru nui

GLOSSARY

Bicultural	A partnership of two people groups in Aotearoa New Zealand
Equipping/Equipped	Being prepared with the knowledge and skills that enable nurses to effectively deliver care to the required service standard
Equity	Fair and just, recognising that people do not come from the same place and require different input and approaches to achieve fair and just outcomes
Indigenous knowledges	Traditional knowledge systems embedded in cultural traditions
In-practice presence	Development and learning about the practice that occurs in practice
Manākitanga	Respect and value
Māori	Indigenous people of Aotearoa New Zealand
Operational leaders	Managers and directors of service delivery
Person-centred care	The person and their whānau/significant others actively participate in their own health care planning and shared decision making with health professionals reflecting individual values and beliefs (International Practice Development Consortium, 2021)
PDU	Professional Development Unit; nurses and midwives working within workforce and clinical education streams to facilitate workforce preparedness and development
PDRP	Professional Development and Recognition Programme; a formal programme that recognises levels of practice within a nursing competency framework (Nursing Council of New Zealand, 2016)
Quality outcomes	The degree to which health services are delivered increases the likelihood of desired health outcomes for individuals and populations; based on evidence-based professional knowledge aimed at being effective, safe, people-centred, timely, equitable, integrated, and efficient (World Health Organization, 2022).
RN	Registered nurse
Releasing time to care	A structured quality improvement programme adapted from the National Health Service, United Kingdom, for the Waikato context (Morrell, 2009)
Rōpu	Collective, group, connected across the area/district
Tāngata whenua	People of the land, original custodians

Te Ao Māori	The Māori world and worldview
Tane Toa	Strong man, male
Tangata whaiora	A person receiving health care, consumer, patient
Tikanga	Māori customs, values, and practices
Trendcare©	The programme and tool used for acuity workload management across Aotearoa New Zealand
Tuakana–Teina	Concept of relationship between older–younger; experienced–inexperienced (Ako Aotearoa, 2022)
Wahine Toa	Strong woman, female
Whānau	Family, significant others
Whakawhanaungatanga	A cultural process of establishing connections and strengthening relationships

CHAPTER I

1.1. Introduction

Increasing clinical demands and evolving service needs are reshaping healthcare delivery within Aotearoa New Zealand. Recent health system reforms in Aotearoa New Zealand have sought to address longstanding fragmentation by consolidating services under a single national organisation, Health New Zealand Te Whatu Ora, with Waikato designated as one of 18 districts (Ministry of Health [MoH], 2020a). Prior to these reforms, Te Whatu Ora Waikato was known as the Waikato District Health Board, one of 18 District Health Boards, each operating with its own governance structure and reporting directly to the Ministry of Health.

Te Whatu Ora, Waikato District is characterised by demographic diversity and a substantial rural and geographic spread, which creates distinct service delivery challenges. Effective strategic direction, robust operational management, and highly skilled teams are, therefore, essential to meet population needs. Nurses comprise the largest professional workforce and are central to continuous, safe, and culturally responsive care. Within this context, post-registration nursing education and development, coordinated by the Professional Development Unit (PDU) within Te Whatu Ora Waikato District, functions to prepare nurses for the specific demands of this practice setting.

In 2015, a district-wide initiative within the former Waikato District Health Board (DHB) aimed to address variability in nursing education by integrating and streamlining provision through the establishment of structured education and professional development teams. This initiative aimed to enhance clinical readiness and foster stronger alignment between educational programmes and frontline practice. A subsequent review, in 2016, tracked the implementation of the initiative's recommendations and reported notable improvements in post-registration education and development, particularly in reinforcing the connection between educational activities and clinical service delivery.

Despite these advancements, the review revealed a persistent and critical gap at the intersection of operational priorities, clinical practice, and educational provision. This misalignment was especially concerning given the initiative's original intent to achieve cohesive integration across these domains. Alongside the initiative, a new district wide strategic plan was introduced in 2016, positioning education and development as a centre of excellence for learning within the Waikato DHB (Waikato DHB, 2016). However, throughout 2017 and 2018, governance and service forums increasingly highlighted the need to reassess

how operational services could more effectively align with the clinical priorities of education and development teams to produce measurable improvements in care quality.

The evolving narrative prompted this research. In 2019, exploratory discussions with executive leaders were undertaken to examine perspectives and strategies for achieving deeper integration. While the initial project laid a valuable foundation, it only partially fulfilled its stated goals. A more comprehensive understanding of the systemic and structural barriers to integration was required. The current research commenced in 2019 with exploratory conversations, followed by a literature review and research design. It was confirmed in 2020, and data were collected in 2021. The timeline for data collection was impacted by the COVID-19 pandemic which impacted participant availability and was further delayed due to an organisation wide cyber-attack at Te Whatu Ora Waikato District impacting access to documents.

Accordingly, this qualitative case study investigated how nursing education and development can strengthen operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District. The study aimed to generate insights to inform the design of education structures capable of delivering sustainable, practice-driven improvements in healthcare quality. The central tension examined in this study arose from the different but interdependent roles of operational management, clinical practice nurses, and education and development teams. Operational management supplies infrastructure and resources; clinical nurses deliver frontline care; and education and development teams cultivate clinical reasoning, cultural competence, professional agency, and compassionate practice by ensuring knowledge and skills are fit for context. This study foregrounded how those functions intersect and where misalignment limited the translation of educational gains into sustained clinical and operational improvements.

This chapter situates the study within a broader policy and service environment; it provides the timeline and outlines the integration and streamlining project that catalysed the research and describes the features of health services in Aotearoa New Zealand relevant to the inquiry. It summarises post-registration nursing education and development activity within Te Whatu Ora Waikato District and reports preliminary discussions with health and nursing leaders that shaped the research focus and identified characteristics for investigation. The chapter concludes with the study rationale, explicit research aims and questions, a preview of the literature review and research design, and an outline of the thesis structure.

1.2. Researcher Positioning

At the commencement of this research, I was employed within the Waikato District as a Deputy Chief Nurse with leadership responsibility for the PDU which included portfolios in education, development, and workforce. As a co-author of the 2015 'Integration and Streamlining Project', I developed a sustained interest in understanding the ongoing issues and concerns that impacted the effectiveness of education and development initiatives.

My leadership experience across quality improvement, clinical, operational management, and education fostered a desire to apply research principles and methodological rigour to the process in contrast to the application of project management and change testing approaches. Narrative accounts and staff feedback about a disconnect between practice and education and development were the dominant catalyst for the research, particularly when it became apparent that, despite implementing all the recommendations in the Integration and Streamlining Project, the anticipated outcomes were not fully realised.

In my role as Deputy Chief Nurse, and as a member of the Nursing Directorate at Waikato DHB, I was engaged in education, development, and workforce activity across Aotearoa New Zealand and Australia. I remained in this role until 2021 when data collection for the research was undertaken. For this reason, particular attention has been paid to ensure ethical processes, including anonymity, of the data collected.

As a nurse who is pākehā with Māori whānau, endeavouring to practice in accordance with Te Tiriti o Waitangi requirements has been a priority across my career. I have been honoured to walk in partnership with wāhine and tane who have consciously guided my well-intended enthusiasm with strength and wisdom to generate clinical practice models of care, and workforce development models that render action and results. In keeping with these bicultural partnerships, their influence is woven throughout the research and Te Reo language is privileged within terminology and concepts.

1.3 Background Context of the Research

Aotearoa New Zealand operates a universal health system funded through public taxation and delivered principally via government-owned DHBs, now consolidated under Health New Zealand Te Whatu Ora (MoH, 2020a). The Health and Disability Service Standards specify the minimum requirements for safe service delivery and emphasise the necessity of an appropriately qualified and competent workforce (MoH, 2021). National population health

monitoring provides one indicator of system performance and the 2020 Health of New Zealanders survey reported that 87.2% of respondents rated their health as good (MoH, 2020b). Examination of population subgroups, however, reveals persistent inequities. In 2019 Māori life expectancy remained substantially lower than that of non-Māori (males: 73.4 vs 80.9 years; females: 77.1 vs 84.4 years), highlighting structural disparities in health outcomes and access.

A significant government review of the health system in 2020 identified systemic barriers to effective care and generated a set of reform recommendations that informed the policy shift to Te Whatu Ora (MoH, 2019, 2020a). The Waitangi Tribunal's Health Services and Outcomes Inquiry (Kidd, 2019) further located these deficits within a framework of Treaty obligations, concluding that longstanding inequities for tāngata whenua amount to a design failure in the health system when measured against Te Tiriti o Waitangi (Kidd et al., 2019; Māori Dictionary, 2022). Consequently, an equity imperative frames national and district-level planning (MoH, 2018), recognising that failure to address social determinants and system design will perpetuate poorer outcomes for Māori and other vulnerable groups.

In addition to inequities affecting Māori, other groups, including Pacific peoples, children, older adults, rural communities, migrants, people with disabilities, and those with mental health conditions, experience disproportionate adverse health outcomes, reflecting entrenched differences in social determinants such as income, housing, education, and justice system exposure (MoH, 2018). These local inequities mirror global priorities articulated by the International Council of Nurses (ICN; 2021, 2024) and the World Health Organization (WHO; 2022), which emphasise workforce sustainability, equitable access, and system resilience as central to meeting increasing health demands.

The increasing global demand for health services, combined with an insufficient and ageing workforce, presents significant challenges for safe, effective, care delivery. The ICN (2021) described these pressures as a critical global dilemma for nursing workforce sustainability. In Aotearoa New Zealand the needs described by the ICN and WHO are amplified by projections of substantial retirements among experienced nurses, which threaten the retention of practice wisdom, organisational knowledge, clinical judgment, and resilience accrued over decades of practice (Watson, 2014). These attributes were developed through longitudinal exposure to evolving population health needs, shifting models of care, and constrained resources, and underpin both clinical and logistical effectiveness. The loss of these attributes is expected to produce skill and knowledge gaps that will compromise the profession's capacity to respond to complex clinical situations.

In response to these workforce projections, Te Whatu Ora Waikato District has implemented targeted workforce and education strategies over the past decade to enhance registered nurse (RN) supply and capability. The PDU, within the Office of the Chief Nurse, has led proactive planning and an integration and streamlining initiative that explicitly aligned post-registration education and development with projected service needs and organisational priorities. This locally situated strategy positioned educational systems as an operational lever to mitigate predicted workforce shortfalls and sustain high-quality, contextually appropriate nursing practice.

1.3.1 Integration and Streamlining Project as a Foundation for the Research

The Integration and Streamlining Project undertaken in 2014–2015 provided the background knowledge and strategic foundation for this qualitative case study (Hayward & Atherfold, 2015; Marriott, 2014). The project's first phase comprised a current-state analysis that included a targeted literature review, national benchmarking with similarly sized health boards, and workforce projection modelling to identify future RN capacity requirements relative to population health demand (Marriott, 2014; Watson, 2014). Benchmarking activities mapped post-registration education and development inputs, identified areas of functional overlap, and elicited staff perspectives on priorities and value.

These findings informed the central inquiry of the current study: how can post-registration education and development structures build upon earlier gains to achieve deeper integration with operational management and clinical practice to address the question, how can nursing education and development care strengthen operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District? Exploratory conversations with executive leaders, managers, and clinical nurses consistently emphasised the importance of integration. While there was evidence of growing synergy between clinical practice and education and development teams, operational factors were frequently described as separate. Integration was widely perceived as essential to achieving a balanced and cohesive approach to workforce development, service delivery, and quality improvement.

Phase one of the Integration and Streamlining Project demonstrated that the current state of Te Whatu Ora Waikato District's PDU (Marriott, 2014) provided an appropriate and comprehensive suite of post-registration education and development activities aligned with MoH workforce projections (Watson, 2014). Nevertheless, findings from the phase one analysis revealed a critical relationship between educational provision, escalating clinical demand, and the operational realities of frontline practice. Participants articulated this

interdependence succinctly: “I think any [educational] development has to be carried out with consideration of the operational reality of staff” (Marriott, 2014, p. 41).

Operational reality encompassed both measurable and subjective elements that shaped the capacity for education and development within clinical settings (Marriott, 2014). Tangible factors included resource constraints, limited budgets for education, restricted release time for staff participation, escalating workloads, increasing patient acuity, and varying levels of workforce competence. Alongside these, more subjective constructs were referred to such as perceptions of busyness, tensions in meeting expected standards of care, and the continual need for rapid, adaptive responses to emergent challenges, which further complicated the integration of education into everyday practice. These operational influences collectively underscored the complexity of aligning educational initiatives with clinical and managerial priorities.

Phase two reconfigured the PDU into two complementary streams as clinical education and workforce development to better reflect the dual imperatives identified in phase one (Hayward & Atherfold, 2015). The clinical education stream prioritised practice-related learning that directly supported bedside decision making and clinical competence. The workforce development stream focused on broader professional capacity building, graduate recruitment, continuing professional development, advanced practice, professional ethics, equity and cultural safety, inquiry and evidence use, leadership for change, and assertive communication which, collectively, contributed to sustained system performance and adaptive capability.

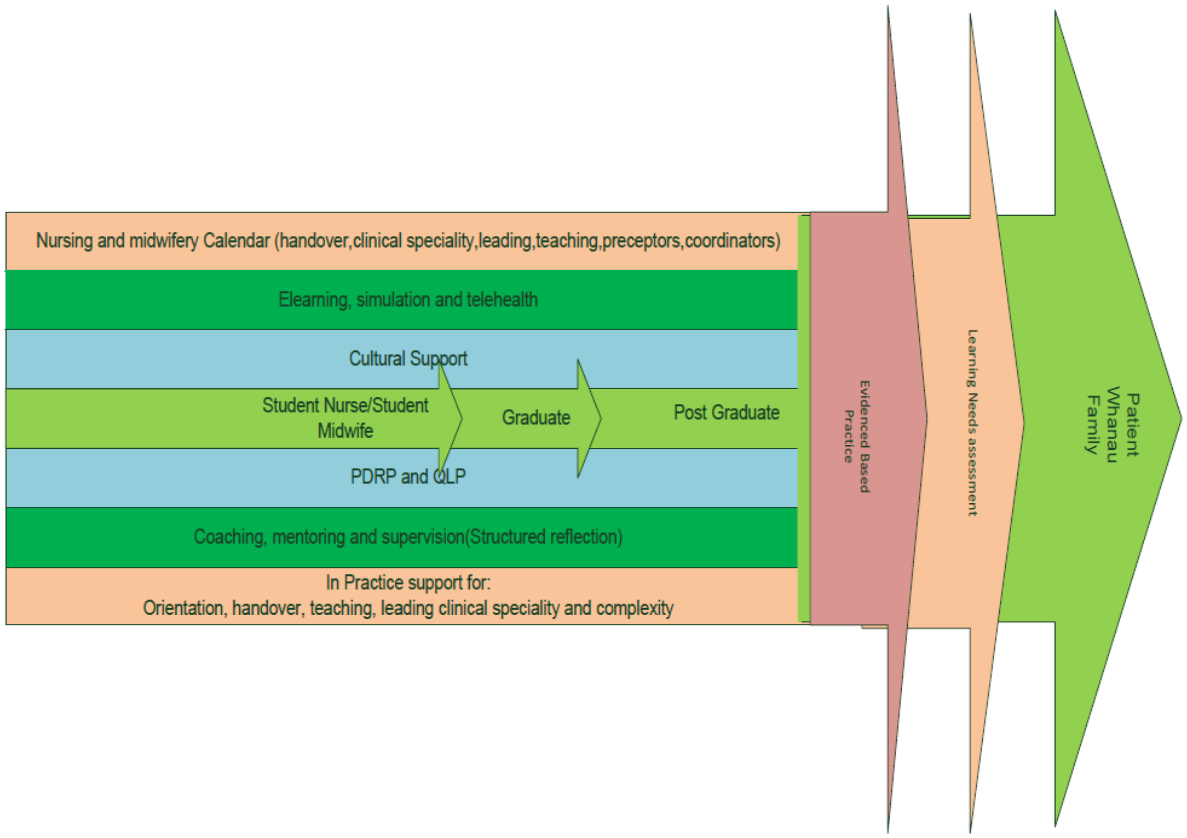
Phase three implemented the new structures and processes, aligning PDU staff with both the clinical or workforce stream and deploying strategies to address imminent workforce attrition and capability gaps. Implementation measures included targeted recruitment of early career nurses, a substantive increase in graduate employment from 108 to 164 (approximately 50% more graduates than previous years) across acute care and community settings. The deliberate design of staged educational and support frameworks across early years of practice to cultivate clinical reasoning, decision making, cultural responsiveness, and leadership of care episodes. This intentional strategy supported the professional growth of nurses from early in their career across the first five years of practice. To facilitate knowledge transfer and socialisation into practice, 55% of the total number of 4300 nurses were supported with education and development for preceptor roles from the second year of practice and mentor roles as their experience developed, with structured learning opportunities for specialist skills training and certification, study days, postgraduate education pathways, and expanded in-house learning. Workforce composition was also realigned to reflect the district’s cultural

demographics through establishment of a full-time senior Māori nurse role and an associated advisory group, creating a culturally responsive foundation for education and practice. This role was the beginning for Māori workforce development, and with the guidance of the advisory group, there was subsequent growth in Māori graduate recruitment, and development of a cultural support team as part of the PDU.

These phased interventions formed the organisational foundation for the present qualitative case study. The contrast of comprehensive educational provision with persistent operational constraints foregrounded the study's central concern: how can post-registration education and development effectively translate educational gains into sustainable clinical and operational outcomes? By situating the inquiry within a context of intentional workforce planning, augmented graduate intake, and culturally informed leadership structures, the research examined mechanisms of alignment among education, clinical practice, and operational management necessary to preserve practice wisdom, resilience, and enhance quality of care.

The outcomes expected of the PDU cover a continuum of education that aligns with Te Whatu Ora Waikato District's strategic aims for nursing (Waikato DHB, 2017). These portfolios are summarised in Figure 1, where workforce design is aimed at the spearhead of the arrow by meeting the needs of patients and whānau, through identified learning needs and evidence-based practice. Activity that supported this strategy included a central continuum within the arrow incorporating students' clinical learning to include graduate, post-registration and postgraduate education, and development of advancing practice roles. Specific programmes using eLearning, simulation, in-practice support, cultural support, coaching, mentoring, supervision, and leadership wrap around the central theme of the development continuum from student to graduate and postgraduate nurse who work within the clinical service to deliver care.

Figure 1. *Education and development provided by Te Whatu Ora Waikato District PDU (Hayward & Atherfold, 2015).*



Abbreviations: PDRP = Professional Development and Recognition Programme for nurses; QLP = Quality Leadership Programme for midwives.

From *Professional development integration and streamlining project: Phase one and two* (p.8), by S. Hayward & C. Atherfold, 2015, Waikato District Health Board. Reprinted with permission.

1.3.2 Next Steps Following the Integration and Streamlining Project

What became apparent from the 2016 review of the Implementation and Streamlining Project was that all identified recommendations had been implemented by the PDU. However, a developing discourse implied that despite having processes and programmes, the PDU was challenged by the need to influence operational management, a dominant factor influencing practice, education, and development. This discourse came from a variety of sources—nurses in education roles within the PDU, managers, and some executive conversations. To understand the context wherein evidenced based education and clinical practices had been applied, I began to explore factors for steps to overcome the identified challenge; the first of which was to understand the emerging discourse with a range of exploratory conversations.

As the Integration and Streamlining Project (Hayward & Atherfold, 2015; Marriot, 2014) had been sponsored by the Waikato DHB Executive, I conducted a series of conversations with

executive leaders and frontline staff. These conversations served a dual purpose: they clarified the research focus and ensured alignment with the local context. Engagement was intentionally broad, encompassing five executive leaders (Chief Nursing Officer, Chief Operating Officer, Executive Director Māori, Executive Director Strategy and Funding, and Executive Director People and Culture); two Deputy Chief Nurses; two Nurse Managers; a member of the Cultural team, and nurses in practice (see Appendix A). This breadth of representation enabled visibility of relevant insights across governance, management, and frontline practice.

A recurrent theme from these conversations concerned the divergence between clinical staff and business or finance teams who reported a disconnect. Clinical nurses described their environments as time- and resource-constrained, requiring continuous prioritisation to maintain acceptable standards of care. In contrast, managers and finance personnel prioritised budgetary alignment, resource sequencing, and performance measures. These differences reflected distinct decision-making priorities. Clinicians tended to prioritise clinical decisions and care delivery; whereas managers prioritised flow and budget priorities to ensure that targets for length of stay, first specialist appointments, follow up treatments, and review were met within the allocated timeframes and budget resource. All conversations reported that such divergences produced disconnects when collaborative mechanisms were absent. However, contributors also observed that clinical, financial, and educational competencies could be mutually reinforcing when structured opportunities for cooperation were intentionally created and that education and development had a contribution to make to this area.

Another theme concerned the district's population health profile and the persistent inequities affecting Māori and other vulnerable groups. Contributors identified unconscious bias and system design factors as significant impediments to progress. Executive leaders acknowledged that equity concerns could not be addressed solely through clinical quality initiatives or isolated educational interventions. Instead, they argued that systemic inequities demanded intentional development of interdisciplinary mechanisms capable of informing both clinical practice and operational decision-making. This perspective reinforced the view that integration required more than technical alignment; it demanded cultural responsiveness and structural change.

The consensus emerging from these conversations was that addressing clinical quality or equity issues in isolation would be insufficient to resolve underlying production and resource challenges. The conversations emphasised the need for structures that could bridge professional boundaries and integrate diverse forms of expertise. Such mechanisms were

seen as critical to ensuring that educational provision remained responsive to operational realities, that clinical practice was informed by strategic priorities, and that equity considerations were embedded within organisational decision-making. Collectively, these observations provided the rationale to further research the steps to progress from the foundation of the PDU Integration and Streamlining Project and see its intentions fully realised as a qualitative case study within the Te Whatu Ora Waikato District context.

Portfolios for the education and development of nursing and midwifery are located within the PDU at Te Whatu Ora Waikato District and encompass acute care, primary and community care, and home-based care settings. Evidence-based practice underpins education and clinical workforce design, and the guiding principle for the PDU is that appropriate preparation to meet the requirements of healthcare recipients will lead to improved quality outcomes. Preparing the nursing workforce requires strategies that address equity, recognising that Te Whatu Ora Waikato region population consists of higher than the national average percentage of Māori (23%) and rural residents (60%) (Stats NZ, 2018), and 55.8% of the population living in the most deprived areas nationally (Chang et al., 2021) with associated poor health outcomes. Against this landscape, clinical nurses seek to navigate complex and often reactionary practice situations.

Situated within this service landscape, the current study foregrounded how culturally informed, equity-centred education strategies and workforce design can contribute to continual improvement of clinical expertise, enhancing adaptive capacity, and improving health outcomes across diverse and geographically dispersed populations in Te Whatu Ora Waikato District. By examining alignment among governance, operational management, clinical practice, and education, the research aimed to generate insights for district-level strengthening of this alignment within Aotearoa New Zealand.

1.4 Presenting the Case

Prior to 1 July 2022, Waikato functioned as one of 20 DHBs. Following the 2020 Health System Review, these entities were consolidated under Health New Zealand Te Whatu Ora, organised into 18 districts to standardise governance and service delivery nationally (MoH, 2020a). Waikato sits within Te Manawa Taki Region alongside Lakes, Bay of Plenty, Hauora Tairāwhiti, and Taranaki, and provides tertiary services across this midland catchment as well as for its own district population (Waikato DHB, 2021). The region's geographical spread spans coastlines, peninsulas, mountain ranges, forested terrain, and high-use tourist areas; as such, it has created substantial challenges for all aspects of health care delivery.

The Waikato population includes a higher proportion of Māori (25.2%) than the national average (16%), with principal iwi affiliations including Hauraki, Ngāti Maniapoto, Ngāti Raukawa, and Waikato-Tainui; alongside many Māori who affiliate with iwi beyond the district boundary (Waikato DHB, 2021). Across Te Manawa Taki, Māori representation similarly exceeds national levels, with high proportions living in Tairāwhiti/Gisborne, Bay of Plenty, Taranaki, and Lakes districts. This demographic distribution is consequential because entrenched disparities in health outcomes for Māori necessitate deliberate attention to the ways services are planned, funded, designed, and staffed. Equitable service design, therefore, must inform workforce education and development strategies (Waikato DHB, 2016).

Equity centred education constitutes a central component of clinical preparedness. Although the Māori workforce in Waikato has increased to 12.5% as of December 2022, it remains substantially lower than the Māori share of the district population, indicating a workforce shortfall relative to demographic need and an ongoing requirement for targeted Māori workforce development (Waikato DHB, 2021). Additionally, the cultural learning needs of internationally educated nurses require attention because differing cultural expectations and practice norms influence clinical interactions and safety (Came et al., 2020). Consequently, curricular design must be grounded in local demographic realities and culturally responsive pedagogy to enhance both clinical competence and equity (Came et al., 2020).

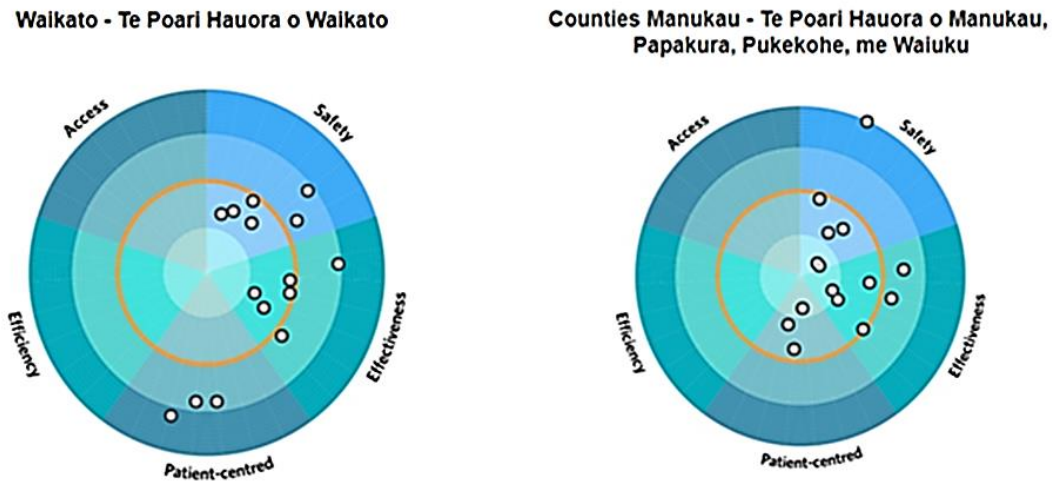
Resource allocation in Te Whatu Ora Waikato District sees approximately 40% of healthcare funding go to general practice, primary care, Māori and Pacific organisations, and community pharmacy, with the remaining 60% directed to hospital services (Waikato DHB, 2021). Comparative quality indicator analyses demonstrate that overall outcomes in Waikato are broadly comparable with similarly sized tertiary districts; however, domains related to Māori health, patient-centeredness, and measures of equity lag comparator districts, signalling the need for targeted improvement in culturally responsive care and equity-focused service redesign (Health Quality & Safety Commission, 2022). These combined system, demographic, and funding dynamics provide the contextual rationale for investigating how post-registration education and workforce strategies can be aligned to enhance equitable access, clinical readiness, and system responsiveness across the Waikato and Te Manawa Taki regions.

Figure 2 maps five quality dimensions of access, safety, effectiveness, efficiency, and patient-centeredness against the national benchmark. The highlighted circle denotes the national average; lighter shading toward the centre indicates relatively better performance, while darker shading toward the periphery indicates below-average performance (Health Quality & Safety Commission, 2022). Individual data points plot specific indicators within each

dimension relative to that national benchmark, enabling visual comparison of each domain. Comparison between Te Whatu Ora Waikato District and Counties Manukau, a similarly sized tertiary district, suggests there are targeted opportunities for workforce education and development when considering Waikato's unique demographic composition and service demands. Further, Waikato demonstrates performance below the national average in safety, effectiveness, and patient-centeredness. These findings provide a critical leverage point for informing education design and shaping experiential learning priorities in post-registration nursing preparation (Health Quality & Safety Commission, 2022).

Figure 2.

Comparison of quality outcomes between the Te Whatu Ora Waikato District and Counties Manukau (Health Quality & Safety Commission, 2022).



From *Comparison of quality outcomes between the Te Whatu Ora Waikato District and Counties Manukau, 2022, by Health Quality & Safety Commission.* https://www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/code-of-expectations-for-health-entities-engagement-with-consumers-and-whanau/

Improvements that respond to the areas of safety, effectiveness, and patient-centeredness support the pivotal role of nursing education and workforce development in delivering safe, equitable, and high-quality care. By equipping qualified nurses with knowledge, skills, and ongoing developmental support, nursing education strengthens practice within Te Whatu Ora Waikato District, a region facing complex health inequities. Strategic alignment with post-registration nursing education is, therefore, not only advantageous but essential.

1.5 Research Rationale

Nursing leadership within Te Whatu Ora Waikato District has purposefully prioritised workforce capability development to support the delivery of safe, high-quality, and equitable care, underpinned by aligned education and professional development initiatives (Waikato DHB, 2017). Concurrent increases in clinical complexity, workforce pressures, and persistent inequities for Māori necessitate a focused inquiry into how post-registration education can be enhanced and more effectively integrated with operational and clinical practice (Marriott, 2014; Waikato DHB, 2016). An integrative literature review was undertaken using the Promoting Action on Research Implementation in Health Services (PARIHS) framework, which foregrounds the interplay of evidence, context, and facilitation in translating knowledge into practice (Rycroft-Malone et al., 2013). The integrative review identified literature addressing discrete components raised in exploratory conversations, such as clinical education models, workforce development strategies, and equity-focused initiatives. However, the review yielded comparatively sparse evidence describing how operational, managerial, clinical, and educational teams collectively enact and sustain improvements in practice and outcomes. This evidentiary gap motivated the selection of a qualitative case study methodology to generate in-depth understanding of specific insights to develop context sensitive recommendations for strengthening education-practice connections in Te Whatu Ora Waikato District.

1.6 Research Overview

1.6.1 Research Aims and Questions

The principal aim of this qualitative case study was to investigate how nursing education and development can strengthen operational and clinical practice to achieve quality outcomes in Te Whatu Ora Waikato District; with the explicit objective of generating evidence-informed, contextually grounded recommendations to enhance quality outcomes for patients and whānau. The study examined strategic priorities and stakeholder perspectives to clarify strategies by which education interfaces with practice and management, and to identify reconfigurations of education and development that optimise clinical effectiveness, safety, equity, and patient-centeredness by exploring how (i) RNs and their operational managers describe the quality of care in clinical practice; (ii) post-registration nursing education influences the quality of care in clinical practice; and (iii) post-registration nursing education could be configured to achieve optimum quality in clinical practice.

1.6.2 Design of the Case Study

A single embedded case study design (Yin, 2018) was selected to investigate Te Whatu Ora Waikato District as a bounded system and enable in-depth examination of its organisational structures, cultural dynamics, and the relationships among strategy, leadership, and clinical practice. This approach permitted an intensive, contextually rich analysis of how post-registration education and workforce development interact with operational realities within a defined geographic and institutional setting, thereby supporting the development of locally relevant recommendations.

The case study design synthesised methodological propositions from Yin (2018), Stake (1995), and Merriam (2009) to combine rigour in case definition and analytic procedures with sensitivity to participant perspectives and constructivist inquiry. Yin's emphasis on systematic case boundaries and multiple sources of evidence guided the logic of inquiry and replication, while Stake's attention to intrinsic case meaning and Merriam's pragmatic guidance on qualitative case study implementation informed sampling, data collection, and interpretive processes.

Analytic processes incorporated critical appreciative approaches to balance a strengths-based orientation with critical social theory. Critical appreciative methods foregrounded existing capacities within clinical teams, management structures, local communities, and Indigenous knowledge systems, while subjecting those capacities to critical interrogation of power, inequity, and structural constraints (Grant, 2012; Grant & Humphries, 2006; Oliver, 2005b). The integration of critical social theory provided a lens for examining systemic influences on practice and education, and for making visible implicit assumptions that shape organisational responses (Fay, 1996).

The study proceeded from the substantive assumptions that publicly funded health services are intended to meet population needs in Aotearoa New Zealand and that clinical education constitutes a primary mechanism for supporting practice development. The research took a qualitative approach to investigate post-registration education and development within the operational context of Te Whatu Ora Waikato District; it did not attempt to quantify the volume or cost-effectiveness of educational provision nor produce generalised results. These boundaries reflected the study's intent to elicit stakeholder narratives and interpretive accounts of effectiveness, alignment, and barriers to integration rather than provide a standalone economic or quantitative performance evaluation.

The chosen case study design facilitated generation of context-sensitive insights and pragmatic recommendations to strengthen the links between operational management, clinical practice, and education (Merriam, 2009; Stake, 1995; Yin, 2018). While findings are specific to Te Whatu Ora Waikato District, the analytical processes and emergent principles offer conceptual transferability to other clinical settings seeking to enhance education-practice integration.

1.7 Thesis Outline

This thesis comprises six chapters that, together, situate a qualitative single embedded case study of post-registration nursing education and development within the bounded context of Te Whatu Ora Waikato District, Aotearoa New Zealand. Chapter One provided the contextual framing and established the foundation for this research by situating the study within the context of Te Whatu Ora Waikato District, a health system marked by a high proportion of Indigenous populations and geographically dispersed rural communities. The chapter began by outlining the background and rationale for the research and then articulated the research aims and question, positioning Te Whatu Ora Waikato District as a compelling case for investigation. It drew attention to the historical efforts between 2014 and 2016 to integrate and streamline nursing development initiatives, noting that while these efforts laid important groundwork, they also revealed that the recommendations had not achieved the desired integration within a clinical and operational interface. This outcome set the stage for a focused inquiry into how educational, clinical, and operational systems interact to shape workforce capability. The chapter concluded by presenting the overarching research questions and introducing the conceptual and methodological design that guided the study.

Chapter Two presents a comprehensive and integrated review of the literature that informs the conceptual and methodological framing of the study. It begins by detailing the search strategy employed to identify relevant sources, including peer-reviewed research, theoretical texts, and grey literature. It outlines the review structure around two interrelated domains: post-registration nursing education, professional development, and advanced practice; and the dynamic interface between operational, clinical, and educational systems in the pursuit of improved health outcomes.

Chapter Three outlines the methodological rationale for adopting a single embedded case study design, tailored to explore the complex, context-specific nature of nursing education and development within Te Whatu Ora Waikato District. The chapter begins by justifying the case selection, then describes the sampling strategy and data collection methods, which include

document analysis, focus groups, and semi-structured interviews with key stakeholders. These sources are treated as embedded units of analysis (UofA), enabling insightful exploration of the case. The chapter describes Braun and Clarke's (2022) reflexive thematic analysis used to interpret the data and ensure rigour and transparency.

Chapter Four presents the findings derived from the document analysis component of the study. It outlines the search strategy used to access documents via Te Whatu Ora Waikato District's document management system, including policy statements, position descriptions, strategic plans, and organisational change records. The chapter provides an analysis of the documents reviewed and explains their relevance to the study's focus on nursing education and development.

Chapter Five presents the thematic findings from stakeholder data gathered from clinical nurses, operational managers, and nurse educators. The chapter is organised around three overarching themes: Influence and impact; Safe, shared practice growth; and Embedding identity, equity, and Te Tiriti o Waitangi in practice. Each of these themes is presented with verbatim quotes that articulate how post-registration education is perceived to shape clinical quality and how education, operational management, and clinical practice might be more effectively aligned to enhance quality outcomes.

Chapter Six discusses the findings and interprets their implications for practice and policy, addresses study limitations, and offers recommendations for structural and functional integration to strengthen education-practice alignment and opportunities for further research. The chapter situates the research within local practice and contributes to the wider literature on workforce development in Indigenous and rural contexts. Future research opportunities are outlined, including mixed-methods studies and comparative district analyses to assess transferability and measurable outcomes.

The thesis concludes with locally grounded, practice-oriented recommendations designed for Te Whatu Ora Waikato District. While the single embedded case study design limits generalisability, the study provides context specific insights into how education and development can strengthen clinical and operational practice to achieve quality outcome in DHBs with similar population and geographic contexts.

1.8 Chapter Summary

This chapter introduced the study and clarified its purpose within the current health context of Aotearoa New Zealand, building on the foundation of the earlier Integration and Streamlining Project (Hayward & Atherfold, 2015). The rationale, research design, and aims were provided with an outline of the thesis structure. The chapters that follow build on this foundation by providing details of the literature review, research design, analysing the findings, and discussing their contribution to theory and practice.

CHAPTER II LITERATURE REVIEW

2.1 Introduction

Chapter Two explores literature that addresses how post-registration nursing education and development strengthens operational and clinical practice to enhance quality outcomes in Te Whatu Ora Waikato District. In keeping with the sequencing of the research process, the review was conducted in 2020 to inform refinement of the research question, study design, and ethical procedures. As such the literature review is a point in time, and has been extended to include publications reflecting the intersection of nursing education and development, operational and clinical practice, and quality outcomes in earlier sources and up to the present time.

The chapter begins with an overview of the integrative review which incorporates grey literature such as commentaries, editorials, local documents, and reports, alongside peer-reviewed articles and texts based on Cronin and George's (2020) methodology. The original question that guided the review was: *What connections link nursing education and development, operational and clinical effectiveness within an Aotearoa New Zealand DHB context?* The question was informed by the need to align nursing education with operational and clinical demands to enhance quality outcomes for the Te Whatu Ora Waikato District population, as identified in background meetings with leaders reported in Chapter One. While the research was situated within the Aotearoa New Zealand context, global English-language literature was drawn upon from the outset. The research question was subsequently refined to reflect insights gained through the literature review, ensuring alignment between the study focus and the broader international evidence base.

Further, the chapter describes context and keywords relating to clinical practice, Kawa whakaruruhau, cultural safety, operational leadership, and professional development, including post-registration education, quality care, and RNs. It places the contemporary landscape of post-registration education, practice development, and advanced practice in historical context by outlining the development of the nursing profession and associated education in Aotearoa New Zealand. Descriptions of how colonisation and ongoing inequities shaped disparities in health outcomes for the Waikato population drew on recurring themes from national reports and strategies in the grey literature and linked those themes to the RN scope of practice. The discussion demonstrates how education, operational, and clinical elements influence quality outcomes and concludes by summarising implications for the study methodology.

2.2 Literature Review Methodology

This integrated literature review examines how knowledge, practice, and professional meaning are constructed and negotiated across organisational and disciplinary boundaries. Drawing on Cronin and George's (2023) conceptualisation, which extends Huff's (2008) notions of sense-giving and sense-making, this review positions these processes as a dynamic bridging mechanism between communities of practice. In doing so, it recognises not only the education and clinical domains as distinct yet interrelated communities, but also situates the researcher as an active interpretive agent who navigates, mediates, and constructs meaning across these boundaries in the pursuit of insight. Within this framework, education and clinical domains are understood as interconnected yet distinct communities, each characterised by its own norms, knowledge systems, and practices. Sense-giving and sense-making facilitate the translation and negotiation of knowledge across these domains, enabling more coherent integration between educational preparation and clinical application. The metaphor of the "bridge" is used to frame the relational, structural, and contextual work required to connect these domains, with particular attention to how such processes influence the development, delivery, and sustainability of nursing education within complex health systems.

The boundedness of such groups is a feature aligning with the 2016 review of the Integration and Streamlining Project within the PDU, where boundaries existed for groups of influence that carried expertise according to role and functions. As such, this type of review was deemed appropriate because of the ability to use a wide range of sources across an extended timeframe which included formal peer reviewed literature synthesised with other sources from the practice context being explored. For this review, the three components that relate to Cronin and George's communities of practice are education and development, operational management, and clinical practice.

2.2.1 Search Terms and Strategy

A comprehensive literature search was conducted using the EBSCOhost and CINAHL complete databases to identify sources using keywords 'education', 'development', 'operational management', and 'clinical practice' in nursing and healthcare. Initially, English language publications from the last 10 years were reviewed; however, the timeframe was extended due to the limited evidence generated. Despite this expansion, the search yielded few studies that incorporated all keyword aspects. Consequently, the strategy was broadened to include additional terms 'professional development', 'quality', 'governance', 'nursing workforce', and 'service improvement'. 'Māori' and 'bicultural' keywords were also added to

include literature relating to the Indigenous population. Boolean operators were applied to refine the search, which generated substantial literature on individual aspects of the topic but few with all.

Additional searches were replicated using Google Scholar, Scopus, and PubMed, yielding comparable results. The use of Medical Subject Headings (MeSH), including terms such as ‘education’ and ‘continuing development’, provided useful insights; however, the overall yield remained limited. To strengthen the search strategy, a snowballing technique was employed, whereby the reference lists of relevant articles were manually reviewed to identify further sources (Merriam, 2009). This hand-searching process facilitated the inclusion of additional resources that might otherwise have been overlooked. The significance of the topic was demonstrated through its contribution to the elements of nursing education strategies and its integration with both clinical practice and operational management. This relevance informed the inclusion criteria which were deliberately structured to capture literature incorporating the three elements. To ensure a comprehensive outcome to the review, grey literature, including strategic documents, were considered.

In total, 43 articles were screened for relevance. Removal of duplicates resulted in 31 articles. An additional six articles were identified and included from other sources using hand searching but, after reviewing abstracts and executive summaries, five were excluded due to lack of relevance to education and development strategies. The final selection comprised 32 articles (summarised in Appendix B).

2.2.2 Description of Key Concepts and Terms

This study draws on key terms and concepts central to nursing and healthcare. These include RNs, professional development (with reference to post-registration education), practice development, Te Tiriti o Waitangi, Kawa whakaruruhau and cultural safety, service and care delivery, quality care and quality outcomes. Each concept is defined in the following paragraphs.

