Received: 1 November 2022 | Revised: 26 January 2023 | Accepted: 10 February 2023

DOI: 10.1111/jan.15609

EMPIRICAL RESEARCH - QUALITATIVE

JAN Loading Global Nursing Research WILEY

A tohu (sign) to open our eyes to the realities of Indigenous Māori registered nurses: A qualitative study

Ebony Komene[1] | Debra Gerrard[2] | Bobbie Pene[3] | Jenny Parr[2] | Cath Aspinall[3] | Denise Wilson[4]

[1]University of Auckland, Auckland, New Zealand

[2]Te Whatu Ora—Health New Zealand Counties Manukau, Auckland, New Zealand

[3]Te Whatu Ora—Health New Zealand Counties Manukau, University of Auckland, Auckland, New Zealand

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

Correspondence
Denise Wilson, Auckland University of Technology, Auckland, New Zealand.
Email: denise.wilson@aut.ac.nz

Funding information
Health Research Council of New Zealand

Abstract

Aims: Identify the experiences of Māori nurses and priorities for a Māori model of relational care working with Māori patients and their whānau (extended family network) in acute hospital services.

Background: Māori, the Indigenous peoples of Aotearoa (New Zealand), have a relational and holistic worldview fundamental to establishing relationships with Māori patients and their whānau. Increasing the Indigenous Māori nursing workforce can improve Māori patient experiences but is challenged by ongoing recruitment and retention issues.

Design: A qualitative Māori-centred research methodology with 12 Māori nurses.

Methods: Data were collected using wānanga (learning through discussion, deliberation and consideration) using he aha ō hikoi (journey mapping) and kōrero mai (storytelling). Inductive thematic analysis was undertaken using a mahi a roopū (group process) approach. This study was conducted between May 2022 and June 2022.

Results: Three key themes: (1) Māori first, nurse second, (2) Cultural loading and (3) Compromised realities were identified. Māori nurses' praxis used their complex cultural and clinical intelligence to engage in a mana-enhancing way (strengths-based) to improve the care delivery for whānau Māori during their hospitalization journey. Cultural loading meant Māori nurses were often burdened with unrecognized workloads as they provided care for Māori patients and whānau, which often compromised their cultural integrity.

Conclusion: Nurses' commitment to care for whānau and their assigned patient load created extra burdens and threatened their cultural integrity. Their experiences highlighted modes of practice rather than models of care required to improve healthcare delivery for Māori entering the hospital. These findings signal issues and areas nursing leaders need to heed, necessary for addressing the retention of Māori in nursing and improving workload equity.

Patient or Public Contribution: Māori nurses and service users were involved in the interpretation of the data.

KEYWORDS
cultural intelligence, hauora, indigenous, inequity, māori health, modes of care, nursing, wānanga, well-being, workforce

1 | INTRODUCTION

Internationally, colonization has failed to deliver equitable health outcomes for Indigenous peoples (Cram et al., 2019). Achieving health equity requires Indigenous worldviews to be instrumental in the development and implementation of new models of healthcare delivery (Brockie et al., 2022). The historical origins of Indigenous nursing demonstrate the complex relationships between colonization and Indigenous nursing experiences and care priorities that differentiate them from traditional nursing (Fournier et al., 2021). Literature reiterates Indigenous nursing praxis contributes to culturally safe care that resists colonial notions of racism and discrimination (Hunter & Cook, 2020a; Wilson et al., 2022). The pre-existing Indigenous and non-Indigenous theoretical models of care and the state of Indigenous health signal an imperative to rethink our care delivery.

Māori (the Indigenous peoples of Aotearoa) nurses often refer to additional workloads in healthcare systems as consistently ill-equipped to deliver culturally safe care, evident in ongoing health inequities (Cram et al., 2019). Pene et al. (2021) found that Māori patients express the least satisfaction with experiences of fundamental care delivery in an acute inpatient setting, experiences not dissimilar to others reporting Indigenous patient experiences of health services (Wepa & Wilson, 2019; Wilson & Barton, 2012). There is a need to understand the experiences and insights of Māori patients and nurses. Māori nurses work comprehensively to address racism and bias in the healthcare system. Their cultural and clinical intelligence, traditionally excluded from Western models of care, add value to the care of Indigenous Māori patients (Wilson et al., 2022). Expansion of the Māori nursing workforce is critical for transforming the health systems, so it is equitable and effective (Brockie et al., 2022; Pene et al., 2021). In this article, we report research about Māori nurses' perceptions of Māori patients and whānau experiences to inform a Māori model of relational care. This study was part of a larger project that explored the experiences of Māori patients and their whānau entering acute hospital services and their priorities for a Māori-centred model of care.