RN: In alignment with the Health Professionals Competence Assurance Act (HPCAA, 2003), a RN is defined as a licenced health professional who has fulfilled the educational, credentialing, and continuing competency requirements established by the Nursing Council of New Zealand (NCNZ; 2024a). The NCNZ functions as the statutory authority under the MoH within Aotearoa New Zealand, regulating nursing practice to ensure public safety and professional accountability.

The RN scope of practice includes the application of nursing knowledge and judgment to assess, advise, and support individuals with complex healthcare needs. This includes the development and implementation of comprehensive care plans and interventions that require substantial scientific and professional knowledge, skills, and decision-making. Such practice is carried out in a range of community and hospital settings in partnership with patients, whānau, and wider communities, reflecting the holistic and relational nature of nursing care (NCNZ, 2024a).

To qualify as a RN in Aotearoa New Zealand, individuals are required to complete and pass a formal tertiary qualification that meets the NCNZ's educational criteria. For internationally qualified nurses (IQNs), education and credentials are assessed for equivalence. Where gaps are identified, nurses may be required to undertake a competency assessment programme or an Aotearoa New Zealand degree programme (Bachelor of Nursing or Master of Nursing Practice) for graduate entry to the profession. All approved programmes that meet the education standards provide entry to the register, ensuring consistency in standards and competencies across the profession (NCNZ, 2024b).

Once registered, nurses are required to maintain competence through ongoing professional development and practice. NCNZ mandates participation in a minimum of 60 hours of professional development and education and 450 hours of clinical practice within each 3-year period (NCNZ, 2024b). These requirements reinforce the principle of lifelong learning, ensuring that RNs remain responsive to evolving healthcare needs, technological innovations, and population health priorities.

Professional development: Constitutes a critical dimension of nursing practice, supporting the ongoing education, skill enhancement, and career advancement of RNs. It ensures that nursing practice remains contemporary, evidence-based, and responsive to the evolving complexities of healthcare delivery. Within the regulatory framework of the NCNZ, professional development is mandated as part of continuing competence requirements, thereby reinforcing its significance for both individual practitioners and the wider health system.

A key component of professional development is post-registration education, which encompasses a range of structured learning opportunities designed to extend and deepen clinical and professional expertise. These activities include short, practice-specific courses often delivered in-house to address immediate service needs, participation in specialty conferences and professional forums that facilitate knowledge exchange, and engagement in formal postgraduate education programmes that advance theoretical and research capacity

(Waikato DHB, 2017). Collectively, these opportunities enable nurses to adapt to technological innovations, policy reforms, and shifting population health needs, while fostering leadership, critical thinking, and reflective practice.

Professional development is integral to sustaining a highly skilled nursing workforce, enhancing patient outcomes, and aligning nursing practice with organisational priorities and national health strategies. It contributes to workforce resilience by supporting nurses in navigating the demands of complex healthcare environments and promoting career satisfaction and retention.

By contrast, professional development is not universally mandated in nursing regulation at a global level. In many countries, continuing education is encouraged but remains voluntary or is only required in specific circumstances such as specialty certification or career progression (Benner et al., 2010). The Aotearoa New Zealand model represents a distinct commitment to embedding lifelong learning within the nursing profession, ensuring that competence is continuously demonstrated rather than assumed. This regulatory emphasis reflects the dynamic and complex nature of healthcare in Aotearoa New Zealand, where nurses comprise the largest professional workforce and play a critical role in operational leadership, service delivery, and population health outcomes.

The value of professional development for Aotearoa New Zealand nurses lies in its dual function: it safeguards public trust by ensuring competence and accountability, while simultaneously fostering innovation, leadership, and responsiveness to cultural and clinical needs. In this way, professional development is both a regulatory requirement and a strategic tool for advancing nursing practice, strengthening workforce resilience, and aligning healthcare delivery with national priorities and Te Tiriti o Waitangi obligations.

Practice development: While practice development reflects components of professional development, within the context of the current research it reflects how education and facilitation can bridge operational and clinical practice, embed accountability, and strengthen quality outcomes. Practice development is defined as a continuous facilitated process that aims to transform healthcare cultures into person-centred, evidenced based, and sustainable systems of practice by enabling all staff to engage in collaboration, reflection, and innovation to improve care quality and organisational outcomes (Manley et al., 2008). Characteristics that align with this study include systematic and continuous approaches to improvement with consideration of context and culture, so that care is consistently person-centred. The focus of person-centeredness refers to patients, families, and communities which aligns with Te Whatu Ora

Waikato District priorities to meet population health needs with equity, cultural competence, and partnership. Processes that support this focus include active facilitation of participatory approaches and collaboration by leaders and educators to identify, learn, apply, and embed new practices that reflect evidence based knowledge and practice wisdom (McCormack et al., 2013).

Te Tiriti o Waitangi: In Aotearoa New Zealand, Te Tiriti o Waitangi is recognised as the foundational document between Māori and the British Monarchy. It was signed on 6 February 1840 by many iwi (tribes) but not all. Te Tiriti o Waitangi shapes law and policy and professional regulation, including the standards set by the NCNZ. Within nursing practice, it involves the integration of knowledge, concepts, and worldviews of both tāngata whenua (people of the land) and tāngata Tiriti (those present by way of Te Tiriti o Waitangi agreement) into nursing practice. RNs are required to uphold and enact the principles of Te Tiriti o Waitangi through Kawa whakaruruhau and cultural safety. This obligation ensures that nursing practice promotes equity, inclusion, diversity, and the rights of Māori as tāngata whenua, and to Pacific and other population groups to ensure responsive healthcare services are culturally safe and equitable (NCNZ, 2024a).

Kawa whakaruruhau and cultural safety: Kawa whakaruruhau refers specifically to the attribution of safety within Te Ao Māori (the Māori worldview) through its values, protocols, and customs that safeguard identity and well-being (Durie, 1994). It is a concept deeply rooted in Māori perspectives and is closely aligned with the obligations of Te Tiriti o Waitangi (Ramsden, 1990a). Developed by Irihapeti Ramsden (1990a), Kawa whakaruruhau requires nurses to critically reflect on their own culture, biases, and power relationships to ensure that care does not diminish, demean, or disempower the cultural identity of patients. While some literature has used Kawa whakaruruhau and cultural safety interchangeably, the NCNZ (2011) distinguishes between them within its regulatory framework. Similarly, the MoH (2021) embeds both concepts within the Health and Disability Service Standards. The distinction lies in scope: Kawa whakaruruhau is grounded in Māori worldviews and Te Tiriti o Waitangi obligations; whereas cultural safety provides a universal framework for nursing practice that addresses equity and inclusion across diverse populations. Together, these concepts form the cornerstone of nursing regulation and practice in Aotearoa New Zealand, ensuring that nurses deliver care that is both culturally responsive and Te Tiriti o Waitangi honouring.

Service and care delivery: Led by directors and managers who facilitate operational management to ensure the strategies of the organisation (in this case, Te Whatu Ora Waikato District) are effectively implemented to meet the health needs of the local population. This

responsibility extends beyond strategic oversight to encompass compliance with national health priorities and standards, with the efficient allocation and management of resources. These resources include personnel, infrastructure, buildings, equipment, budget, supplies, and projects, all of which are required to be coordinated promptly and effectively to maintain service quality and continuity (MoH, 2021). Given the dynamic and complex nature of healthcare systems, operational leaders are required to have expert knowledge of the population they serve, the organisation's structure, range of services provided, and clinical requirements necessary to deliver safe and effective care.

Within Te Whatu Ora Waikato District, nurses represent more than 50% of the workforce, making them the largest professional group employed across the organisation and the primary group delivering care. This demographic reality underscores the central role of nursing in service delivery and highlights the importance of collaboration between operational managers and nursing staff. Nurses are frontline providers of care and key contributors to quality improvement initiatives, workforce development, and the integration of clinical practice with organisational priorities. Effective collaboration between managers and nurses ensures that operational strategies are translated into meaningful outcomes for patients and communities, while supporting professional development and sustaining a culture of quality care.

Quality care and quality outcomes: Quality care refers to the extent to which healthcare services increase the likelihood of a patient achieving desired health outcomes, based on current evidence-based and professional practice knowledge. Quality outcomes, in turn, reflect the impact of healthcare interventions aimed at delivering quality care (WHO, 2018). Donabedian's (1980) seminal work defined it as:

> The kind of care which is expected to maximize an inclusive measure of patient welfare after one has considered the balance of unexpected gains and losses that attend the process of care in all parts, or the ability to achieve desirable objectives using legitimate means. (p. 43)

This early definition implied that quality is determined as the best care within the available resources and that it is measured 'for' patient welfare rather than 'with' patients.

Subsequent interpretations expanded Donabedian's stance to include 'current professional knowledge' also referred to as 'evidence-based practice' (Institute of Medicine, 1990). The European Commission (2010) began to describe other factors as contributors to quality outcomes, such as safety, equity, access, and efficiency. In 2018, the WHO consolidated these perspectives, defining quality care as:

> Effectiveness of providing evidence-based health care services to those who need them; safety and avoidance of harm for those receiving the care; and people-centred by providing care that responds to individual preferences, needs, and values … To realise the benefits of quality health care, health services must be timely equitable, integrated, and efficient. (p. 13)

The evolution of these definitions highlighted a shift toward recognising the health consumer's experience and perception as central to quality care. Operational components such as systems, coordination, and improvement methods and tools were further described by the Health Foundation (2021) in the United Kingdom as focused on those closest to the issues affecting care quality, emphasising the time, permission, skills, and resources required to address them. It entails a systematic and coordinated approach to problem-solving, employing defined methods and tools to achieve measurable and sustainable improvement.

The key terms outlined above have formed the conceptual foundation for understanding the scope and complexity of registered nursing in Aotearoa New Zealand. These concepts have defined the professional expectations of RNs and shaped the systems and structures within which they operate. Building on this foundation, the following section explores the ways that post-registration education and development can strengthen operational and clinical practice.

2.3 Post-registration Education, Practice Growth, and Advanced Practice

To enhance quality outcomes, individual and organisational commitment to appropriate learning is required for the complex and dynamic work undertaken by nurses. The facilitation of such learning requires operational logistics and resources, as well as engagement with educational opportunities that sustain competence, innovation, and practice growth.

Post-registration education in Aotearoa New Zealand can be broadly divided into two categories. The first includes in-service education delivered locally within clinical settings, often as focused study days, short courses, specialty conferences, and forums. While these offerings do not contribute toward formal academic qualifications, they are vital for ensuring that practice remains informed by emerging evidence and is responsive to immediate service needs. The second category encompasses postgraduate education delivered by tertiary institutions and contributes to qualifications such as postgraduate certificates, postgraduate diplomas, master's degrees, and doctoral programmes (Doctor of Health Science and Doctor of Philosophy). These tertiary programmes align with three overarching career pathways: (i) advanced clinical practice, including scopes such as designated nurse prescriber and nurse practitioner; (ii) nursing education; and (iii) research and quality improvement.

The development of clinical expertise and leadership gained momentum in the 1980s, influenced by Benner's (1984) novice-to-expert model. This work informed the creation of the Professional Development and Recognition Programme (PDRP), which established a structured career pathway for nurses demonstrating clinical skill and leadership, with links to remuneration (Peach, 1998, 2013). The PDRP provided a framework for articulating nursing practice across four levels: beginner, competent, proficient, and expert. At the beginner level, nurses consolidate knowledge and develop critical thinking skills during their first year of practice. Competent nurses demonstrate confidence and capability in managing their practice and responding to clinical changes. Proficient nurses guide and support others while leading responses to complex clinical situations. Expert nurses synthesise advanced knowledge and skills to anticipate and manage evolving clinical needs.

Over time, the PDRP evolved to include leadership, management, quality improvement, and research, particularly for senior nurses pursuing postgraduate education. These developments paralleled the growth of postgraduate qualifications and the competency-based practising certificate renewal process introduced by NCNZ. Programmes leading to advanced scopes of practice, such as nurse practitioner, are accredited by the NCNZ to ensure consistency in standards and expectations.

In addition to clinical qualifications, postgraduate pathways in leadership, education, and research supported a comprehensive and strategically designed nursing workforce. Integration of a strategically aligned career progression, regulatory oversight from NCNZ, and academic advancement, reflects a deliberate alignment with organisational priorities. It ensures that nurses are both clinically competent and equipped to lead, educate, and innovate within complex health care environments.

2.4 The Connection Between Operational, Clinical, and Education to Enhance Quality Outcomes

This section reviews the literature that met the inclusion criteria focusing on how the integration of operational leadership, clinical practice, and education and development contributes to achieving quality outcomes in nursing. These interconnections informed the refinement of the research question.

Strategic documents such as the MoH Strategy (2016), Health New Zealand Te Whatu Ora Waikato District's Strategic Plan (2016), and Nursing at Waikato's Strategic Aims (Waikato DHB, 2017) emphasise learning and development as mechanisms for achieving organisational

priorities (MoH, 2016; Waikato DHB, 2016, 2021). Benner et al. (2010) described nursing education as comprising three interrelated apprenticeships: (i) theoretical and scientific foundations, (ii) mastery of skilled practice, and (iii) the formation of professional identity and agency. Although Benner et al.'s study focused on pre-registration education, it was included in the review due to its emphasis on integrating knowledge, clinical reasoning, and ethical practice as elements essential to quality care.

2.4.1 Governance and Accountability

Benner (2012) argued that bridging the gap between theory and practice requires shared responsibility between education and clinical practice. While not explicitly labelled as governance, this integration aligns with governance principles that support quality outcomes. Several authors (Francis, 2013; Gauld & Horsburgh, 2015; Hastings et al., 2014; Hoare et al., 2011; Hollnagel et al., 2015; Howard, 2016; McSherry & McSherry, 2013) have identified clinical governance and quality frameworks as essential to accountability and development.

Despite the recognised importance of standards in delivering quality care (Francis, 2013; McSherry & McSherry, 2013), misalignment persists between these standards and workforce structures, employment models, and funding mechanisms. Education is often acknowledged as beneficial but remains inconsistently integrated into service development. Learning needs assessments and capability measures can enhance the responsiveness of education teams (McAllister & Flynn, 2016).

Governance structures varied in their inclusion of stakeholders which shaped how accountability and quality outcomes were described and achieved. Gauld's (2003) earlier work provided a collective view of a range of Aotearoa New Zealand contributors establishing a foundation for systemic response. In this work, Gauld distinguished between corporate governance which focuses on systems, and resources, planning, and clinical governance which addresses frontline care. His later publications confirmed the links between governance and quality outcomes, to which education contributes; however, stronger emphasis on this connection appeared in his earlier analysis (Gauld, 2003). Practice examples included nursing education teams referred to as PDUs which functioned as vehicles for integrating education and clinical practice. From these examples, recommendations emphasised the implementation of PDUs as part of a broader systemic response, positioning them to strengthen governance, enhance accountability, and embed quality outcomes within everyday service delivery.

Hollnagel et al. (2015) noted that quality outcomes were often assessed by identifying failures rather than successes. When synthesised with Gauld's (2003) findings, a critical tension was highlighted; that was, while governance frameworks tended to emphasise deficits, one of the successes in quality outcomes lay in participation and in-practice education. This suggested that governance models needed to move beyond deficit-based evaluation to recognise the positive impact of educational engagement and collaborative practice.

Further contributions reinforced this integrative perspective. Osei-Kyei et al. (2017) demonstrated that recognising the unique contributions of operational leadership and education to clinical contexts added value across domains. Similarly, practice development approaches described by Manley et al. (2017) and McCauley et al. (2014) promoted participatory integration and relational effectiveness, embedding clinical governance principles within everyday practice. Collectively, these approaches underscored that governance and accountability were most effective when they facilitated collaboration, supported education, and acknowledged the relational dimensions of clinical leadership.

2.4.2 Indigenous Frameworks

Indigenous frameworks offered valuable models for integrated healthcare approaches particularly within Aotearoa New Zealand. Methodologies grounded in Māori values emphasised collaboration, effective relationships, and holistic well-being as principles that align closely with population health priorities and that have demonstrated positive outcomes (Berghan et al., 2017; Gardner et al., 2018; Kidd et al., 2019; McCalman et al., 2019; Pitama et al., 2014; Wilson & Baker, 2012). These frameworks challenge conventional biomedical paradigms by foregrounding cultural context and collective responsibility; thereby framing health delivery as a relational and community centred practice rather than a primarily clinical transaction.

Systemic evaluations across international contexts further underscore the limitations of current healthcare models. Benner et al.'s (2010) critique of the United States' health system resonates with findings from the Francis (2013) report in the United Kingdom and the Simpson Report (MoH, 2020a) in Aotearoa New Zealand. Each report identifies structural inadequacies in meeting contemporary healthcare demands, particularly in relation to equity and responsiveness. Together, these evaluations highlighted the global challenge of aligning health systems with diverse population needs and reinforced the value of Indigenous approaches that prioritised equity and cultural responsiveness (Kidd et al., 2019).

From a population health perspective, the Wai 2575 claim (Waitangi Tribunal, 2019, 2023) provided compelling evidence of systemic failure in addressing Māori health needs. It highlighted the enduring impact of colonisation and institutional racism on health outcomes. In response, the Meihana Model (Pitama et al., 2014) offered a culturally grounded clinical framework that integrates systemic, historical, and cultural dimensions into assessment and care planning. This model exemplified how Indigenous knowledge systems can inform holistic, responsive, and equitable healthcare delivery, positioning Māori values and worldview as central to advancing health equity and the associated quality outcomes.

2.4.3 Systemic Disconnects

Across the review, authors consistently referred to systemic disconnects that undermined practice development. Lavery (2016) and Manley et al. (2017) framed development across micro (individual), meso (service/unit), and macro (system-wide) levels; yet, translation of policy into practice remained uneven. The Francis (2013) inquiry and McSherry and McSherry (2013) exposed how operational imperatives eroded clinical standards, normalising substandard care and weakening leadership, communication, and compassion. Similar divides were evident in Aotearoa New Zealand where Gauld (2003) and Gauld and Horsburgh (2015) described persistent tensions between management and frontline clinicians. Across contexts, literature highlighted recurring gaps between clinical roles and service delivery demands, between professional groups, and between education and practice. Collectively, these findings underscored that systemic disconnects were not isolated incidents but structural features of healthcare organisations. A key point of convergence between the Francis Report (2013) in the United Kingdom and the Simpson Report (2020) in Aotearoa New Zealand lies in the structural conditions under which publicly funded health systems operate. Both identify how government mandated directives, commonly operationalised as performance targets, shape organisational priorities and practices. While intended to drive accountability and efficiency, these target-based frameworks can contribute to systemic disconnects between policy intent and frontline care delivery.

Governance frameworks emerged as a central response to these disconnects. Hastings et al.'s (2014) systematic review of 133 studies on governance mechanisms and workforce, demonstrated that shared governance models involving clinical staff, including nurses, improved job satisfaction, attitudes, and quality initiatives while reducing turnover. However, workforce engagement did not increase as anticipated, highlighting the need for clearer goals and stronger integration of governance with practice development.

Across the literature, authors identified multiple forms of systemic disconnect. The most prominent gap lay between clinical nursing roles and the operational demands of service delivery, particularly in relation to resource allocation. Additional gaps were noted between professional groups which contributed to fragmented care, and between education and practice, commonly referred to as the theory–practice gap.

The Mid-Staffordshire National Health Service Foundation Trust Public Inquiry in the United Kingdom (Francis, 2013) revealed a significant disconnect between operational managers and clinical nurses, a finding explored by McSherry and McSherry (2013). Their report identified a lack of accountability for poor standards and priorities that stemmed from the absence of structure and processes to make accountability visible and applied. Workforce preparedness, particularly the knowledge and skills required to deliver care that met expected standards, was also implicated. This gap reflected a practice culture in which substandard person-centred care had become normalised. The inquiry revealed deficiencies in nursing leadership, communication, and compassion, alongside a closed organisational culture where operational imperatives undermined clinical standards and relationships. Both McSherry and McSherry and the Francis report emphasised the need to strengthen partnerships between education and clinical practice within a robust clinical governance framework to address these systemic issues.

Similar concerns have been identified within the Aotearoa New Zealand context. Gauld's (2003) work, which recommended connection with dedicated PDUs, and later Gauld and Horsburgh (2015), described a persistent divide between operational leaders (referred to as management) and frontline clinicians. Drawing on 2012 national survey data, they advocated for the implementation of clinical governance and professional development frameworks to guide service delivery and improve outcomes. Their recommendations positioned clinical governance as a mechanism for systemic reform aimed at enhancing patient safety and quality of care through interdisciplinary engagement, collaboration, and relational connection with education as a contribution to success.

Evidence of the benefits of such interdisciplinary approaches is found in Bidwell and Copeland's (2017) study of a professional development initiative in primary care. Conducted across a small sample of urban general practices in Aotearoa New Zealand, the study demonstrated improved patient outcomes and enhanced collaboration. Despite its limited scale (14 participants with an 86% response rate), the initiative reflected the typical size of urban primary care teams and underscored the value of integrating clinical practice, logistics, and professional development.

Across these studies, quality outcomes consistently emerged as a foundational measure of health service effectiveness. However, an emphasis on performance targets has the potential to narrow accountability by privileging measurable outputs, thereby shifting focus away from the broader, more complex dimensions of care quality. Both the Francis (2013) inquiry and Gauld's (2003) edited compilation of Aotearoa New Zealand authors, underscore the centrality of quality outcomes in evaluating healthcare performance. More recently, this focus has evolved into a results-oriented focus, where quality outcomes are explicitly defined and used to guide strategic improvements in service delivery. Such a focus is consistent with the WHO (2018) who described quality outcomes as the "degree to which health services delivered increase the likelihood of desired health outcomes for individual and population; based on evidenced professional knowledge aimed at being effective, safe, people-centred, timely, equitable, integrated, and efficient" (p. 14). This evolution reflects a shift from structural reform toward outcome driven accountability positioning quality as the unifying theme across governance and professional development.

2.4.4 Clinical Governance as a Framework for Change

Clinical governance has been framed as a mechanism for making quality outcomes both visible and valued, while ensuring accountability within healthcare systems through transparency and responsibility in practice. Hoare et al. (2011) undertook a collaborative study across the United Kingdom, Australia, and Aotearoa New Zealand to situate clinical governance within diverse health contexts. In the United Kingdom, the statutory requirement for accountability in quality care was introduced in 1999, marking a significant shift from a predominantly financial focus to one centred on clinical outcomes. The Department of Health (1999a, 1999b, 1999c, as cited in Hoare et al., 2011) identified six essential conditions necessary for clinical governance to thrive. These are summarised in Table 1 and provide a foundational framework for understanding how clinical governance can be operationalised to improve care quality, foster professional development, and enhance accountability across health systems.

Table 1.

The six essential conditions for effective clinical governance

Conditions for clinical governance	
1.	Open and participative culture in which education, research, and the sharing of good practice are valued and expected
2.	Commitment to quality that is shared by staff and managers, and supported by clearly identified local resources, both human and financial
3.	Tradition of active working with the public, users of services, and carers
4.	Ethos of multi-disciplinary working at all levels of the organisation
5.	Regular Board level discussion of all major quality issues for the organisation and strong leadership from the top
6.	Good use of information to plan and assess progress

From The role of government policy in supporting nurse-led care in general practice in the United Kingdom, New Zealand, and Australia: An adapted realist review, by K., Hoare, J. Mills & K. Francis, 2011, Journal of Advanced Nursing 68(5) p.971. Blackwell Publishing Ltd.

Hoare et al.'s (2011) examination of government policy and its role in supporting nurse-led care in primary settings identified only two articles from Australia and none from Aotearoa New Zealand; however despite the limited literature base, both countries were described as aligning with global principles of clinical governance. In Aotearoa New Zealand, the concept of clinical governance was formalised in policy in 2009, with clear expectations from the MoH that clinical governance reporting was an active process within the then-DHB structure of the public health system. Hoare et al. noted that while the terms 'clinical' and 'governance' implied clinician led, clinical governance was often corporate led, suggesting ownership by executives rather than clinical staff.

Subsequent studies highlighted variability in the application of clinical governance. Gauld and Horsburgh (2015) and Bamford-Wade and Moss (2010) argued that policy alone was insufficient to drive change, emphasising the need for active facilitation and education to improve implementation. The Health Quality Safety Commission (2017) in Aotearoa New Zealand advanced a model of clinical governance that positioned clinicians, managers, and other staff as partners in improving and being held accountable for the quality and safety of health and disability services. Key characteristics of this model included patient-centred care,

an open and transparent culture, active participation by all staff, and a continuous focus on quality improvement. Significantly, education and professional development were expected to underpin the application of these principles.

Gauld and Horsburgh (2015) suggested that the application of clinical governance was often variable, with education and development identified as critical components for clinicians, including the acquisition of specific clinical knowledge and skills, clinical audit, analysis of failures and successes, professional supervision, and mentoring. Clinical governance was heralded as the process that saw strategy become applied and accountable with active processes to demonstrate effectiveness and quality of care. This approach brought clinical priorities to the fore, with other corporate functions to support, enable, and achieve those goals. Guiding documents informing Te Whatu Ora Waikato District's service delivery, such as the NZ Health Strategy (MoH, 2016), Waikato DHB Strategic Imperatives (2017), Nursing at Waikato DHB (2017-2022), and Nursing at Waikato Strategic Aims (2017-2023), have consistently documented clinical governance as the mechanism for ensuring accountability, improving care quality, and enhancing patient experience (Health Quality Safety Commission, 2022).

Taken together, the literature suggested variability in the application of clinical governance, which created policy-practice gaps that undermined accountability and equity. Gauld and Horsburgh (2015) highlighted that governance policies alone were insufficient without education and development to support clinicians, while the Wai2575 report (Kidd et al., 2019; Waitangi Tribunal, 2019, 2023) demonstrated how such gaps translated into systemic failures to meet Te Tiriti o Waitangi obligations, with negative consequences for Māori health outcomes. These findings, which resonated with the Francis (2013) inquiry, signalled the role of organisational culture in perpetuating failures of care. Across contexts, the evidence pointed to genuine partnerships, cultural competence, and collaborative education as the integrative strategies required to transform governance from a deficit-based, corporate-led process into a participatory framework that prioritised equity and quality outcomes. The culmination of these concepts illustrated how systemic disconnects were addressed through governance reform, reform was operationalised through education and partnership, and the ultimate measure of success was the achievement of equitable, patient-centred quality outcomes.

Kidd et al. (2019) argued that genuine partnerships were essential to influence practice and organisational culture in ways that equipped nurses to address equity, lead and facilitate clinical and cultural competence, and advocate for a workforce to meet health needs. Berghan et al. (2017) reinforced this perspective through an equity lens, noting that connections and

partnerships were central to addressing Māori health needs and that equitable approaches ultimately benefited all populations by raising standards of care. Learning from the consequences of failing to meet Te Tiriti o Waitangi obligations was positioned as a strategy for building partnerships that deliver results, aligning governance with equity, accountability, and cultural competence.

A consistent theme across the literature is a lack of clarity regarding accountability for education and professional development within organisational structures, particularly in relation to supporting clinical governance. This ambiguity reflects a broader systemic disconnect, where responsibility for workforce capability is diluted across organisational boundaries, weakening alignment between educational provision and the realities of clinical practice. Hastings et al. (2014) highlight how insufficiently defined roles and fragmented organisational arrangements can undermine effective governance and workforce development. From a sense-making perspective, this lack of clarity disrupts the “bridges” between education and practice communities, limiting shared understanding of roles, expectations, and outcomes.

A further manifestation of systemic disconnect is evident in the persistent mismatch between available resources, most notably nursing staff, and the needs of consumers/tāngata whaiora. This misalignment was noted to compromise care delivery and highlights the tension between service demand and workforce capacity. Lavery (2016) similarly identifies how resource constraints and workforce pressures can erode care quality and contribute to variability in service provision. In Aotearoa New Zealand, workload management tools such as the Care Capacity Demand Management (CCDM) framework provide empirical evidence of these pressures, demonstrating ongoing nursing resource shortfalls (MoH, 2016). These findings reinforce the gap between organisational planning and frontline realities, where the capacity to deliver safe, high-quality care is constrained by structural limitations.

Collaboration and partnership are frequently proposed in the literature as mechanisms to mitigate these challenges; however, Hastings et al. (2014) caution that their effectiveness depends on clearly defined roles, shared accountability, and strong relational coordination. Recruitment strategies, including the employment of internationally qualified nurses (IQNs), form a key part of workforce responses. While IQNs bring valuable expertise and cultural diversity, their integration further exposes the need for coherent systems of support. In particular, orientation to the bicultural context of Aotearoa New Zealand, and alignment with Te Tiriti o Waitangi obligations, requires structured transition processes that enable meaningful learning and professional adaptation (NCNZ, 2022b).

Taken together, these issues illustrate how systemic disconnects—between education and practice, capacity and demand, and policy and implementation—are not merely operational challenges but reflect deeper issues of coordination, accountability, and shared meaning within health systems. As Lavery (2016) suggests, addressing such complexity requires attention not only to structural reform but also to the relational processes that enable integration. In this context, a focus on sensegiving and sensemaking provides a useful lens for understanding how effective "bridging" across organisational and professional boundaries can be achieved.

2.4.5 Partnership and Collaboration

Partnerships and collaboration consistently emerged as key strategies for bridging gaps in workforce resourcing and integrating knowledge and skills within clinical teams. Practice development theory emphasised that values and purpose should precede structures and processes in shaping collaborative practice (Manley et al., 2017). Indigenous models reinforced this perspective. Pitama et al. (2014) described the Hui process and Meihana Model as Indigenous knowledges that enabled safe, participatory ways of forming connections and addressing tensions. Baker (2008) articulated Te Arawhata o Aorua as a process for bridging the tension between Māori, as Indigenous peoples, and others who arrived later in Aotearoa New Zealand. Wilson and Baker (2012) extended this bridge concept by incorporating advocacy, Māori worldview, tikanga (cultural beliefs and practices), and workforce development. While their grounded theory study focused on bridging cultures, the principles were applicable to bridging operational and clinical tensions, particularly when facilitated through education and development.

The literature review highlighted a persistent absence of meaningful partnership between operational and clinical practice, as well as between education and development functions. Howard (2016) attempted to establish a collaborative pathway for shared accountability across corporate, operational, and clinical domains, emphasising that both clinicians and managers were motivated by a commitment to patients' best interests. The core challenge, however, lay in creating organisational environments that genuinely supported collective action toward common goals. The MoH (2016) strategy articulated the notion of 'One Team', promoting integrated practices across management, governance, and wider system actors. Despite emphasis on collaboration, the role of education and development in enabling these joint priorities remained limited beyond governance-focused training.

The 2023 iteration of the MoH strategy incorporated the Pae Ora Healthy Futures Act (2022), and shifted focus considerably, prioritising a learning culture as one of its six key priorities. The other priorities included the voice at the heart of the system, partnerships for health and well-being, valuing the workforce, a resilient and sustainable system, and flexible and appropriate care. These priorities were reinforced through policies, systems, practices, relationships, and behaviours, aligning with much of the literature reviewed. Pae Ora was the most active strategy to date in Aotearoa New Zealand in terms of applying Te Tiriti o Waitangi. The establishment of Te Aka Whai Ora (Māori Health Authority) (Te Aka Whaiora, 2022), to advise the MoH and undertake planning and commissioning of services represented a significant shift from consultation to active governance. However, its subsequent disbandment and incorporation into Health New Zealand – Te Whatu Ora, with a Hauora Māori Health Directorate, reflected ongoing structural tensions.

Partnerships that balanced Te Tiriti o Waitangi articles of kāwanatanga (governorship) and tino rangatiratanga (self-determination) were highlighted in the Wai2575 (2019) inquiry. In contrast a further gap was evident in the inconsistent application of these principles, despite their frequent reference in strategy documents. For example, the New Zealand Health Strategy (MoH, 2016) mentioned tino rangatiratanga in its introduction but not in the body of the document, revealing disconnection between vision and implementation (Kidd et al., 2019). Gardner et al. (2018) echoed this finding in their systematic review of continuous quality improvement in Aboriginal and Torres Strait Islander primary healthcare, noting that cultural values and Indigenous knowledges were central to generating a culture of quality improvement.

Similar cultural considerations were outlined by McCalman et al. (2019), who undertook a systematic review of Indigenous primary healthcare workforce development across Canada, Australia, New Zealand, and the United States (CANZUS). Their review of 28 studies reported impacts of improved workforce sustainability, capacity, growth, and healthcare performance, alongside strategies to enhance recruitment, retention, teamwork, supervision, and mentoring. However, the role of education and development in supporting sustainability and performance indicators remained unclear. A notable characteristic of their findings was the enduring impact of British colonisation on poor Indigenous health outcomes compared with non-Indigenous populations. Supportive policy, strong leadership, and accessible tools such as electronic records were perceived as enablers of Indigenous workforce growth and retention. Conversely, weak leadership and loss of continuity undermined patient trust, contributing to stress, turnover, and tensions among nurses attempting to meet professional requirements without sufficient workforce support. Six studies identified chronic disease prevention and

management as priorities, particularly where collaboration between providers and communities was evident. Notably, the use of culturally specific knowledge and practices empowered health consumers and strengthened quality outcomes.

McCauley et al. (2014) demonstrated practice development collaboration through values clarification and negotiated processes for clinical care and person-centred approaches. While their emphasis was on the practice development process, rather than specifically the operational, clinical, and development interface, many aspects of their review echo the theoretical underpinnings of this study from the Waikato District Integration and Streamlining Project (Hayward & Atherfold, 2015; Marriott, 2014). McCauley et al. found that process facilitation was an active, negotiated endeavour, shaped by the values underpinning the work. Through explicit values clarification and the establishment of shared ground rules, the facilitation approach created conditions that supported both interdepartmental and interprofessional collaboration. Aqtash et al. (2022) similarly reported that coaching and development initiatives improved quality outcomes and professional goals among nurse managers based on analysis of their survey of 105 nurse managers. Yet, both McCauley et al. and Aqtash et al.'s studies overlooked the structural governance components that embed accountability and sustain collaboration. In contrast, Ayeleke et al. (2019) identified shared governance as a mechanism for achieving sustainable leadership and operational change, emphasising the importance of structural alignment that empowers decision-making and enhances clinical care and quality outcomes. Their discussion of governance is situated within a practice-development and leadership context, highlighting how distributed authority and collaborative structures can strengthen professional engagement and support continuous improvement.

2.4.6 Leadership, Education, and Development

Structural alignment was reinforced across the literature as an enabler of quality outcomes. Osei-Kyei et al. (2017) emphasised that effective systems required integration of purpose, accountability, performance measures, resource and quality standards. Osei-Kyei et al. highlighted that structures are not effective simply by existing and that they became meaningful when clarity of purpose and accountability mechanisms were implemented and teams received the appropriate development.

In a study local to Waikato, Howard (2016) described decision-making close to patient care as a process for bridging operation and clinical teams, aligning with Hollnagel et al. (2015) who promoted a quality perspective that facilitated collaborative decision-making between

operational and clinical teams framed as Safety II. Hollnagel et al.'s quality approach was distinctive in that it shifted from a lens of what had gone wrong as a means to understand how to improve, to a lens of what had gone well and learning from similar situations with improved outcomes. Ayeleke et al. (2019) explored the impact of practice development on leadership and management competence, noting they were two distinct practice areas. Their systematic review demonstrated that competence was a driver for effective change, and that the social context of healthcare brings both leadership and management close together. Nurse managers were the most frequently represented participants, although other managers and leaders were included. The range of development interventions included reflection, coaching, communication effectiveness, as well as functional components such as meeting standards and leading projects and teams. Further, Aqtash et al.'s (2022) study showed that an education programme for leadership and management competence for nurse managers drew similar outcomes. The particular focus they drew attention to is quality improvement based on the premise that effective leadership and management assure the expected quality of care is provided. Their use of the Standards for Quality Improvement Reporting Excellence (SQUIRES) guidelines provided a tangible measure of significant improvement, with secondary data coming from pre- and post-course assessments.

Similarly, McAllister and Flynn (2016) developed the Capabilities of Nurse Educators (CONE) tool for 266 nurse educators from universities and health services to self-report areas of capability, areas for development, and evaluate professional development interventions using six subsets: teaching knowledge and practice, drawing from nursing knowledge, teaching relationships, leadership, research orientation, and research action. They noted the complexity of nurse educators' roles in both academic and practice settings, and findings were compelling in planning for practice and professional development and career planning. Notably, those nurse educators working in both clinical and academic settings achieved the best results in all six categories. The authors noted that the opportunity for shared models of work across both academic and clinical settings should be part of career frameworks for those working in nursing education.

Gardner et al. (2018) integrated the clinical and quality benefits of professional groups collaborating for primary healthcare for Indigenous populations in the Torres Strait Islands. Including these components prevented operational management from defaulting to reactionary problem-solving in complex circumstances. Ducat et al. (2016) described methods for understanding these situations, drawing on outcomes from their qualitative descriptive study of rural and remote clinicians undertaking supervision. They found that a structured approach to professional supervision supported evidence-based practice and patient safety by relieving

a sense of isolation and providing protected time for developing the knowledge and skills that lead to confidence in isolated, complex, and changing situations.

Howard (2016) described the value of structure supporting the specialist body of knowledge and skills for operational management. He noted this was often assumed to be intuitive or automatic if one has other expertise (i.e., clinical). In other words, if a person is effective clinically, the expectation is that they will also reflect strengths in operational management. This may not necessarily be the case. As with all disciplines, a unique body of knowledge informs what Howard described as the mastery of their professional discipline's skill and function. Valuing this skill set of specialty strengths is fundamental to the reciprocal connection where clinical and operational expertise are applied (Howard, 2016). However, mastering a clinical skill set does not automatically translate to an operational management skill set which may take time and experience to refine and master. This does not exclude nurses and other clinical staff from growing their knowledge, skills, and expertise for operational management, or vice versa. However, Howard identified that structured development for the specific operational management skill set needs to be undertaken. For example, nurses or clinicians desiring to become operational leaders may undertake education and development to reflect the unique skills for operational management. While the principles of clinical governance (Gauld & Horsburgh, 2015) address practice and operational management issues by providing an integrated structure, a dominant discourse continues about the perceived disconnect between operational and clinical practice/practitioners and the associated role of education and development.

2.5 Chapter Summary

Chapter Two outlined the literature review process and context which resulted in the refined research question as: *How can nursing education and development strengthen operational and clinical practice to enhance quality outcomes within Health New Zealand Te Whatu Ora Waikato District?* The review demonstrated that education and development initiatives contribute to addressing clinical and operational demands in healthcare delivery. However, the evidence revealed a notable gap, education and development were not consistently embedded within structural accountabilities, resulting in a lack of clarity about how these functions can be leveraged to achieve and sustain quality outcomes. This gap directly informed the focus of the research. The clarification and refinement process established clear boundaries, ensuring that the study centred on the interface of education and development within the Te Whatu Ora Waikato District. Although wider workforce and governance issues remain pertinent and merit future inquiry, the specificity of the research question necessitated

a methodological approach capable of capturing the organisational, cultural, and contextual dynamics shaping this particular setting. Thus, the literature review identified the evidence gap and shaped the methodological choice. The case study design presented in Chapter Three was selected to explore how education and development can strengthen operation and clinical practice within Te Whatu Ora Waikato.

CHAPTER III RESEARCH DESIGN

3.1 Introduction

This chapter presents the research design used to guide the research addressing how nursing education and development can strengthen operational and clinical practice to achieve quality outcomes within Te Whatu Ora Waikato District. Part One outlines the methodology which incorporates the critical interpretative research paradigm (Moon & Blackman, 2014) informed by critical social theory (Fay, 1987). Next, the methodological stance of an integrated approach to a single embedded case study is presented. This approach draws on the foundational work of Yin (2018), Merriam (2009), and Stake (1995). The methodology is further enhanced by critical appreciative processes (Grant & Humphries, 2006) and bicultural principles informed by Te Tiriti o Waitangi and the work of Durie (1994).

Part Two outlines the methods used within the single embedded case study design, including participant engagement, data collection, and analysis procedures. It presents the research protocol (Yin, 2018) and details the specific methods applied to address the two UofA: strategic intentions and stakeholder perspectives. Data collection involved focus groups, individual interviews, and document review. Document data were managed as a distinct collection process while focus group and interview data were combined and reflexive thematic analysis undertaken (Braun & Clarke, 2022). The chapter concludes with the ethical considerations to ensure the research was conducted with rigour, cultural responsiveness, and ethical integrity.

3.2 Part One: Research Paradigm and Methodology

This section outlines the research paradigm, epistemological stance, and methodology adopted within the study's design. This qualitative research study was framed within a critical interpretative paradigm (Moon & Blackman, 2014) and informed by critical social theory (Fay, 1987). Guided by this ontological perspective, the study explored practice realities, structural dynamics, inequities, and historical conditions to address the research question: *How can*

nursing education and development strengthen operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District?

The critical interpretive paradigm provides a framework through which participants' knowledge, experiences, and practice realities can be meaningfully interpreted. It recognises that both participants and researcher are shaped by broader structural, cultural, and organisational influences (Cresswell & Cresswell, 2018; Crotty, 2020), and that these factors influence how the research question is understood within Te Whatu Ora Waikato District. This paradigm aligns with the methodological foundations of the study by incorporating the structured, case study approach associated with Yin (2018), and the socially constructed nature of meaning emphasised by Merriam (2009) and Stake (1995). Together, these perspectives support an inquiry that is interpretive and responsive to the organisational and contextual influences of the case. The paradigm's emphasis on boundedness is particularly relevant within Te Whatu Ora Waikato District, where cultural, structural, and operational factors shape the experiences being explored, and align with critical social theory (Fay, 1987).

A central principle of critical social theory (Fay, 1987) is the recognition that existing social arrangements are neither neutral nor inevitable, and that inquiry should illuminate where change is necessary and possible. Rather than solely describing practice, critical social theory is oriented toward transformation, seeking to expose and critique the structural, relational, and ideological conditions that shape action and constrain possibilities. It foregrounds the operation of power within institutions, policies, and dominant discourses, highlighting how these can reproduce inequities unless subject to critical interrogation.

Within this study, critical social theory provided an analytical lens through which the context of Te Whatu Ora Waikato District could be understood as historically and socially situated. This is particularly significant in Aotearoa New Zealand, where Te Tiriti o Waitangi establishes obligations to uphold equity, partnership, and active protection. From a critical and decolonising perspective, these obligations require examination of how colonial legacies continue to shape health systems, organisational structures, and professional practices. Critical social theory therefore supported interrogation of how inequities experienced by Māori and other groups are not incidental, but are produced and maintained through systemic arrangements, including policy, resource allocation, and institutional norms.

The integration of a critical interpretive paradigm with critical social theory enabled both in depth understanding and critical analysis. While the interpretive component facilitated engagement with participants' lived experiences, critical social theory situated these

experiences within broader structures of power and inequality. This dual approach allowed the study to move beyond individual accounts to examine how organisational priorities, funding models, and performance expectations may constrain the enactment of culturally safe and equitable care. It also highlighted tensions between espoused commitments to equity and the realities of practice within complex health systems.

Further, this approach aligns with decolonising methodologies that seek to challenge dominant knowledge systems and centre perspectives that have historically been marginalised. By examining the intersections between operational management, clinical care, and education and development, which are areas often considered in isolation, the study addresses a gap identified in the literature. It explores how these domains interact within the organisational and cultural context of Te Whatu Ora Waikato District, and how these interactions shape both opportunities for, and barriers to, equitable practice.

In this way, the study adopts a critical and action oriented stance, making visible the multilevel influences on practice, individual, professional, organisational and systemic factors, while maintaining a focus on the structural conditions that ultimately enable or constrain change. Consistent with both critical social theory and Te Tiriti o Waitangi obligations, the intent is not only to understand the current state, but to identify pathways toward more equitable and transformative health care practice.

3.2.1 Single Embedded Case Study

A single embedded case study methodology was selected for the research, using an integrated approach drawing on the foundational work of Yin (2018), Merriam (2009), and Stake (1995). Luck et al. (2006) referred to the integration within case study methodology as a ‘bridge between paradigms’ thus extending it from earlier references of a bridge between the literature and research perspectives. This metaphor served as a conceptual thread, symbolising the connection and integration of diverse elements such as theoretical frameworks, stakeholder perspectives, and bicultural approaches within the study. The bridge metaphor provided a meaningful way to navigate and reconcile differing epistemological and methodological positions, supporting flexibility and responsiveness. To illustrate this bridging concept, Table 2 outlines the individual contributions of Yin, Merriam, and Stake, based on Yazan’s (2015) comparative analysis. Yazan noted that Yin, Merriam, and Stake are recognised as seminal figures in case study methodology, particularly within educational research as a context that aligns closely with this study. These integrated features were then overlaid with critical appreciative processes (Grant & Humphries, 2006) and bicultural approaches informed by Te Tiriti o Waitangi, forming the methodological foundation of the study. Building on the

perspectives of Yin, Merriam, and Stake, the following section elaborates on how this integrated framework informs the methodology.

Yin's (2018) positivist perspective emphasised logical and systematic observation and analysis to ensure validity and reliability. In contrast, Merriam's (2009) constructionist stance focused on the social construction of meaning through the interpretation of lived experiences. Stake's (1995) earlier constructionist approach highlighted the co-construction of meaning by stakeholders, recognising that individuals interpret experiences in diverse ways. These three perspectives informed the development of the research design by incorporating constructivist and positivist epistemologies. The synthesis provided both structure and adaptability, essential for investigating a complex organisation such as Te Whatu Ora Waikato District. Further, it introduced the study's inclusion of critical appreciative inquiry and bicultural responsiveness, enabling the research to span traditional boundaries and generate contextually grounded insights.

Yin (2018) defined a case study as "an empirical investigation of a contemporary phenomenon in-depth within its real-world context" (p. 15), typically guided by 'how' or 'why' questions. His predominantly positivist approach emphasises a clearly defined structure to ensure validity and reliability, commonly referred to as rigour and research quality. Central to Yin's methodology is the use of a research protocol and clearly specified units of analysis (UofA), which provide structure and support systematic data collection and analysis.

In this study, however, the UofA were not predetermined solely by methodological prescription, but were derived from and aligned with the research question. Yin's approach therefore informed the identification and organisation of the UofA, rather than defining them. This reflects a more interpretive orientation, consistent with Stake (1995), who emphasises the importance of understanding the case through its context and meanings, and Merriam (1998), who positions case study as flexible and responsive to the research focus.

Drawing on these perspectives, the study adopted a pragmatic approach in which Yin's structured processes, such as the use of a research protocol, were used to enhance transparency and rigour, while Stake and Merriam informed a more inductive approach reflecting the context. The UofA were therefore conceptualised as analytically useful categories grounded in the research question, enabling exploration across different levels of the case.

Reliability, or trustworthiness, was strengthened through the use of multiple sources of evidence. Consistent with Yin's emphasis on triangulation, documentary data were

incorporated alongside participant perspectives. In this study, strategic documents, policies, and guidelines functioned as organisational-level data sources, providing insight into system-level influences. These were analysed in conjunction with participant experience, allowing for a more nuanced understanding of the phenomenon across individual, professional, and organisational dimensions.

Table 2.

How attributes of Yin, Stake, and Merriam informed the research design (Adapted from Yazan, 2015).

Construct	Yin (2018)	Stake (1995)	Merriam (2009)	This Case Study
Epistemology and paradigm	Positivism. Primarily qualitative, seeking meaning, context, and situated knowledge.	Constructionist qualitative.	Constructionist qualitative.	Constructionist qualitative (Braun & Clarke, 2022; Payne, 2021).
UofA	Forms part of the structure within the case.	Priority is for rich organisational context rather than UoA.	Integrates UofA with the rigour of Yin and the interpretation of Stake.	Two UofA: i) Strategic priorities of Te Whatu Ora Waikato District ii) Stakeholder perspectives
Definition	Asks 'how' or 'why'.	Interrelationship between the phenomenon and contexts.	Focus on the phenomenon.	How, why, interrelationships.
Design	Single embedded case study. Can be qualitative and quantitative. Propositions. UoA. Logic linking data to propositions. Criteria for interpreting the findings. Protocol provides structure.	Qualitative. Sensitivity and scepticism.	Qualitatively conduct effective interviews and mine data from documents.	Single embedded case study with two UofA: i) Strategic priorities of Te Whatu Ora Waikato District ii) Stakeholder perspectives Proposition: Effective connections between operational, clinical, and educational and developmental aspects enhance quality outcomes.
Data	Documents, interviews, artefacts.	Interviews, documents.	Interviews, documents.	Documents, interviews, artefacts. Participatory approaches (Manley et al., 2021).
Analysis	Pattern matching, explanation, timeframes, programme logic (NVivo), models and cross-case synthesis. Triangulation of data sources and participant checking.	Categorial aggregation, direct interpretation, triangulation, and reflection.	Reflection, analytic induction.	Aggregation of codes and categories using NVivo, models, reflections, triangulation, and participant checking. Reflexive thematic analysis and analytic induction (Braun & Clarke, 2022).
Validation	Internal and external with protocols and databases within NVivo.	Data source triangulation, investigator triangulation, theory triangulation, and methodological triangulation.	Triangulation, participant checks, audit trail, thick description.	Research protocol (Appendix C). Triangulation between interviews, focus groups, documents, participant checking, and descriptions reflect theory.

Adapted from Three approaches to case study methods in education: Yin, Merriam and Stake, by B. Yazan, (2015), *The Qualitative Report, 20*(2), p. 158-150.

Yin's (2018) framework categorised case studies as either holistic (with a single UofA) or embedded (with multiple UofA). The distinction between single- and multiple-case designs depends on the number of cases examined. Based on this classification, the research adopted a single embedded case study design, justified by the presence of one case as Te Whatu Ora Waikato District, with two distinct UofA.

Additionally, Merriam (2009) and Stake (1995) contributed constructivist perspectives that complemented the methodological approach. Merriam described a case study as "an in-depth description and analysis of a bounded system" (p. 40), encompassing people, policies, and programmes. Her approach recognised that individuals generate multiple interpretations of shared experiences within a social context, particularly relevant in health and education settings. Merriam's emphasis on the social nature of inquiry informed the research design, guiding theory development and the construction of a model and mechanisms for investigation. Her particularistic focus on the phenomenon of post-registration education and development aligned with the study's aim to strengthen operational and clinical practice.

Stake (1995) conceptualised the case study as a bounded and integrated system. His foundational work influenced both Merriam and Yin, though each developed distinct theoretical emphases. Stake's approach prioritised subjective interpretation, compiling diverse viewpoints to construct meaning. This flexibility made his methodology well-suited to research involving people and programmes. However, the absence of a structured protocol in Stake's model introduced potential limitations in rigour, as all impressions and familiarities were considered data, while organisational documents were typically excluded.

Stake's (1995) constructivist stance offered adaptability and depth, complementing Merriam's (2009) bounded focus and Yin's (2018) structured design. He emphasised the 'what' of the case as issues of greatest significance, while Yin focused on the 'how'. Stake's approach incorporated political, social, historical, and personal contexts, enabling the exploration of problems, conflicts, and complex backgrounds. While Stake's perspective provided rich insight, the particularity of Merriam and the rigour of Yin's protocol were essential to effectively address the complexity of the research question.

In accordance with Yin's guidance for organisational case studies, the study sourced data aligned with each the two UofA: (i) strategic priorities and (ii) stakeholder perceptions. Strategic documents, policies, and guidelines informed the first UofA; while stakeholder

perspectives were gathered from operational and management leaders, clinical nurses, and nurses involved in education and development roles. The research protocol structured the investigation process, ensuring rigour and coherence. This structure was further enriched by the integration of critical appreciative processes (Grant & Humphries, 2006) and bicultural approaches grounded in Te Tiriti o Waitangi, which collectively shaped the methodological foundation of the study.

3.2.2 Critical Appreciative Processes

Critical appreciative processes bridged both critical and appreciative stances, offering a framework for navigating paradoxes and contrasting perspectives (Grant & Humphries, 2006). This tension produced valuable insight by balancing challenge and affirmation which is less likely when these perspectives are considered in isolation. Ridley-Duff and Duncan (2015) further distinguished critique as a means of inquiring into systems and experiences, while appreciative inquiry focuses on constructing a future state that values existing strengths.

Strengths-based approaches align with appreciative inquiry (Cooperrider & Godwin, 2012), initiating organisational change through appreciation, stakeholder collaboration, and the generation of new possibilities (Cooperrider & Sekera, 2006; Cooperrider et al., 2008). This appreciative stance resonated with the Safety-II quality approach (Hollnagel et al., 2015) discussed in Chapter Two, which was presented at the 2019 Health Quality and Safety Commission conference in Aotearoa New Zealand. Safety-II shifted the focus of quality analysis from identifying what went wrong to learning from what worked well (Hollnagel et al., 2015). However, without a balance of critique the development of possibilities risked overlooking the influence of structural and systemic factors (Ridley-Duff & Duncan, 2015). Therefore, the integration of critical appreciative processes was considered appropriate for this research which was situated within a critical social theory paradigm.

Critical appreciative processes informed the research design, particularly in the preparation of facilitators and the development of interview and focus group questions. These processes ensured critical engagement with organisational structure, culture, and power dynamics. Informed by this awareness, the research design also addressed Indigenous knowledges relevant to the Te Whatu Ora Waikato District context, reinforcing the study's bicultural commitment.

3.2.3 Alignment with Te Ao Māori in the Aotearoa New Zealand Context

Equity served as a central focus in aligning the research design with Te Ao Māori. Within the Te Whatu Ora Waikato District context, equity referred to ensuring access to appropriate care that enables individuals to achieve comparable health outcomes. Equity contrasts with equality, which assumes uniform care for all—an approach that has historically contributed to poor health outcomes for Māori (MoH, 2023). The literature review highlighted the value of Indigenous knowledges as mechanisms for addressing equity, which informed their integration into the research design.

This alignment also reflected a legal and ethical commitment grounded in Te Tiriti o Waitangi. The research addressed equity through a partnership model, exemplified by the involvement of Te Kāhui Tapuhi Māori Nursing and Midwifery Advisory Group, Te Whatu Ora Waikato District which played a central role in ensuring the research design was culturally responsive and aligned with Te Ao Māori and Te Tiriti o Waitangi. Their involvement reflected a commitment to equity, partnership, and power-sharing within the Te Whatu Ora Waikato District context. The advisory group provided strategic guidance throughout the research process, contributing to the development of the methodology and informing key decisions related to research procedures. This included shaping the facilitators' workshop, advising on purposive sampling to ensure Māori representation, and guiding the incorporation of tikanga in data collection. The group also affirmed the importance of adopting a strengths-based approach, challenging deficit narratives commonly associated with Māori health outcomes. Their contributions ensured that the research upheld ethical and cultural obligations, while embedding Indigenous knowledges and practices into the study's design and implementation.

3.2.4 Summary: Paradigm and Methodology

The complexity of framing the paradigm and methodology for this research was addressed through its grounding in critical social theory (Fay, 1987), with the integration of key methodological influences from Yin (2018), Merriam (2009), and Stake (1995) within a single embedded case study design. This design enabled the exploration of the interface between operational, clinical, and educational and developmental domains within Te Whatu Ora Waikato District.

Critical appreciative processes provided a mechanism to balance critique and affirmation, reflecting priorities identified in previous work within the district. These processes supported a strengths-based approach while maintaining critical engagement with organisational structures and practices. Alignment with Te Tiriti o Waitangi was achieved through

collaboration with Te Kāhui Tapuhi Māori Nursing and Midwifery Advisory Group, Te Whatu Ora Waikato District. Their guidance affirmed the importance of a strengths-based perspective and informed key aspects of the research procedures, including facilitator preparation, sampling strategies, and the incorporation of cultural protocols.

3.3 Part Two: Methods

This section outlines the research methods used to implement the qualitative single embedded case study methodology (Merriam, 2009; Stake, 1995; Yin, 2018), supported by critical appreciative processes (Grant & Humphries, 2006) and bicultural approaches (Came, 2013). These methods were designed to address the 'how' and 'why' of the research question within the specific context of Te Whatu Ora Waikato District.

The section begins with an overview of the protocol used to gather data from documents and the sampling strategy employed to recruit participants for stakeholder focus groups and interviews. It then discusses facilitator preparation and participant checking, ensuring alignment with the overarching methodology. Reflexive thematic analysis is described as the approach used to interpret the qualitative data. The section concludes with a discussion of the procedures undertaken to ensure rigour, robustness, and ethical integrity throughout the research process.

3.3.1 Research Protocol Overview

The research protocol guided the design and implementation of the study, consistent with Yin's (2018) single embedded case study methodology. The components are outlined in the protocol summary and detailed in the following sections.

An integrative literature review established the theoretical and contextual foundation in answering the question, how can nursing education and development strengthen operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District? Meetings with key stakeholders including the Chief Nursing and Midwifery Officer; Deputy Chief Nurses with portfolios in practice development, education, quality, safe staffing and care capacity; and the Te Kāhui Tapuhi Māori Nursing and Midwifery Advisory Group Committee refined the research question and confirmed relevance. The study was epistemologically aligned with a qualitative, critical interpretive paradigm (Moon & Blackman, 2014), underpinned by critical social theory (Fay, 1987), critical appreciative processes (Grant & Humphries, 2006; Oliver, 2005b), and bicultural approaches (Cameron et al., 2020). The

methodology integrated constructivist and positivist elements (Merriam, 2009; Stake, 1995; Yin, 2018), ensuring both structure and responsiveness.

Validity and rigour were achieved through triangulation of data sources, reflexive analysis, participant checking, and stakeholder feedback (Cresswell & Cresswell, 2018; Merriam, 2009). Institutional enablers of rigour included strong stakeholder engagement and access to internal documents and intranet platforms. External barriers, including the COVID-19 pandemic (2020–2022) and an organisation wide cyber-attack (2021) impacted timelines but did not compromise research integrity. Ethical integrity was maintained through procedures overseen by the Research Office at Te Whatu Ora Waikato District of Health New Zealand.

Purposive invitations were used to recruit participants from the three communities of practice categorised within the literature review—operational leaders, clinical nurses, and nurses involved in education and development. In alignment with Te Tiriti o Waitangi, equitable representation of Māori participants was applied by the Research Office inviting all Māori nurses reflected in the three communities of practice to participate. Participants were identified from the Te Whatu Ora Waikato district database of Māori nurses.

All participant contact was undertaken by the Research Office and all workshop facilitation was undertaken by independent facilitators. Building on the integrated perspectives of Yin, (2018), Merriam (2009), and Stake (1995) the following section elaborates on how this integrated framework informed the methodology undertaken by the independent facilitators which involved two workshops led by the researcher and attended by three independent facilitators not employed within Te Whatu Ora Waikato District. These workshops applied the International Practice Development Consortium (IPDC) Facilitation Standards (2017) and supported the co-development of semi-structured interview and focus group questions, informed by guidance from the Māori Nursing Advisory Committee.

Data collection included focus groups and interviews with stakeholders across operational, clinical, and educational roles. Independent facilitators led these sessions to ensure neutrality and cultural safety. Document analysis was conducted to examine how education and development were embedded within strategic and organisational documents, including change processes and nursing position descriptions.

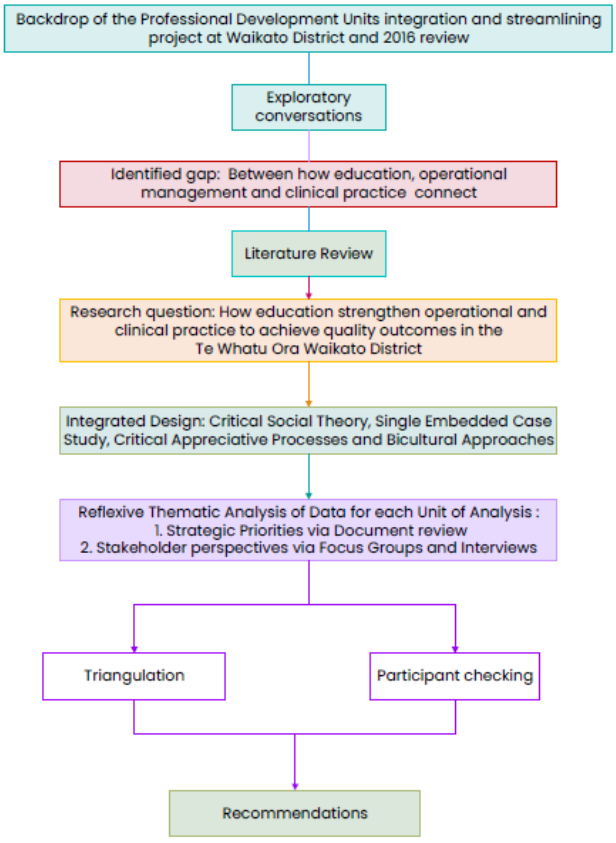
Data from the document analysis, interviews, and focus groups were analysed using reflexive thematic analysis (Braun & Clarke, 2022), allowing the researcher to identify patterns and themes across the two UofA (i) strategic priorities and (ii) stakeholder perspectives. Rival

perspectives were considered (Yin, 2018) to explore both congruence and incongruence in stakeholder views and document content. Triangulation ensured that operational, clinical, and educational perspectives were reflected in the analysis.

To validate findings, participant checking was conducted via a pre-recorded virtual presentation using voice-over PowerPoint. This presentation summarised the findings and introduced the emerging model or framework, inviting feedback and discussion. The final stage of the protocol involved synthesising insights into actionable recommendations to inform future practice within the Nursing PDU. The research process is summarised in Figure 3.

Figure 3.

Research process.



3.3.2 Units of Analysis

The concept of UofA is central to case study research design, though authors frame it in slightly different ways. Stake (1995) emphasised that the UofA is the case itself, understood as a bounded system with clear limits in time, place, or activity. His constructivist perspective highlighted the importance of studying the case holistically, attending to its context and meaning rather than fragmenting it into isolated variables. Merriam (2009) similarly defined

UofA as the case but underscored the need to establish boundaries that make the study coherent and manageable. For her, the UofA provides clarity about what the research is fundamentally about, while data may be drawn from multiple sources to illuminate that case (Miles, 2019). Yin (2018) extended the discussion, linking UofA directly to the research questions, cautioning that confusion between UofA and units of data can lead to errors in analysis. Considered together in the design of this study, using Yazan's (2015) approach, these perspectives suggest that UofA is both a conceptual and practical anchor that defines the scope of inquiry (Merriam, 2009; Stake, 1995), and ensures alignment with the research questions and conclusions (Yin, 2018). This study, therefore, identifies its UofA with careful attention to boundaries, coherence, and alignment, while distinguishing them from the units of data collection which are sources of evidence.

Within the exploration of the literature in Chapter Two, two recurring components emerged as central to evaluating quality outcomes. First, the strategic priorities of organisations were consistently identified as key indicators of effectiveness. Second, the perspectives of stakeholders appeared repeatedly as critical in understanding both the achievement of outcomes and the challenges encountered in the process. These themes guided the identification of the two UofA in the current study: strategic priorities and stakeholder perspectives. These UofA ensured that the research design captured both structural priorities and the lived experiences and viewpoints that shape within nursing at Te Whatu Ora Waikato District. The data for the two UofA was drawn from documents, focus groups, and interviews. To ensure alignment and consistency, documentary sources were collected at the same time as the focus groups and interviews were undertaken. Only documents current at the time of data collection were included.

3.3.3 Documents

Document data were collected from a range of sources, including policies, reports, and organisational artefacts, to provide contextual depth and support triangulation of findings (see Table 3). The Quality and Patient Safety team facilitated access to the Te Whatu Ora Waikato District Document Management System and targeted searches were conducted using search terms 'education' and 'development'. These terms were selected to answer the part of the research question regarding the specific education and development component. Documents containing references to these terms were selected for analysis to determine how education and development were represented and operationalised within the organisation.

In addition to the documents identified through the formal search process, supplementary materials related to organisational change processes, the nursing learning needs analysis summary, the education calendar, and relevant intranet resources were included to enrich the dataset. These materials provided further insight into how education and development initiatives were communicated, prioritised, and implemented across the district.

The document review contributed to understanding the strategic framing of education and development within Te Whatu Ora Waikato District and supported the first UofA. The findings from this process are presented in Chapter Four.

Table 3.

Types of documents included in data collection.

Document	Rationale
Organisational charts	Links and structures
Policy and guidelines	Standards and guidance for practice
Change processes	Outline how standards are met
Position descriptions	Accountabilities and priorities
Learning needs analysis	Identified knowledge and skills required to deliver service requirements
Nursing education calendar	Plan for meeting learning needs
Intranet resources for nursing education	Other documents and artefacts that may become relevant throughout the process

3.3.4 Participant Recruitment

Participants for the focus groups and interviews were recruited from the nursing workforce within Te Whatu Ora Waikato District. In qualitative case study design, the identification of participants is not merely a procedural step but a theoretical act of bounding the case (Merriam, 2009; Stake, 1995). Stakeholder perspectives represent a critical dimension of the bounded system under investigation, providing insight into how organisational priorities are interpreted, enacted, and contested across different perspectives.

The sample comprised three distinct stakeholder groups: operational leaders (including service directors and managers), clinical nurses, and nurses whose roles encompassed education and professional development. These groups were purposefully selected to reflect the communities of practice identified in the literature (Cronin & George, 2020). Communities of practice theory suggests that knowledge is socially constructed and sustained through

interaction among practitioners who share a domain of interest. By recruiting participants across operational, clinical, and educational domains, the study acknowledges that organisational effectiveness is not located in a single perspective but emerges from the interplay of multiple communities of practice.

This theoretical framing positions stakeholder perspectives as more than sources of data; they are integral to the construction of the UofA itself. Operational leaders embody the strategic and managerial priorities of the organisation, clinical nurses represent the lived realities of frontline practice, and nurses in educational and developmental roles articulate the processes through which professional knowledge is cultivated and sustained. Together, these groups provide a comprehensive lens through which the interface between organisational strategy, clinical practice, and professional development can be understood. In this way, the participant selection strategy operationalises the UofA by ensuring that the perspectives most relevant to the research question are systematically incorporated into the study design.

Purposive sampling was employed to ensure representation across stakeholder groups and to meet the requirements of confidentiality and equity as outlined in section 3.1.3, particularly the inclusion of Māori perspectives. The terminology used to describe stakeholder roles is defined in the glossary to ensure clarity and consistency throughout the thesis. The sampling framework was developed in consultation with the Chief Nursing Officer and the Nurse Consultant for Cultural Workforce Development. These discussions ensured that the recruitment strategy aligned with the first UofA strategic priorities. Further guidance was provided by Te Kāhui Tapuhi Māori Nursing and Midwifery Advisory Group, whose input ensured that bicultural principles were embedded in the recruitment process. Section 3.2.3 has elaborated on equity, representation, and methodological alignment.

3.3.5 Sampling Framework

The sampling framework for this study was purposive (Cresswell & Poth, 2024), designed to intentionally engage a diverse range of experienced nurses and operational leaders (including directors and managers) within Te Whatu Ora Waikato District. This approach ensured that participants reflected the key stakeholder groups relevant to the research elements: operational, clinical, and education and development roles. These categories were identified as critical to understanding the interface between organisational systems and nursing practice, particularly considering the disconnect highlighted in the literature review.

To mitigate potential conflicts of interest arising from my professional role within the organisation, participant recruitment was conducted independently by the research officer from Te Whatu Ora Waikato District Research Office. The Research Office operates outside the nursing and midwifery reporting structure and has access to all staff groups, thereby ensuring neutrality and confidentiality in the recruitment process.

Recent nursing research has highlighted that insider researchers, those embedded within the professional context they study, face unique challenges related to power dynamics, role duality, and participant vulnerability. Aburn et al. (2021) noted that while insider status can foster trust and rapport, it also risks introducing bias and perceived coercion if participants feel obligated to participate. Similarly, Ora et al. (2019) emphasised that insider nurse researchers must adopt deliberate strategies to maintain rigour and trustworthiness, including independent recruitment and transparent communication of roles. By delegating recruitment to the independent Research Office, this study operationalised these principles in practice. It acknowledged the potential influence of organisational hierarchies and proactively addressed them through structural safeguards. This approach aligns with contemporary nursing evidence that advocates for methodological rigour, reflexivity, and ethical transparency when conducting research in settings where the researcher holds professional influence (Polit & Beck, 2021).

Purposive recruitment targeted stakeholders from operational leadership, clinical practice, and education and development contexts. Clinical nurses were defined as those delivering direct care to tāngata whaiora across hospital and community settings. Nurses in education and development roles were responsible for facilitating learning to meet clinical and service requirements. Operational leaders, including service directors and managers, were recognised for their influence on organisational systems and strategic direction.

Initial plans included offering focus groups to all stakeholder categories to encourage cross-group dialogue and integration of perspectives. However, operational leaders opted to participate only in individual interviews. This outcome was considered appropriate, given the potential influence of power dynamics associated with line management and resource responsibilities. In organisational research, particularly within nursing contexts, power differentials between leaders and frontline staff are well documented. Leaders hold authority over staffing, resource allocation, and performance evaluation, which can create implicit pressure for team members to conform to perceived expectations (Aburn et al., 2021). When such hierarchies are present in group settings, participants may be constrained, avoid critique, or defer to dominant voices; thereby limiting the authenticity and diversity of perspectives.

Polit and Beck (2021) highlighted that these dynamics can compromise both the ethical integrity of the research and the validity of findings if participants feel constrained in their contributions.

Mitigating power differentials was, therefore, essential to ensure that stakeholder perspectives were captured in a way that reflected genuine experiences rather than organisational hierarchies. Individual interviews provided a confidential and context-sensitive environment, reducing the risk of coercion or inhibition and enabling operational leaders to articulate their insights without influencing or being influenced by others. This approach aligns with contemporary recommendations in nursing research which emphasise methodological safeguards to protect participant autonomy and foster trustworthiness in data collection. By adopting individual interviews for operational leaders, the study acknowledged the structural realities of organisational power and proactively addressed them. This strategy enhanced the credibility of the research by ensuring that data were not distorted by hierarchical pressures, while upholding ethical principles of respect, confidentiality, and participant empowerment.

The research officer distributed invitations via email to operational leaders, clinical nurses (through the senior nurses' communication group), and nurses in educational roles. Māori nurses were identified and invited through the Māori nurses' database, ensuring that the invitation encompassed all three stakeholder categories. This inclusive approach supported the study's commitment to equity and bicultural responsiveness, as outlined in Te Tiriti o Waitangi and embraced by Te Whatu Ora Waikato District.

Participants were given the option to self-select their preferred method of contribution as either focus groups, individual interviews, or both. This flexibility acknowledged the value of focus groups in generating responsive, collective insights (Dewar & Sharp, 2013), while recognising that individual interviews could elicit specific views, address sensitive topics, and navigate perceived power dynamics (Ora et al., 2019).

The recruitment process resulted in the participation of 32 stakeholders across three focus groups and 10 individual interviews. Participants worked across a wide spectrum of practice areas, including community health, internal medicine, emergency care, older persons and rehabilitation, orthopaedics, general surgery, trauma, cancer care, palliative care, respiratory services, infectious diseases, cultural workforce development, practice development, and graduate education. Among the 32 participants, four identified as Māori, six held operational leadership positions, 13 held clinical roles, and 15 held roles focused on education and development. This diversity of experience and perspective contributed to the depth and

relevance of the data collected, supporting the study's commitment to equity, bicultural responsiveness, and methodological rigour.

3.3.6 Focus Groups and Interviews

This section outlines the role of focus groups and interviews in exploring stakeholder perspectives, the second UofA. It details the rationale for using the Research Office and independent facilitators, the standards applied during facilitator preparation, and the development of guiding questions used during data collection.

Given my professional role within the Te Whatu Ora Waikato District at the time of the data collection, the research officer and three independent facilitators were engaged to lead all focus groups and interviews. This decision was made to minimise potential bias and ensure neutrality in data collection. The facilitators were selected based on their affiliations with different academic institutions and their recognised expertise in facilitating complex group processes and conducting research within health contexts.

Facilitator preparation was conducted through a dedicated workshop focused on establishing a shared understanding of the research purpose, question, methodology, and epistemological rationale (Grønkjær et al., 2011). The workshop emphasised the integration of single embedded case study methodology with critical appreciative processes and bicultural approaches. Guidance from the Nurse Consultant for Cultural Workforce Development ensured that tikanga were embedded in the facilitation process, including practices such as opening with karakia to acknowledge wairua (spiritual context), offering kai (food), recognising connections through whanaungatanga (relationship-building), and providing koha (gifts) to honour participant contributions. These practices are further detailed in Section 3.2.12 on ethical procedures.

An agreed-upon facilitation approach was established between the researcher and facilitators, guided by the IPDC (2017) facilitation standards. These standards, developed through a Delphi study involving experts from 10 countries (Martin & Manley, 2018), provided an evidence-based framework for facilitating across complex organisational boundaries. The facilitator preparation workshop resulted in a guide (Appendix D) that included a set of prompt questions developed to elicit reflective and contextually grounded responses from participants in focus groups and interviews. These questions were designed to explore stakeholder perspectives on nursing education and development in relation to quality outcomes. The prompts included: How do you describe quality patient outcomes? How can nurses be

equipped to meet these? What kind of teaching and learning occurs in your area? How does mentoring and coaching play a role in this? And what would success look like if we got education and development right? Facilitators used these questions flexibly, adapting them to the dynamics of each group or individual interview to encourage open dialogue and deeper exploration of the themes central to the research.

3.3.7 Reflexive Thematic Analysis

Reflexive thematic analysis was selected as the method of data analysis (Braun & Clarke, 2006), aligning with the critical social theory framework (Fay, 1987). This approach views themes as patterns of shared meaning that emerge from the data, capturing both explicit and implicit ideas. It positions the researcher subjectively within the process, acknowledging the interpretive lens brought to understanding organisational complexity (Creswell & Poth, 2024). Reflexivity enabled me to explore the implications of emerging patterns and their significance to stakeholders and nurses within Te Whatu Ora Waikato District. The process involved immersion in the narrative data from focus groups and interviews, followed by reflective engagement and pattern recognition through discussions with supervisors and a senior Māori nurse. Reflexivity positions subjectivity not as a limitation but as a strength enhancing the researcher's personal awareness, supporting facilitators and participants in the research process, and contributing to the richness and credibility of data generation and reporting. (Braun & Clarke, 2022; Luttrell, 2019).

The six phases of reflexive thematic analysis, familiarisation, coding, generating initial themes, developing and reviewing themes, refining and naming themes, and writing up the analysis, were followed systematically. Transcripts from interviews and focus groups were anonymised by an external academic transcriber and organised using NVivo software. Familiarisation and coding led to the generation of 80 initial codes, which were refined to remove duplication while preserving nuance. Codes were then grouped into initial themes, with some codes contributing to multiple themes due to their interconnected nature. These themes formed the basis of a conceptual model used during participant checking. The themes focused on how organisational structures and individual nurses, when equipped and connected, contribute to quality outcomes, with cultural priorities emerging as an overarching theme. Final theme naming and confirmation were informed by participant feedback and further reflection, including triangulation with strategic priorities to ensure alignment with the research question.

3.3.8 Familiarisation, Initial Codes, Initial Themes, Refined Themes, and Named and Defined Themes

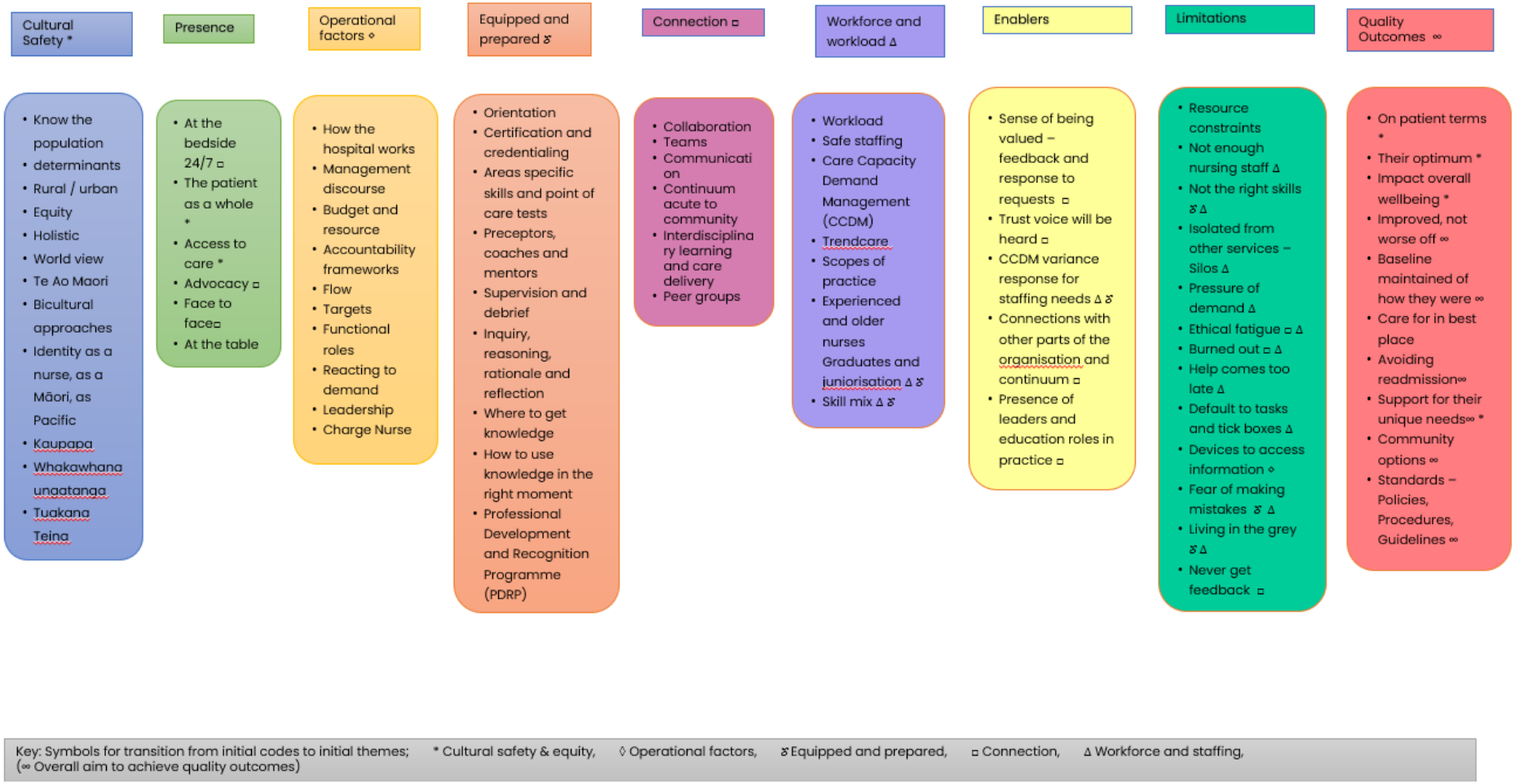
In accordance with Braun and Clarke's (2022) reflexive thematic analysis the phases are named familiarisation, initial codes, initial themes, refined themes, named and defined themes and writing themes. Familiarisation generated patterns of ideas that were organised into groups as initial codes reflecting stakeholders' perspectives on operational management, education, connectedness, cultural safety, identity, equity, workload and workforce pressures, and quality processes and activities. Through this process, a collective description of quality outcomes emerged as central to the research question. Stakeholders consistently emphasised that achieving quality outcomes represented the optimum and most desired result of healthcare delivery. This was a foundational step in the process of analysis as it brought clarity to achieving quality outcomes. These recurring ideas within the stakeholder perspectives formed the construct of quality outcomes and contributed to the initial codes followed by initial themes. Figure 4 summarises the initial codes identified during this process. Appendix E presents the summary of concepts from the patterns within initial codes. Each code was assigned a symbol, which was carried forward into the thematic alignment. Where a code related to more than one theme, it was aligned accordingly with each initial theme.

Further mind mapping and individual reflection, along with participant checking of the initial codes in Figure 4, led to the development of initial themes in Figure 5. The reflexive process is included in Appendix F. These themes interacted to address the research question. During this process, stakeholders described quality outcomes as a goal to achieve with education and development and effective practice. As a result, quality outcomes were retained in the transition from initial codes to initial themes, not as a theme itself but as a definer and descriptor of the research aim. Whenever quality outcomes were referenced, stakeholders used the term to denote an individualised optimum defined by the patient as an improvement that is holistic in nature and achieved without causing harm (focus groups and interviews).

The movement from initial codes to initial themes in this case study is based on the interpretive aspects of reflexive thematic analysis. Rather than treating coding as a linear exercise, it was a reflexive process of questioning, clustering, and interrogating the data to identify meaningful patterns (Braun & Clarke, 2022). This involved critically examining the distinctiveness of codes, exploring overlaps, and considering how they aligned with or challenged one another. The process was not simply about grouping similar codes but about situating them within the broader analytic aim of the study.

Figure 4.

Initial codes from familiarisation (phases one and two RTA – symbol belongs to column).



Codes were assessed for their alignment with priorities, as well as for divergence, contradiction, or other insights. This reflexive approach ensured that emerging themes were not imposed from pre-existing ideas but developed through interpretive engagement with the data. In doing so, the variance between alignment and difference was apparent, highlighting both areas of mutual understanding and points of tension.

By weaving these strands together, analysis moved beyond descriptive initial codes and initial themes to a more conceptual level of interpretation. The resulting themes captured both shared understandings and contested meanings, offering a nuanced account of how strategic priorities were experienced and interpreted within the case study context. This synthesis reflected Braun and Clarke's (2022) emphasis on reflexivity and Fay's (1996) call for attention to mutual understanding, situating the findings within a broader interpretive framework that acknowledges complexity, alignment, and difference.

In Figure 5, the reflective process underpinning this phase of analysis required reconsideration of certain codes due to their cross-cutting impact. For instance, the juniorisation of the workforce and skill mix related to both workforce and staffing as well as operational factors. Similarly, ethical fatigue and burnout were described as affecting both connectedness and staffing. Thus, in Figure 5, the first symbol aligns each code with the primary context that generated the pattern during focus group or interview discussions, while the second symbol indicates its association with an additional theme.