1.1 | Background

Inequities in health outcomes are considered unjust and unfair and are a direct consequence of colonization and the ongoing consequences of historical and intergenerational trauma (Health Quality & Safety Commission [HQSC], 2019). Significant health inequities in Indigenous populations because of colonization are not peculiar to New Zealand—similar health inequities exist for Indigenous peoples in Australia, Canada and the United States of America (Clark et al., 2021).

It is nationally agreed that achievement of equity in health outcomes for Māori is not only an organizational and health system responsibility but also a moral obligation (Waitangi Tribunal, 2019). The New Zealand government identified Māori as a priority population group, alongside other minority groups such as Pacific and disabled peoples, also needing improvement in equity of health outcomes. Māori life expectancy is almost 7.5 years less than non-Māori, non-Pacific peoples living in Aotearoa, New Zealand (Statistics New Zealand, 2019). Māori are also more probable than non-Māori, non-Pacific peoples to experience long-term health conditions such as diabetes (Mullane et al., 2022) and preventable hospitalizations and mortality (HQSC, 2019). Furthermore, Māori, compared with other population groups, encounter differential access to determinants of health, quality of care and timely healthcare services (Cormack et al., 2018).

Before the colonization of Aotearoa, Māori were observed to be fit and healthy related to their well-developed processes for health, well-being and health promotion (Warbrick et al., 2016). Current discourse and hegemony blame Indigenous peoples for the inequities in health and health outcomes (Warbrick et al., 2016). There are many signals, highlighted in the Waitangi Tribunal Inquiry into health services and outcomes (known as the WAI2575 report) that illustrates the New Zealand health system does not meet the needs of Māori (Waitangi Tribunal, 2019). The Waitangi Tribunal (2019) noted the underrepresentation of Māori in the health workforce and recommended exploring the establishment of an independent Māori Health Authority (Te Aka Whai Ora, 2022). A new health system structure includes the establishment of Te Aka Whai Ora—Māori Health Authority to lead change in how the health system responds better to Māori health needs. This research explores how mainstream services can better meet the needs of Māori given the underrepresentation of Māori in the health workforce.

The World Health Organization's State of the World's Nursing report emphasized the importance of investment in the nursing workforce to address a shortfall of 5.9 million nurses internationally and increase the domestic production of nurses in countries with large numbers of internationally educated nurses (Chalmers, 2020). However, an obvious omission in the WHO's (World Health Organization) State of the World's Nursing commentary is the importance of the international Indigenous nursing workforce and its impact on Indigenous health (Chalmers, 2020).

A culturally matched health workforce makes a difference in health outcomes for people with inequities in their access to services and receiving quality health care. Māori have indicated their preference for having Māori nurses care for them (Wepa & Wilson, 2019; Wilson & Barton, 2012). However, Māori nurses comprise 7.5% of the registered nursing workforce (Nursing Council of NZ, 2019), while Māori comprise 16.5% of the population. There has been no appreciable shift in the proportion of

Māori nurses over the last four decades, languishing between 6% and 7.5% (Wilson et al., 2022). The nursing population in Aotearoa, New Zealand is predominantly New Zealand European/Pākehā (58.6%), while internationally qualified registered nurses comprise 27% (Nursing Council of New Zealand, 2019). More than 40 years of intentional efforts to increase Māori registered nurses reflect a failure to do so (Wilson et al., 2022).

Internationally, Indigenous nursing leadership is considered critical in improving inequities in Indigenous peoples' health outcomes and healthcare experiences. Indigenous nurses recommended the need for national and international targets for Indigenous nursing workforces so they better reflect their populations (Brockie et al., 2022). Brockie et al. claim Indigenous ways of knowing about well-being are critical for healing. Yet, internationally, Indigenous nurses and their leadership continue to be undervalued by their respective nursing leadership.