Figure 5Waikatoriver2028

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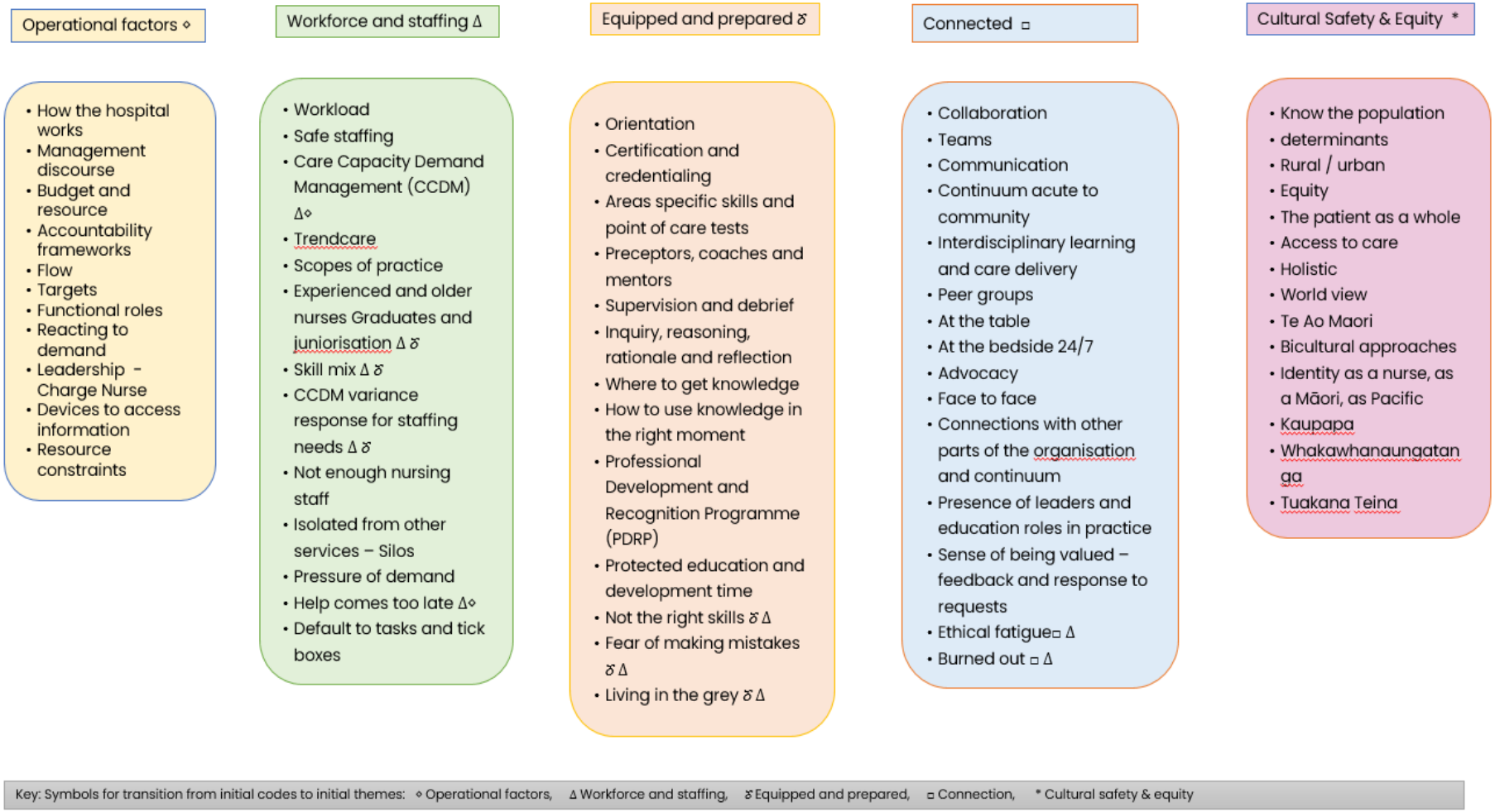
Initial themes (Phase 3 RTA).



The transition from initial themes (Phase Three) to refined themes (Phase Four), and subsequently to named and defined themes (Phase Five), occurred through reflective conversations with stakeholders, Māori advisors, and feedback from facilitated participant checks. The sessions for these checks were facilitated by one of the independent facilitators. The iterative mapping and remapping of concepts and ideas enabled alignment with the theoretical foundations of critical appreciative processes and practice development, while maintaining an inductive approach and researcher reflexivity. The dominant premise guiding this phase was recognition that change was necessary to strengthen education and development in operational and clinical practice, thereby achieving quality outcomes for patients/tāngata whaiora.

As a result, three refined themes emerged from stakeholder perspectives. The first theme, Organisational Structure, captured how systems, processes, and leadership frameworks influenced nursing practice and operational effectiveness. The second theme, A Learning Culture, reflected the importance of continuous professional development, mentorship, and preparedness for practice within dynamic clinical environments. The third theme, Cultural Priorities and Indigenous Knowledges, emphasised the integration of cultural safety, equity, and Te Ao Māori world view as essential components of quality outcomes.

Throughout the reflexive process, there were conflicting factors such as extracts related to the stakeholders' fear of making mistakes or failing to achieve desired outcomes for tāngata whaiora. As well as being interpreted through the analysis, these factors were acknowledged and viewed through the lens of person-centeredness (Martin & Manley, 2018), which gave value to the experience of the nurse aiming to achieve the best care, and for tāngata whaiora as receivers of the care. Additional considerations, including meeting patients' needs and promoting cultural safety, were addressed through a shared trust in processes that support both nurses and patients. The transition from these refined themes to named and defined themes is presented as findings in Chapter Five.

3.3.9 Validity, Rigour, and Trustworthiness

Establishing trustworthiness in qualitative case study research requires a deliberate and multi-layered approach (Nowell et al., 2017). In this study, validity and rigour were achieved through a synthesis of methodological strategies drawn from established case study scholars (Merriam, 1998; Stake, 1995; Yin, 2018); facilitation standards, such as those articulated by the IDPC (2017); and the integration of bicultural approaches (Cameron et al., 2023). It involved applying the principles of the IDPC facilitation standards by establishing collaborative

principles and cooperative inquiry, exploring participant's roles skills and styles within the interviews and focus groups, identifying strengths of approach and outcomes in relation to the research question, while being culturally authentic and aligned with the aim of the research.

Credibility was strengthened through methodological triangulation, a cornerstone of Yin's (2018) case study design. Data were collected from multiple sources including focus groups, interviews, and organisational documents, allowing for convergence of evidence. In addition, participant validation was embedded in the facilitation process, consistent with IDPC standards, ensuring that interpretations were confirmed. Reflexivity further enhanced credibility, as I critically examined my own assumptions with reflective discussions throughout the analytic process (Merriam, 2009).

Dependability was achieved by maintaining transparency in the analytic journey. The use of facilitation protocols, aligned with IDPC standards, ensured consistency across data collection sessions, reinforcing reliability. This systematic approach reflected Merriam's (2009) emphasis on the researcher paying careful attention to methodological consistency.

Confirmability was supported through reflexive practices and cultural input. Reflexive journaling made explicit my position, reducing the risk of findings being shaped solely by personal bias. Cultural perspectives were actively integrated into the analysis, ensuring that themes were not imposed but generated through dialogue that respected local tikanga. This aligned with Stake's (1995) call for interpretive sensitivity and Merriam's (2009) emphasis on transparency in the researcher's role. By foregrounding cultural authenticity, the study enhanced confirmability and ethical validity.

Transferability was facilitated through thick description, a hallmark of Stake's (1995) approach to case study research. Detailed accounts of organisational processes from the foundation of the Integration and Streamlining Project (Hayward & Atherfold, 2015) and the context, strategic priorities, and stakeholder perspectives, provided contextual detail to assess the applicability of findings to other settings. The inclusion of cultural perspectives further enriched this description, situating the findings within a broader socio-cultural context. Yin's (2018) emphasis on contextualisation was extended through cultural sensitivity, ensuring that the findings were both methodologically rigorous and culturally grounded.

Finally, the analytic process was guided by the central question of alignment of education and development with strategic priorities. By interrogating codes and themes in relation to these priorities, data analysis maintained coherence and relevance. This ensured that validity was

methodically sound, addressing the research aims while acknowledging areas of alignment, divergence, and novel insight.

3.3.10 Triangulation

Triangulation of multiple data sources including interviews, focus groups, and documents was applied to identify both consistency and contrast in the findings (Yin, 2018). Participant checking served as a key component of this triangulation, confirming the rigour of the analysis (Merriam, 2009; Stake, 1995,) and aligning with the collaborative and inclusive characteristics of critical appreciative processes and bicultural approaches. Yin (2018) emphasised that triangulating diverse forms of information enhances consistency, reliability, and reflexivity in qualitative research.

Braun and Clarke (2022), supported by Stake (1995) and Merriam (2009), advocated for triangulation from alternate epistemological positions to ensure accurate interpretation and avoid misrepresentation of the case; in this instance, the individual organisation. Integration of theoretical lenses within the case study enabled triangulation across stakeholder perspectives, documentary evidence, and researcher reflexivity. It affirmed the outcomes through alignment with critical and appreciative processes. Braun and Clarke referred to this approach as qualitative sensibility, encompassing values, assumptions, critical questioning, cultural context, and a tolerance for ambiguity. The implications of this triangulated approach are discussed in Chapter Six.

3.3.11 Participant Checking

Participant checking formed part of triangulation as a validity strategy grounded in critical social theory (Fay, 1996) and critical appreciative processes (Grant & Humphries, 2006). It enabled participants to engage with the critical interpretive research paradigm through their own lens. This process was conducted through two interactive discussions to which stakeholders were invited. Each session lasted approximately 1 hour and was facilitated by one of the original facilitators of the focus groups and interviews to ensure consistency and participant anonymity. The same facilitation principles outlined in the original guide (Appendix D) were applied in both sessions.

To maintain participant anonymity, the initial themes from the reflexive analysis were presented through a pre-recorded video created by the researcher. This presentation included voice-over slides, a scripted narrative, and suggested questions to guide discussion (see Appendix G). The video lasted approximately 15 minutes, followed by a 1-hour facilitated

discussion of the research findings. The same facilitator who led the original focus groups and interviews conducted both sessions to ensure consistency, applying the principles outlined in the original facilitator guide (Appendix D).

During the discussions, participants were prompted to reflect on key aspects of the findings. They were asked to consider which areas of strength they would like to see duplicated and how this might be achieved. The conversation also explored how nursing could ensure meaningful participation in interdisciplinary integration, and whether structural changes might be needed to give education a stronger voice at decision-making tables, including consideration of different levels of influence. Participants discussed how nurses might influence existing limitations and whether Indigenous or bicultural approaches could enhance quality outcomes, identity, and the growth of a Māori workforce in support of cultural priorities and equity. Finally, they considered practical changes in the way education and development teams operate that could help realise their aspirations. The participant checking process was used to confirm the way the data had been interpreted throughout the analysis and considered with discussion and recommendations.

3.3.12 Ethical Considerations and Processes

The nature of a single embedded case study exploring individual perceptions and experiences of responsiveness and quality outcomes required ethical protocols that ensured the research design was sound, data were managed with integrity, and participants' contributions were respected and used appropriately within an evolving context (Roller & Lavrakas, 2015). Ethical approval was granted by the Auckland University of Technology Ethics Committee (AUTEC 20/316, see Appendix H), and all approved procedures were followed.

Key ethical considerations included responsiveness to Kawa whakaruruhau and Te Tiriti o Waitangi, particularly the risk of replicating ineffective engagement practices identified in the WAI2575 evaluation, where Māori were asked to approve pre-developed ideas (Kidd et al., 2019). To mitigate this risk, input was sought from Te Puna Oranga (Māori Health Services, Waikato DHB) at the earliest stage of the research. Their guidance emphasised the principle of equal explanatory power (Health Research Council, 2019; Whiringa-a-Rangi, 2002) and the importance of involving Māori throughout the research process (Berghan et al., 2017; Came, 2013). Additional support and oversight were provided by Te Kāhui Tapuhi – Māori Nursing and Midwifery Advisory Group, Te Whatu Ora Waikato District, and through participant verification to confirm the articulation of findings. Reflective discussions with a senior Māori

nurse further ensured culturally appropriate interpretation and application of the data (Appendix I).

Potential conflicts of interest arising from my professional role were managed through confidentiality protocols and attention to power dynamics. Access to participants and documents was approved by the Chief Nursing and Midwifery Officer via the Health New Zealand Te Whatu Ora Waikato District ethics process (Appendix H). Recruitment was facilitated by the research officer within Quality and Patient Safety at Te Whatu Ora Waikato, who promoted the study through the district's intranet, nursing meetings, forums, and newsletters. Participation in focus groups and interviews was voluntary, following distribution of an information sheet (Appendix J) and consent forms (Appendix K), which were collected by three external facilitators. Consistency across data collection was ensured through discussions between the researcher and facilitators (Appendix D).

Focus groups and interviews were recorded using a password-protected device, transcribed by an independent transcriber who signed a confidentiality agreement, and anonymised prior to analysis. Some participants, particularly those in rural areas, opted for video interviews, which were recorded and managed using the same secure protocols. All non-public data were stored in password-protected electronic files and locked cabinets for hard copies. The facilitators recorded the focus groups and interviews which were transcribed by an independent transcriber, without any identifiers. All identifiable information were excluded from analysis and reporting, with letters and sequential numbers applied to stakeholder quotes in the transcripts.

Experienced facilitators had agreed to apply the Facilitation Standards (IPDC, 2017) to safely navigate power dynamics and tensions (Martin & Manley, 2018). Support was available through structured reflection with professional supervisors or the confidential Employee Assistance Programme, should participants experience discomfort. As this support was offered confidentially, the number of individuals who accessed it remains unknown.

3.4 Chapter Summary

This chapter outlined the research paradigm, theoretical foundations, methods, and methodology that informed the integrated design of the study. The research was conducted as a single embedded case study, supported by critical appreciative processes and bicultural approaches that reflected the priorities of Te Whatu Ora Waikato District. The case study design (Merriam, 2009; Stake, 1995; Yin, 2018) was selected for its suitability in applying

systematic inquiry to generate context-specific recommendations aimed at strengthening operational and clinical practice within the district.

Critical appreciative processes (Grant, 2012; Grant & Humphries, 2006) provided a framework for engaging with complexity and recognising both insight and tension within stakeholder experiences. These processes were complemented by facilitation standards (Martin & Manley, 2018), which supported safe and inclusive engagement, and reflexive thematic analysis (Braun & Clarke, 2022), which enabled the interpretation of patterns across diverse data sources. Together, these methods allowed for the exploration of both positive and challenging experiences in ways that contributed to meaningful outcomes.

Validity and rigour were addressed through multiple strategies embedded in the research design. These included the application of facilitation standards, triangulation of data sources (Yin, 2018), participant checking (Merriam, 2009; Stake, 1995), and researcher reflexivity (Braun & Clarke, 2022). These elements ensured that the findings were trustworthy, contextually grounded, and aligned with the principles of critical inquiry and bicultural responsiveness.

Chapter Four presents the findings from the document review. Chapter Five details the findings derived from focus groups and interviews.

CHAPTER IV FINDINGS DOCUMENT REVIEW

4.1 Introduction

Chapters Four and Five present the findings that answer the research question, *how can nursing education and development strengthen operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District of Health, New Zealand?* Chapter Four presents the findings from the first UofA, strategic priorities, primarily derived from a document review. The document search yielded a range of materials, including strategic and annual plans, policy documents, change management processes, and position descriptions. In addition, the review incorporated artefacts, such as the nursing and midwifery education calendar and the learning needs analysis. The insights into the role of nursing education in enhancing clinical and operational outcomes provided by these documents are supported by direct quotations.

4.2 Document Review

Te Whatu Ora Waikato District's document management repository yielded a range of documents that either referenced or omitted the terms education, learning, and development. Both inclusions and absences were considered significant to the review. Documents are summarised in Table 4 and resources in Table 5. The identification of links to development and education are colour-coded as below:

Education and development overt in document
Education and development not overt in document

Table 4.

Summary of documents.

Documents: Title and Date	Document Type	Inclusion of Education and Development	Comment
Waikato DHB Strategy. (Waikato DHB, 2016)	Organisational strategy	Whole section	DHB strategy includes a strategic imperative on excellence in learning and education.
Nursing at Waikato 2017-2021. (Waikato DHB, 2017)	Nursing strategic aims	Woven through the whole document	All nursing strategic aims reflect education and development as mechanisms to enhance quality outcomes, with links to resources that support implementation.
Waikato DHB Annual Plan 2019/2020. (Waikato DHB, 2019)	Implementation plans to achieve the strategy	Included with reference to workforce	Includes reference to career pathways, postgraduate education, and professional development activities to support workforce preparedness.
Waikato DHB Annual Plan 2021/2022. (Waikato DHB, 2021)	Implementation plans to achieve the strategy	Included with reference to workforce	Building on the 2019/2020 plan, this plan focuses on clinical and financial sustainability, with learning and development as contributors.
Waikato DHB, Learning and Development Policy. 2019.v6.1	Defines education and training requirements to access	Included in purpose and processes	Describes legal and professional requirements under the HPCAA, 2003. Describes processes for access and approval of release time, funding and bookings.
New Clinical Graduate Entry to Practice Policy, 0010v09. (Waikato DHB, 2021)	Processes for graduate entry to practice programmes within Te Whatu Ora Waikato District	Learning and practice support programmes for nursing, midwifery, allied, and medicine	Contains a section describing the education structure and clinical experience for each profession's programme. Nursing education includes structured learning recognised at the postgraduate level, a preceptor, cultural support, interprofessional learning opportunities, and access to professional supervision.
Final confirmation of changes to Hospital and Community services, Waikato DHB. (Waikato DHB, 2020)	Final outcome of the change process	One general phrase within the change process documents	This phrase was one of the key elements in the leadership role of directors within the new structure during the restructuring process of Hospital and Community Services (Waikato DHB, 2020).
Nursing Position Descriptions x 18 detailed in Appendix L. (Waikato DHB, 2021)	Position descriptions	Roles associated with the PDU (i.e., nurse manager clinical education, nurse educator, nurse coordinator roles)	NB: Clinical nurse manager role does not include references to education or quality outcomes. The most significant outcome is that nurse educator and nurse coordinator roles provide expectations regarding education and development. Other roles refer to education and development primarily for own professional development and orientation and in practice support.

Table 5.

Summary of artefacts.

Artefacts Title and Date	Document Type	Inclusion of Education and Development	Comment
Learning Needs Analysis. (Waikato DHB, 2021)	An electronic summary of priorities that charge nurses identified for learning	Contains lists based on the previous year covering leadership, clinical requirements, and cultural safety	A summary of learning that charge nurses provide to the PDU as the basis for education planning. This was not linked to the offerings within the Nursing and Midwifery Education Calendar.
Nursing and Midwifery Education Calendar, 2021. (Waikato DHB, 2021)	An electronic calendar profiling education that is available with a linked booking system	Plan for meeting learning needs	Comprehensive range of education offered primarily based on last year's plan and perceived need, no direct link to learning needs analysis.

NB: The researcher did not author any of these documents.

4.2.1 Strategic and Annual Plans

This section presents findings from the 2016–2021 Te Whatu Ora Waikato District Health Board (Waikato DHB) Strategic Plan (Waikato DHB, 2016), the 2017–2021 Nursing Strategy (Waikato DHB, 2017), and relevant annual plans (Waikato DHB, 2019; 2021). These documents were current at the time of data collection and provided foundational insights into Te Whatu Ora District's strategic intentions. The Strategic Plan employed the term imperatives to define its priorities and aims, while the annual plans detailed corresponding actions. Collectively, the documents demonstrated alignment with national health priorities, MoH expectations, and mechanisms for implementation. The strategic imperatives for 2016–2021 included:

> Productive partnerships; effective and efficient care and services; being a centre of excellence in learning training, research, and innovation; people-centered services; safe quality services for all; and health equity for high-need populations. (Waikato DHB, 2016, p. 16)

Figure 6 illustrates the Waikato DHB Strategy and shows how the six strategic imperatives connect to the overarching vision and mission of 'healthy people, excellent care, through smarter, innovative delivery' (Waikato DHB, 2016). At the centre of this illustration are the organisational values of 'Whakamana–give and earn respect; Whakarongo–listen to me talk to me; Mauri Pai–Fair play; Whakapakari–growing the good; and Kotahitanga–stronger together' (Waikato DHB, 2016, p, 16). These values guided collective action toward achieving the strategic vision. The use of the term imperatives signalled a mandated approach to outcomes, suggesting a stronger directive than aspirational aims.

One of the strategic imperatives outlined in the Waikato DHB strategic plan (2016–2021) was to establish the district as "a centre of excellence in learning, training, research and innovation" (p. 16), which includes "relationships with education providers, staff attraction through excellent education and research, a culture of innovation, research learning and training, and a research environment sensitive to population needs" (Waikato DHB, 2016, p. 17). This statement provided a foundational mandate for cultivating a culture that supports education and learning, encourages inquiry, and promotes evidence generation through practice adaptation and research. It reflected an understanding of health determinants, equity and access, and proposed strategies to address these challenges through partnerships with education teams and tertiary providers.

Figure 6.

Strategic imperatives Waikato DHB 2016–2021

From *Healthy people, excellent care: Waikato District Health Board strategy (p.16), 2016, by Waikato DHB. Reprinted with permission.*

Strategies to support the excellence in learning, training, research and innovation imperative included student learning experiences, peer-to-peer teaching among nurses and health professionals, joint appointments bridging practice and education contexts, and active engagement with research activity to generate evidence about effective initiatives. Later in the same document, the strategic intent was further clarified as:

> WHAT DO WE MEAN? Innovation, research, learning, and training are not just something most people do. They need to be fostered and nurtured to create a culture where staff are encouraged to be innovative, research is valued, learning is prioritised, and training is respected. (Waikato DHB, 2016, p. 35)

This statement reinforced the prioritisation of education and research as essential components of service delivery rather than optional activities to be pursued when time permits. It also emphasised the importance of respecting educators and researchers within both practice and academic contexts.

Additionally, the strategic plan highlighted the importance of cultural competence in workforce development, “We must ensure our workforce is trained to work within the diverse cultural environment that exists in Waikato” (Waikato DHB, 2016, p. 35). This statement underscored the need for culturally responsive education aligning with broader goals of equity and population responsive care. Achieving excellence in learning, training, research, and innovation within the Te Whatu Ora Waikato District required an understanding of unconscious bias, equity, and the role of Te Tiriti o Waitangi in Aotearoa. The Waikato DHB Strategic Plan (2016–2021) served as the lead document that established direction and expectations, embedding elements of a learning culture throughout its strategic imperatives. These elements directly informed the Nursing Strategic Plan (Waikato DHB, 2017), which articulated four aims that integrated education and development:

1. Lead and apply a strong nursing culture which harnesses and values the contribution of nurses (p. 12);
2. Build workforce capability, readiness, and capacity (p. 13);
3. Nursing uses and contributes to the delivery of effective health care based on research and acknowledged best practice (p. 14);
4. Improve care coordination across the health continuum to enhance timely access to health care for the Waikato population (p. 15). (Waikato DHB, 2017)

These aims positioned nurses as leaders within a participatory culture, using best practice evidence to inform models of care that span the patient journey across community and acute care settings. The emphasis on capability and readiness implied that nurses must possess the necessary knowledge and skills to deliver best practice, and that the workforce must be sufficiently resourced to meet population health demands. Each aim was supported by specific objectives and actions that aligned with the overarching Waikato DHB 2017–2021 Strategy, reinforcing the strategic commitment to education, development, and evidence-informed practice.

The strategic documents were followed by the Te Whatu Ora Waikato District Annual Plan (Waikato DHB, 2019–2020), which provided limited detail regarding workforce development. The section on service coverage and change acknowledged the need to equip the workforce

but did not specify how this would be achieved. The plan primarily addressed service eligibility, access, staffing levels, and funding, without elaborating on how the workforce would attain the expertise and skills required to meet population health needs. These omissions were notable, as references to education and learning were minimal and not articulated as actionable strategies.

One reference to education and development appeared in the following statement:

> To have a defined and clear career pathway for nurses and midwives. The pathway will be aligned to service needs. It will include Nurse Practitioner development, create governance of learning that will set the direction and make key decisions regarding learning and development across the organisation. Organisational capability needs analysis to identify the critical shared requirements of the organisation's workforce. (Waikato DHB, 2019. p. 55)

This quote indicated a commitment to establishing career pathways and governance structures that support advanced practice roles, such as Nurse Practitioners. It also highlighted the importance of organisational capability analysis to inform workforce development. However, compared to the Annual Plan, the Nursing at Waikato 2017–2021 strategy provided more comprehensive implementation strategies. These included alignment with needs analysis, workforce design, standards of care, knowledge acquisition, career progression, and the delivery of evidence-based, compassionate care (Waikato DHB, 2017).

Central to these strategies was the Professional Development Framework, which outlined expectations for clinical competence and continuous learning:

> Every nurse must adhere to the professional development framework and display an understanding of the minimum standards of knowledge and skills in practice expected of them. Achieving these and being engaged in quality and patient safety activities promotes a confident and competent nursing workforce able to deliver the care needed for the population requiring it. Direct line managers will use this to match expectations against actual level of skills, knowledge and organisational engagement. Identified gaps will be supportively addressed. (Waikato DHB, 2017, p. 10)

This framework emphasised consistency in practice standards across career stages, with tailored pathways for enrolled nurses, RNs, and senior nurses. It enabled clinical team

composition to reflect the required skill mix and supported the development of a culturally aware, evidence-informed workforce aligned with organisational priorities.

The strategy also outlined mechanisms for collaboration with education providers to inform curriculum design and clinical learning experiences. It supported graduate and postgraduate education, research engagement, and credentialing processes. The Nursing Development Framework provided a stepped approach to career progression, aligned with national standards such as the PDRP, which linked career advancement with remuneration. The relevance of this framework to the research question was clear: it provided a structured approach to practice growth that integrated educational, operational, and clinical expectations. For example, the framework described the attributes of nurses at different levels:

> Proficient level: An experienced nurse, able to manage clients with complex needs/complex situations, lead the team in a range of situations, guide and support colleagues with complex decision making/problem solving, shares knowledge informally. Takes on additional responsibilities, e.g. Shift coordinator, preceptor, projects, and appraisals.
>
> Expert level: Applies specialist knowledge, known for expertise, shares knowledge formally, leads quality improvement initiatives, initiates changes in practice, acts as a Charge Nurse or Associate Charge Nurse, leads projects, represents the ward at cluster meetings, completes appraisals, delivers education sessions, and acts as a professional development programme assessor. (Waikato DHB, 2017, p. 9)

These descriptions illustrated how education and development were embedded within career progression, contributing to a responsive, skilled, and confident nursing workforce capable of delivering quality outcomes across Te Whatu Ora Waikato District.

In summary, the strategic and annual planning documents of Te Whatu Ora Waikato District Health Board demonstrated varying degrees of commitment to nursing education and workforce development. While the overarching strategic plan articulated a clear vision for excellence in learning, training, research, and innovation, the annual plan lacked detailed actions to operationalise this vision. In contrast, a significant strength of the Nursing at Waikato 2017–2021 strategy was the clear objectives for education and development teams with a robust framework for career progression, clinical capability, and education, underpinned by governance and alignment with national standards. These documents collectively revealed the importance of structured learning pathways, cultural competence, and evidence-informed

practice in achieving quality outcomes. The presence of a professional development framework and strategic alignment with educational providers positioned nursing education as a critical enabler of operational and clinical excellence across Te Whatu Ora Waikato District.

4.2.2 Policy Documents

This category included two key documents: the Learning and Development Policy and the New Graduate Entry to Practice Policy. Both policies explicitly referenced education and outlined standards relevant to the Te Whatu Ora Waikato District, including legal and contractual obligations and the processes for applying these standards in practice.

The Learning and Development Policy defined the purpose and accountabilities for learning and development across the organisation. It addressed legal and compliance education required for clinicians to maintain practising certificates and described procedures for accessing ongoing professional development while employed within the Te Whatu Ora Waikato District. Specific provisions relevant to nursing included graduate programmes, postgraduate study, courses, conferences, in-house education, and in-service education within clinical settings. Beyond administrative processes such as funding approvals and release arrangements, the policy outlined key criteria for participation: “the relevance of the programme to the employee’s career or work goals, fit with their personal development plan, service needs and organisational goals” (Waikato DHB, 2019, p. 10). These criteria aligned with the expectations set out in the Nursing at Waikato (Waikato DHB, 2023) career frameworks and provided a structured process for nurses to access educational opportunities. The policy also detailed the steps required to obtain approval and resources to support professional development.

One programme referenced in the policy was the New Graduate Entry to Practice Policy (Waikato DHB, 2021), which described the support structures available to newly qualified nurses during their first year of practice. Section 5.1 of the policy, titled ‘Education Structure and Clinical Placements’, stated: “All entry to practice’ programmes delivered by Waikato DHB are formal, structured, supportive and are approved/authorised by the relevant professional group/national body” (Waikato DHB, 2021, p.12).

The NCNZ was identified as the authorising body responsible for auditing the programme against specifications set by the MoH. These specifications included preceptor-supported transitions into clinical practice; structured education days focused on professional, clinical,

and cultural development; and competency assessments to demonstrate integration of learning and practice.

The policy also outlined practical arrangements for clinical placements and the associated release time required to attend education sessions and workshops. By formalising these requirements, the policy ensured that new graduates received consistent support through access to preceptors, educators, and clinical coaches. This structured approach protected the educational and developmental needs of new nurses, reinforcing the organisation's commitment to building a competent and confident workforce.

Together, the Learning and Development Policy and the New Graduate Entry to Practice Policy reinforced Te Whatu Ora Waikato District's commitment to structured, supported, and standards-based education for nurses. These policies operationalised strategic intentions by outlining clear processes for accessing learning opportunities, ensuring compliance with professional standards, and supporting nurses, particularly new graduates, through formalised programmes. The alignment between policy, strategic frameworks, and national standards demonstrated a coherent approach to workforce development, where education was positioned both as a compliance requirement and a strategic enabler of clinical excellence and quality care. This foundation sets the stage for examining additional artefacts that contribute to nursing education and development within the Te Whatu Ora Waikato District.

4.2.3 Change Process Documents

Change processes were initiated to improve the organisation and delivery of services in alignment with strategic priorities. One example reviewed in this study was the Final Confirmation of Changes to Hospital and Community Services which stated the rationale for change as: "To work collectively across the system to improve health equity for communities and ensure better outcomes for patients" (Waikato DHB, 2020, p. 5).

The change document outlined several guiding principles directly relevant to the research question as effective leadership, empowerment, collaboration, and accountability. These principles were designed to enhance both operational and financial performance, thereby improving the overall effectiveness of the organisation. The document emphasised a shared delegation model, noting that professional leaders and operational directors held equivalent levels of authority to support clinical and operational partnerships. It further clarified the responsibilities and tasks associated with each role in the new structure, highlighting the importance of integrated leadership:

> Responsibility: Leadership Teams.
>
> Task: Bridges the divide between clinical and management, facilitating the interpretation of conflicting communications, tempering unrealistic expectations, educating, and facilitating compliance with proper processes and policies wherever possible, thereby levelling the balance of power across the divide. (Waikato DHB, 2020, p. 12)

The change document contained only one explicit reference to education or related terminology; yet this mention was significant. It indicated that leadership responsibilities included an educational dimension, particularly in connecting clinical and operational teams. This role was framed as essential for reducing tensions that arise from competing priorities, such as patient/tāngata whaiora care and financial constraints. The reference to "proper processes" (Waikato DHB, 2020, p. 12) suggested that leadership within the new structure was grounded in collaboration, mutual respect, and the facilitation of learning. For instance, interpreting and applying new evidence to inform practice or policy requires educational support to ensure nurses can integrate this knowledge into their clinical work. Although education was not a central theme in the change document, its inclusion within leadership tasks implied its importance in achieving the goals of the restructured system. Building on this premise, the review extended to nursing leadership position descriptions to explore how educational responsibilities were embedded within the broader nursing structure.

The review of change process documents revealed that while education was not a central focus, it was acknowledged as a critical leadership function within the context of structural reform. The principles of effective leadership, empowerment, collaboration, and accountability were designed to support strategic goals, including improved health equity and operational performance. Education was referenced specifically in relation to leadership responsibilities, highlighting its role in bridging clinical and management domains and facilitating evidence-informed practice. Although mentioned only once, this reference underscored the importance of education in enabling organisational change and informed the subsequent analysis of nursing leadership position descriptions to assess how these expectations were embedded across the nursing workforce.

4.2.4 Position Descriptions

Position descriptions serve as formal documents that define the roles and responsibilities of nursing staff in delivering service requirements. A total of 18 nursing position descriptions were

reviewed and summarised in Appendix L. Of these, only nine explicitly referenced education or development activities. Roles such as RN and community mental health nurse included preceptorship and orientation support for students. Positions within the PDU such as nurse manager, nurse educator, and nurse coordinator, demonstrated a clear focus on education and development. Specialist roles, including clinical nurse coordinators, clinical nurse specialists, and nurse practitioners, incorporated teaching and development responsibilities aligned with their clinical expertise. Associate charge nurse manager roles included coaching and supervision, while charge nurse roles did not mention education. However, all position descriptions included expectations related to quality improvement, suggesting that education may be implicitly understood as a mechanism for achieving service excellence.

The findings indicate that educational responsibilities are unevenly distributed across nursing roles within Te Whatu Ora Waikato District. While some roles explicitly support education and development; others, particularly those in frontline leadership, lack formal recognition of these functions. This inconsistency may limit the strategic alignment of workforce development with organisational goals. The implicit reliance on education to support quality outcomes, without explicit articulation in role descriptions, risks undervaluing its importance. To strengthen operational and clinical practice, it is essential to formalise educational expectations across all nursing roles, ensuring that development activities are recognised, supported, and aligned with strategic priorities.

4.3 Resources

Returning to the guiding document for nursing, it was evident from the objectives and outcome measures outlined in the Nursing at Waikato Strategy (Waikato DHB, 2017) that achieving the required standards of nursing care relies heavily on ongoing post-registration education and development. To support these strategic aims, a comprehensive suite of resources was made available to nurses at the point of care.

These resources were accessible electronically via the Health New Zealand Te Whatu Ora Waikato District Nursing and Midwifery intranet site. Each resource included a clear statement of purpose and detailed the associated educational tools, processes, and support mechanisms. Collectively, they provided nurses with immediate access to evidence-based guidance, clinical protocols, and learning materials designed to reinforce safe, effective, and culturally responsive practice. The scope and function of these resources are summarised in Table 6.

Table 6.

Resource platforms supporting education and development.

Type of Resource	Purpose	Detail
Intranet / Internet Nursing and Midwifery Page	Reflects the outworking of the Nursing and Midwifery Strategic Aims (2017)	How to access PDRP, supervision /reflective practice, Nurse Entry to Practice Programme, Health Care Assistant Training Programme (NZQA Accredited), Nursing Midwifery Education calendar, orientation, certification and credentialing for intravenous therapy, resuscitation, Nursing and Midwifery Roundtable, post graduate education and research, Lippincott Clinical Procedures.
Ko Awatea is a shared learning platform for organisation-specific requirements	eLearning repository to support practice and onboarding	Code of conduct, privacy legislation, medication management, intravenous therapy certification, catheterisation, pain, epidural, restraint, point of care testing.
Lippincott Clinical Procedures NZ Instance	Point of care international evidenced based practice procedures reviewed annually and agreed for the Aotearoa New Zealand context	Available to all Midland DHBs and their contract partners across the continuum of care (hospital, community, primary, aged residential care), excluding Aotearoa New Zealand context for mental health. Four thousand sites globally contribute to the best practice evidence, then changes and updates reviewed by New Zealand specialty representatives each quarter.
Nursing Reference Centre Clinical Practice Database	Updated annually for the Australasian context	Evaluates and ranks current clinical research and evidence within point-of-care research in clinical areas.
MIMs and Injectable Drugs	Reviewed annually	A factual resource of evidence and safe guidance for medication management, including administration, actions, interactions, and adverse reactions.
Releasing Time to Care Programme Principles and Modules	Licensed NHS quality programme	A modular programme implemented by nurses in clinical areas to address priorities for quality improvement.

The resources available on the Te Whatu Ora Waikato District intranet played a critical role in supporting nursing education and development in practice. Aligned with the strategic aims outlined in the Nursing at Waikato strategy (Waikato DHB, 2017), these resources enhanced clinical decision-making by providing timely, evidence-based guidance at the point of care. They included access to medication databases, dosing, and administration tools, and learning platforms for orientation and specialty knowledge, complementing in-person education. These digital supports contributed to consistency in care and reduced the risk of error. However, their effectiveness was limited by practical challenges, particularly the availability of devices for access. This highlights the need for infrastructure investment to fully realise the potential of digital learning and clinical support tools in nursing practice. The following conclusion summarises the key insights from the document review.

4.4 Chapter Summary

The document review revealed that few organisational documents explicitly addressed structures and processes for nursing education and development. The two exceptions were the Waikato DHB Strategic Plan (2016) and the Nursing at Waikato Strategy (Waikato DHB, 2017), notable for their clear prioritisation of education as a central mechanism for achieving effective health service delivery, representing a significant organisational strength. However, this strategic intent was not consistently reflected in other documents, such as change processes, position descriptions, policies, procedures, and guidelines. Education was notably absent from many organisational structures with only specific roles, primarily within the PDU, formally recognising education and development responsibilities.

Online platforms and point-of-care resources were acknowledged as valuable adjuncts, offering accessible support for clinical practice and learning. However, their integration into broader organisational frameworks appeared limited. These findings suggest gaps between strategic aspirations and operational implementation, including that the annual plan outlined the goals related to education and development but lacked actions, the absence of education in senior nursing roles with the exception of education roles, and the absence of the education within change processes and clinical governance. These findings reinforce the need for more consistent and embedded approaches to access nursing education and development across Te Whatu Ora Waikato District.

Chapter Five presents the findings from the second UofA, focusing on stakeholder perspectives.

CHAPTER V FINDINGS: STAKEHOLDER PERSPECTIVES

5.1 Introduction to Themes

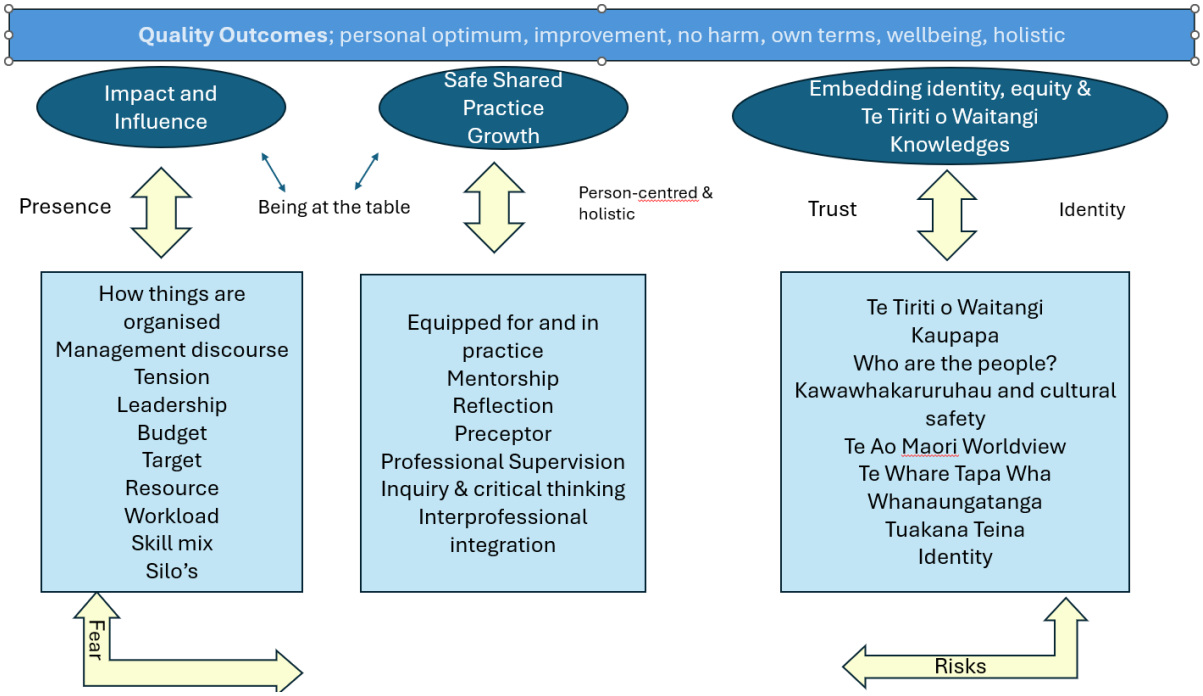
Chapter Five presents the findings from the second UofA, stakeholder perspectives. These findings build on the document review by incorporating data as verbatim quotes from focus groups and interviews with nurses from practice, education roles, and operational managers and leaders. This qualitative data provided deeper insight into how nursing education and development were perceived in relation to strengthening operational management and clinical practice within Te Whatu Ora Waikato District. The findings are organised into three overarching themes, each supported by associated codes. These themes reflect stakeholders' perspectives on (i) impact and influence; (ii) safe, shared practice growth; and (iii) embedding identity, equity, and Te Tiriti o Waitangi in practice.

The first theme, 'impact and influence', captured the reactive nature of practice environment and significance of nurses' presence in care delivery. It also highlighted tensions between clinical and management priorities, the composition of the workforce, and the persistence of siloed structures. The second theme, 'safe, shared practice growth', emphasised the importance of equipping nurses with the necessary skills, the value of mentoring for individual and team development, and the role of interprofessional collaboration, The third theme, 'embedding identity, equity, and Te Tiriti o Waitangi in practice', focused on cultural safety, Kawa whakaruruhau, Te Ao Maori worldviews, identity, and Tuakana-Teina relationships. These themes are visually represented in Figure 7, where stakeholders described quality outcomes as a "personal optimum as an improvement without harm, on the patient's terms, and as holistic, reflecting well-being" (Focus Groups & Interviews).

Verbatim quotes are labelled using 'FG' followed by the focus group number, and 'I' followed by the interview letter.

Figure 7.

Illustration of themes.



5.2 Theme One: Impact and Influence – How Organisational Structures Impact Nursing Practice and Influence Outcomes

The theme of impact and influence captured how organisational structures shaped nursing practice, either empowering or constraining nurses' ability to influence care. This theme emerged through codes such as how things were organised, being reactive, dominated by management and budget discourse, and the constrained clinical voice, particularly where nursing education was excluded from decision-making forums. Despite nurses being present at the bedside 24 hours a day, 7 days a week, their influence was often limited by siloed systems and a lack of representation in strategic discussions.

Initial coding also revealed workforce and workload realities that contributed to the dynamic, including short staffing, junior skill mix, and delayed responses to acuity and demand. Tools, such as variance response systems, were noted but their late activation further diminished nursing influence. These findings shifted the thematic focus from a narrow view of organisational structure to a broader understanding of how systemic conditions impact nurses' ability to shape practice and contribute meaningfully to operational and clinical outcomes.

5.2.1 Presence as Influence in Clinical Practice

Impact and influence in healthcare required presence. In clinical settings, presence involved active engagement with tāngata whaiora (patients), participation in service planning, and involvement in decision-making processes. Stakeholders identified nursing as the largest workforce resource within healthcare organisations, including Te Whatu Ora Waikato District. They also recognised nurses as the most consistently present health professionals in inpatient settings. Unlike medicine, allied health, and other multidisciplinary roles that engaged episodically, nurses maintained continuous contact. As one interviewee noted, "*Nurses are pivotal because they are with the person 24/7*" (I C). This constant presence across day and night shifts enabled nurses to respond to subtle changes in patient condition. Their proximity facilitated emotional support, advocacy, and coordination of care, often extending to whānau and others present outside standard working hours.

Despite their presence across all aspects of care delivery, and comprising half of the Te Whatu Ora Waikato workforce, nurses' limited influence revealed a structural incongruence raising critical questions about organisational dynamics and inclusion in decision-making. Another stakeholder emphasised the need for nurses to be actively involved: "*We need to be at the table with operational, to sit at the table if something comes up to drive forward … it's really important, that relationship, and respect*" (I G). The metaphor of 'being at the table' reflects presence as the importance of inclusion in decision-making. When education teams remained excluded, consultation occurred after decisions have been made. For example, when quality audits identify issues, education is typically proposed as a reactive solution. In such cases, education is accessed through referral rather than proactive engagement. In contrast, involving education teams early in issue identification allows for tailored responses about whether the need is for knowledge acquisition or practical application.

Proactive engagement supported the ongoing work of education teams, including orientation, post-registration, and postgraduate programmes. These initiatives aimed to build clinical competence, leadership, preceptorship, and mentorship from the outset of employment. Structured approaches enhanced staff capability and fostered growth in both organisational and clinical knowledge. However, the absence of a coordinated platform for education teams to influence service organisation, particularly in complex circumstances, resulted in delayed and reactive responses. This gap between nursing presence and organisational influence revealed structural incongruence and underscored a deeper tension between clinical priorities and management-driven agendas where decisions often reflected operational efficiency over frontline realities.

5.2.2 How Things are Organised – The Tension Between Management and Clinical Priorities Including Budget and Targets

Stakeholders described the way things were organised as reflecting management discourse, incorporating terms such as flow, rosters, workload, resource allocation, efficiency, productivity, targets, budgets, procurement, and policy. This terminology clearly acknowledged that management played a critical role in healthcare delivery and that management skills enabled the alignment of resources and logistics with service delivery needs and clinical care. For instance, finance professionals ensured resources were available to support clinical priorities, while directors and service managers provided logistics and implemented actions that delivered on priorities.

Despite these contributions, focus group and interview data revealed that management decisions often generated tension. Stakeholders perceived that management discourse frequently overshadowed clinical perspectives, prioritising operational goals, such as meeting targets and managing budgets, over patient-centred care. Focus group participants consistently described their practice environment as reactive, with limited opportunity for proactive planning or critical reflection. One participant stated plainly: "*because we are very reactive*" (FG1).

Nurses framed this reactive stance as a defining feature of their daily operations. It was not merely situational but embedded in the organisational culture, driven by immediate pressures such as patient deterioration and emergency response. While there is some benefit to a reactive approach in emergency situations, in everyday activity it was considered to limit planned activity based on assessment, as one nurse explained, "*I think we often find ourselves quite reactive, and there's no time to really assess the situation ... because at the back of everyone's mind is the need to get this patient discharged because there's a waitlist*" (FG1). This comment illustrated how time pressure and discharge targets constrained nurses' ability to engage in thorough assessment for person-centred care and evidence-informed decision-making. The phrase "*no time to really assess*" pointed to a lack of time and thinking space for the assessment to inform clinical reasoning, reinforcing the tension between nursing values and operational demands.

Further, the reactive nature of practice extended into educational contexts. One nurse, who acknowledged the clinical demand and need for in practice preceptorship support, stated, "*The moment that the ward starts recruiting nurses, I need that preceptor. Everything is just so reactive; there's not enough. There's* not *enough*" (FG1). This statement underscored the

mismatch between expectations for structured learning and the reality of limited resource, particularly time, staffing, and access to educational materials. Despite the presence of support roles, such as preceptors, their effectiveness was compromised by systemic constraints, reinforcing the theme that organisational structures significantly influence nursing practice and development.

These findings illustrate how reactive practice has become embedded in daily operations, shaping both clinical decision-making and educational support. While nurses consistently responded to immediate patient needs, the lack of time and resources for proactive planning limited their ability to engage in person-centred care and structured learning. This reactive environment constrained the influence of nurses, despite their constant presence at the bedside.

Stakeholders described experiencing fear and anxiety in reactive, high-pressure environments, where they felt vulnerable to making mistakes or missing essential aspects of care. One focus group expressed this concern: "*the tension of management discourse in response to clinical demand and fear of missed care and mistakes*" (FG2). This group highlighted the strain between clinical and managerial priorities, particularly around efficiency, workflow, and resource constraints. While they recognised that managers aimed to enhance quality outcomes for tāngata whaiora and maintain fiscal accountability, they also felt that nurses were caught between competing demands. This created a dilemma, as nurses feared compromising care while trying to meet both clinical and operational expectations.

It was understood that operational management employed targets as a shared language to drive health outcomes. Yet, stakeholders noted that meeting targets in one part of the system often produced unintended consequences elsewhere. One interviewee reflected:

> *In health, we have a target for a good purpose, but when we implement the target, the target becomes an end of itself, but it isn't. It's the outcomes for the people we serve. So, it's a slightly different perspective.* (I C)

This comment acknowledged the original intent behind targets but warned against losing sight of their purpose. When targets became the primary focus, they risked obscuring the broader impact on tāngata whaiora, whānau, and communities. The tension between managerial efficiency and clinical care raised important questions about how healthcare systems balanced strategic objectives with frontline realities.

5.2.3 Leadership, Workload, and Skill Mix

Stakeholders emphasised the critical relationship between operational leadership, implementation, and clinical teams in achieving person-centred care and quality outcomes. While they acknowledged efforts to strengthen this connection, they also identified a structural gap. One focus group participant observed:

> *There's a disconnect between the two that, what we see as important, and what the DHB see, and the structures that we operate within, perhaps they don't all align and that can often be a challenge when trying to provide quality patient care.* (FG2)

This quote highlighted the misalignment between clinical and organisational perspectives. Stakeholders recognised that differing priorities and structural limitations hindered the delivery of quality care. Within nursing, operational leadership styles, such as nurse manager, played a key role in resource utilisation. However, participants noted that resource availability often shaped priorities. One interviewee explained: "*Between management and nursing, it is all driven by the nurse manager role, and they gain a pure management operational perspective over what they do*" (I A). This comment suggested that nurse managers' style often operated with a predominantly logistical and resource-focused lens, which added complexity to their clinical responsibilities.

As leaders of charge nurses across wards and clinics, nurse managers served as a bridge between operational and clinical domains. Yet, stakeholders observed that operational demands often dominated this role, challenging the ability to prioritise clinical needs. However, one interviewee described the priority of the nurse manager role to be that of clinical, operational and education working together:

> *As a nurse manager it was around how I operationalise what I am being told to achieve, including quality indicators, how do I get my staff to come on board … so I think education plays a big role working together with clinical areas to meet needs of staff at the operational interface.* (I K)

This quote acknowledged that the manager role operates as a critical translational function within the organisation, mediating between strategic directives in the reference of "*being told to achieve*" and clinical practice. Quality indicators and performance expectations do not simply cascade downward; they require active interpretation and operationalisation at the local

level. Managers, therefore, engage in a process of sense-making that enables organisational priorities to be meaningful and actionable for staff.

Engaging staff to contribute to achieving organisational goals emerges not as a matter of compliance but as a relational and communicative process shaped by leadership practices, and the perceived relevance of quality measures to everyday clinical work. Education is positioned as a key enabling mechanism within this process. It functions to build capability and support staff to integrate new expectations into their practice. A practical example from a clinical issue in practice was described as:

> *At the moment there is a problem with IV pumps; we talked about how the staff are overwhelmed by the impact of this, so we have focused on drip rates and how to work the pumps, trying to chunk it together so the staff have time to process what they need to keep the patients safe.* (I K)

This situation highlights the implications of a breakdown in the electronic functioning of intravenous (IV) pumps that operate through embedded digital protocols. These protocols typically provide tailored, evidence-informed guidance, acting as a safety net for the administration of specific medications and fluids. Their sudden absence disrupted established workflows, requiring staff to revert to manual infusion processes and equipment. For nurses accustomed to automated systems, this shift introduced a heightened cognitive and operational burden, necessitating rapid sense-making and adaptation in a context of increased uncertainty. Consequently, the disruption exposed vulnerabilities in both technological reliance and system resilience, with potential implications for patient safety.

This example highlights the need to balance the provision of information, knowledge, and technical skills with the realities of clinical workflow. The intervention targeted both the operational dimension (ensuring staff could practically use the equipment) and the clinical dimension (maintaining safe and accurate infusion practices). The responsiveness of this approach highlights that rather than delivering comprehensive training in a single, overwhelming package, the support was sequenced and adapted to staff capacity, workload, and immediate clinical risk. By aligning the educational strategy with staff needs at the point of care, the process supported safer clinical outcomes while mitigating the stress associated with rapid operational change.

The analysis highlighted the importance of collaboration at the operational interface between management and clinical areas. This interface represents a dynamic space where

organisational intent encounters contextual realities, requiring negotiation, adaptation, and ongoing dialogue. Effective operationalisation, therefore, depends on managers' ability to work alongside clinical teams, and education and development teams, to identify needs, address constraints, and co-construct approaches that are both feasible and aligned with quality imperatives. In this sense, the nurse manager role can be understood as connecting strategic priorities with the lived experience of clinical work. Skill mix and workload go hand-in-hand to reflect the experience, knowledge, and skill for the area of practice with sufficient expertise for the clinical demand and support the development of less experienced nurses.

Stakeholders identified organisational tools that supported quality outcomes, such as the Releasing Time to Care programme and the Care Capacity Demand Management (CCDM), which uses the Trendcare© methodology to calculate skill mix and workload based on clinical acuity and care required. One participant stated: "*Releasing time to care supports that stuff as well. Trend care does support that, and if they were taken away, that would detrimentally affect the patient's quality outcomes*" (I B). This quote confirmed the perceived value of these programmes. The Releasing Time to Care quality programme improved both the environment and processes within clinical areas, allowing nurses to spend more time on direct patient care. CCDM and Trendcare© supported effective staff allocation based on acuity, helping nurses respond to patient needs. Stakeholders warned that removing these tools could disrupt care delivery and compromise outcomes at the patient–nurse interface.

Workload impact was significant for experienced nurses who supported less experienced nurses in practice:

> *You need face to face teaching with the online and practical workshops, then the nurses come back to practice … it's not just right follow me I've got a workload and I'll teach you as best I can. For me it's … I'm going to give you some time, do some teaching and training until you have the confidence to go solo.* (FG3)

This nurse highlighted the substantial workload implications for experienced nurses who are required to support less experienced colleagues in practice. It articulates a teaching burden that extends beyond formal education sessions. While structured learning opportunities with face-to-face teaching, online modules, and practical workshops provide an essential foundation, the real pressure emerges when nurses return to the clinical environment and require ongoing, situated support. The quote illustrates that this support cannot be reduced to a simple "*follow me*" model of learning. Experienced nurses emphasised that they are simultaneously managing their own clinical workload while attempting to provide safe,

high-quality teaching. This dual responsibility creates tension between the need to maintain patient care standards while also ensuring that less experienced nurses develop the competence and confidence required for independent practice.

What emerges is a picture of informal, relational, and time intensive teaching work that is often invisible within formal workload calculations. The experienced nurse in this account articulated a commitment to creating protected time for teaching by saying "*I'm going to give you some time*" and support until the novice nurse is ready to "*go solo*". This reflects a form of practice-based mentorship that is responsive, adaptive, and grounded in professional responsibility; yet, it also intensifies the workload of those who take on this role and requires consideration in the operational management of both workload and skill mix. This example reinforces the emotional, cognitive, and practical demands placed on experienced staff who provide this type of support in the clinical environment. It also highlights the organisational challenge of balancing service delivery pressures with the need to cultivate a safe and supportive learning environment for developing practitioners.

Finally, nurses linked workload and staffing to operational pressures. They noted that these factors directly affected care quality and, although nursing represented the largest workforce in Te Whatu Ora Waikato District, it was often viewed as the costliest. As one participant explained, highlighting a sense that financial scrutiny disproportionately targeted nursing, even though adequate staffing was fundamental to service quality and patient safety, "*And nursing budgets, because we're quite costly, because there are so many of us*" (FG3).

Nurses expressed concern that, despite their numbers, they lacked proportional influence in decision-making. One interviewee stated: "*And for nursing, maybe 48% of the workforce, 3,800 of us overall, we don't have the influence*" (I C). This quote illustrated the perceived disconnect between workforce size and organisational influence. Stakeholders viewed this imbalance as a structural issue that limited nurses' ability to shape decisions and contribute to safe, effective care. Building on this issue, stakeholders also identified that the structural disconnect between operational and clinical priorities often manifested in siloed practices, further constraining teamwork, collaboration, and the ability to deliver cohesive, person-centred care.

5.2.4 Silos and Teamwork

Directors and managers described nursing as isolated or siloed within the broader healthcare system. This perception stemmed from the size of nursing teams, which were significantly

larger than those in allied health or medicine, and from the presence of profession-specific management roles at multiple organisational levels. For example, nurse managers provided operational oversight to charge nurses and clinical teams; whereas similar roles in medicine and allied health were typically general operations managers without profession-specific alignment.

Stakeholders linked these structural differences to challenges in service integration and interprofessional collaboration. They believed that siloed structures limited opportunities for shared decision-making and teamwork. One interviewee suggested that allocating nursing staff across various levels of influence could help prevent silos and foster a culture of collaboration. "*About silos, all sorts of things constrain, if we collaborate properly and always be enquiring, that's what brings about changes*" (I C). In reflecting on this issue, the stakeholder acknowledged that silos, defined as divisions, fragmentation, or a lack of integration among team members, professional groups, and departments, created significant barriers to growth and improvement. They explained that siloed working limited communication and coordination within teams and across the broader clinical context.

The phrase "*all sorts of things constrain*" confirmed the presence of barriers, even though the speaker did not name them explicitly. However, the stakeholder contrasted this with the potential of collaboration, which they described as fostering inquiry and enabling change. Attributes of effective collaboration—such as open communication, respectful challenge, and shared decision-making—emerged as essential to overcoming isolation and promoting collective approaches to care.

Another interviewee reflected on silos from a hierarchical perspective, offering further insight into how structural and cultural dynamics influenced interprofessional relationships and team effectiveness: "*And not having that siloed approach, where nursing has almost become like an island in terms of the higher-level organisation*" (I G). This quote highlighted a concern that nursing often functioned like an island, suggesting a partial disconnect from other parts of the organisation. Stakeholders implied that this separation extended to senior leadership levels, where the absence of integration, representation, visibility, and influence limited the alignment between operational and clinical practice. They emphasised that integration required intentional structure and consistent application across all levels of executive, service leadership, and clinical teams. They also noted that isolation at higher levels could restrict influence throughout the system, particularly given the size of the nursing workforce which, at nearly 4,000, risked becoming inwardly focused. To counter this issue, stakeholders

advocated for interdisciplinary development and learning to support collaborative care delivery.

Interdisciplinary partnerships are facilitated by learning and practice engagement through structured and informal interdisciplinary reviews and education, for which planning is required to ensure that appropriately timed collaboration can occur. The contrast to this planned approach is that left to ad hoc mechanisms risks are missed, communication opportunities are limited, and conversations are confined to those who can connect in the moment. Stakeholders described features of structures for interdisciplinary meetings to identify and overcome these risks as:

> *A partnership approach across the professions where nursing, doctors and allied health have an equal voice in terms of what a priority is and what the important outcomes are for the patient, for the population that they are working with*. (I E)

This quote emphasised a partnership model where connections and engagement occur across the health professional team based on respect and shared accountability that is outcomes focused. It reinforced the value of team culture where there is equal voice in establishing shared goals of care for individuals and addressing wider population health needs.

Participants viewed interdisciplinary teamwork and strong leadership styles both within units and across services as key to overcoming silos. When these elements were present, teams responded to demand and complex situations with greater confidence. Recovery from high-pressure shifts required conscious facilitation, and participants described moments when everyone worked together to meet challenges. Nurses expressed that they were not deterred by high acuity or complex needs, provided they had the necessary knowledge, skills, and support. However, repeated exposure to such conditions without adequate support led to dissatisfaction among nurses, tāngata whaiora, and their whānau. These experiences increased stress and anxiety during shifts and eroded nurses' sense of psychological safety. One focus group of clinical nurses emphasised that rebuilding trust in the system required time, support, and a commitment to recovery: "*we actually need a healthy environment for a sustained length of time for our nurses to heal and do well and to feel trust in the system*" (FG3).

A sustained, healthy work environment required more than intermittent or reactive responses; it demanded a deliberate focus on workforce recovery. Nurses described experiencing

prolonged periods of stress and identified stability as essential to rebuilding trust as an element central to this study's focus on promoting safe, shared practice and cultivating a culture of learning. Education and professional development played a critical role in this process. Stakeholders emphasised that knowledge, clinical skills, critical thinking, and reflective practice all contributed to creating a trusted and resilient environment.

Ensuring that the workforce was appropriately sized to meet clinical care demands further underscored the importance of strategic staffing and planning. Programmes such as Releasing Time to Care and CCDM supported nurses in leading quality initiatives and maintaining safe staffing levels. These tools enabled nurses to focus on direct patient care and allocate resources based on acuity, reinforcing their capacity to deliver high quality care.

These insights into workforce recovery and the need for sustained support naturally led stakeholders to emphasise the importance of shared practice growth. They highlighted how a strong learning culture, grounded in collaboration, reflection, and continuous development, was essential for building resilience and ensuring high-quality, person-centred care.

5.3 Theme Two: Safe, Shared Practice Growth – A Learning Culture

The theme of safe, shared practice growth captured the characteristics and behaviours that reflected a strong culture of learning within clinical environments. Stakeholders described how nurses were equipped and prepared for practice through structured support, contextual learning, and ongoing development. They articulated the importance of team connection, both within nursing teams and across the wider organisation, as a foundation for shared growth. Functional supports such as mentoring, coaching, and peer learning were acknowledged to play a vital role in strengthening individual and collective capability. Interprofessional collaboration emerged as a key enabler, fostering mutual respect, shared decision-making, and a unified approach to care. Together, these elements contributed to a learning culture that supported safe, reflective, and continuously improving practice.

5.3.1 Equipped and Connected

A learning culture emerged as a direct response to practice priorities. Nurses described how being equipped for their roles meant having the knowledge and skills specific to their clinical context, along with meaningful connections within their teams and across the wider organisation. Clinical knowledge remained central, but participants also emphasised the importance of access to learning opportunities, time for reflection, critical thinking and inquiry,

and the sharing of practical knowledge. Being connected extended beyond team cohesion; it included the ability to escalate clinical or coordination concerns, access timely support, and engage in reasoning and decision-making without fear of criticism or reprisal.

When these connections occurred, nurses valued them as indicators of a positive workplace culture, one that enhanced both their professional experience and the care provided to tāngata whaiora. As described by Focus Group 3, these experiences reflected a culture where learning, safety, and collaboration were not only encouraged but embedded in daily practice: "*A culture that's really positive that enables people to ask questions to help them critically think and have that culture, where people are driving each other to provide evidence-based care and see opportunities for people's growth*". Insight from this quote conveyed the participants' experience of working within a clinical team where learning was embedded in day-to-day practice. This implied the presence of supportive leadership styles and consistent access to education. The stakeholder described a learning culture that fostered collaboration and improved practice as one that was dynamic and responsive. Mechanisms such as reflection, knowledge sharing, and continuous skill development were seen as essential for professional growth and team effectiveness.

Another stakeholder reflected on learning from situations where things had not gone well, highlighting the importance of psychological safety and openness in cultivating a learning environment.

> *Permission to be wrong and learn in the workplace, so it sometimes feels a bit punitive. I worked in an environment where if you put an incident report, you were seen as an asset … and then as a team would decide what outcomes you had to have. It's so empowering, whether it was your fault or not; you were then seen in a positive light, like 'thank you so much'*. (I C)

This quote illustrated the value of feeling safe within a practice environment where mistakes were acknowledged as opportunities for learning rather than sources of blame. The participant described a team culture in which incidents were collectively analysed, solutions were explored, and improvements were implemented collaboratively. This approach reflected a direct correlation between team culture and the quality of incident outcomes. Stakeholders noted that leadership style and team dynamics shaped how a nurse's voice was heard, interpreted, and acted upon.

While nurses consistently strived to deliver high-quality care, some described contexts where incidents led to formal reporting such as through the Datix incident management system and were perceived as punitive. The use of terms like "*fault*" suggested a culture of blame, which undermined psychological safety. In contrast, Interviewee C described a more constructive approach, where incidents were framed as quality improvement activities. They used terms like "*collaborative group*" to describe teams that worked together to identify solutions and implement changes, which were then collectively owned.

This shift from blame to learning highlighted the importance of responsiveness and the concept of 'permission to be wrong'. Rather than tolerating errors, this idea reflected the need to support nurses in doing their best and accessing the best available resources. It acknowledged the tension nurses experienced when poised to act while aware of clinical needs but cautious of potential negative consequences. As one focus group described, this balance between action and fear required a culture that supported learning, not punishment: "*I think success would look like retained nurses who love being in the place that they're working in and feel confident and safe and, secure enough to lead there too eventually!" (FG3).*

This quote identified success as the experience of thriving within a positive team culture as one where nurses felt confident in their clinical and professional practice. Participants described how a safe and supportive environment enabled shared growth by encouraging individuals to take initiative, step into leadership roles, and contribute meaningfully to team development. This growth occurred because nurses were supported in building the knowledge, skills, and resilience required to practise effectively. The presence of a learning culture empowered them to lead, reflect, and continuously improve, reinforcing a sense of professional identity and collective responsibility for high-quality care. Central to this culture of growth was the role of mentoring, which stakeholders described as a vital mechanism for building confidence, transferring knowledge, and fostering leadership within and across clinical teams.

5.3.2 Mentoring, Reflection, Preceptorship, Professional Supervision, and Critical Thinking

Mentoring was identified as a foundational element in supporting nurses through transitions, sustaining professional growth, and fostering a resilient workforce. Various forms of mentoring and support were identified as integral to joining a clinical team, retaining staff, and mitigating ethical fatigue, burnout, and disconnection from professional purpose. Preceptors played a key role in supporting the transition to practice, particularly for new graduates or staff entering

unfamiliar clinical contexts. Related practices such as coaching and role modelling reinforced the importance of mechanisms that built competence and confidence, while affirming the value of both the individual nurse and the nursing team.

Stakeholders emphasised that these positive outcomes were only possible through intentional knowledge sharing and the commitment of experienced nurses to mentor others, despite the added demands on their already complex workloads. At the same time, education and learning were seen as hallmarks of a positive culture, contributing to quality outcomes and, in turn, positively influencing workload. The effectiveness of mentoring depended on timely collaboration, strong interpersonal connections, and skilled facilitation in the moment, as illustrated in the following interview: "*A big influence is supporting preceptors and senior nurses on the floor, to be able to use Socratic questioning … so that they can demonstrate an understanding and knowledge of what they're doing." (I K).*

The reference to the specific use of Socratic questioning (Ho et al., 2023) added depth to this theme, revealing it as an exploratory and participatory strategy that supported inquiry, reasoning, and confidence-building. Stakeholders contrasted this approach with more interrogative methods, such as closed questions focused on 'what', 'when', or 'who', which were perceived as limiting. The use of the term *Socratic questioning* signalled an intentional effort to develop critical thinking and inquiry by encouraging deeper exploration and meaning-making which informed clinical reasoning and decision-making. Participants described how preceptors and mentors who adopted this approach created environments that encouraged curiosity and reflection. These environments supported psychological safety by allowing individuals to learn from both successes and challenges, reinforcing the value of learning through exploration rather than fear of error. As one participant explained, "*Being responsive to that uncertainty, seeking confirmation and advice, if they've had things come up in that shift, they've had opportunities to talk to more senior staff … for learning opportunities" (I A).*

A valuable aspect of mentoring and preceptorship was achieved through presence during clinical shifts and being physically and professionally available within the practice setting. Stakeholders described how this presence enabled the integration of work and learning, allowing mentors to provide timely support, model best practices, and guide safe clinical decision-making in real time. This embedded approach to learning was seen as essential for building confidence and competence, particularly during high-pressure situations. One focus group clearly articulated this value: "*People misunderstand what nursing is about, it's about the knowledge base, and building on it, you know competence, capability, confidence as well it's like do what you need to do and escalate when you need to escalate*" (FG1).

The above observation illustrated how continual learning and development deepened nurses' understanding and strengthened their clinical reasoning. Stakeholders emphasised that knowledge alone was insufficient; competence, capability, and confidence reflected the ability to access and apply knowledge effectively, adapt within scope, and escalate concerns when necessary. Preceptors and mentors, particularly experienced nurses, played a vital role in modelling and facilitating practice-based learning. In the absence of such support, nurses described feeling ill-equipped to manage complex clinical situations, which impacted their confidence and decision-making: "*Living in the grey and making it up as we go along, and trial and error, that's another learning, you know*" (I A).

The reference to a "*grey area*" described aspects of nursing practice that were not always clearly defined. Stakeholders acknowledged that nurses often needed to demonstrate agility and responsiveness in dynamic clinical environments. When adequately equipped, nurses managed these complexities through sound clinical reasoning and the effective application of knowledge and skills, while demonstrating innovation. In contrast, a lack of knowledge and skill contributed to uncertainty and fear, particularly when navigating ambiguous situations or making critical decisions under pressure.

> *Fear factor … I think there's this big fear factor … like I can't look after that because I'm not sure and I don't know … So then you get a person who has to have a specific procedure, and I can understand why they're like, 'Oh, we're scared to do this'*. (I B)

Interviewee B's reflection revealed how fear acted as a barrier to care, particularly when nurses expressed uncertainty about their capabilities by stating, "*I can't look after that*". Such statements reflected a lack of confidence and an awareness of specific knowledge and skill gaps. When these gaps were identified, they became opportunities for targeted support and professional development.

Stakeholders also discussed how certification and credentialing processes could both enhance and constrain skill acquisition. Within Te Whatu Ora Waikato District, the learning culture was defined by comprehensive immersion in evidence-based education and guided practice. Nurses demonstrated clinical reasoning and technical proficiency to achieve certification, which served as a formal validation of competence.

> *I have seen it working successfully; you don't have the depth of knowledge that you have in this certification process at Waikato. For example, when accessing ports, in other hospitals, you would read the protocol, you would access it, you would de-*

> *access it, and that's what you do. But here you must learn about the anatomy and the different products and practice it and do it in front of somebody … that part of its really good, that you're encouraged and mandated to do all the learning behind it*. (I B)

In this instance, the stakeholder identified the value that knowledge and evidence brought to clinical practice, with certification serving as formal confirmation that professional standards had been met and applied. The interviewee inferred that while a task could be completed and the desired outcome achieved, performing it without a depth of understanding risked reducing the act to a procedural task rather than an informed clinical decision. Certification, therefore, represented more than technical competence; it reflected the nurse's ability to apply clinical reasoning and evidence-based knowledge in practice. This distinction underscored the importance of embedding learning into clinical care, ensuring that delivery was both effective and thoughtful, safe, and aligned with professional standards.

> *In other hospitals, you often just don't get time to do the learning, so you have to access the port, you read the protocol, you ask a question if you are not sure, and you do it. So, there is an element of not knowing what you don't know. What if you're doing something wrong? So, I really understand why they have the certification process, but it doesn't really work.* (I B)

Within this aspect of practice, stakeholders argued that while procedural outcomes may appear successful at a superficial level, the absence of deeper learning posed significant risks. Without a solid foundation in underlying knowledge and clinical rationale, assessments and decision-making processes risked being incomplete or insufficiently informed. The comment, "*don't get time to do the learning*" (I B), suggested that protocols were often relied upon to justify actions, implying that the existence of a procedure was sometimes viewed as a substitute for understanding. However, stakeholders emphasised that protocols were designed to support and not replace clinical reasoning. Comprehensive learning, including the development of critical thinking, inquiry, and contextual understanding, was considered essential to complement procedural guidance and ensure safe, informed, and reflective practice.

The same interviewee described how in-depth preparation and certification supported capability development. However, they also identified a tension: certification was sometimes used as a gatekeeping mechanism that restricted access to certain clinical areas. This dual function, which both enabled and constrained, highlighted the complexity of implementing certification processes in ways that promote learning without unintentionally creating barriers

to care. Stakeholders emphasised the need for certification to serve as a developmental tool rather than a restrictive threshold, ensuring that its application aligned with inclusive and equitable access to clinical opportunities.

> *The sort of culture that we have in Waikato, which is different to other hospitals that I've worked in, where the first option is 'Oh no, I don't know how to do that, I can't do that'. Whereas in other hospitals, 'I don't know how to do that, and I have to find out how to do it because my patient needs it'. Part of it is that Waikato's certification process gives you an opt-out … I am not going to do that, I'm not certified for that … Whereas in other DHBs you don't get that opt out. You do it.* (I B)

The stakeholder highlighted a notable cultural distinction within Te Whatu Ora Waikato District, exemplified by the response, "*I don't know … I can't do that*" (I B). This statement reflected a practice environment where the absence of knowledge or certification could be used to decline patient admissions. In contrast, stakeholders noted that in other hospitals such limitations were not accepted as justification to opt out of care. Instead, there was an expectation that nurses would acquire and apply the necessary knowledge and skills to meet clinical demands. This practice diverged from the intended purpose of certification which was designed to support capability development, not restrict access to care.

The incongruence between a comprehensive learning and verification process for specialty skills, and its use as a limiter, suggested that nurses were using this stance to influence logistical and resource decisions. Exploring such tensions within a safe, shared learning culture aligned with the principles of in-practice mentoring and professional supervision. Stakeholders described in-practice mentoring as a collection of activities grounded in connection and effective communication which enabled collaborative problem-solving around capability, capacity, and skill-related concerns. This mentoring was not always formal or tied to a designated role; it often involved educators, preceptors, or clinical coaches but extended beyond individual relationships. Instead, it reflected a set of shared values that fostered a safe and inclusive learning environment across teams.

Extending this concept, stakeholders articulated mentorship as requiring protected opportunities for intentional, practice-based reflection and reflexivity. Professional supervision was identified as a valuable mechanism to support this process.

> *Clinical supervision is a really good point … being supported to develop, for better patient outcomes, it's from a non-biased point of view, it's learning to keep your eyes*

focused forward, where are we moving to, how are we getting there and doing it, doing it collectively and confidently. (FG1)

The stakeholder acknowledged the relevance and value of supervision in supporting reflection and fostering the type of development that enhanced capability and resilience. They directly linked the need for learning and psychological safety to the quality of patient care. Building such capacity within the learning culture did not diminish the importance of formal professional supervision; rather, it complemented it. By embedding these approaches into the learning culture, nurses accessed support close to the time and place where they consciously identified the need to debrief or reflect. Stakeholders cited examples of this occurring after a challenging shift or following a complex interpersonal or clinical situation.

The supervision skill set, particularly the facilitation of reflection and insight, provided structured processes and dedicated time for nurses to unpack and make sense of difficult experiences. Stakeholders described challenges such as fears of operating in uncertainty, concerns about delayed assistance, and the risk of making errors under the pressure of clinical demand and high workload. These concerns shared common elements, notably the absence of clear resolution, which stakeholders identified as contributing to burnout and as conditions to be avoided at all costs.

Stakeholders identified nurse leaders, educators, allied health team members, clinical coaches, and experienced nurses within the practice area as possessing the skills to facilitate these intentional conversations. Both the provision of and training in professional supervision and development-focused dialogue, particularly within mentoring contexts, were described as beneficial: "*Supervision and supervision training really helped. I think mentoring is the single biggest thing that I get the most positive feedback about*" (FG3).

Stakeholders consistently emphasised the importance of supervision and mentoring skills, noting that these were the most frequently referenced areas in received feedback which reflected the perceived value they contributed to others through these practices. However, one commonly cited limitation was the logistical challenge of providing protected time for formal professional supervision to approximately all 3,900 nurses. Despite this constraint, stakeholders affirmed that embedding supervision and mentoring practices in varied formats significantly supported proactive, development-focused initiatives and reinforced a learning culture.

Furthermore, extending these approaches across interdisciplinary teams were seen to facilitate the integration of learning culture attributes that encompassed nursing while broadening its influence beyond traditional boundaries. These supervision and mentoring practices strengthened individual professional development and laid the groundwork for more cohesive interprofessional collaboration, where shared learning and reflective dialogue extended across disciplinary boundaries.

5.3.3 Interprofessional Collaboration

Stakeholders regarded interprofessional collaboration as essential to achieving person-centred care. They described it as a partnership that promoted shared decision-making and mutual accountability. Effective interdisciplinary collaboration occurred through planned learning and practice engagements, including structured reviews and informal education sessions. Stakeholders emphasised the need for intentional planning to ensure that collaboration took place at appropriate times, allowing for meaningful and timely engagement across disciplines.

In contrast, when collaboration relied on ad hoc mechanisms, stakeholders observed increased risks, missed communication opportunities, and limited dialogue confined to those present in the moment. To address these challenges, they described structural features of interdisciplinary meetings designed to identify and mitigate risks, such as:

> *A partnership approach across the professions where nursing, doctors, and allied health have an equal voice in terms of what a priority is and what the important outcomes are for the patient, for the population that they are working with.* (I E)

Stakeholders emphasised a partnership-based model in which engagement and connection occurred across the health professional team. This model was grounded in mutual respect and shared accountability, with a clear focus on achieving outcomes. It reinforced the importance of team culture, where all members contributed equally to establishing shared goals of care for individuals and addressing broader population health needs. Teams reported that such integration enhanced effectiveness; however, they also noted the challenge of ensuring that the distinct skills of specific staff or professional groups were not overlooked. Instead, they advocated for mechanisms that enabled these skills to be accessed through the team and made available when needed: "*Collaborative across the organisation … that sort of multi-skilled approach … where you're not passing a person from one profession to another. You're like jobbing*" (I E).

The interviewee described a model of interprofessional integration in which staff worked collaboratively to address the needs of tāngata whaiora. Rather than individual professionals contributing in isolation, during discrete episodes of care, teams coordinated their efforts to achieve greater continuity. Stakeholders contrasted this approach with the concept of "*jobbing*", where professionals performed only their designated tasks, potentially leading to compartmentalised care. In contrast, connected teams enabled responsive collaboration through relational, functional, and structural links. This collective approach allowed teams to work toward shared aims and goals, enhancing the quality and consistency of care.

Collectively, the components of a learning culture are characterised by safety and a growth in shared practice, which gives nurses confidence in their knowledge and skills and the functional relationships and connections they develop across health professionals within the care context. Mentorship, preceptorship, and professional supervision provide learning and opportunities for reflection and practice. The next theme examines the characteristics of bicultural commitments and cultural practices that foster a culture of learning.

5.4 Theme Three: Identity, Equity, and Te Tiriti o Waitangi in Practice

This theme explores how stakeholder perspectives reflect legislative and strategic commitments to Te Tiriti o Waitangi, as articulated through the Health Services Review (MoH, 2020a), MoH directives, and Te Whatu Ora Waikato District strategies. These mandates underpin a culturally responsive practice environment that prioritises equity, identity, and Indigenous knowledges.

Stakeholders described how concepts such as Kawa whakaruruhau (cultural safety), the Te Ao Māori worldview, identity, and Tuakana-Teina relationships informed both individual and collective approaches to care. These cultural priorities were seen as both ethical imperatives and foundational to a learning culture that values relational practice, inclusivity, and the recognition of diverse ways of knowing. The theme highlights how bicultural commitments are enacted in everyday clinical practice, shaping professional identity and contributing to equitable outcomes for tāngata whenua and all communities.

5.4.1 He Tāngata, Kawa Whakaruruhau, and Cultural Safety

The primary premise of this theme reflects healthcare and quality outcomes for he tāngata, the people of Te Whatu Ora Waikato District, according to the principles of Te Tiriti o Waitangi. Stakeholders described Kawa whakaruruhau and cultural safety as essential components that

enabled Māori and other population groups to access healthcare in ways that aligned with their values and beliefs, as required by Te Tiriti o Waitangi and the Health and Disability Services Standards (MoH, 2021). Planning and care delivery were informed by codes that reflected population health determinants and equity, highlighting stakeholder perspectives on culturally responsive practice.

Beyond Kawa whakaruruhau, stakeholders emphasised that cultural safety encompassed a broad spectrum of cultural and religious systems, including ethnicity, gender, parity, faith, and individual values and beliefs. One interviewee acknowledged that these dimensions of cultural safety had not yet been fully realised in practice, indicating an ongoing need for development and reflection.

> *We thought that the introduction of cultural safety back in the 1990s would improve health outcomes and reduce inequities … But actually, it hasn't. I suppose a lot of it is about having to change people's thinking, attitudes, and their behaviours … Part of the process we go through is building their own self-awareness. And then we move on to look at what is equity? What's equality? And then to start looking at so what are the inequities?* (I H)

This stakeholder reflected critically on the persistent gap between awareness and action, noting that despite applying knowledge of Kawa whakaruruhau and cultural safety, meaningful change in health outcomes and equity for Māori and other populations had not been achieved. The lack of progress over many years suggested that systemic and societal structures continued to uphold historical power dynamics and patterns of behaviour. The stakeholder emphasised that gaining insight and self-awareness was essential for recognising personal biases; understanding privilege, particularly for those of settler ancestry; and acknowledging one's position as a nurse. Only through this reflective process could equity be meaningfully considered and areas of inequity within healthcare be identified.

This perspective underscored that transforming practice requires more than cultural awareness or knowledge acquisition; it demands active learning that confronts systemic barriers and individual biases. Critical reflection about oneself, others, and the context of practice, was seen as a necessary process for fostering culturally safe care.

Nursing education programmes in Aotearoa New Zealand are underpinned by the requirement to uphold Kawa whakaruruhau and cultural safety (NCNZ, 2022b). While personal development is expected during training, stakeholders acknowledged that the journey is

deeply individual, shaped by each nurse's values, beliefs, and lived experiences. Nevertheless, all nurses are required to meet the NCNZ's competence standards for cultural safety, which contribute to creating environments that support diversity and difference. Another interviewee reflected this as:

> *And how it looks for working with Māori, how it works for working with Pacific, working with somebody else from different groups, to make it safe for others, to share their cultural values and beliefs so that we can all learn from each other.* (I C)

In this reflection, the stakeholder emphasised the importance of creating a safe environment for all individuals receiving healthcare, particularly Māori, Pacific peoples, and those from other cultural backgrounds. The focus on "making it safe for others" was inclusive and respectful, demonstrating openness to reciprocal learning and extending the nurse's intention beyond clinical tasks to encompass the patient's lived experience. At the individual level, this highlights the commitment of nurses to enacting culturally safe practice in their everyday interactions.

At a collective level, stakeholders acknowledged that building capacity for Kawa whakaruruhau and cultural safety reflects a broader professional response within nursing, as practitioners work together to address inequities and challenge bias in practice. This includes navigating tensions between individual bias and entrenched colonial mindsets, requiring ongoing reflection and shared responsibility across the profession.

However, these efforts occur within a wider systemic context. The findings signal that, despite individual and collective commitments to equity, organisational structures, such as funding models, performance targets, and institutional priorities, can perpetuate inequities. This layered dynamic reveals a misalignment between what nurses are striving to achieve within their practice and the structural conditions that continue to reproduce inequitable outcomes. Consequently, addressing inequity requires not only action at the individual and professional levels but also critical engagement with organisational and system-level drivers. Another interviewee noted:

> *Cultural competence or cultural responsiveness and developing a workforce … It's really hard to develop a workforce that has closed minds or has biases that are related to one set of people getting something [care] over another. I really do think there needs to be some decolonising of a lot of people's minds. I think when people come to work in Aotearoa New Zealand, especially in a place like Waikato DHB with the Kingitanga* [Māori monarchy] *in mind and that we're with Tainui* [tribe located in the Waikato and home of the monarchy]*, that they need to be responsive to the people that they're*

> *nursing. And actually, set aside biases and their beliefs and values and actually nurse the person at face value.* (I J)

This stakeholder offered a critical reflection on the central focus of cultural competence and responsiveness in developing a healthcare workforce capable of delivering equitable care. They emphasised that such competence required the ability to understand, connect with, and interact in ways that were appropriate for the patient or tāngata whaiora and their whānau. This included adapting communication and behaviour to promote respect, safety, and equity. The stakeholder identified the persistence of longstanding biases that resulted in preferential treatment for some groups and a lesser standard of care for others. Their call to decolonise mindsets challenged entrenched attitudes and power imbalances in practice as an effort that, they argued, could only be achieved through a fundamental shift in worldview, particularly among those who hold a predominantly Western lens (I H).