Health is a socio-cultural construction shaping how people understand health, well-being and illness (Nursing Council of NZ, 2019). This means that people's worldviews relating to health are uniquely shaped. Therefore, understanding the cultural imperatives of each group of patients that nurses encounter is not second nature. Thus, it is even more critical that nurses ensure services are safe and accessible to meet the health needs of Indigenous peoples. Wilson et al. (2018) maintained:

> ... as nurses work with many different individuals and groups, we have to find ways of ensuring a more embracing, culturally responsive healthcare environment which respects and values the beliefs of others (p. 3810).

2 | THIS STUDY

2.1 | Aim/s

This research aimed to identify Māori nurses' experiences providing care to Māori patients and their whānau while in acute services. This study also aimed to explore Māori nurse's priorities for a Māori-centred model of relational care for future implementation and evaluation in a publicly funded hospital in-patient setting. The research questions exploring Māori nurse's experiences of Māori patients and whānau were:

- What are the experiences of Māori nurses caring for Māori patients and whānau in acute services in a hospital?
- What is most important when caring for Māori patients and whānau?
- What do Māori nurses think better care for Māori patients and whānau in a hospital would look like?

Analysing Māori nurses' data ensured the inclusion of their voices and insights on Māori care development.

2.2 | Design

We used a qualitative design and a Māori-centred research methodology. Māori values and principles informed engagement with participants, data collection and analysis and the findings' interpretation and dissemination (Smith, 2012). Māori-centred research aims to keep Māori, as tangata whenua (people of the land), central throughout this study, ensuring the research process and findings are beneficial for Māori. By centring on Māori, we aimed to inform the improvement of outcomes for Māori from a Māori healthcare perspective. While the project is not Māori-led, as expected, extensive collaboration with Māori members was undertaken. The Māori-centred research methodology drew on mātauranga (Māori knowledge systems), Māori cultural values and concepts, decolonization theory and intersectionality (Smith, 2012; Wilson et al., 2021).

The study site is a publicly funded hospital providing mainstream health services and is the only option for most of the population it serves for acute secondary and tertiary services. Using the hospital's improvement and innovation centre, the research team promoted Māori mana motuhake (autonomy, self-determination) and tino rangatiratanga (absolute sovereignty) during the research process. The research team was guided by the CONSIDER statement for research with Indigenous peoples, and also worked with the mana whenua roopuu (Māori who tribally belonged to the area the hospital is located), the hospital Māori cultural support team and Māori nurses.

Thus, tikanga (cultural processes and protocols) guided the research process, especially the wānanga. Kaupapa Māori (by Māori, for Māori, with Māori) ethical values guided the conduct of the research: whanaungatanga (connectedness, relationship-building necessary for engagement in the research); manaakitanga (compassionately caring, ensuring the process is culturally safe); aroha (generosity of spirit, always acting with compassion and empathy); māhaki (humility); mana (status and authority); titiro, whakarongo and kōrero (look, listen and then speak); and kia tūpato (being cautious) (Pipi et al., 2004, Smith, 2012). These processes complemented research ethics related to informed consent, confidentiality, data storage and destruction and ensuring the safety of all participants throughout the research process.

2.3 | Sample/participants

Registered nurses who identified as Māori and who worked in a high-needs urban hospital and delivered care to Māori patients in acute services were included. Purposive sampling informed the recruitment of nurses from a range of acute services, aided by a small group of Māori nurses. Those who did not identify as a Māori nurse or working in an acute setting were excluded. Using whanaungatanga (connectedness), participants were invited to participate via email, phone and face to face by Māori members of the research team. The sample consisted of 12 Māori registered nurses with various nursing experiences working in different clinical disciplines, including cardiology, renal, medical, surgical and mental health. Sample

demographics were purposely not recorded or included to maintain participants' confidentiality because of the high risk of identification. A small sample was culturally appropriate and pragmatic to identify patterns in the data (Moyle, 2014).