Further insight into the local context, especially in relation to Tainui iwi and Kīngitanga, revealed an expectation that nurses demonstrate knowledge of and respect for both historical and contemporary influences within Te Whatu Ora Waikato District. Cultural awareness was seen as essential to delivering care that is clinically competent and culturally grounded.

Interviewee J concluded by emphasising the importance of "*putting aside self*" to nurse the person at face value as a person-centred attribute of culturally safe practice. From one perspective, this notion appeared incongruent with whanaungatanga, which reinforces bringing one's self into the relationship to foster genuine connection. However, another stakeholder clarified that "*putting aside bias*" enabled nurses to engage with the person authentically and respectfully, aligning with the principles of cultural safety and responsiveness (I H). Whakawhanaungatanga lays the foundation for connection by building trust, respect, and shared understanding. It is not just an introduction; it is a relational process that acknowledges whakapapa, mana, and the lived experiences of both patient and practitioner.

Considering decolonisation reflexively was framed as a process of restoring Māori authority and influence over Māori health, thereby enabling the achievement of Kawa whakaruruhau. Both the nursing voice and the Māori voice were identified as essential, with early involvement in conceptual development and dialogue. Interviewee C linked both voices as necessary, stating:

> *We need to have the nursing voice at every level where there are changes happening; we need to have the nursing voice and the Māori voice. Right from the beginning. Often nursing and Māori are brought in when everybody's developed the change and how it's going to happen; and then we've got no say in it. Or we're coming in and we're having to say well actually this is not going to work and people aren't so willing to change because they've got this set in their mind. Look we need to be at the table to have the beginning discussion so that then we're all on the same page*. (I C)

This stakeholder advocated for the inclusion of both nursing and Māori voices at every level of decision-making. They acknowledged that engagement often occurred too late in the process, resulting in tokenistic involvement with limited opportunity to influence planning or even to question whether the right issues were being addressed. Invitations for Māori and nursing representatives to validate pre-developed plans reflected organisational processes focused on endorsement rather than genuine participation. This approach led to decisions being made for Māori, rather than with them. The stakeholder emphasised that early involvement was essential to mitigate this issue and to honour both professional and cultural expertise.

By ensuring early and meaningful engagement, dominant discourses could be challenged and authentic partnerships established to promote equity. The stakeholder's stance reflected the collective worldview of Māori and many Indigenous cultures, exemplified by the principle of not leaving anyone behind. They asserted that fostering bicultural partnerships enabled cultural responsiveness and supported the inclusion of values and beliefs held by all healthcare recipients, nurses, and other health professionals. This was expressed in the interview as:

> *Cultural practice is not just about Māori … with our culturally and linguistically diverse workshops that considers culture from a really broad perspective and particularly our migrant and our refugee populations. Everybody brings their own culture as well as our patients … so people, are not being afraid, talking about culture that it's not just about Māori and Pākehā, that it's much broader than that.* (I H)

This stakeholder reflected on the value of intentional inclusion across diverse cultures and Indigenous knowledges, while acknowledging the complexity of identity. For example, they described how a nurse who was also a migrant or refugee embodied multiple layers of cultural identity, requiring culturally safe responses that were agile and adaptive. They advocated for

courageous conversations and active reflection on power and difference, recognising the strengths such diversity brought to the healthcare context.

They viewed cultural safety as dynamic and evolving; never diluting the status of Māori as tāngata whenua but creating space for all within Te Tiriti o Waitangi as the guiding framework. Te Whatu Ora Waikato District have implemented systems and processes to support bicultural learning and practice, notably through the 2015 Integration and Streamlining Project (Hayward & Atherfold, 2015; Marriott, 2014). However, historical influences continued to impact health workforce readiness and outcomes. Addressing these challenges required time, education, and intentional workforce development.

The MoH (2020a) health reforms aimed to address these issues at a political level; however, stakeholders emphasised that meaningful change in workplace culture depended on partnership-based participation. One participant noted that nurses could support the protection of self-determination by developing a deeper understanding of their own identity, values, and beliefs, and how these connected with others. This process of self-determination, while powerful, also presented challenges in shifting organisational culture. As interviewee J reflected: "*So, what needs to happen or needs to shift within Waikato DHB is, is people being open and not scared, of Māori taking charge of their own health!*". This quote offered a bold call to recognition of self-determination for Māori, highlighting the importance of openness to culturally grounded approaches to healthcare.

The nurse contrasted this approach with the prevailing fear of moving away from dominant Western models, noting that meaningful change required structural shifts. These included enabling Māori leadership and embedding cultural competence and capability at all levels of practice, supported by robust accountability mechanisms. The stakeholder argued that cultural safety must be actively cultivated not passively assumed, and that Māori ways of knowing should guide practice rather than be marginalised. This finding further underscored the need for courageous leadership and systemic transformation to ensure that Māori voices are not only heard but lead the way in shaping equitable healthcare environments.

5.4.2 Te Ao Māori Worldview and Te Whare Tapa Whā

From a Te Ao Māori worldview, the absence of Kawa whakaruruhau and cultural safety presents a significant risk that healthcare delivery will default to a Western paradigm, contributing to persistent deficits in health outcomes for Māori (I J). One stakeholder acknowledged Te Whare Tapa Whā as a culturally grounded model that reflects Te Ao Māori

worldview and offers a holistic framework for addressing these deficits and barriers. Stakeholders viewed this model as central to embedding cultural safety in practice, enabling health professionals to engage with Māori patients and whānau in ways that honour their values, beliefs, and lived experiences.

> *It's working alongside the patient and their whānau; we have a large Māori population down here. So, it's being able to provide that culturally sensitive care, that's culturally competent, that works with the whānau and with support services like Kaitiaki* [Māori support worker and advocate] *because quite often like looking at the four pillars* [Te Whare Tapa Wha] *of healthcare for them*. (I I)

In reflecting on this stakeholder's perspective, collaboration with both the patient and their whānau was identified as central to cultural competence. This approach highlighted relational priorities that other stakeholders referred to as bicultural practice, genuine partnerships that value holistic care and uphold the principles of Kawa whakaruruhau. Bicultural approaches ensure that cultural competence and sensitivity extend beyond the individual to include whānau and broader support networks, with the kaitiaki acting as a facilitator and navigator of culturally safe care.

The four pillars of Te Whare Tapa Whā (Durie, 1994) were consistently referenced by this interviewee and others as a holistic model of health that contributes to quality outcomes. The model emphasises balance across taha tinana (physical health), taha hinengaro (mental and emotional well-being), taha whānau (family and social relationships), and taha wairua (spirituality and connectedness). Stakeholders viewed these dimensions as mechanisms for translating Kawa whakaruruhau into practice, ensuring that care is both clinically effective and culturally responsive.

The kind of relationship that enables this balance is built through whakawhanaungatanga, as the process of forming meaningful connections. It involves sharing one's self: who you are, where you come from, and who the significant people in your life are. Within an episode of care, whakawhanaungatanga includes identifying the roles of all involved, as the tāngata whaiora, nurse or health professional, whānau, and other support persons. Stakeholders highlighted that authentic sharing within whanaungatanga requires acknowledging identity, both personally and professionally. It goes beyond simply stating one's name and role; and is essential for establishing connection and enabling culturally competent therapeutic engagement.

5.4.3 Identity and Te Tiriti o Waitangi

Several Māori stakeholders gave visibility of their identity by sharing their ethnicity. They described that as 'a Māori nurse' they were clear that they contribute positively to the improved health outcomes. They stated that, as Māori, they and their whānau were recipients of the disparity despite their best efforts to improve this situation.

> *Specifically … as a Māori nurse I mean I'm going to say it from that perspective because that's what I am. … Māori people must be treated with respect, and also colleagues must understand the importance of the difference and why there is deprivation and why Māori have a worse outcome than any average Joe in New Zealand. Like for me it's around replication of cultural competency into practice because, being 23% Māori here in Waikato, it's so important that our Māori people come back for treatment that they need, and they're not going to come back in a judgemental, stereotypical and sterile environment*. (I J)

This Māori nurse actively positioned themselves within both their cultural identity and professional role, advocating for equity and emphasising the necessity of respect and cultural understanding. They illuminated the historical roots of deprivation and its enduring impact on Māori, who represent a significant portion of the Waikato population. Drawing on personal experiences of disadvantage within the health system, the nurse underscored the systemic barriers faced by Māori. Their reference to Māori tāngata whaiora avoiding treatment in environments perceived as judgmental, stereotypical, and sterile, affirmed that such conditions led to disengagement and further exacerbated health inequities. Through reflective practice, the nurse demonstrated that cultural competence must extend beyond theory and be applied in practice to foster trust and encourage meaningful engagement. While Indigenous knowledge offered pathways to achieve this outcome, both conscious and unconscious bias continued to obstruct progress.

A significant barrier within Aotearoa New Zealand stemmed from the fact that not everyone viewed Māori positively. Reflections on historical perspectives shared by stakeholders revealed that during the 1980s and 1990s understandings diverged between multicultural and transcultural approaches versus bicultural approaches. Multicultural and transcultural frameworks encompassed a wide range of global worldviews; whereas biculturalism, within the context of Te Tiriti o Waitangi, honoured the partnership between Māori and all other cultures, represented collectively through the Crown. This distinction underscored that, while many cultures integrated aspects of both approaches, biculturalism in Aotearoa New Zealand

prioritised Māori and recognised Indigenous knowledge rooted in Te Ao Māori, emphasising guardianship and care for all.

By applying bicultural approaches, stakeholders identified benefits that extended across communities. However, the failure to uphold these priorities disadvantaged Māori in every aspect of self-determination. It began with land confiscation and continued through restricted opportunities for growth and provision, systemic discrimination in education and health, and the resulting vulnerability and bias (Ramsden, 1990a). One interviewee reflected this as: "*Not everybody looks at Māori in a favourable way. They look at us Māori often in a deficit. It's always in the bad. Because that's often what they're exposed to. So, the media have played a big role in that, and everything's always you know if anything's wrong they identify the person as Māori, but they don't identify people as Caucasian or Pākehā."* (I H)

This stakeholder highlighted the deficit framing of Māori within Aotearoa New Zealand and explained how it contributed to negative perceptions, particularly in media representations. They noted the disproportionate emphasis placed on Māori identity compared to non-Māori in similar contexts, which perpetuated bias and shaped both individual and public perceptions. Stakeholders described their journeys not merely as becoming nurses who are Māori, but as growing into Māori nurses where cultural identity was fully integrated into their professional selves. This unique experience of identity unfolded at an individual pace, within the protective and nurturing context of Kawa whakaruruhau as described by Interviewee C: "*I've been on a journey to know for myself who I am as a Māori nurse and bring that to my practice and then being able to articulate it*". This Māori nurse offered deep insight into their self-reflection, articulating how their cultural identity and values informed their practice. They described an internal sense of knowing, which they consciously applied outwardly in their professional role. By expressing their Māori identity, they actively role-modelled and advocated for the cultural values embedded in a Te Ao Māori worldview. The nurse emphasised that attending to Te Ao Māori as part of a holistic approach was essential for achieving quality outcomes, as it influenced both the nurse and tāngata whaiora as equal partners in care.

This partnership fostered a space for Kawa whakaruruhau and cultural safety, enabling the genuine integration of diverse worldviews into all aspects of care, described as: "*There's always a Māori worldview, you know, we don't pop in and out for a session*" (I H). Within this quote, the nurse identified themselves as part of the Te Ao Māori worldview, emphasising that it was a constant presence rather than something applied selectively. They described these holistic values as continuously shaping all aspects of care.

In contrast, many measures of quality outcomes were framed through a Western lens, which often prioritised individualism over the collective orientation central to Te Ao Māori. As a result, targets and indicators only partially reflected the health outcomes desired by Māori communities. This nurse noted:

> *Māori because we measure outcomes in different ways. How do we look at success? That's something you know that Māori have achieved something and it's a very different approach as opposed to a Western focus where you can measure them, health targets have been very much a part of that.* (I H)

Indigenous knowledges consistently reinforced holistic health, and Te Whare Tapa Whā exemplified how the MoH applied these principles to support health professionals in understanding holistic practice (Durie, 1994). In the context of Māori health in Aotearoa New Zealand, holistic care was grounded in four interconnected dimensions: tinana (physical), hinengaro (mind and emotions), whānau (family and valued connections), and wairua (spiritual beliefs). Māori nurses described bicultural approaches as central to delivering holistic healthcare and emphasised their potential to foster a culture of learning and practice that embraced culturally diverse worldviews.

They noted that such approaches led to positive outcomes for nurses and tāngata whaiora, and for whānau and other members of the health team. Within the Te Ao Māori worldview, success was understood as health improvements across whānau, hapū, and iwi, with reflexive insight affirming Māori identity from within rather than through external validation. Māori nurses asserted that achieving quality outcomes in health required expanding evaluative frameworks to include collective insights rather than relying solely on individual metrics. They advocated for critically appreciative processes as a means to identify the strengths and benefits of cultural perspectives in healthcare. A shift toward Kawa whakaruruhau, cultural safety, and equity—rather than continued deficit framing—was described by Interviewee C.

> *The hardest thing to actually get people to move from a deficit approach to strengths-based, and I do that with everything that I do, because otherwise people will just look at the deficit and then they give up on people … and whānau, and so it's giving up on whānau, hapū, and iwi because that's the ongoing impact so I suppose part of the work that we do for our Māori graduates is decolonisation!*

This quote identified deficit thinking and the barriers it created, urging a shift toward strength-based approaches. The nurse reflected on how deficit framing positioned Māori as a problem

to be fixed rather than as holders of knowledge, culture, and resilience as elements foundational to holistic health. The statement, "*they give up on people*" (I C), conveyed a sense of grief and disempowerment, highlighting the need for decolonisation to dismantle the structures that perpetuate such harm.

The nurse's assertion, "*everything I do*" (I C), affirmed their active commitment to practising within a learning culture aligned with the Te Ao Māori worldview where learning is relational and power dynamics are open to challenge. Without the genuine involvement of bicultural partners in all aspects of care, meaningful partnership could not be sustained. Bicultural partnership was described as integral to every stage of this research, including exploratory discussions, data collection and analysis, care planning and delivery, and professional development for nurses and other health professionals. These perceptions, in turn, influenced interactions and outcomes within healthcare settings. By revisiting Te Tiriti o Waitangi and its integration into the NCNZ's competencies for nurses, the stakeholder identified a pathway to mitigate this bias. They advocated for the use of Māori approaches to support learning and growth, positioning Indigenous knowledge as central to culturally safe and equitable practice.

5.4.4 Tuakana–Teina

Stakeholders described the Māori principle of Tuakana–Teina as a relational approach that guided and supported learners in becoming experienced and capable. The Tuakana assumed the role of teacher and guide, although the relationship was often reciprocal depending on the context; the Tuakana could become the Teina, and vice versa. While mentoring and preceptorship shared similarities with Tuakana–Teina, the cultural dimensions of the Māori approach were more fluid and contextually responsive. Stakeholders observed that the agility of this model enhanced cultural responsiveness to both clinical and operational needs when applied across nursing teams. In turn, they identified that this approach reduced risks for Māori and Pacific tāngata whaiora, as nurses actively supported and guided one another to achieve the best possible outcomes. One interviewee described this as:

> *It's like Tuakana–Teina where everyone learns from everybody and it becomes a very safe learning environment, so a lot of sharing happens in that space. I do a lot of facilitation of learning. I don't stand up the front and field, left, right and centre. I'm into appreciative enquiry so I ask a lot of questions, and I fill in gaps.* (I J)

This stakeholder described the Tuakana–Teina model as a shared learning relationship grounded in psychological safety and openness. They emphasised the use of appreciative

inquiry and facilitation as key strategies that fostered co-learning, aligning with the principles of reciprocity, connection, and collaboration inherent in Tuakana–Teina. In addition, they highlighted how mentorship and preceptorship, particularly in guiding and supporting Māori nurses in their personal, cultural, and professional identity, were deeply rooted in the Te Ao Māori worldview.

Although this nurse did not explicitly refer to the concept of weaving, their emphasis on shared learning, appreciative engagement, and addressing gaps in knowledge evoked the metaphor of weaving as an active and integrative process. This process occurred both practically and philosophically within Te Ao Māori, creating a safe space for Māori nurses to grow.

Overall, the data within this theme support that Kawa whakaruruhau, cultural safety, and cultural consciousness, can achieve a transition from deficit to strengths while contributing to improved health outcomes. Within the Aotearoa New Zealand health context, understanding Te Ao Māori worldview, applying whakawhanaungatanga (processes to connect), and holistic models of health such as Te Whare Tapa Wha and learning principles such as Tuakana–Teina are examples of how this can occur. Collectively these components form a consistent and powerful narrative that Māori nurses are not only practitioners but cultural leaders, advocates, and change agents. Their reflections demonstrated that bicultural practice, grounded in Te Ao Māori and Te Tiriti o Waitangi, is essential for achieving equity, cultural safety, and holistic health outcomes. The integration of Indigenous knowledge, relational learning, and strength-based approaches emerged as critical to transforming healthcare environments. These findings call for intentional, sustained efforts to honour Māori expertise, challenge dominant discourses, and embed culturally responsive practice across all levels of the health system.

5.2 Chapter Summary

This chapter presented the findings from the analysis of stakeholder perspectives to contribute to answering the question of how nursing education and development can strengthen operational and clinical practice to achieve quality outcomes within Te Whatu Ora Waikato District. Stakeholder perspectives confirmed the presence of a learning culture in some areas of the organisation, while highlighting tensions between operational efficiency and the aspiration to deliver quality outcomes for tāngata whaiora. These tensions were reflected as resource, the pressure to meet discharge requirements to support patient flow priorities, and the tension of having skill mix and preceptors with capacity to provide in-practice support and

education. The education and development team's limited involvement in early planning for complex situations further constrained their ability to respond effectively.

The findings underscored the importance of nursing leadership in fostering a safe, shared learning culture that integrates cultural priorities. Such a culture strengthens nursing education and development and enhances both operational and clinical practice. Within this learning environment, mentorship and reflective dialogue, drawing on principles of professional supervision, emerged as key mechanisms for embedding cultural and clinical knowledge.

Cultural priorities and Indigenous knowledges were applied through Kawa whakaruruhau, bicultural approaches, and broader concepts of cultural safety. The Te Ao Māori worldview offered a philosophy of teaching and learning grounded in connection, reciprocity, and collective growth. The Tuakana–Teina model exemplified this philosophy, reflecting an appreciative and relational approach that supported both practice and learning.

The next chapter situates these findings within broader literature, exploring their contribution to the research question. It also discusses limitations, offers recommendations, and identifies opportunities for future research.

CHAPTER VI DISCUSSION

6.1 Introduction

Chapter Six explores how nursing education and development can strengthen operational and clinical practice to enhance quality outcomes, focusing on the interplay between organisational aspirations, stakeholder perspectives, and the integration of education, clinical, and operational domains within Te Whatu Ora Waikato District. The chapter situates the findings within the existing literature and highlights new insights that extend current understandings of workforce development, system responsiveness, and culturally grounded practice.

The first section examines the strengths and challenges across operational, clinical, and education and development functions within Te Whatu Ora Waikato District, identifying the structural, relational, and cultural conditions that shape workforce capability and service delivery. The second section explores the mechanisms through which education and development teams support clinical priorities and contribute to quality outcomes, including capability building, reflective practice, and culturally responsive learning. The third section discusses the potential for deeper integration of education and development within operational and clinical priorities, emphasising the importance of aligned governance, shared purpose, and system-level coherence.

The chapter concludes with an integrated analysis of the implications for strengthening education, clinical practice, and operational leadership, highlighting the interconnected nature of these domains and their collective role in achieving quality outcomes. These insights provide the foundation for the recommendations and future directions presented in the following chapter.

6.2 Strengths and Challenges Influencing Quality Outcomes

Understanding the conditions that shape quality outcomes within Te Whatu Ora Waikato District requires an examination of the organisational, structural, and contextual factors that influence how nursing education and development can contribute to clinical and operational practice. The findings from this study reveal a system characterised by both strong strategic intent and significant operational complexity, each exerting a direct influence on the capacity of education and development teams to strengthen practice. This section critically analyses the strengths that support quality, the systemic and operational challenges that constrain progress, and the ways in which these dynamics collectively define the environment in which education and development must operate. In doing so, it illuminates the enabling and limiting

conditions that determine whether education and development can fulfil its strategic potential as a driver of capability, coherence, and improved outcomes.

A clear organisational strength was the presence of well-defined strategic priorities for learning, supported by action plans aimed at improving quality outcomes. Stakeholders consistently described strong alignment between education and development teams and the organisation's strategic direction, as articulated in the Nursing at Waikato Strategy (Waikato DHB, 2017).

The PDU was recognised for actively integrating workforce initiatives, clinical knowledge and skills, evidence-based practice, preceptorship, advanced practice, and cultural and Indigenous frameworks into education programmes. The inclusion of Kawa whakaruruhau, cultural safety, Te Whare Tapa Whā, whakawhanaungatanga, and Tuakana–Teina demonstrated a deliberate commitment to embedding Te Ao Māori worldviews within professional learning. These strengths provided a solid foundation for capability building and contributed positively to quality outcomes.

Leadership also emerged as a key enabler. Charge nurse managers were identified as pivotal in creating the structural and cultural conditions that support learning—prioritising staff release, modelling cultural safety, and fostering psychologically safe environments where staff could learn from both successes and challenges. Stakeholders emphasised the importance of courageous leadership, particularly in advancing Māori nursing leadership and supporting bicultural practice aligned with Te Tiriti o Waitangi and the revised RN scope of practice (NCNZ, 2023).

The Tuakana–Teina approach further strengthened the leadership environment by offering an agile, relational, and strengths-based model of learning and leading. Its reciprocal nature, where individuals shift between learner and leader depending on context, aligned with Indigenous leadership principles highlighted in the WAI 2575 Inquiry and reflected in Wayfinding Leadership (Spiller et al., 2015). These approaches collectively reinforced a culturally grounded leadership environment capable of navigating complexity and supporting adaptive learning.

Despite strong strategic intent, several systemic and operational challenges constrained the impact of education and development. The district's complexity, large rural geography, high Māori population, and role as a tertiary referral centre; created significant service pressures that shaped day-to-day practice.

Structural limitations were also evident. Education and development teams were not consistently included in service planning or design processes (Waikato DHB, 2019), reducing their ability to contribute proactively to workforce capability and quality improvement. Stakeholders described operational and clinical practice as largely reactive to escalating service demand, limiting opportunities for strategic, anticipatory development.

The reliance on informal processes was particularly visible in responses to adverse events such as medication errors or serious incidents. Education was often requested after problems occurred, rather than being embedded through proactive planning or systematic learning needs analysis. This reactive pattern highlighted a structural gap between management and clinical practice and underscored the need for more intentional, system-level mechanisms to support capability development (Oliver, 2017).

The interplay of strengths and challenges created an environment where education and development had strong strategic foundations but limited structural integration. Stakeholders emphasised that greater responsiveness and impact would require early inclusion, participation, and collaboration across teams.

Participatory approaches described by Manley et al. (2021) provide a way to overcome the challenges that contribute to siloed practices by integrating education and development teams into planning processes, productivity meetings, escalation management, clinical governance forums, service change initiatives, and role expectation discussions. Such approaches prioritise the patient or tāngata whaiora, foster a learning culture, and support collective problem-solving as conditions that stakeholders indicate would strengthen quality outcomes.

Strengthening the link between learning needs analysis and proactive education planning was identified as a critical enabler. Evidence from Pilcher (2016) and Dyson et al. (2009) demonstrated the value of integrating self-identified learning needs, managerial priorities, performance appraisal findings, and context-specific competencies. Embedding these processes would allow Te Whatu Ora Waikato District to anticipate future capability requirements and align education more closely with operational and clinical priorities.

The combined lens of Wayfinding Leadership (Spiller et al., 2015) and the Systems Thinking for Health Action Framework (Thelan et al., 2023) offers a conceptual bridge between strategic intention and operational action. These frameworks emphasise interconnectedness, dynamic relationships, adaptive decision-making, and collective sense-making as elements that directly address the gap identified in the findings. Applying these approaches could strengthen the

structural and relational conditions necessary for education and development to influence operational and clinical practice more effectively.

6.3 The Contribution of Nursing Education and Development to Quality Outcomes

Situating the contribution of nursing education and development within the clinical context of Te Whatu Ora Waikato District highlights the mechanisms through which capability is built, workforce readiness is enhanced, learning is translated into practice, and clinical priorities are advanced. The findings from this study indicate that the PDU plays a pivotal role in shaping these mechanisms, offering a comprehensive range of learning strategies that directly contribute to clinical quality and workforce capability. By situating these activities within the broader organisational context, this section evaluates the extent to which education and development enable nurses to meet the complex demands of contemporary practice and contribute to improved quality outcomes across the district.

The literature strongly supports the view that capability building is foundational to quality outcomes (Hastings et al., 2014; Taylor et al., 2021). International evidence, such as the United States National Academies Committee for the Future of Nursing (2021), identifies education and professional development as essential for strengthening competencies in critical thinking, clinical decision making, care coordination, and navigating ethical and social complexity. Complementing this, the International Council of Nurses (ICN, 2024) positions education as a core component within its strategic priorities, embedding it across workforce, leadership, and policy domains. Within ICN's strategic framework, education is not treated as a discrete element but as a key mechanism for enabling a competent, adaptable, and equity-focused nursing workforce, supported through policies that address workforce development, leadership capacity, and the alignment of education with health system needs. Brunt and Morris (2023) similarly argued that initiatives commonly delivered by the PDU including preceptorship, mentorship, simulation, and cultural support, would enhance the implementation of evidence-based practice, thereby improving clinical quality.

The CONE model (McAllister & Flynn, 2016) provides conceptual reinforcement by identifying six components: teaching knowledge and practice, nursing knowledge, teaching relationships, leadership, research orientation, and research action. Together, these six components ensure professional development is responsive to service needs and contributes to quality outcomes. These findings collectively demonstrate that capability building is a core mechanism through which education and development strengthen clinical practice.

Stakeholders consistently emphasised that education and development activities enhance workforce readiness by preparing nurses to respond to the clinical demands of a complex and diverse population. Oldland et al. (2020) identified seven domains of nursing responsibility for quality care; these being, care environment, safety, person-centred care, interpersonal behaviours, clinical leadership and governance, technical competence, and evidence-based practice. The effectiveness of these domains depends on enabling elements such as professional development, cultural knowledge, critical thinking, problem solving, and context-specific expertise.

These enabling elements were visible within the PDU's offerings and supported nurses to develop both foundational and advanced competencies. This aligns with McSherry et al.'s (2013) interpretation of the Francis Report, which emphasised the need for structural integration across team development, interdisciplinary collaboration, continuous quality improvement, and accountability. Together, these insights highlight that workforce readiness is strengthened when education and development is embedded within organisational systems and supported through clear governance arrangements.

A recurring theme in stakeholder accounts was the importance of translating learning into practice through timely, context-specific support. Education teams were described as critical in helping nurses apply new knowledge, particularly through in-practice coaching, simulation, and mentorship. These mechanisms support the consolidation of learning and enable nurses to integrate evidence-based approaches into everyday care (Manley et al., 2021).

However, the study identified structural gaps that limited the consistent translation of learning into practice. Document analysis and stakeholder perspectives revealed an absence of formal links between quality activities, learning needs analysis, and the nursing education calendar. These processes were often conducted separately, resulting in informal and inconsistent connections. Quality improvement data from the Releasing Time to Care Programme (Morrel, 2009) showed that education was frequently listed as an action following unfavourable quality indicators, yet there was no systematic mechanism to ensure that learning needs were identified, addressed, and monitored through integrated planning.

Integrating learning needs analysis and quality improvement activities into service planning, particularly through clinical governance forums, would strengthen the translation of learning into practice by ensuring that education is timely, targeted, and aligned with organisational priorities.

The findings indicate that education and development contribute to clinical priorities when its activities are aligned with organisational strategy and supported through clear governance.

While the PDU demonstrated strong alignment with strategic intentions, the absence of formal structures linking education to quality indicators and service planning limited its ability to influence clinical outcomes at scale.

Ensuring alignment requires embedding education and development within operational and clinical decision-making processes, enabling proactive planning rather than reactive responses (Manley et al., 2021; Oliver, 2017). Such alignment would ensure that the nursing workforce is prepared, resourced, and accountable in ways that reflect Te Whatu Ora Waikato District's strategic priorities.

This analysis shows that education and development contribute to clinical practice by cultivating capability, preparing the workforce, enabling the application of new knowledge, and aligning learning with clinical priorities. These benefits, however, are contingent on the strength of integration across education, clinical, and operational functions. The subsequent section examines how such integration can create a more coherent system, strengthen shared responsibility, and drive sustained improvements in quality outcomes across Te Whatu Ora Waikato District.

6.4 Building Coherence Through Integration and Collaboration

The research confirmed that structural connections between operational management, clinical nurses, and education and development teams within Te Whatu Ora Waikato District were largely absent. Stakeholder accounts highlighted key organisational structures, such as the Board of Clinical Governance, service delivery directorates, and service plans, did not formally include education and development within their governance or accountability arrangements. This absence constrained coherent service planning, limited workforce engagement, and reduced the organisation's ability to implement responsive and coordinated improvements.

Stakeholders frequently used the metaphor of a bridge to describe the structures and processes required to connect teams. The bridge symbolised more than a link; it represented the mechanism through which strategic intent is translated into operational and clinical action. This metaphor aligns with Jones et al. (2019), who used a journey metaphor within the United Kingdom National Health Service to illustrate improvement as a staged, purposeful progression. Their work emphasised readiness, governance participation, capability development, and a learning culture as prerequisites for movement. Both metaphors underscore that improvement is not incidental but emerges through deliberate, structured interaction between people, processes, and systems. In both studies, learning and development functioned as the mechanism that strengthened the connection between

operational and clinical teams, effectively forming the bridge that stakeholders in this study also described.

Stakeholder perspectives reinforced that empowerment, safety, equity, and cultural knowledge were most effective when embedded as everyday practices rather than isolated initiatives. This was consistent with the strategic intentions articulated in the Waikato District and Nursing strategies (Waikato DHB, 2016, 2017). Charge nurse managers and nurse managers were identified as pivotal in enacting these values by enabling access to resources, supporting staff release for education, facilitating patient flow, prioritising equity, and modelling cultural practices grounded in Te Ao Māori and cultural safety. When these practices were enacted through connected pathways that aligned organisational goals with daily action, strategic intent was more consistently realised. These findings resonate with Durie (1994) and Came et al. (2020), who emphasised that equity-focused health system change requires structural integration, cultural grounding, and operational alignment.

Structural empowerment theory provided a useful lens for interpreting these findings. Kanter (1993) and Ibrahim (2022) argued that organisational effectiveness depends on environments that foster psychological safety and enable teams to thrive. Structural empowerment includes access to information, support, resources, growth opportunities, and influence within organisational systems. These elements directly relate to the research question: when applied, they clarify how education and development functions as a mechanism that strengthens the connection between clinical and operational practice. Structural empowerment theory reinforces the need for visible and influential education and development leadership within the Board of Clinical Governance and within service-level planning. Such positioning ensures that learning, capability development, and cultural safety are embedded within organisational structures, thereby enhancing clinical and operational outcomes.

Evidence from Aotearoa New Zealand supports this interpretation. Connelly et al. (2018) found that structural empowerment attributes among emergency department nurses fostered psychological empowerment, particularly when clinical leaders demonstrated strong relational skills, mentorship, cultural safety, and the ability to navigate organisational systems. These behaviours created environments where nurses felt safe to ask questions, exercise initiative, advocate for patients, mentor peers, and contribute positively to team dynamics. Empowerment structures that support these behaviours transform educational input into operational and clinical benefit by enabling nurses to enact leadership and learning in practice.

Stakeholders in the current study emphasised relational connectedness, identity, and shared purpose as central to effective integration. These elements functioned as descriptors of collaboration and reflected how integration was experienced and enacted. Rather than viewing integration solely as a structural or procedural exercise, stakeholders described it as emerging through social connection, mutual commitment, and collective identity. Although the term empowerment was not frequently used, participants described practices consistent with Kanter's (1993) framework, including participation in decision-making, contextual application of knowledge, and access to support and resources. This aligns with Laschinger et al. (2010), who demonstrated that empowering nurses enables them to empower patients, and with Connelly et al. (2018), who highlighted the importance of cultural support, mentorship, and whanaungatanga. These relational and cultural dimensions align closely with Wiapo and Clarke's (2022) Whakapapa model.

The Whakapapa model's congruence with the findings lies in its demonstration that strengthening clinical and operational practice depends on education and development that are both structurally supported and culturally grounded. The model shows that education and development is most effective when organisational structures enable access to resources, mentorship, and decision-making, while Te Ao Māori principles shape relational practice, cultural safety, and collective responsibility. The model's metaphor of a kete, with whakapapa as the whiri (backbone) binding the strands together, mirrors the role of education and development, which similarly binds together diverse knowledge, skills, and cultural competencies to support capability building across clinical and operational settings.

The seven strands drawn from Te Ao Māori are: mana taurite (equity); whakamana te tāngata (dignity); ngā piki me ngā heke (embracing challenges); tika; pono; aroha (integrity); and accountability to whānau, hapū, and iwi. These strands highlight the relational, reflective, and culturally informed behaviours that education and development must intentionally cultivate. When embedded in education and development programmes, these characteristics strengthen clinical and operational practice and contribute directly to improved quality outcomes (Cameron et al., 2023. Wiapo & Clarke, 2022).

Mainstream leadership theories underpinning the Whakapapa model reinforce this connection. Transformational leadership emphasises shared values and long-term change (Northouse, 2009); adaptive leadership supports value-based responses in complex environments (Heifetz et al., 2009); and trait theory (Stogdill, 1948) acknowledges that leadership effectiveness emerges from the interaction of personal attributes with relational and situational factors. Wiapo and Clarke (2022) argued that these theories provide vision,

values-based direction, and a commitment to equity and justice. These are the attributes that education and development programmes within Te Whatu Ora Waikato District actively cultivate, and they reinforce the need for structural changes that position education and development leaders within clinical governance and service planning.

Within the bicultural partnership articulated by Te Tiriti o Waitangi, these qualities become the 'handles of the kete', enabling education and development leaders to inform, equip, and support operational and clinical teams to carry out their responsibilities in culturally grounded and contextually relevant ways that enhance quality outcomes (Wiapo & Clarke, 2022). This metaphor reinforces the idea that leadership in education and development is not merely a technical function but a culturally anchored practice that supports collective responsibility, relational integrity, and equitable care.

Integrating the Whakapapa model (Wiapo & Clarke, 2022) with Ibrahim's (2022) structural and psychological empowerment framework further strengthens its relevance to education and development. The Whakapapa model highlights how identity, relationships, perspectives, values, and timing shape decision-making and collective action. When combined with structural and psychological empowerment, it becomes clear that culturally grounded relationships and empowerment processes operate most effectively when aligned. Identity and connection influence how individuals understand their roles and potential, while structural conditions—such as access to information, resources, support, and opportunities for participation—determine whether that potential can be realised.

Together, these frameworks demonstrate that education and development strengthen clinical and operational practice when they are both structurally supported and culturally grounded. This dual approach enables leaders and teams to act with cultural competence, relational awareness, and organisational clarity, ultimately enhancing quality outcomes across Te Whatu Ora Waikato District. Although originating from different traditions, the integration of structural and psychological empowerment creates conditions for meaningful organisational change. These frameworks support environments in which individuals and teams can influence decisions, innovate, demonstrate competence, and feel valued. Achieving this in practice requires operational management to allocate protected time for mentorship, learning, and cultural support, including whanaungatanga and peer networks. Without structural integration, such practices risk remaining informal rather than intentional and embedded.

To realise these outcomes, strong connections between the three communities of practice as operational management, clinical practice, and education and development; are essential.

These connections rely on reciprocal and transparent communication and on the integration of clinical and cultural knowledge into decision-making, with respect for Te Ao Māori. Alignment with the value of manākitanga reinforces a relational ethic that prioritises care, respect, and collective responsibility, which is fundamental to professional interactions among clinical team members, tāngata whaiora, and whānau. Within this context, Wiapo and Clarke (2022) emphasised that whakapapa dimensions of connection, identity, and purpose underpin effective relationships by grounding practice in a shared sense of belonging, power, and mutual obligation as attributes that characterise a strong learning culture.

Taken together, these findings, grounded in both stakeholder perspectives and theoretical frameworks, highlight the need for intentional structural integration and culturally responsive practice. Building on this foundation, the following section outlines the implications for education and development, clinical practice, operational management, and future research.

6.5 Integrated Implications for Education and Development, Clinical Practice, and Operational Leadership

6.5.1 Capability Building

Across all stakeholder groups, capability emerged as a strategic requirement rather than an optional enhancement. Nurses must be equipped with the knowledge, skills, organisational understanding, and reflective capacity needed to respond to increasing clinical complexity. Education and development teams play a central role in designing learning that is responsive, culturally grounded, and aligned with service needs. Clinical teams enact this learning through relational leadership, reflective practice, and shared decision-making. Operational leaders must ensure the structural conditions, resourcing, staffing, protected time, and governance alignment that enable capability to be developed and sustained (Health Quality and Safety Commission, 2024; Newberry, 2021). This system-level view of capability aligns with contemporary literature (Thelen et al., 2023) emphasising reflective practice, leadership mastery, and adaptive capacity as essential for high-quality care. The implication is clear: capability building must be embedded across the system, supported by intentional structures and relational practices that enable continuous learning.

6.5.2 Structural Integration and Governance Alignment

The study revealed that fragmentation across operational, clinical, and education domains limits responsiveness and weakens the translation of strategic priorities into practice. Structural integration is, therefore, essential. It includes embedding education and

development leadership within governance forums, ensuring clinical teams have clear pathways for development, and aligning operational processes with workforce capability needs.

An integrated approach to governance enables shared decision-making; strengthens accountability; and ensures that planning, reporting, and service design reflect the interdependencies between workforce development and clinical delivery (Gauld & Horsburgh, 2015; Health Quality and Safety Commission, 2024). This aligns with structural empowerment theory (Newberry, 2021), which highlights the importance of access to information, resources, and opportunities. When these structural enablers are present, teams are better positioned to anticipate needs, design responsive services, and embed learning into everyday practice.

6.5.3 Relational Leadership and Learning Culture

Relational leadership emerged as a critical mechanism for strengthening practice across all domains. Stakeholders described how reflective dialogue, shared learning, and relational trust supported psychological safety, team cohesion, and adaptive problem-solving. These relational practices enable teams to navigate operational pressures, fluctuating staffing levels, and increasing acuity while maintaining a focus on quality outcomes (Manley et al., 2021; Oliver, 2017).

Education and development teams contribute to a learning culture by facilitating reflective practice, mentorship, and supervision. Clinical leaders enact it through relational behaviours that encourage inquiry, collaboration, and shared purpose. Operational leaders reinforce it by creating environments where staff feel safe to question, reflect, and contribute to improvement without fear of blame. Together, these relational practices form the cultural infrastructure that sustains continuous improvement.

6.5.4 Cultural Grounding and Te Tiriti o Waitangi

Cultural responsiveness is not a separate consideration but a foundational dimension of system performance. The Whakapapa model (Wiapo & Clarke, 2022) and Wayfinding Leadership (Spiller et al., 2015) highlight the importance of identity, connection, collective purpose, and navigation through complexity. These frameworks align with Te Tiriti o Waitangi obligations and reinforce the need for culturally grounded leadership across all domains.

Embedding Te Ao Māori principles strengthens relational practice, enhances trust, and ensures that care delivery reflects the values and aspirations of Māori communities. This requires culturally responsive measures of quality, culturally safe learning environments, and leadership practices that honour the articles of Kāwanatanga, Rangatiratanga, and Ōritetanga.

When cultural grounding is integrated across education, clinical practice, and operational leadership, the system becomes more equitable, coherent, and responsive (Wiapo & Clarke, 2022).

6.5.6 Implications for Quality Outcomes

The integrated analysis suggests that quality outcomes are more likely to be achieved when structural, relational, and cultural dimensions operate together. Education and development provide the mechanisms for capability building; clinical teams enact learning through relational and reflective practice; and operational leaders create the structural conditions that enable learning to translate into improved care. Quality outcomes, as defined by stakeholders, reflect improvement without harm, grounded in the patient's perspective and holistic well-being. Achieving these outcomes requires a system where learning is embedded, Kawa whakaruruhau and cultural safety are prioritised, and strategic intent is consistently enacted across all levels of practice (Taylor et al., 2021; Waitangi Tribunal, 2023).

6.5.7 Summary of Implications

This section has outlined the implications of the research to answer the question of how education and development can strengthen operational and clinical practice to enhance quality outcomes and inform the next steps within Te Whatu Ora Waikato District. Building on earlier work undertaken at Te Whatu Ora Waikato (Hayward & Atherfold, 2015; Marriott, 2015), a key insight from the current study is that organisational structures and design must reflect interdependencies required for responsive engagement. This includes ensuring that education and development leadership is embedded within governance processes at an organisational and service level. Such positioning would support reciprocal engagement as a routine and expected function rather than reliance on informal processes.

Stakeholders described instances where characteristics of structural empowerment (Kanter, 1993) were evident. Being present in planning processes led to proactive leadership, targeted learning, and timely access to resources and support. These examples contributed to nursing education and development and enhanced system readiness. Given the prominence of cultural priorities in the findings, the integration of Kanter's (1993) structural empowerment framework with the Whakapapa model (Wiapo & Clarke, 2023) and Wayfinding Leadership (Spiller et al., 2015) as culturally grounded Te Ao Māori frameworks, has provided a conceptual bridge between relational and structural functions. This integration supported the inclusion of education teams and promoted system responsiveness within the following recommendations.

6.6 Chapter Summary

This chapter has examined how nursing education and development can strengthen operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District. Through an integrated analysis of stakeholder perspectives, organisational documents, and relevant literature, the discussion demonstrated that the effectiveness of education and development is shaped by the interplay of structural, relational, and cultural conditions across the system. Three overarching themes—impact and influence; safe, shared practice growth; and embedding identity, equity, and Te Tiriti o Waitangi—provided the analytical foundation for understanding these dynamics.

The chapter first identified the organisational strengths and systemic challenges that influence the capacity of education and development to contribute to quality outcomes. While strong strategic intentions and culturally grounded learning frameworks were evident, gaps in structural integration and reactive operational patterns limited the full realisation of these strengths. The analysis then explored the mechanisms through which education and development strengthen clinical practice, highlighting capability building, workforce readiness, translation of learning into practice, and alignment with clinical priorities as essential drivers of quality care.

A further layer of analysis demonstrated that integration across education, clinical, and operational teams is critical for system coherence. Structural integration, through governance, processes, and accountabilities, must be complemented by relational integration grounded in trust, communication, and shared purpose. Cultural responsiveness, particularly through Te Ao Māori frameworks such as Whakapapa and Wayfinding Leadership, emerged as a vital dimension of effective integration, ensuring that practice is relationally grounded, equitable, and aligned with Te Tiriti o Waitangi.

The implications for education and development leadership, clinical teams, and operational leaders collectively emphasised the need for intentional structural alignment, culturally informed leadership, and reflective learning as system-level mechanisms for improvement. Across all domains, the findings underscored that capability building is not a peripheral activity but a strategic requirement for achieving quality outcomes. Strengthening the system, therefore, requires embedding education and development within governance, workforce planning, and service delivery, supported by clear accountabilities and culturally grounded leadership practices.

Taken together, the discussion demonstrates that enhancing quality outcomes at Te Whatu Ora Waikato District depends on a system where education and development, clinical practice,

and operational leadership are structurally connected, relationally aligned, and culturally coherent. These insights form the foundation for the recommendations that follow, which outline the organisational, leadership, and practice changes required to embed these principles and sustain system-wide improvement.

CHAPTER VII RECOMMENDATIONS AND CONCLUSIONS

7.0 Introduction

This final chapter brings together the key insights generated through the research and outlines the practical, theoretical, and strategic directions to answer the question: *how can education and development strengthen operational and clinical practice to enhance quality outcomes within Te Whatu Ora Waikato District?* Building on the findings and implications discussed in the previous chapter, a set of recommendations designed to strengthen the contribution of education and development to operational and clinical practice within Te Whatu Ora Waikato District is offered. These recommendations are grounded in the study's evidence and informed by the integrated theoretical perspectives that shaped the discussion, including structural empowerment, Whakapapa and Wayfinding Leadership, and systems thinking.

In addition to the recommendations, the chapter identifies opportunities for future research that could extend, refine, or challenge the study's conclusions. These opportunities reflect areas where further inquiry is needed to deepen understanding of capability development, cultural responsiveness, system integration, and the evolving role of nursing leadership within Aotearoa New Zealand's health system.

The chapter also acknowledges the study's limitations, recognising the methodological, contextual, and practical boundaries that shaped the research. These limitations provide important context for interpreting the findings and highlight considerations for future studies.

The chapter concludes by synthesising the overall contribution of the research, articulating its significance for nursing education and development, operational management and clinical leadership, and the wider health system. Together, these elements provide a coherent and forward-looking foundation for ongoing improvement and transformation within Te Whatu Ora Waikato District.

7.1 Recommendations

Recommendations are organised across the three interconnected communities of practice—clinical, operational, and education and development—each of which plays a critical role in shaping nursing practice and achieving quality outcomes. While the actions differ in focus, they collectively strengthen organisational learning, leadership responsiveness, and workforce capability, reinforcing the shared goal of improving care experiences and health outcomes for tāngata whaiora.

7.1.1 Embedding Strategic Priorities

Embedding strategic imperatives across clinical, operational, and education and development domains is essential for ensuring alignment with organisational goals and the consistent delivery of quality outcomes. Stakeholders repeatedly emphasised that strategic intent must be visible and actionable within everyday practice, rather than remaining aspirational or confined to high-level planning documents. When strategic priorities are clearly articulated and operationalised, teams demonstrate greater cohesion, responsiveness, and clarity of purpose—particularly in environments where cultural safety and learning are prioritised as core components of care delivery. Achieving this requires a systematic approach to embedding strategic imperatives within the structural and procedural fabric of the organisation.

Recommendation:

Embed strategic priorities across clinical, operational management, and education and development by ensuring they are explicitly documented and operationalised within policy, procedures, service planning, and associated education to promote a culture of learning and cultural safety.

Proposed Actions:

1. Conduct a comprehensive stocktake and update of planning documents, policies, guidelines, change proposals, position descriptions, service plans, and performance monitoring frameworks to reflect strategic priorities.

2. Formulate measurable quality outcomes that align with organisational goals.

3. Communicate priorities and expectations clearly and consistently to staff.

7.1.2 Integration Across Structures and Practice

The findings highlighted a need for stronger integration across governance, operational, clinical, and education and development leadership. Stakeholders described fragmentation between these domains which limited collaboration, reduced responsiveness, and created silos that hindered system-wide learning. Although strategic documents referenced interdisciplinary engagement, operational mechanisms to support integration were often absent. Without formal structures that bring these teams together during planning, reporting, and implementation, opportunities for shared decision-making and alignment with strategic priorities were frequently missed.

Effective integration requires both structural and relational mechanisms. Structurally, all three communities of practice must be represented in governance and planning forums. Relationally, integration depends on shared values, mutual respect, and a commitment to collective outcomes. When education and development teams are included alongside clinical and operational leaders, the system becomes more capable of identifying workforce needs, designing responsive services, and embedding learning into everyday practice.

Recommendation:

Establish integrated governance at organisational and service levels to ensure representation from clinical, operational, and education and development leaders in planning and reporting processes.

Proposed Action:

Revise terms of reference for all relevant committees and planning groups to include representation from operational, clinical, and education and development teams, ensuring collaborative decision-making and shared accountability.

7.1.3 Early Inclusion of Education Teams

The research revealed that early inclusion of education and development teams in system design and service planning is essential for achieving strategic alignment and workforce responsiveness. Stakeholders described delays in applying knowledge into practice when education teams were engaged reactively, often after issues had already emerged. This reactive approach limited opportunities for proactive learning, timely intervention, and system-wide improvement.

Embedding education teams at the outset of planning processes enables co-design of services informed by workforce capability, learning needs, and evidence-based practice. Early involvement ensures that education leaders help shape the conditions under which care is delivered, anticipate future needs, and support the implementation of culturally responsive and clinically effective models of care.

Recommendation:

Ensure early inclusion of education and development teams in system design and service planning to align workforce capability with strategic priorities.

Proposed Action:

Include education nurse leaders in all system design and change initiatives, and monitor the impact and outcomes of their involvement.

7.1.4 Culturally Responsive Measures of Quality

The research identified a significant gap in how quality is defined and measured within culturally diverse healthcare contexts. Existing frameworks often emphasise clinical efficiency, safety, and compliance but do not adequately reflect the values, experiences, and well-being of tāngata whaiora, particularly within a Te Ao Māori worldview. Stakeholders emphasised relational care, cultural safety, and equity as essential components of quality, yet these dimensions were rarely captured in formal evaluation processes.

Developing culturally responsive measures of quality is essential. These measures must be grounded in Indigenous knowledge systems and co-designed with Māori health leaders, education teams, and clinical stakeholders. Such indicators should reflect clinical outcomes as well as relational integrity, identity, and holistic well-being. Embedding these measures into organisational quality frameworks will support more inclusive and meaningful evaluations of care and reinforce the principles of Te Tiriti o Waitangi.

Recommendation:

Develop, validate, and implement culturally grounded indicators of quality that reflect Te Ao Māori values, equity, and relational care.

Proposed Action:

Collaborate with Māori health leaders, education teams, and clinical stakeholders to co-design, validate, and implement measures that assess cultural safety, responsiveness, and well-being outcomes for tāngata whaiora.

7.1.4 Summary of Recommendations

Collectively, these four recommendations provide a strategic roadmap for advancing nursing education and development within Te Whatu Ora Waikato District to strengthen operational and clinical practice and enhance quality outcomes. They respond directly to the findings of the current research by addressing the structural, relational, and cultural dimensions of care delivery. By embedding strategic imperatives, integrating team composition, strengthening

leadership, involving education teams early, and developing culturally responsive measures of quality, the organisation can foster a more coherent, inclusive, and effective health system.

These actions are necessary for achieving quality outcomes, honouring the principles of Te Tiriti o Waitangi, and supporting the aspirations of tāngata whaiora and the wider workforce. Implementation will require sustained commitment, collaborative leadership, and ongoing evaluation to ensure meaningful and lasting impact.

7.2 Limitations

The recommendations presented in this study are grounded in robust qualitative analysis and meaningful stakeholder engagement; however, several limitations must be acknowledged. First, the findings are context-specific to Te Whatu Ora Waikato District and may not be directly generalisable to other districts without adaptation to local conditions, governance structures, and cultural contexts. While this limits transferability, several Te Whatu Ora districts—such as Lakes, Tairāwhiti, Whanganui, and Northland—share similar population demographics and may find the insights applicable with appropriate contextualisation (New Zealand Statistics, 2023).

Second, the study relied on stakeholder perspectives and strategic priorities gathered through interviews, focus groups, and document review. Although these methods generated rich and nuanced insights, they may not fully represent the diversity of views across all nursing, operational, and education and development teams. Perspectives from groups not included in the sample may have provided additional depth or alternative interpretations.

A further limitation relates to the implementation of the recommendations. Their effectiveness will depend on organisational readiness, leadership commitment, and the availability of resources, factors that may fluctuate over time due to system pressures, workforce constraints, or shifting strategic priorities. The integration of culturally responsive frameworks, such as the Whakapapa model, also requires sustained collaboration with Māori health leaders and communities, and must be undertaken with cultural humility, respect, and adherence to Te Tiriti o Waitangi principles.

Finally, while the study identified strategic gaps and opportunities for strengthening education and development, further research is required to evaluate the long-term impact of the recommendations on workforce capability, patient outcomes, and system performance. Longitudinal studies, implementation evaluations, and comparative analyses across districts would provide valuable evidence to support ongoing system improvement.

7.3 Opportunities for Future Research

Building on this case study, several avenues can be undertaken as future investigations of the post implementation phase as integrated, responsive, culturally grounded education and workforce development within the Te Whatu Ora Waikato District and other similar health settings. These include complementary quantitative evaluations of educational reach and outcomes, cost-benefit analyses of workforce development strategies, and comparative case studies across districts to examine the extent to which identified mechanisms are reproducible in differing demographic and governance contexts.

Opportunity: Evaluation of early involvement of education nurse leaders in system design and initiatives.

Future research could explore the impact of involving education-focused nurse leaders at the inception of health system design and transformation initiatives. This line of inquiry would assess how their early engagement influences the alignment of workforce development with strategic goals, enhances responsiveness to clinical education needs, and fosters a culture of continuous learning. Such studies could also examine the extent to which their participation contributes to more sustainable and contextually relevant models of care, particularly in regions like Waikato where cultural and community considerations are paramount.

Opportunity: Investigation of structural empowerment and bicultural practice approaches in practice.

Investigating how structural empowerment frameworks intersect with bicultural practice approaches offers a rich avenue for understanding how health professionals are supported to deliver culturally safe and equitable care. Research in this area could examine organisational policies, leadership practices, and team dynamics that enable or hinder bicultural competence. In the Te Whatu Ora Waikato District, where Te Tiriti o Waitangi obligations are central, such studies could provide critical insights into how empowerment strategies can be tailored to uphold Māori health aspirations and foster inclusive, culturally grounded practice environments.

Opportunity: Assessment of learning needs analysis and impact on education implemented for measurable outcomes.

A focused assessment of learning needs analysis processes and their translation into targeted educational interventions would help determine the effectiveness of current workforce development strategies. Future research could evaluate how accurately these analyses identify gaps in knowledge or skills, and whether the resulting education leads to measurable improvements in clinical practice, patient outcomes, or staff retention. This would be particularly valuable in dynamic health settings where responsiveness to evolving service demands and population health needs is essential.

Opportunity: Develop and validate culturally responsive measures of quality.

Developing and validating culturally responsive quality measures is essential for ensuring that health services are clinically effective and culturally safe and equitable. Research could focus on co-designing indicators with Māori communities and other stakeholders to reflect values such as manākitanga, whanaungatanga, and rangatiratanga. These measures would provide a more holistic understanding of service quality and could be used to benchmark progress in achieving equity goals, particularly in regions with significant Indigenous populations like Waikato.

Opportunity: Assess the role of PDUs and teams in driving system-wide change

Exploring the role of PDUs and teams as catalysts for system-wide change could illuminate how these entities contribute to strategic imperatives such as innovation, capability building, and equity-informed practice. Research could investigate their structures, leadership models, and collaborative practices to understand how they influence organisational culture and drive continuous improvement. In the context of integrated care systems, such studies would be instrumental in identifying best practices for leveraging education teams to support transformation and sustainability.

The opportunities for future research highlight the importance of continued inquiry into integrated, culturally grounded education and workforce development within Te Whatu Ora Waikato District and similar health contexts. By evaluating leadership involvement, empowerment strategies, learning needs, culturally responsive quality measures, and the strategic role of professional development teams, future research can build on this case study to inform more equitable, innovative, and sustainable health system transformation. Collectively, these avenues offer a roadmap for advancing practice that is both responsive to local needs and aligned with national health equity goals.

7.4 Conclusions

This case study has examined how strategic priorities and stakeholder perspectives influence the education and development of the nursing workforce within Health New Zealand Te Whatu Ora Waikato District. Using Braun and Clarke's (2022) reflexive thematic analysis, alongside critical appreciative inquiry, the research has revealed that structural, cultural, and relational dimensions significantly shape the interface between workforce development and service delivery.

The findings highlight a clear strategic intent by Te Whatu Ora Waikato District to integrate education into organisational structures; however, operational pressures, role ambiguity, and inconsistent access to planning processes constrain the responsiveness and visibility of education teams. Stakeholders consistently advocated for the early and sustained inclusion of education and development leaders in operational and governance forums, recognising this as a key enabler for aligning clinical priorities with workforce capability.

Applying Kanter's (1993) theory of structural empowerment to the findings reveals that equitable access to information, resources, and opportunities was not uniformly embedded across roles or services, and that Ibrahim's (2022) addition of psychological empowerment for nurses was dependant on informal power in terms of impact and influence rather than structured for success. When considered alongside Wiapo and Clarke's (2022) Whakapapa model and Spiller et al.'s (2015) Wayfinding Leadership, the study affirms the critical importance of relational leadership, cultural grounding, and accountability in shaping effective and sustainable educational practices.

The recommendations arising from this research emphasise the need for a seamless interface between education, operations, clinical practice, and leadership, an approach that must be structurally supported and relationally enacted, with cultural responsiveness at its core. Achieving this interface will require intentional strategies to empower education teams, clarify role expectations, and embed workforce development within service design and quality improvement processes.

Ultimately, this study contributes to a growing body of knowledge on fostering empowered, culturally responsive, and strategically aligned nursing education within complex health systems. It underscores the importance of ongoing research into how structural and cultural models can work in concert to promote the health and well-being of both the workforce and the communities they serve.

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APPENDICES

Appendix A – Summary of Exploratory Conversations

Exploratory Conversations were undertaken with the Chief Nursing Officer, Chief Operating Officer, Executive Director of Māori, Executive Director of Strategy and Funding, Executive Director of People and Culture, two Deputy Chief Nurses, two Nurse Managers, a Nurse Consultant Cultural Workforce Development, and a group of Clinical Nurses.

Main points
Patient perspective, narrative, and desire to deliver the best care and experience, it is difficult to see their contribution to change processes. Education and development support to equip for these needs both in practice presence and formal learning.
Clinicians do not always value the skill set of management (such as accountants and overtly operational); they need to value the contribution as it is an enabler of practice; true partnership is reflected in relationships, processes, and policy. Barriers occur when there is a lack of recognition of the needs of all groups to deliver on the common aim. Understanding resource needs informs the ability to meet clinical needs.
The operational and equipping interface relates to understanding accountability and productivity. Clinicians come from choosing a position and confirming and refuting; managers' position is to negotiate the way forward. Sometimes, this is like two different languages impacting both trust and capability. Understanding the clinical problems does not fix the operational and production problems. Education and development often focus on clinical problems, and understanding resource planning and productivity ensures service delivery.
Unconscious bias and institutional racism undermine genuine partnership. Without good systems, people cannot access health care; without good clinical practice, that care cannot be delivered.
Workforce development needs to reflect priorities for commissioning across the localities for the population and identified clinical needs.
There is a sense of waiting for the invitation to contribute to professional development, "we'll invite you if we need you". Conversely, there is no acknowledgment of mastery of the operational and management skill set.
The culture of the organisation needs to be reflected in education and development.
There has been slow progress in achieving results from education and development initiatives over decades, particularly with bicultural approaches. This is despite the inclusion of curriculum and government priority. Therefore, an outcomes focus needs to come from undergraduate programmes as well as in practice education and development.
The professional aim is to inform the operational aim. Workforce development is intrinsically linked to education and practice.

As a result of the need for a well-prepared workforce, a qualitative case study was planned to explore the strategic influences and stakeholder perspectives about ways that nursing education and development can strengthen operational and clinical practice to enhance quality outcomes within the Waikato District.

Appendix B – Summary of Literature Included in the Literature Search

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
1. Aqtash, S., Alnusair, H., Brownie, S., Alnjadat, R., Fonbuena, M., & Perinchery, S. (2022). United Arab Emirates	Evaluation of the impact of an education program on self-reported leadership and management competence among nurse managers.	Open Nursing	Leadership and management with nurse managers. Executive co-coaching with clinical supervision for the purpose of development of clinical management and leadership	Qualitative evaluation using Quality Standards for Reporting Excellence, and post-course evaluation of 105 nurse managers.	Nurse manager development improves quality improvement and professional goals. Leadership and management are essential components of any healthcare organisation's clinical care delivery system. Findings indicate that leadership quality improvement initiatives positively influence and improve nursing middle managers' leadership and management competencies. Hospital network nurse executives have noticed a positive impact on the participating managers' leadership skills. The managers showed more active engagement and innovation in matters related to patient safety initiatives. They were also able to function based on their new understanding of the utilised nursing practice model structure and processes, which they learned during their participation in the program. This finding supports the delivery of similarly structured leadership programmes to strengthen critical leadership skills.
2. Ayeleke, R., North, N. H., Dunham, A., & Wallis, K. (2019). New Zealand	Impact of training and professional development on health management and leadership competence.	Journal Health Organisation & Management	Development for leaders and managers competence	Systematic review, mixed methods, 19 studies. Notes first review of training and professional development interventions on management and leadership competence.	Improved competence and performance for individuals following the professional development interventions. Insufficient evidence to determine organisational performance improvement.
3. Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). Multi Centre	Educating nurses: A call for radical transformation. The Carnegie Foundation.	Josey-Bass, U.S.	Development regarding the practice education/theory gap	Nine centre study exploring how nurses prepare for the profession, survey, site visits including document analysis, focus groups, interviews, with leaders,	Improved clinical reasoning. Responsiveness to change. Reduced gap from theory to practice.

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
				preceptors, and participants of education. Thematic analysis using NVivo. Ethnographic, interpretive, and evaluative.	Categorised as three apprenticeships (i) theory and scientific methods, (ii) mastery of skilful practice, (iii) the formation of professional identity and agency separately and as a whole.
4. Bamford-Wade, A., & Moss, C. (2010). New Zealand	Transformational leadership and shared governance: An action study.	Journal of Nursing Management	Development of a competent, confident, and committed workforce at a unit and organisational level	Transformational leadership, shared governance, and action research are woven together.	Practical inter-weaving of transformational leadership, shared governance and action research provided a framework for sustainable change.
5. Benner, P. (2012). United States	Educating nurses: A call for radical transformation. How far have we come?	Journal of Nursing Education	Asking the question about how nursing education has progressed 3 years following the Carnegie Foundation Stud	Editorial.	
6. Berghan, G., Came, H., Coupe, N., Doole, C., Fay, J., McCreanor, T. & Simpson, T. (2017). New Zealand	Te Tiriti o Waitangi-based practice in health promotion.	STIR NZ	Applying the elements of the Te Tiriti o Waitangi in genuine shared power relationships (Indigenous approaches)	Translational research that incorporates auto-ethnographic components.	Report that provides a way of working with treaty-based relationships/ partnerships. Equipping health professionals with practical application of bridging the gap to manage Te Tiriti partnership, Indigenous participation, and protection for health care professionals with collaboration.
7. Bidwell, S., & Copeland, A. (2017). New Zealand	A model of multidisciplinary professional development for health professionals in rural Canterbury.	New Zealand Journal of Primary Health Care	Multidisciplinary model of professional development	A survey, 14 participants, 86% response rate.	Increased consistency of patient care, a forum for interaction, and fresh ideas. Shared with other practices.

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
8. Ducat, W., Martin, P., Kumar, S., Burge, V., & Abernathy, L. (2016).	Oceans apart yet, connected: Findings from a qualitative study on professional supervision in rural and remote allied health services.	University of Otago Press	Connections to achieve effectiveness in care with multiple stakeholders	A qualitative descriptive study with 42 health professionals, 9 operations managers, and 4 professional supervisors.	Multiple and varied stakeholders (operational, clinical, and professional) reduce isolation, improve patient safety due to increased best practices and enhanced skills.
9. Frances, R. (2013).	Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary.	Official documents UK Government	Identification of system failures and the impact on patient outcomes	Public inquiry.	Identification of the need for clinical governance, operational leadership accountabilities, delivery of quality care standards with appropriate clinical knowledge and skill, education, and support/resources to enable this.
10. Gauld, R. (2003). New Zealand	Continuity amid chaos: Health care management and delivery in New Zealand.	University of Otago Press	Health system development and the relationship to care delivery	Book.	Explores the relationship between care and management identifying development as a contributor to effectiveness
11. Gauld, R., & Horsburgh, S. (2016). New Zealand	Are some health professionals more cognizant of clinical governance development concepts than others? Findings from a New Zealand study.	Journal of Public Health	Application of structure, clinical governance, and integration 3 years post Ministry of Health policy implementation	Quantitative national study with 41030 responses. Comparative study.	Variable knowledge and limited application of clinical governance. Identified the need to traverse the management–professional/clinical divide. Generated national baseline data for patient safety (quality outcomes).
12.Gardner, K., Sibthorpe, B., Chan, M., Sargent, G., Dowden, M.. & McAullay, D. (2018). Australia	Implementation of continuous quality improvement in Aboriginal and Torres Strait Islander primary health care in Australia: A scoping systematic review.	Journal of Health Organisation and Management	Problem solving using continuous quality improvement processes for change	Systematic review of 60 articles exploring breadth and focus; and 21 articles exploring enablers and barriers for Indigenous population.	Continuous quality improvement processes were effective for the indigenous context. Cultural processes are not described as part of this.

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
13. Hayward, S., & Nursing at Waikato DHB 2017-2021. (2017). New Zealand	Nursing at Waikato DHB 2017-2021: Expectations, professional development frameworks and nursing strategic aims.	Waikato DHB	Standards and strategies to deliver quality nursing care within Waikato DHB	Strategic plan with associated objectives and actions.	Four strategies aligned with actions and a professional development framework to enable achievement.
14. Hastings, S. E., Armitage, G. D., Mallinson, S., Jackson, K., & Suter, E. (2014). United Kingdom	Exploring the relationship between governance mechanisms in healthcare and health workforce outcomes: A systematic review.	BMC Health Service Research	Relationship between health system governance and workforce outcomes	Systematic review of 4,300 abstracts from Canada, UK and Netherlands, NZ, Australia, US. Peer-reviewed papers and grey literature. Rates on quality and relevance and classified into themes. 113 articles discussing workforce and governance were retained.	Professional development and shared governance were associated with improved health workforce outcomes (job satisfaction, attitude, and quality initiatives, reduced turnover). However, there was no expected impact or focus on the workforce within the governance structure when considering the impact that the workforce has on overall quality outcomes.
15. Waitangi Tribunal (2019, 2023). New Zealand	Wai2575 health services and outcomes Waitangi Tribunal Inquiry.	Waitangi Tribunal NZ Government	Addresses claims in relation to health care provided to Māori in Aotearoa New Zealand in accordance with the requirements of Te Tiriti ō Waitangi	The inquiry addressed all claims and grievances in relation to health services and outcomes which were of national significance.	The tribunal found that the Crown had breached Te Tiriti by failing to administer the current primary health care system to actively address persistent health inequities by the Te Tiriti guarantee of rangatiratanga (autonomy and self-determination).
16. Hoare, K. J., Mills, J., & Francis, K. (2012). United Kingdom, Australia, New Zealand	The role of Government policy in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: An adapted realist review.	Journal of Advanced Nursing	Government policy in supporting nurse-led care in general practice	Adapted realist review, 4,300 abstracts found in searches, 47 studies met inclusion criteria. (45 UK, 2 Aus, 0 NZ)	UK, Australia, and NZ share a similar model of the first point of access via general practice. Clinical governance is fundamental to nurse-led care.

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
17. Hollnagel, E., Braithwaite, J., & Wears, R. (2013). Netherlands	Resilient health care for quality outcomes.	Book Publisher	Quality processes and systems improvement Safety 11	From Safety 1 to Safety 11.	Incorporating integrated perspectives and 'what went right into quality processes with improved patient safety outcomes.
18. Howard, G. (2016). New Zealand	The accountable organisation.	Book Publisher	Structure-based on clinical and operational governance with clear accountability for quality outcomes closest to the patient	Case study methodology to examine and inform structure and process in a New Zealand Health Board.	Identified the management and clinical divide and the unique knowledge and skill of each group. Collaborative service leadership group structure for effectiveness incorporating operational management and clinical effectiveness.
19. Kidd, J. Warbrick, I., Hall, A., & Came-Friar, H. (2019). New Zealand	Briefing on: Waitangi Tribunal health Kaupapa report – Wai2575 (stage one).	Taupua Waiora Research Centre Auckland University of Technology	Key messages from the outcome of the Inquiry	Briefing report.	Recommendations • Amend Treaty and equity clauses in NZPHDA 2000 • Investigate a standalone Māori Primary Care Authority by 2020 • Review primary health funding including compensation for underfunding • Review and strengthen accountability mechanisms & monitoring • Co-design Māori primary care research agenda • Reinstate Māori health plans and Treaty clauses in contracts • Redesign partnership mechanisms at all levels "Finally, we recommend that the Crown acknowledge the overall failure of the legislative and policy framework of the NZ primary health care system to improve Māori health outcomes since the commencement of the NZPHDA 2000" (p. xvi).
20. Lavery, G. (2016).	Quality improvement – rival or ally of practice development?	International Practice Development Journal	Practice development and quality improvement	Critical comment comparing the two paradigms and recommending a strengths-based outcome of integration.	Discusses the micro, mezzo, and macro applications of practice development and quality improvement and how integration can achieve greater benefits.

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
21. McAllister, M., & Flynn, T. (2016). Australia and New Zealand	The Capabilities of Nurse Educators (CONE) Questionnaire: Development and implementation.	Nurse Education Today	Developing an effective measure of the nurse educator's role in the development and intervention	CONE questionnaire (self-diagnostic tool) to identify educator capability, 266 participants.	93-item capability measures for self-assessment, and planned development with six subsets measuring Teaching Knowledge and Practice, Drawing from Nursing Knowledge, Teaching Relationships, Leadership, Research Orientation, and Research Action.
22. McCalman, J., Campbell, S., Jongen, C., Langham, E., Pearson, K., Fagan, R., Martin-Sardesai, A., & Bainbridge, R. (2019) Canada, Australia, New Zealand, United States (CANZUS)	Working well: A systematic scoping review of the Indigenous primary healthcare workforce development literature.	BMC Health Services Research	Systematic scope of literature for studies that described or evaluated models and systems that support sustainability and growth of Indigenous primary healthcare workforce to provide effective primary healthcare provision	A systematic review of 11 databases, 10 websites, and clearinghouses, and reference lists of 5 review articles were searched for relevant studies from CANZUS nations in English using thematic analysis. 28 studies were found of which 12 were evaluations.	Primary healthcare can strengthen workforce models by bringing together providers to consider strategies and enabling conditions for meeting the health needs of local communities. Linking development to service needs, making opportunities for shared learning and knowledge exchange.
23. McCauley, K., Cross, W., Moss, C., Walsh, K., Schofield, C., Handley, C., Fitzgerald, M., & Hardy, S. (2014). Australia, United Kingdom	What does practice development (PD) offer mental health-care contexts? A comparative case study of PD methods and outcomes.	Journal of Psychiatric and Mental Health Nursing	Comparison of three bespoke initiatives within mental health exploring 'what mental health-care services does PD offer in terms of transformational change approaches and the promotion of effective workplace cultures?'	Comparative case study. Three projects in mental health.	Integration of PD within mental health care context promoting culturally sensitive care delivery and effective workplace cultures.

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
24. McSherry, R., McSherry, W., & Pearce, P. (2013).	Can clinical governance act as a cultural barometer?	Nursing Times	Analysing the Mid Staffordshire findings in the context of governance and learning	Report.	Identifies shared learning as a key contributor to quality outcomes
25. McSherry, R., Pearce, P., Grimwood, K., & McSherry, W. (2012)	The pivotal role of nurse managers in enabling excellence in nursing care leaders and educators.	Journal of Advanced Nursing	Establishment of genuine shared working partnerships and collaborations between nurse managers, leaders, educators, and organisations	A discursive analysis exploring excellence in nursing care with a resulting exemplar framework incorporating education, quality and practice, communication, research and development with a central focus of person-centeredness.	Nurse managers, leaders, and educators respond to the complexity in practice by leading, managing, enabling, empowering, encouraging, and resourcing staff to be innovative and entrepreneurial in practice.
26. Manley, K., Buscher, A., Jackson, C., O'Connor, S., & Stehling, H. (2017). United Kingdom	Overcoming synecdoche: Why practice development and quality improvement approaches should be better.	Integrated. International Practice Development Journal	Practice development and quality improvement	Critical commentary about the interface between practice development and quality outcomes.	Integration is achieved by understanding shared meaning as this informs structures. Systems and processes follow values and purpose.
27. Ministry of Health. (2016, 2023). New Zealand	New Zealand health strategy. Future direction.	Ministry of Health	2016: Five key priorities; value & high performance, people-powered, closer to home, one team, smart system 2023: Six priorities; Voice, the flexibility of care, workforce, learning, resilient	Strategic frameworks.	2016: Integrated, collaborative, workforce. Equity in decision-making and outcomes, active partnerships addressing gaps. 2023: Proactive application of Te Tiriti o Waitangi and quality outcomes.

Authors, year, country	Title	Publication	Phenomenon of interest / Insight	Sample, design & research	Evaluation and key findings
			sustainable system, and partnerships		
28. Miskelly, P., & Duncan, L. (2014). New Zealand	'I am actually being the grown-up now': Leadership, maturity and professional identity development.	Journal of Nursing Management	Building practice maturity and leadership capacity using practice development principles	Mixed methods evaluation of participants' outcomes from a practice development programme.	Empowered transformational culture, improved self-confidence, and undertaken quality roles.
29. Osei-Kyei, R., Chan, A., & Ernest, E. (2017). United Kingdom, Hong Kong, Australia	A fuzzy synthetic evaluation analysis of operational management critical success factors for public-private partnership infrastructure projects.	Benchmarking International Journal	Integration of management principles for operational effective, quality, and clinical outcomes	Purposive sampling mixed method devising 15 accountability measures.	Identification of unique knowledge and skills. Integration and collaboration.
30. Pitama, S., Huria, T., & Lacey, C. (2014). New Zealand	Improving Māori health through clinical assessment: Waikare o Te Waka o Meihana.	New Zealand Medical Journal	Māori model of healthcare	Address individual and collective health, the health system, and influences such as migration and colonisation.	Framework for clinical assessment that incorporates education and the health system.
31. Waitangi Tribunal. (2019, 2023). New Zealand	Hauora: Report on stage one of the Health Services and outcomes Kaupapa Inquiry.	Waitangi Tribunal, New Zealand Government & Legislation Direct	Versions of the report that analyse the requirements of Te Tiriti o Waitangi obligations in healthcare in Aotearoa New Zealand	Inquiry report and recommendations. The 2023 version revises the recommendations.	Identified failure in all areas of obligations. Recommendations are made to address these based on the principles of Te Tiriti o Waitangi.
32. Wilson, D., & Baker, M. (2012). New Zealand	Bridging the tension of two worlds. Māori mental health nursing.	Qualitative Health Research	Culturally responsive workforce	Grounded theory in-depth interviews with 10 participants.	Identification of two themes for Indigenous minority nurses 'going beyond' and 'practicing differently'. Genuine partnership between stakeholders

Appendix C – Research Protocol

Purpose of the research: Explore how education and development can improve responsiveness to clinical and operational needs and demands, to enhance quality outcomes.

Salient characteristics: In building on a previous project (Marriott, 2014; Hayward & Atherfold, 2015), an apparent disconnect remains between the operational and professional development contexts within the organisation.

Clarification of the issue: Undertake exploratory conversations with executive leaders, managers and clinical nurses within Te Whatu Ora Waikato to gain insight into the apparent disconnect between operational and clinical care delivery, noting how education and developments can contribute to enhancing quality outcomes (Appendix A).

Institutional enablers and barriers: Enablers include engagement with key stakeholders, participants, and access to documents and intranet platforms. Barriers include the COVID-19 global pandemic impacting the availability of participants (2020-2022), and the cyber-attack during the document process (2021), impacting the timeline but not the outcomes.

Literature review: Integrative literature review using the PARiHS Framework (Kitson et. al., 2017).

Meetings with key stakeholders: Craft the research question and confirm what the research needs to address, and ensure the larger context is understood.

- The Chief Nursing Midwifery Officer
- Deputy Chief Nurses with portfolios in (i) Practice Development and Education, (ii) Quality and Care Capacity Demand Management, (iii) Virtual and specialist services
- Te Puna Oranga; Māori Health Services

Epistemological alignment and methodology: Single embedded case-study methodology with critical appreciative processes to provide strengths focus to critical considerations. Validity and rigor via a range of data, reflection, participant checking and stakeholder feedback (Merriam, 2009; Payne, 2021; Stake, 1994; Yin, 2018),

Philosophy and theoretical underpinnings: Practice Development (PD) theory (McCormack & McCance, 2017; McCormack & Wilson, 2008), Critical Appreciative Processes

(CAP) (Grant, 2012; Grant & Humphries, 2006; Oliver, 2005b), participatory approaches (Manley et al., 2021).

Paradigm: Qualitative, attributes of pragmatism and constructivism; situated in the organisation and participants' experience. Researcher analysis (Braun & Clarke, 2022; Payne, 2021)

Ethics: The Research Office maintains confidentiality and integrity by undertaking recruitment, independent facilitation, confidential transcription, and the provision of anonymised transcripts (see Ethics approval)—participant information sheet and consent documents facilitated by the Research Office, Te Whatu Ora Waikato.

Purposive sampling: To reflect the three groups identified out of the exploratory conversations (operational, clinical, and education and development).

Facilitator preparation: Two facilitator workshops with the researcher and three independent facilitators not employed within Te Whatu Ora Waikato. Apply IDPC Standards (2017)—co-development of research questions for semi-structured focus groups and interviews.

Data collection: Focus groups and interviews. Insights and perspectives were gathered from operational leaders, clinical nurses, and nurses with educational roles in focus groups and interviews led by independent facilitators.

Knowledge synthesis: The researcher analysed the data in NVivo using thematic analysis (Clarke & Braun, 2022) and synthesised it into a model/framework that can inform recommendations and applications. Address rival perspectives (Yin, 2018) by identifying and considering congruence and incongruence.

Documents: Exploration of documents by searching the Te Whatu Ora Waikato document management system for the purpose of establishing how education and development are cascaded within strategic and organisational documents. This was undertaken using key terms such as education, development, learning and teaching.

Triangulate: perspectives on themes to ensure that operational, clinical, educational, and developmental aspects are reflected in the analysis.

Synthesis legitimacy: Participant checking with a pre-recorded virtual presentation using voice-over PowerPoint to summarise the findings and discuss.

Derive recommendations and actions to align with the findings.

Appendix D – Facilitators Guide

Discussion Guide for Focus Groups and Interviews

Project Title

"How can nursing education and development strengthen responsiveness of operational and clinical practice to quality outcomes within Waikato District Health Board?"

Participants

Purposive recruitment of participants who are either an operational leader, a clinical nurse or a nurse working in the field of education and development currently working within the Waikato DHB.

Recruitment has been undertaken by the Waikato DHB Research Coordinator within Quality and Patient Safety to avoid any conflict of interest.

Time

60-90 minutes

Commencement

Whanaungatanga to introduce participants within the focus group or interview and establish connections.

Introduction to the purpose of the research based on the Participant Information Sheet and opportunity for questions

Confirmation of consent as per consent form

Discussion

Facilitation of generative discussion that explores the research question can be spontaneous and also utilise indicative questions such as:

Indicative questions for the individual interviews and focus groups include

- Can you describe education and development that is effective in your clinical area?
- Are there examples that can be recognised and learnt from for future education and development?
- Based on your experience how do you see education and development activity supporting the goals of your clinical area?
- Which quality indicators do you use to inform development and education?
- Do you have innovative ideas and suggestions for how education and development could enhance practice?
- How could development and education activity be more responsive to learning needs?
- How can education and development be prioritised to strengthen capabilities?

NB: Facilitation will be informed by Critical Appreciative Processes (Grant & Humphries, 2006; Oliver 2018), and Facilitation Standards for an integrated approach to workplace learning, development, improvement and inquiry (Manley, Jackson, Wright, 2015). These will be provided as part of the facilitator preparation session.

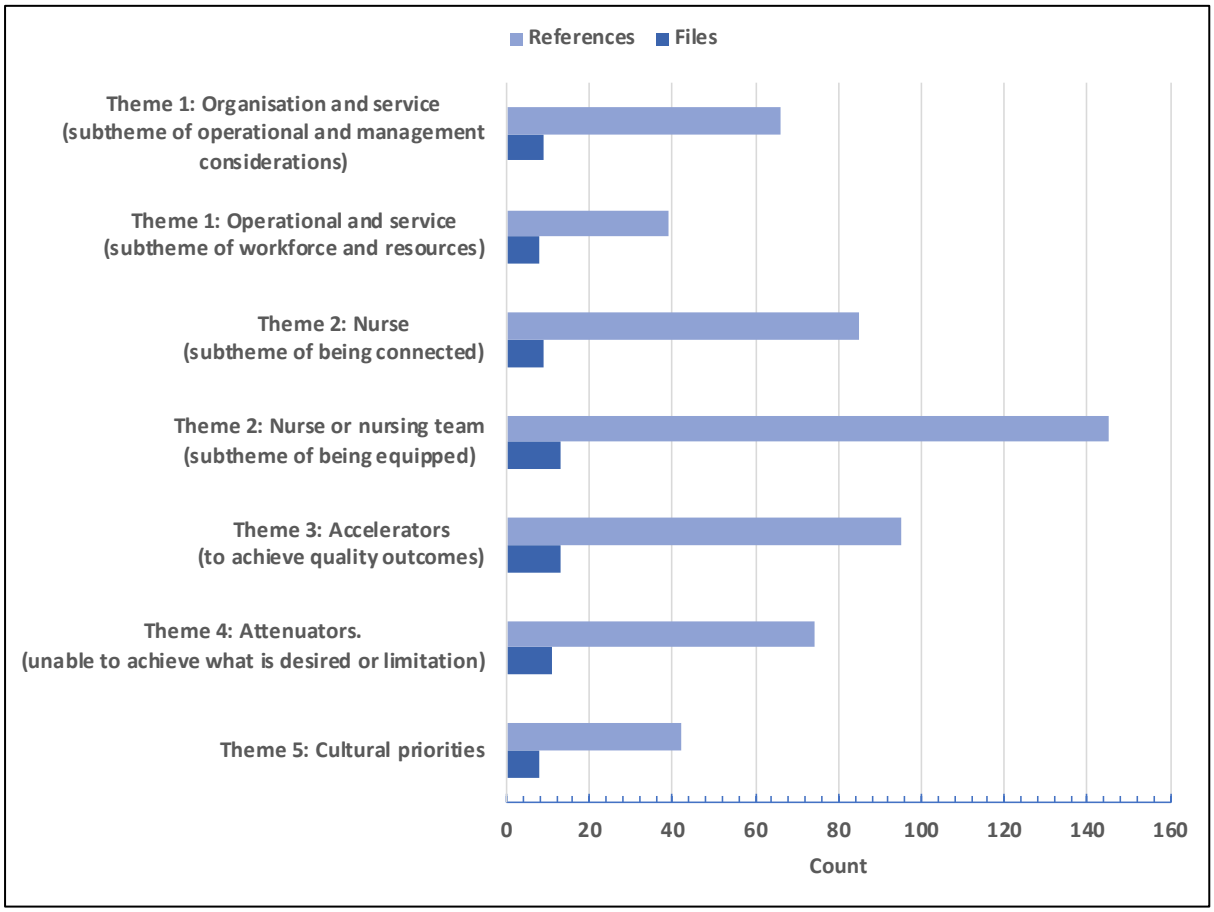
Conclusion

Conclude with thanks, reinforcement of contact details for any queries or support.