2.4 | Data collection

Data collection was by four Māori members of the research team (including an experienced Māori researcher to aid Indigenous research capacity building) which commenced in May 2022 and concluded in June 2022. Wānanga as a Māori relational method involved the sharing and producing of mātauranga (knowledge) in a culturally safe place, space and way. Whakawhiti kōrero (exchanging discussion) enabled participants to share and reflect on whakaaro (thoughts) about their experiences and aspirations for change and contributed to the co-construction of 'new' knowledge to improve Māori and whānau experiences when engaging healthcare services (Wilson et al., 2021). Tikanga was adhered to by including a cultural support team during both wānanga using mihimihi processes (mihi [introductions], waiata [songs], karakia [prayer], whakawhanaungatanga [relationship building], kai [food] and koha [gift exchange]). Participants attended an initial 3.5 h wānanga with registered nurses and then a second wānanga with patients and whānau. In the first wānanga, Māori registered nurses were invited to share their experiences and insights in providing care to Māori patients and their journey. The second wānanga patients, whānau and nurses discussed and checked themes derived from the first wānanga and explored their priorities for a Māori-centred model of relational care.

Wānanga used two methods to collect data. First, ***He aha ō hikoi (journey mapping).*** Nurses shared their perceptions of Māori patients and their whānau experiences (good and not so good), their care and priorities for improvement for each stage of their journeys—admission, inpatient experience and discharge—and noted these on colour-coded notes. Journey maps were photographed and electronically transcribed. Then, ***kōrero mai (storytelling)*** followed he aha ō hikoi. Kōrero mai allowed participants to share their experiences and open-ended questions enabled exploration as conversations proceeded to gain a better understanding. Discussions lasted 1.5 h and were recorded and transcribed verbatim, along with notes captured during the wānanga. Kōrero mai at the second wānanga lasted 3 h and was recorded and transcribed.

2.5 | Data analysis

A collective Indigenous approach, mahi a roopū, was used to guide the process of identifying themes in the data (Wilson et al., 2021). Mahi a roopū involved four Māori research team members meeting to analyse data collectively. This process enabled the researchers to engage in critical discussions to decide what codes, categories and properties were grounded in the data. Because participant numbers were small, we have de-identified the data and participants using the name of whetu (stars)—these are: Waita, Waitī, Hiwa-i-te-rangi, Tupuānuku, Pōhutakawa, Waipuna-a-rangi, Ururangi, Tupuārangi and Matariki. This process of negotiated data analysis required the researchers' commitment to reach a consensus and respect other members' contributions. Aided by humility, this approach enables a vigorous debate as part of the analytic process leading to consensus decision-making. Mahi a roopū strengthened the analytic process by enabling critical Indigenous interrogation and decolonization (Smith, 2012), and identifying the strengths of Māori nurses. The results were presented to participants prior to finalization, and to the mana whenua roopuu at the completion of this study.

2.6 | Ethical considerations

Ethics committee approval was obtained in August 2021 from the local district health board and the Auckland Health Research Ethics Committee (AHREC). There was a potential for participant distress when sharing experiences. Therefore, we ensured the research was conducted using tikanga and had cultural supports available. We obtained written and verbal informed consent from participants. The main ethical concern was confidentiality due to the small ethnic-specific sample, which risked participants' identification. Thus, we stored data, transcripts and recordings in a secure cloud server, de-identified data and blinding quotes.

2.7 | Methodological rigour

Mahi a roopū aided in establishing the findings' authenticity, reliability and rigour (Wilson et al., 2021). The methodological approach strengthened this study's trustworthiness, mainly the undertaking of the second wānanga when preliminary findings were presented to participants and mana whenua. We ensured Māori remained at the core of the research using a culturally appropriate processes for data collection, analysis and dissemination at the second wānanga (Haitana et al., 2020).

3 | FINDINGS

All 12 participants identified as Māori through their whakapapa (ancestral connections) and were registered nurses with varying levels of experience and areas of clinical practice. Four Māori nurses also participated in a second feedback wānanga. Māori nurses' experiences and priorities associated with improving Indigenous care for Māori in the hospital manifested in three themes: Māori first, Nurse second, Cultural loading and Compromised realities. Indigenous nursing care and practices were grounded in Māori cultural, emotional and relational intelligence to uphold the mana motuhake (autonomy, independence) of the patients and their whānau because they were Māori first and a nurse second. Cultural loading for Māori nurses caring for Māori patients and whānau undermined having

an equitable workload and well-being. Finally, Māori nurses routinely experienced being culturally compromised in their work in a Western biomedically oriented hospital service—they frequently witnessed discriminatory healthcare practices that negatively impacted healthcare outcomes for Māori patients and their whānau.

3.1 | Māori first, nurse second

Registered nurses portrayed themselves as being Māori first and nurses second. Grounded in Indigenous Māori values, theories and knowledge, they integrated these with clinical competencies and skills into their everyday nursing practice. Their sense of responsibility to Māori first was voiced by Waitī:

> 'When you see someone that has brown skin as well, you're like I got you, you're with me'.

Māori nurses' relationships with Māori patients and whānau through whakapapa meant whakawhanaungatanga, manaakitanga, tino rangatiratanga and mana enhancement (all part of Indigenous Māori knowledge) were foundational to their ethic and philosophy of care. As Hiwa-i-te-rangi explicitly voiced:

> 'Whakawhanaungatanga. We acknowledge everybody regardless of their culture. Regardless I can't speak te reo [Māori language], so we get interpreters into manaakitanga, so we get it right for our people…For our people, it's all about tikanga, it's all about kawa, it's all about whānau, it's all about aroha, regardless of the raruraru [disapproval] that gets chucked at us'.

A commitment to Indigenous knowledge meant Māori patients, whānau and nurses engaged in a collective process that enhanced decisions and contributions to their health. In practice, collaboration showed the enactment of Indigenous philosophy, whereby Māori nurses fostered the sharing of knowledge and expertize. The hybrid of Indigenous and clinical intelligence was reflected in the connections with whānau and the use of clinical resources that prioritized mana-enhancing patient care. The importance of cultural values, theories and knowledge underpins the first and subsequent interactions when Māori patients and whānau begin their hospitalization journey is articulated by Tupuānuku:

> 'I find with Māori whānau you only get one shot; you muck that up [don't do it right], you don't get a second one [chance]. They'll [patients and whānau] label you like everyone else, "'the system"'.

Excluding Indigenous knowledge compromised Māori patient's and whānau mana and was collectively detrimental. Matariki described how they:

> 'Felt mamae [pain] for Māori patients coming into the hospital when they experienced poor care… I felt incompetent [because current care for Māori patients was a] takahi [disregard, abuse or trample] on a person's mana'.

Māori nurses reported that poor health outcomes are probably for patients when care was uninformed by Indigenous knowledge. Indigenous caring required advocacy to support patient tino rangatiratanga. Advocating acknowledged and directly addressed the inequitable and foreign context that Māori patients navigated in and outside the hospital. As Pōhutukawa said:

> '[I] felt guilty even though I wasn't the admitting nurse that I could have prevented escalation [of a situation] with manaaki and whakawhanaungatanga'.

Therefore, including Māori Indigenous knowledge, values and theories was a key priority in improving Māori patient experiences in acute services. The nurses offered suggestions such as regulating patient ratios to enable time for whakawhanaungatanga because this directly benefitted relational engagement.

The combination of Indigenous and clinical knowledge in a biomedical model meant Māori nurses adapted healthcare interventions and treatments such as procedures, treatments, referrals and education, to enhance the hauora (holistic well-being) of Māori patients and whānau. For example, Waipuna-ā-rangi explained how incorporating clinical knowledge with a commitment to Māori first enabled them to overcome analgesia inequity:

> 'We know our Māori are under-prescribed analgesia disproportionately… [But when the] patient experiences relief from pain/suffering, whānau trust us with their rangatira'.

Another example by Waitī about a patient who was diagnosed as palliative from her early intervention, 'when you look at a patient, you just know', further described not only the clinical intelligence of assessing a patient's appearance but also using cultural intelligence to read a patient's wairua (spirit) when unwell.

The hybridity of Indigenous and clinical intelligence enhanced the delivery of equitable care for Māori-by-Māori nurses positioning them to prioritize and improve the care of Māori in the hospital. Nurses drew on mātauranga Māori including whakawhanaungatanga, manaakitanga, tino rangatiratanga and mana-enhancing interventions all of which aimed to uplift the mana motuhake of Māori.