Appendix E – Initial Codes and Themes

Frequency of concepts reflected in refined codes from Familiarisation

RTA Step One



References are the number of times the concept was mentioned across all transcript files

Files are the number of transcript files in which the concept was mentioned. Focus groups contained several participants, which is why the number of files appears low in comparison to the references.

Initial codes RTA Step Two

1. **Cultural priorities** reflect a range of ideas and concepts about the health needs of he tangata / the population of the district, cultural safety, equity, and the tension between world views – Te Ao Māori and others.
2. **Presence** reflects being present in practice for care delivery, advocacy, role modelling, and mentoring.
3. **Quality processes** reflect requirements and activities that contribute to achieving quality outcomes

4. **Quality outcomes** demonstrate measurable results for care delivery based on expected standards for care delivery
5. **Operational considerations** reflect how services and care delivery are managed and organised
6. **Connection** reflects the way that structure, processes, teams, and processes integrate to achieve the desired outcome for care delivery
7. **Equipped** reflects how nurses access knowledge, skills, education, support, and resources to enable them to deliver effective care
8. **Workforce** encompasses the composition of staffing levels, experience and skill mix
9. **Limitations** impinge the ability to deliver care and enhance quality outcomes
10. **The sense of not achieving** is reflected in how this is experienced by nurses

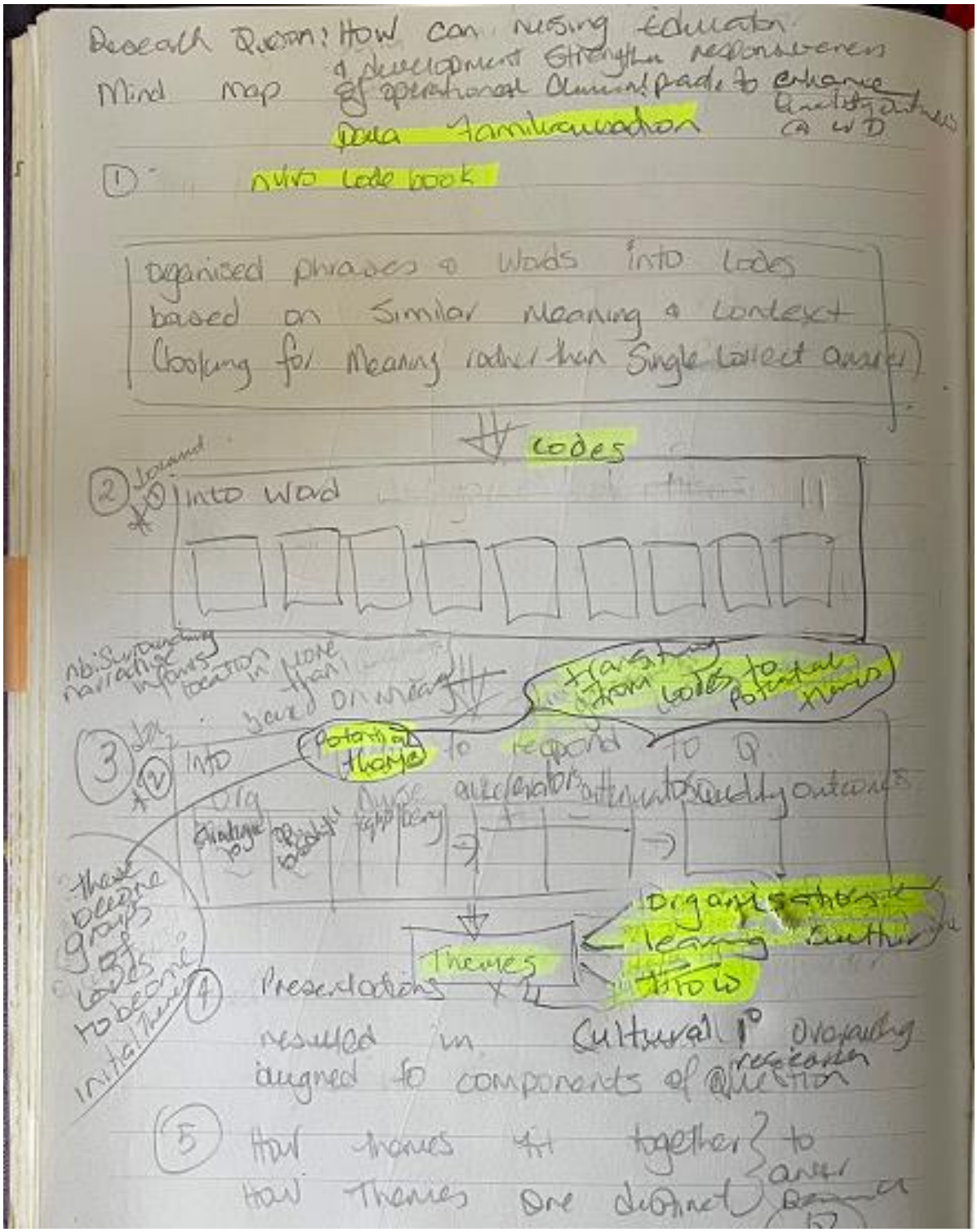
Potential themes RTA Step Three (*see summary of slides below)

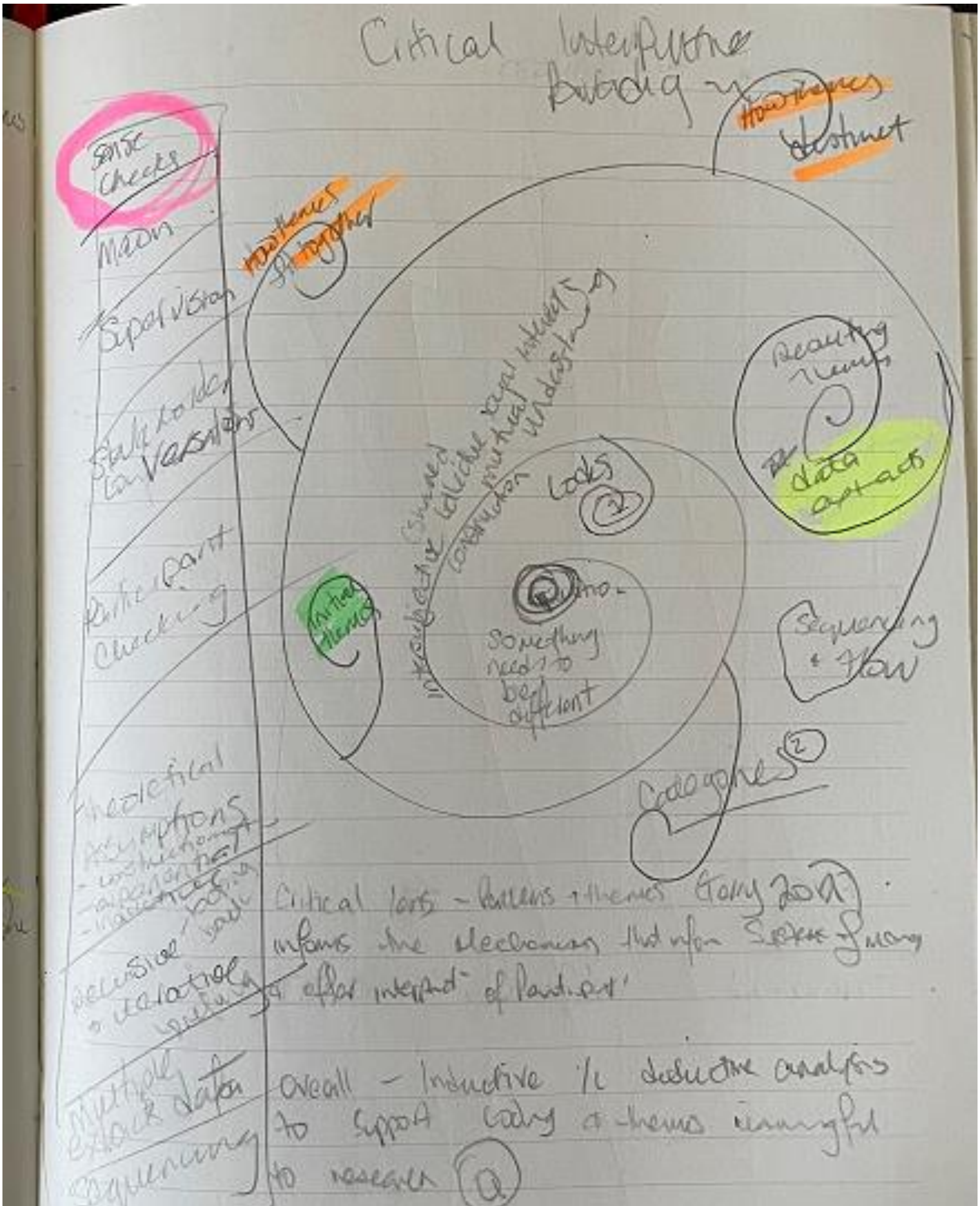
1. **Organisational considerations** reflect operational, management, workforce, and resources impacting the way things work
2. **Nurse and Nurses** reflect nurses' ability to do what they need to function and enhance quality outcomes
3. **Amplifiers** reflect enhancers that enable quality outcomes to be achieved; these become enhancers in theme development
4. **Attenuators** reflect factors that limit the ability to enhance quality outcomes; this becomes limiters in theme development
5. **Cultural priorities** reflect an overarching range of ideas and concepts about the health needs of the tangata / the population of the district, cultural safety, equity, bicultural approaches and the tension between world views – Te Ao Māori and others.

Refined, Defined Themes RTA Step Four and Five (*Figure 3 Chapter IV)

1. **Organisational structure – The Waikato Way** reflects how the Waikato District is organised and functions, impacting the ability of nurses to deliver care that achieves quality outcomes.
2. **The learning culture** reflects how the culture and practices within the Waikato District enhance and limit care delivery and quality outcomes. It includes being equipped for and in practice with mentorship, intentional reflection, and integrated connection.
3. **Cultural priorities and Indigenous knowledges** reflect the overarching context of Kawa Whakaruruhau and cultural safety as ways of achieving quality outcomes.

Appendix F – Reflexive mapping



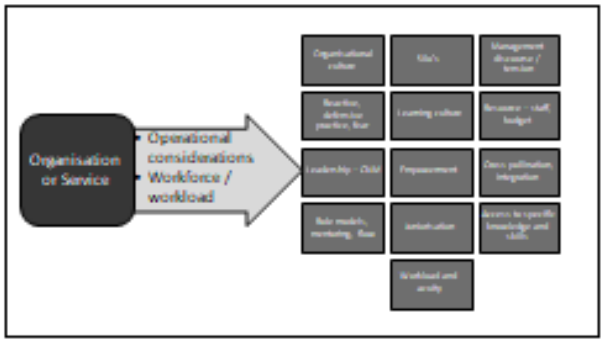

Critical
Sense checks
Supervision
Participant checking
Theoretical assumptions
something needs to be different
Initial themes
data extracts
Sequencing + Flow
Categories
Looks
Critical lens - Patterns + themes
Overall - Inductive deductive analysis

Appendix G – Participant Checking

Summary of slides from organisation and participant checking sessions

RTA Step Three

1



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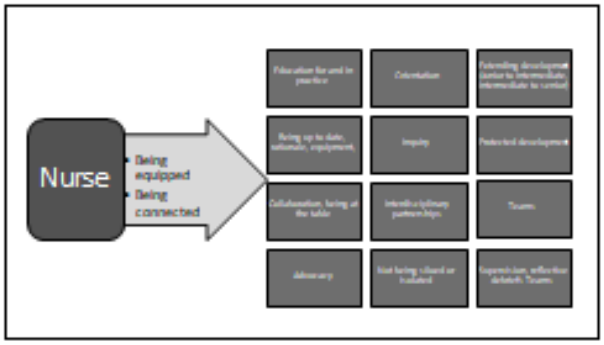

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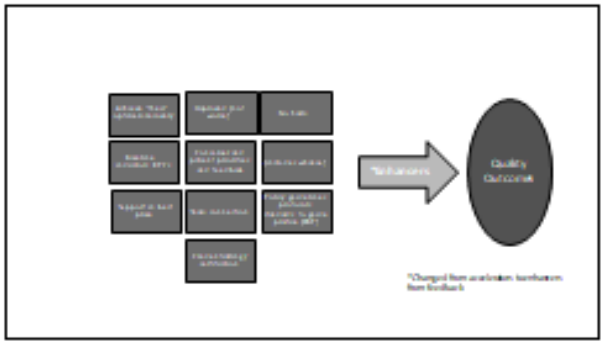

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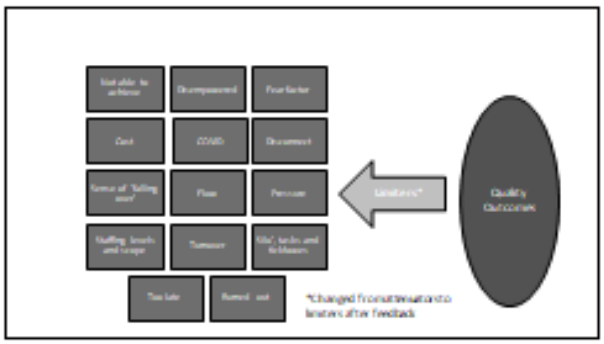
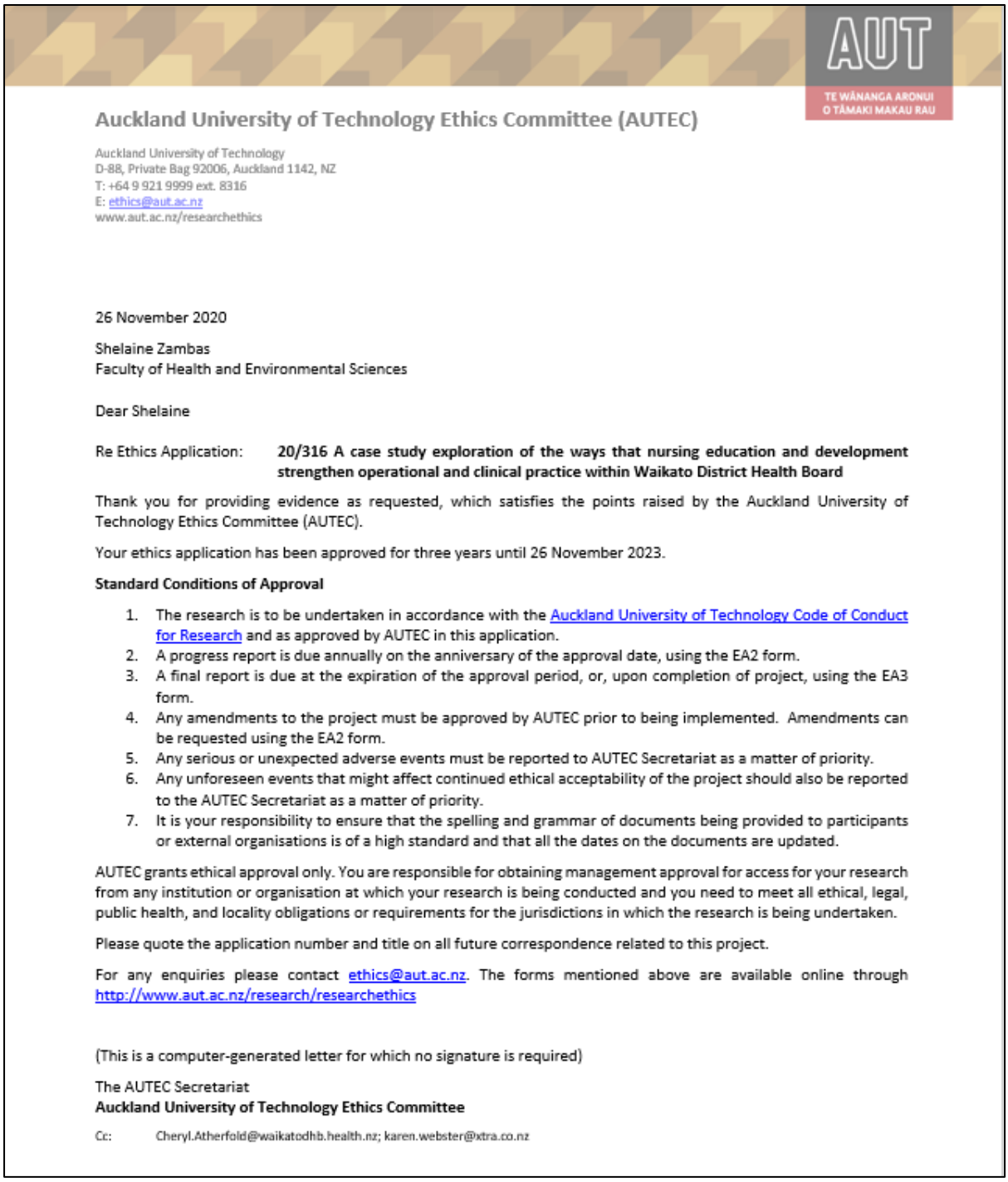


5

6

Appendix H – AUT Ethics Approval and Te Whatu Ora Waikato District Approval



AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

26 November 2020

Shelaine Zambas
Faculty of Health and Environmental Sciences

Dear Shelaine

Re Ethics Application: **20/316 A case study exploration of the ways that nursing education and development strengthen operational and clinical practice within Waikato District Health Board**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 26 November 2023.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Cheryl.Atherfold@waikatodhb.health.nz; karen.webster@xtra.co.nz

Waikato DHB Approval of Research

RD020128	A case study exploration of the ways that nursing education and development strengthen operational and clinical practice within Waikato District Health Board?"

Project Personnel

Principal Investigator:	Dr Shelaine Zambas Auckland University of Technology (AUT) Shelaine.zambas@aut.ac.nz 021 02973157
Waikato DHB named investigators:	Cheryl Atherfold Cheryl.atherfold@waikatodhb.health.nz 021 549 813
Primary contact name and contact details (email and phone):	Cheryl Atherfold

Date Submitted:	30/11/2020
Type of Project:	Observational: qualitative/epidemiological
Multisite?	Not a multi-centre project
Department:	Professional Development Unit
Service:	Nursing & Midwifery
% of Māori with condition of interest	The project relates to staff
What are your plans for recruiting Māori?	Purposive invitation to all who reflect the criteria of being either clinical, operational or education staff. The views of Māori staff are key to understanding the development needs for equity and quality outcomes.
Is ethnicity a variable in your study? (Māori c.f. non-Māori)	No
Will your study involve collecting tissue samples?	No
Will you expect to publish your results?	Yes
Finance/Resource Requirements:	Researcher time;

Waikato DHB research approval form V3 January 2013

(eg staff time, extra clinics, extra procedures, consumables)	Participant's time of 60-90 minutes for interview/ focus group. Recruitment via the research office sending out invitations and compiling acceptances estimated at 2 hours

Project Description (300 words max – background, aim, methods):

Start Date: 01/02/2021

End Date: 30/09/2022

Sample Size: 36 participants in focus groups and a further 12 for optional interviews.

This research aims to find out about how education and development teams can enhance the way they facilitate learning for nurses in ways that support operational and clinical priorities at Waikato District Health Board (DHB). This will involve exploring what works currently and what opportunities there are to enhance and strengthen education and development in clinical practice.

Aims:

- Identify the connections and tensions between operational and clinical practice teams at Waikato DHB;
- Explore how education and development teams can facilitate learning for nurses that supports operational and clinical priorities; and
- Identify potential actions that can provide recommendations to integrate education and development strategies that enhance operational and clinical practice.

The research builds on an earlier Waikato DHB project (2015) which implemented the current structure and approach for education. However current demands require further consideration of how to enhance responsiveness based on the local context noting the Waikato region population consists of higher than national average of Māori (23%), rurality (60%) and deprivation (Department of Statistics NZ, 2013), with poor health outcomes (Waikato DHB, 2016; 1019).

The Methodology is based on Yin's embedded single case study design (2018) with application of critical appreciative processes (Grant & Humphries, 2006) to gain critical insights from a strengths perspective.

Involved in the research will be service leaders and managers, clinical nurses and nurses with education and development roles at Waikato DHB. These people will be invited to be participants in focus groups and interviews.

Access to data and other documents will be via the document management system with access arranged via the Waikato DHB Research Office. Facilitators and interviewers for focus groups and interviews will be sourced externally from local education providers and

recruitment will be undertaken by the Waikato DHB Research Office to avoid any conflicts of interest.

Management and Resource Sign-offs

This study does not require HDEC review. Will have University (AUT) ethics.

Locality Review – *the undersigned agree to the following statements:*

- The study protocol and methodology are ethical and scientifically sound.
- This researcher has identified that this study does not require Health & Disability Ethics Committee (HDEC) review.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Cultural consultations have occurred or will be undertaken as appropriate
- Appropriate confidentiality provisions have been planned for.
- Appropriate arrangements are in place to notify other relevant local health or social care staff about the study, and for making available any extra support that might be required by participants, where relevant.
- Conducting this research will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that the results of the study will be disseminated and where practical and appropriate the findings of the study will be translated into evidence based care.

Queries about this research must be made to the Primary Contact person listed.

Dept/Service /Org	Role	Name (print clearly)	Signature	Date signed
Nursing	Chief Nursing & Midwifery Officer	Sue Hayward		3/11/20
~~Te Puna Oranga~~	~~Māori Research Review Cttee~~	~~Nina Scott~~		

Clinical Support Services Sign-offs

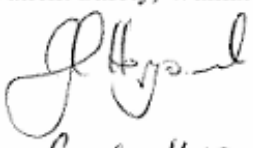
CROSS OUT/ADD SIGN-OFFS APPLICABLE TO THIS PROJECT

SIGNATORIES DECLARATION: We agree that appropriate resources are available in our service to support this project

Clinical Support Service	Name (print clearly)	Signature	Date signed
~~DHB Pharmacy~~	~~Rajan Ragupathy~~ ~~OR Alice Chang~~		
~~DHB Pharmacy~~	~~Marinda van Zyl-Greene~~ ~~OR Jan Goddard~~		
~~Laboratory~~	~~Kay Stockman~~		
~~Radiology~~	~~Leigh Harvey~~		
~~Medical Records~~	~~Denise Jon~~		

Please return to the Research Office (via Sarah Brodnax, Level 2, Hockin Building) along with required documents as identified in the checklist for final approval.

Office use only:
Quality & Patient Safety, Waikato DHB

Signature:  **Date:** 16.12.13

Name: C. C. Hansen **Position:** CMO

Appendix I – Letter of Support for Bicultural Processes

Health New Zealand
Te Whatu Ora

12 December 2025

Tēnā Koutou katoa

Letter of Support for Thesis

I have been pleased to provide cultural advice for Cheryl Atherfold throughout her thesis and excited about her findings following her examination of how nursing education and development can strengthen operational and clinical practice to enhance quality outcomes.

I have worked alongside Cheryl in a number of roles as a bicultural partner in the development and implementation of initiatives related to nursing education and development, particularly in relation to Māori nursing workforce development and application of Te Tiriti o Waitangi to meet the needs of Māori, improve health outcomes and equity for Māori. This work has aligned well with Cheryl's research and our collaborative way of working.

My role as Cultural Advisor started with supporting Cheryl with early discussion of her research, preparation of her ethics application, specifically cultural considerations in relation to Te Tiriti o Waitangi, equity and appropriate processes for participants who identify as Māori. Her research was also supported by Te Kahui Tapuhi, the Māori Nurses Advisory Group at Waikato DHB. Cheryl has sought cultural advice at relevant stages throughout her research including the analysis of data shared by Māori participants to ensure accuracy of her interpretation of the data. She has been responsive to advice provided and respectful of our bicultural relationship.

I look forward to collaborating with Cheryl as she implements the recommendations from her research, including the development of culturally responsive quality measures grounded in Indigenous knowledge systems co-designed with Māori and other key stakeholders.

Ngā mihi,

C. Baker

Chris Baker
Iwi Waikato Maniapoto
Nurse Consultant Cultural Workforce Development
Nursing Professional Development Unit
Health New Zealand Waikato District

Appendix J – Information Sheet for Participants

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Participant Information Sheet

Date Information Sheet Produced:

14 November 2020

Project Title

"How can nursing education and development strengthen responsiveness of operational and clinical practice to quality outcomes within Waikato District Health Board?"

An Invitation

Tena koutou, you are invited to take part in this research project. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for your consideration of this request.

I am a doctoral Student at Auckland University of Technology, School of Health and Environmental Studies. This research project is towards my thesis.

What is the purpose of this research?

The aim of this project is to explore how nursing education and development can strengthen responsiveness of operational and clinical practice to quality outcomes within Waikato District Health Board? The research is a case study that builds on an earlier Waikato DHB project (2015) which implemented the current structure and approach for nursing education. This will involve exploring what works currently and what opportunities there are to enhance and strengthen education and development in clinical practice for changing health care demands. Information obtained from this research will be used to inform ways that education and development activity responds to operational and clinical priorities. The findings may be used for academic publications and presentations.

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

You are being invited to participate in focus groups or interviews to contribute to knowledge which will be used to inform ways that development activity responds to operational and clinical priorities from your perspective. The invitation is specific to you as either an operational leader, a clinical nurse or a nurse working in the field of education and development currently working within the Waikato DHB.

To ensure confidentiality and avoid any conflict of interest I have arranged for the Waikato DHB Research Coordinator to recruit participants for the project based on the research criteria. Responses will remain confidential. Facilitators for focus groups and interviews are external to Waikato DHB employment and have been sourced from local education providers (Wintec and University of Waikato).

The focus groups and interviews will take up to 60 minutes and include the opportunity to share your thoughts about the topic.

The focus group or interview will be recorded and will then be transcribed and analysed to generate themes that can be used to inform the research outcomes which will be reported in the thesis, academic publications and presentations. Should a video call be the preferred option for you to participate this will be recorded and transcribed and remain confidential in the same way as recordings from in person focus groups or interviews.

The focus groups and interviews are confidential which means that only participants within the focus groups and facilitators will be aware of your identity. The research data will be combined in the analysis process and pseudonyms used with any quotes. Your identity will not be revealed in any reports, presentations or public documentation. I will provide the opportunity for participant checking and for you to confirm and contribute to the themes in either groups or individually. Only my supervisors - Dr Shelaine Zambas and Dr Karen Webster and I will read the de-identified notes and transcripts. The transcripts and recordings will be kept securely and destroyed on 30 June 2025.

How do I agree to participate in this research?

Should you agree to participate in this research please confirm your acceptance by email to the Waikato DHB Research Office Research@waikatodhb.health.nz

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. You are able to withdraw from the research at any point; however the information you have provided in a focus group to that point will not be able to be withdrawn as it is part of a discussion with the other participants.

What will happen in this research?

The focus groups and interviews will take up to 60 minutes and include the opportunity to share your thoughts about the topic.

Participation in this research is entirely optional. Should you decide to participate you have the right to:

- choose not to answer any question
- request that the recorder to be turned off at any time during the focus group or interview
- ask any questions about the study at any time
- request a summary of key points from the focus group discussion
- receive any reports of this research by emailing the researcher to request a copy

The focus group or interview will be recorded and will then be transcribed and analysed to generate themes that can be used to inform the research outcomes which will be reported in the thesis, academic publications and presentations. Should a video call be the preferred option for you to participate this will be recorded and transcribed and remain confidential in the same way as recordings from in person focus groups or interviews.

What are the discomforts and risks?

A private space will be provided for the focus groups and interviews. There may be different points of view within the focus groups and this can sometimes be uncomfortable however it is valuable to capture these views to understand and answer the research question. Facilitators will be prepared with a set of standards for the group discussion and they have been selected for their skill in leading group discussions for complex and varied ideas.

How will these discomforts and risks be alleviated?

If issues or concerns arise from the focus group or interview discussion, AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

The benefits of participating in this research are that you contribute to the findings to inform recommendations to Waikato DHB that inform ways that development activity responds to operational and clinical priorities.

The research project contributes to the requirements of my Doctor of Health Science studies.

How will my privacy be protected?

Confidentiality will be provided by

1. Neutral recruitment to the research via the Waikato DHB Research Office,
2. No access to contact details of participants to the focus group and interview facilitators'
3. Interviews are available to those participants who prefer to share information individually rather than in the group (you can participate in both),
4. De-identification of any information by the independent transcriber and use of pseudonyms in the research thesis report, and
5. Confidentiality agreements with the recruiter, facilitators and transcriber.

As an AUT Doctoral student I am aware of my role as Deputy Chief Nurse employed by Waikato DHB and have sourced neutral people to undertake the recruitment, facilitation and transcribing of data from focus groups and interviews to remove any potential for influence and power imbalance.

What are the costs of participating in this research?

The main contribution is that of your time which is estimated at 60 – 90 mins.

Petrol vouchers will be provided for those who travel.

What opportunity do I have to consider this invitation?

Please reply to this invitation within one month.

Will I receive feedback on the results of this research?

On completion of the research a summary of the findings will be provided by email from the Research Office.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Shelaine Zambas (64) 2102973157 shelaine.zambas@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

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

Primary Researcher Contact Details:

Cheryl Atherfold (64) 021549813 Cheryl.atherfold@waikatodhb.health.nz

As an AUT Doctoral student I am aware of my role as Deputy Chief Nurse employed by Waikato DHB and have sourced neutral people to undertake the recruitment, facilitation and transcribing of data from focus groups and interviews to remove any potential for influence and power imbalance.

Project Supervisor Contact Details:

Dr Shelaine Zambas (64) 2102973157 shelaine.zambas@aut.ac.nz

Dr Karen Webster (64) 0274452267 karen.webster@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix K – Consent Form Focus Groups and Interviews

Consent Form for Focus Groups and Interviews

Project Supervisor: *Dr Shelaine Zambas*

Researcher: *Cheryl Atherfold*

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 6 June 2020.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group, and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participants signature: .....

Participants name: .....

Participants contact details (if appropriate):.....

Date: ...../...../.....

Appendix E Ethical Approval

Approved by the Auckland University of Technology Ethics Committee on 20/11/2020 and 20/136
Note: The participant should retain a copy of this form.

Appendix L – Summary of Senior Nurse Position Descriptions

Summary of information from Position Descriptions 2021/2022

Position Title	Purpose	Care	Quality	Professional Development (PD) and Education	Equity
Specialty Clinical Nurse	Specialty care	Patient care and education for the specialty	Develops, applies policy, procedures and guidelines, undertakes audits	Self and specialty	Yes
Research Nurse	Nursing research	Clinical leadership and guide care related to the research	Clinical audit, monitors, analyses and informs care	Participates in PD activity, monitors trends & incidents, reports education and upskilling needs	Yes
Registered Nurse Graduate	Competence for graduates' first year of practice NETP-Nursing Entry to Practice, NESP-Nursing Entry to Specialty Practice (mental health)	Entry-level care	Applies policy, procedures and guidelines. Participates in unit-based quality activity.	Undertakes own education as part of the NETP / NESP programmes. NESP engages with supervision	Yes
Registered Nurse	Patient care, service provision	Patient care and education related to the care	Applies and develops policy, procedures and guidelines. Participates in unit-based quality activity.	Education of students, graduates and other nurses, Health Care Assistants	Yes
Public Health Nurse	Early intervention, advocacy, prioritise vulnerable high needs populations, and respond to outbreaks.	Preschool/ school /well child service, population health, family-focused, education, advocacy,	Applies and develops policy, procedures and guidelines. Team quality activity. Data management and tracking.	Not mentioned	Yes
Nurse Manager Clinical Education	Professional and practice development to meet service, professional and organisational requirements that achieve improved health outcomes for the population of Waikato	Leads and manages clinical education for improved patient outcomes with other Nurse Managers and Nurse Directors. Learning needs analysis for practice improvements and the workforce anticipates changes.	Ensures standards are established, reviewed and maintained. Audit evaluation of education.	Predicts workforce changes are anticipated and prepared for. Systematically enhances education delivery in the DHB. Monitor and aligns staff development to needs and priorities Aligns education to strategic imperatives	Yes
Nurse Manager	Efficient operational management of service, managing and leading	Staffing and budget.	Monitor compliance with specifications, standards, policies, procedures, and guidelines.	Ensure systems, processes, and practices support service and patient needs in conjunction with	Yes

	people, systems, processes and resources. Business planning, finance, human resources and budget. Contribute to the development of the strategic direction.	Delivery of Nursing services to contract specifications and models of care. Workforce scheduling.	Identify and manage quality and risk. Morbidity and mortality reviews. Manage patient feedback.	models of care. Ensure qualified staff are employed and developed to deliver the service.	
Nurse Practitioner	Advanced clinical practice to the Nurse Practitioner Scope. Expert clinical and professional leadership Research to influence policy and strategic planning	Advanced clinical practice, including diagnosis and prescribing Patient education Interdisciplinary team collaboration	Research Audit Lead and advise practice Contribute to national policy Practice innovation Development of policy, procedures and guidelines.	Teach, coach, mentor and role model Participate in undergraduate and postgraduate education Implementation of research and innovation	Yes
Nurse Educator	Develop and deliver education for service and across the DHB Quality standards Develop the competency and capability of the workforce Contribute to policy.	Plans and delivers care for nurses to deliver high-quality nursing and clinical care.	Contribute to the application and development of policy, procedures and guidelines. Meet quality standards. Participates in clinical audit.	Plan, deliver and educate. Analyse needs and plan for education. Contribute to graduate and postgraduate education programmes Service and organisational education.	Yes
Nurse Coordinator (generic)	Supports and coordinates programmes that have a direct impact on practice	Programmes to support patient care	Audit Evidence-Based Practice Change processes Review and monitor practice Interdisciplinary engagement	Sharing and contributing to expertise/knowledge locally, nationally and regionally, Develop the expertise of others	Yes
District Nurse	Nursing care in a community setting Contributes to education, teaching, support, and service delivery	Patient care in community settings Collaborates with interdisciplinary team	Engages with quality improvement Applies and develops policies, procedures, and guidelines.	Education, development, and training of others Own PD Students	Yes
Clinical Resource Nurse	Expert clinical care and leadership, liaison, advocacy, identified clinical skill and knowledge deficits.	Leads clinical care, advises, supports, and advocates	Clinical audit Incident investigation and outcome	Participates in staff development activity On-floor education Own PD	Yes
Clinical Nurse Specialist	Specialist care and expertise Research, evaluate, and implement standards	Direct patient care within specialty and support of others to deliver care	Leads development of pathways and policies, procedures, and guidelines in specialty. Sets standards for area of specialty. Clinical audit.	Contributes to education and PD Own PD for specialty practice Research and evaluation	Yes

Community Mental Health Nurse	As a member of the Disciplinary Team, support tangata whaiora achieve their Mental Health potential	Keyworker	Multi-Disciplinary Team. Quality activity and plans to monitor and improve the standards of nursing. Applies and develops policies, procedures, and guidelines.	Contributes to Mental Health knowledge and skills. Participates in education for student nurses, graduates and unregulated staff. Educates agencies Supports provision of supervision. Own supervision.	Yes
Charge Nurse Manager	Manage systems, processes, and resources that enable staff to meet patients' needs efficiently and effectively. Clinical leadership for Multi-Disciplinary Team Professional leadership for nursing Contributes to the strategic direction for clinical area	Direct and delegate nursing care. Nursing services meet specifications Nursing standards are met. Service planning. Patient flow. Collaborate with collegial decision-making.	Implements clinical management and decision-making. Policies, procedures, and guidelines developed and applied. Risk and audit. Reviews and monitors quality indicators.	Does not specify	Yes
Clinical Nurse Coordinator	Coordination of people, systems, and resources for a shift or a group to ensure service delivery is efficient and effective Supervision/coaching staff	Coordinate care Contribute to knowledge and expertise Respond to staffing changes Use EBP change mgmt. Emergency management for shift	Ensures Policy, Procedures and Guidelines applied and developed. Identified areas for improvement and participates in quality activity for team.	May contribute to supervision or coaching of staff. Participates in education of graduates, Enrolled Nurses, students, unregulated and support workforce.	Yes
Associate Charge Nurse Manager	Supports Charge Nurse Manager Coordination and expertise for an effective practice environment Key Performance Indicators for the operational plan of area	Clinical leadership and direct care, coordination Pt flow AWM data and response Direction and delegation	Applies and develops Policy, Procedures and Guidelines, and identifies areas for improvement Participates in unit Quality Activity	Assists with coaching and supervision of staff	Yes
Duty Nurse Manager	After-hours operational management of hospital services, including bed management, interhospital management, crisis and facility management.	Demonstrates applied clinical expertise either directly or through coaching or supervision. Capacity management Emergency response Clinical management decision-making.	Uses clinical knowledge and decision-making to ensure patient safety is upheld. Ensure teams work to the current policy, procedures and guidelines. Review and monitor quality indicators and relevant policy, procedures and guidelines.	Communicates through orientation, training, policy and documentation	Yes

Nurse Practitioner	Advanced clinical practice to the Nurse Practitioner Scope. Expert clinical and professional leadership Research to influence policy and strategic planning	Advanced clinical practice, including diagnosis and prescribing Patient education Interdisciplinary team collaboration	Research Audit Lead and advise practice Contribute to national policy Practice innovation Development of policy, procedures and guidelines.	Teach, coach, mentor and role model Participate in undergraduate and postgraduate education Implementation of research and innovation	Yes
Nurse Educator	Develop and deliver education for service and across the DHB Quality standards Develop the competency and capability of the workforce Contribute to policy.	Plans and delivers care for nurses to deliver high-quality nursing and clinical care.	Contribute to the application and development of policy, procedures and guidelines. Meet quality standards. Participates in clinical audit.	Plan, deliver and educate. Analyse needs and plan for education. Contribute to graduate and postgraduate education programmes Service and organisational education.	Yes
Nurse Coordinator (generic)	Supports and coordinates programmes that have a direct impact on practice	Programmes to support patient care	Audit Evidence-Based Practice Change processes Review and monitor practice Interdisciplinary engagement	Sharing and contributing to expertise/knowledge locally, nationally and regionally, Develop the expertise of others	Yes
District Nurse	Nursing care in a community setting Contributes to education, teaching, support, and service delivery	Patient care in community settings Collaborates with interdisciplinary team	Engages with quality improvement Applies and develops policies, procedures, and guidelines.	Education, development, and training of others Own PD Students	Yes
Clinical Resource Nurse	Expert clinical care and leadership, liaison, advocacy, identified clinical skill and knowledge deficits.	Leads clinical care, advises, supports, and advocates	Clinical audit Incident investigation and outcome	Participates in staff development activity On-floor education Own PD	Yes
Clinical Nurse Specialist	Specialist care and expertise Research, evaluate, and implement standards	Direct patient care within specialty and support of others to deliver care	Leads development of pathways and policies, procedures, and guidelines in specialty. Sets standards for area of specialty. Clinical audit.	Contributes to education and PD Own PD for specialty practice Research and evaluation	Yes
Community Mental Health Nurse	As a member of the Disciplinary Team, support tangata whaiora achieve their Mental Health potential	Keyworker	Multi-Disciplinary Team. Quality activity and plans to monitor and improve the standards of nursing.	Contributes to Mental Health knowledge and skills. Participates in education for student nurses, graduates and unregulated staff.	Yes

			Applies and develops policies, procedures, and guidelines.	Educates agencies Supports provision of supervision. Own supervision.	
Charge Nurse Manager	Manage systems, processes, and resources that enable staff to meet patients' needs efficiently and effectively. Clinical leadership for Multi-Disciplinary Team Professional leadership for nursing Contributes to the strategic direction for clinical area	Direct and delegate nursing care. Nursing services meet specifications Nursing standards are met. Service planning. Patient flow. Collaborate with collegial decision-making.	Implements clinical management and decision-making. Policies, procedures, and guidelines developed and applied. Risk and audit. Reviews and monitors quality indicators.	Does not specify	Yes
Clinical Nurse Coordinator	Coordination of people, systems, and resources for a shift or a group to ensure service delivery is efficient and effective Supervision/coaching staff	Coordinate care Contribute to knowledge and expertise Respond to staffing changes Use EBP change mgmt. Emergency management for shift	Ensures Policy, Procedures and Guidelines applied and developed. Identified areas for improvement and participates in quality activity for team.	May contribute to supervision or coaching of staff. Participates in education of graduates, Enrolled Nurses, students, unregulated and support workforce.	Yes
AssociateCharge Nurse Manager	Supports Charge Nurse Manager Coordination and expertise for an effective practice environment Key Performance Indicators for the operational plan of area	Clinical leadership and direct care, coordination Pt flow AWM data and response Direction and delegation	Applies and develops Policy, Procedures and Guidelines, and identifies areas for improvement Participates in unit Quality Activity	Assists with coaching and supervision of staff	Yes
Duty Nurse Manager	After-hours operational management of hospital services, including bed management, interhospital management, crisis and facility management.	Demonstrates applied clinical expertise either directly or through coaching or supervision. Capacity management Emergency response Clinical management decision-making.	Uses clinical knowledge and decision-making to ensure patient safety is upheld. Ensure teams work to the current policy, procedures and guidelines. Review and monitor quality indicators and relevant policy, procedures and guidelines.	Communicates through orientation, training, policy and documentation	Yes