3.2 | Cultural loading

All the nurses in this study described cultural loading. Cultural loading burdened Māori nurses with additional and unpaid work, often going unrecognized. Māori nurses were expected to fill Indigenous

knowledge gaps and educate their non-Māori colleagues, undertake care of Māori patients and whānau in addition to their daily work and act as unofficial spokespersons for Māori patients and whānau. The pressure to prioritize and improve Māori health was not an imperative shared by non-Māori colleagues, as Waitī indicated:

> 'We're a safety net for our people, it's a shame'.

There was a paradox present when providing dual Indigenous knowledge and clinical care in work environments. As explained by Waitā, this way of working was fulfilling but was also exploitative, with Māori nurses bearing the burden of patient care, which was exhausting:

> 'The reality is if you're Māori and you're looking after other Māori, we do extra hours; we cut our breaks, we do all those things, our eight-hour shift turns into a 10-h shift. And, that still creates for me a great sense of doing, I feel good about this. But in the end, it will wear us down… I always used to say, one Māori person or patient is worth three normal people, I would always laugh, but I think we need to start thinking that there has to be sense in that'.

The load borne by Māori nurses, especially where they were the only Māori or one of a small group, meant they were expected to become token representatives of the Indigenous peoples. The effort to include Māori nurses, although it appeared fair and equitable for Māori health, created internal conflict between their Indigenous and nursing responsibilities. The extra responsibilities without recognition and remuneration, as Ururangi described, compromised their Indigenous mana, their role and Māori identity:

> 'What makes it hard for me as a Māori nurse is that increased pressure. As a problem solver, because of my whakapapa. Even though I didn't share any whakapapa with this patient, I had a lot of pressure to make him happy and deescalate [the situation]. And it burnt me out quite a bit. And when I couldn't deescalate, I felt, am I even Māori? If I can't help this Māori man? if you can't trust me'.

Non-Māori nursing colleagues making assumptions about 'difficult Māori patients' were seen to cause harm and attitudes of aroha and care required a conscientious effort. There is a need for healthcare teams to explore underlying causes and cultural realities of Māori because surface-level engagement did not improve care.

Māori nurses recognized cultural safety imperatives were a national standard set by the Nursing Council of New Zealand for all nurses and the priority to improve Māori health. The resistance by non-Māori colleagues when they encountered 'the aggressive, angry or difficult Māori patient' was not a reason to absolve their nursing, cultural and team responsibilities. Tupuārangi reinforced this:

> 'He [Māori patient] demanded to speak to somebody only in Māori and I only got involved to de-escalate because he was very angry. The nurses told him that I spoke fluent Māori, I don't speak fluent Māori, just laughed when he laughed'.

Universal Indigenous philosophies described earlier, need to be integrated into non-Māori practices of equitable care as they can aid in improving Māori health. The resistance by non-Māori to whakawhanaungatanga, providing culturally appropriate care and the expectation for Māori nurses to intervene is harmful and unsustainable. For example, Pōhutakawa said of non-Māori nurses 'assuming that they [Māori] probably need a care partner when they've been aggressive' when all the patient needed was a laugh, connection or 'cup of tea tikanga'.

Continuous cultural loading of Māori nurses perpetuated distrust in their non-Māori colleagues' ability to provide care for Māori. When non-Māori engaged with and prioritized whakawhanaungatanga, positive opportunities for patient connection and improved healthcare were established. An opportunity described by Hiwa-i-te-rangi highlighted how their non-Māori colleague alleviated the cultural load:

> 'Making sure my colleagues knew, but also how we change our handover as well. Usually, we do bedside handovers, but we don't directly involve the patient just because it's time-consuming, and they're often asleep during our handovers in the afternoon. But I would walk in and be like, "Kia Ora; this is your nurse for the afternoon" Just as we would normally do with our whānau, and that helped a lot with that positive transition from a Māori nurse to a non-Māori nurse'.

Collective empowerment and trust, especially when another Māori nurse is available for support, directly improved care for Māori. When non-Māori had an awareness of their responsibility to respond to the cultural load, this directly improved the collective well-being and care for Māori patients and whānau. To sustainably counter the cultural load, educating non-Māori to provide Indigenous care in partnership with Māori nurses is crucial. As Matariki neatly explained:

> 'Educating my fellow colleagues, talking it out seeing, seeing what the patients need, seeing what the whānau need, both good and not so good experiences, the whole gamut of things. Just all are working together as a multidisciplinary team. We need each other honestly otherwise I would never have survived… this is not just a Māori thing [responsibility]'.

Māori nurses need to be the safety net for Māori entering the hospital. But this comes at a cost with increased pressure to solve problems and work prolonged and unrecognized hours. Colleagues and teams' resistance to providing culturally appropriate care increased cultural loading for Māori nurses. These situations underserved Māori

seeking healthcare and illustrated the need to address cultural loading, sharing the care for Māori navigating a complex health system.

3.3 | Compromised realities

The healthcare system and structures they worked in compromised the hybridity of Māori nurses' expertize that combined their respective Indigenous knowledge, priority for equity and application of clinical theory to patient care. Their practice reality and opportunities to care diminished both their mana and that of their patients and whānau. Tupuārangi felt jeopardized:

> 'How do you care? In that situation? How do you enhance the mana in that situation? How do you get someone to trust you? When you work for a system that doesn't do good for Māori?'

Hegemonic systems and Western models of practice in the hospital disregarded and under-prioritized Māori patients' needs throughout their hospitalization journey. Systems that aimed to prioritize Māori health, such as early warning systems, frequent flyers and 'red-flagging', were seen to compromise care further. For example, Waipunarangi spoke about inequitable data reporting that misinformed care for Māori:

> 'When you pull up the Emergency Department board list and you see these frequent, frequent fliers, all these red flags and then you start wondering. Why did they just red flag them or sign them off like that instead of being like, well, what's the cause? What keeps them from coming back?

Māori nurses experienced frustration about health systems that not only failed but also worsened the health of Māori patients and whānau. The reality between caring in an Indigenous way and navigating non-Indigenous hospital models of care was a conflicting space that meant they disengaged with their cultural identity to continue in their nursing role, as Waita:

> 'When I feel like I just need to get things done. I always say, oh, I use my island side. So that I don't have to whakawhanaungatanga. So, it's almost like a pick your battles, kind of? … it depends on the day, I guess'.

Countering the tensions of their compromised realities was difficult for Māori nurses, something not shared by their colleagues, hospital systems and structures in place. Hiwa-i-te-rangi, for example, mentioned visiting policies during COVID-19 and the need to confront policies that compromised the delivery of Indigenous care:

> 'We get smashed out of the mainstream [hospital services] because we're making this decision, and we know they're the right ones. But it's often perceived as stepping over somebody, targeting the senior nurse's mana, or not doing what everyone else does, but we're brave. That's why we came into this. We're courageous, compassionate; we're brave'.

It was important for the hospital system to act equitably by recognizing the time spent and space for Indigenous modes of care that are resourced by Māori. Matariki further elaborated on the need to 'fix' hospital systems and where this responsibility was situated by stating:

> 'They [Māori] need a different conversation. They need Māori help. They need someone who can sit there and just talk through some of the pains and issues of our job when we're working frontline to be able to facilitate that. That's the stronger action for us. Otherwise, we're forever trying to fix things, and then we're completely exhausted, and you come away in my mind more hurt because you just hadn't been able to do everything for that whānau'.

Trust continues to be a crucial component that healthcare systems and structures fail to prioritize for Māori. The nurses in this study believed when health systems seize the opportunity to truly care for Māori, then equitable Indigenous care can be provided.

4 | DISCUSSION

The findings not only signal the importance of culturally matched workforces but also highlight the pressures Māori registered nurses experience because of their perceived value in working with Māori patients and whānau. This study aimed to understand the experiences of Māori nurses caring for Māori patients and whanau in an acute inpatient setting. It also aimed to understand Māori nurses' priorities for a Māori model of relational care. While the nurses' individual experiences were diverse, their collective voices spoke to unfair patterns of work and discriminatory healthcare environments that enable culturally unsafe care for Māori patients and whānau.

4.1 | Modes of practice

Driven by their need to care for Māori, knowing their realities and recognizing Māori patient and whānau needs make them leaders in an optimal mode of practice for engaging with Māori patients and whānau. The findings confirm its not another model of care that is needed, instead we need to develop modes to facilitate respectful and effective engagement with and responses to patients and whānau, cognizant of their realities. Modes of practice involve mana-enhancing engagement processes between healthcare providers, patients and their whānau that recognizes their social and physical contexts and realities to meet their health needs. As identified

by Māori nurses, modes of practice are informed by dual cultural and clinical knowledge and skills and enacting cultural imperatives such as whakawhanaungatanga (making connections), manaakitanga (hospitality, caring and generosity) and aroha (empathy and compassion). However, with these unique Indigenous nursing practices in Western biomedical organizations, Māori nurses experienced cultural loading and compromised realities. These undermined their cultural and clinical competence.

Māori prefer to be looked after by Māori because they know Māori nurses understand their fears and needs, something also found by others (Barton & Wilson, 2008; Wepa & Wilson, 2019). However, there are insufficient numbers of Māori nurses to meet the demands. Many existing Māori models of care do not appear to work in practice because the systems, structures and people using them impose their Western lens and understanding, creating tensions and conflicts that do not work for Māori and their whānau (Wilson et al., 2022). Instead, the application of Indigenous models of health or care should be done in partnership with Indigenous peoples. Therefore, we need to hear the voices of Māori, their whānau and Māori nurses in designing and planning systems of care that aim to improve health equity in outcomes to ensure they are inclusive of vital cultural concepts and are applied appropriately.

We argue that these Māori values and practices are not dissimilar to the concepts of caring and communication in nursing, although are embedded in a collective, holistic worldview. The difference is Māori nurses' collective (rather than individual) orientation and inherent sense of responsibility to manaaki others, like Māori patients and their whānau. Thus, a mode of practice has its foundation in engagement—that is, whakawhanaungatanga (engagement and making connections), manaakitanga (hospitality, generosity and caring) and aroha (having empathy and compassion)—to establish relationships and trust. This is a similar finding to other research with Indigenous nurses (Brockie et al., 2022). If we lose the contextual meaning and definitions that sit under te ao Māori concepts, like whānau, this can minimize a concept's cultural integrity, layers of complexity and misinforms modes of care. Therefore, having a specific model of care that is not well understood and applied can restrict and undermine Indigenous healthcare because necessary cultural and contextual information can be lost in translation and reduced to something superficial.

4.2 | Being indigenous Māori

The findings reinforce the value of Māori registered nurses in the nursing workforce. They bring with them an understanding of te ao Māori and cultural values and practices. This enables them to effectively engage with and respond to Māori and their whānau to meet their needs. Māori nurses in this study saw themselves as fundamentally Māori first, and therefore, intrinsically prioritized Māori cultural knowledge and practices. Their cultural obligations inherent in whanaungatanga and manaakitanga, for instance, and knowledge of the inequities in access and quality of care motivated their need to support Māori patients and their whānau.

Haitana et al. (2020) maintained that improving service delivery required privileging the voices of Māori. Māori nurses used their experience of knowing what it means to be Māori, how to connect and understanding the importance of prioritizing their care of Māori patients and whānau. Furthermore, Māori nurses are acutely aware of the everyday realities and circumstances of whānau Māori and the precarious health experiences they may be living with.

Māori nurses' ethnic and cultural identification as Māori first, nurse second reflects who they are and come from a place of collective responsibility and accountability, rather than focusing on individuals (Barton & Wilson, 2008; Hunter & Cook, 2020b; Wilson & Baker, 2012). Thus, Māori concepts like whakawhanaungatanga, tino rangatiratanga, mana motuhake and manaakitanga are not simplistic transliterations that informs their practice. Mika and Stewart (2017) also highlighted this as Māori nurses' modes of practice being informed by the complex layers in Māori concepts and the contexts of Māori patients and whānau. Like the nurses in this research, Wilson and Baker's (2012) research succinctly clarified the position of being Māori first, nurse second:

> I'm a Māori who happens to be a nurse—not a nurse who happens to be Māori. And for me, that's what it is all about, the way that I was brought up, the way that I see the world. I'm a Māori who happens to be a nurse (cited in Wilson & Baker, 2012, p. 1077).

Māori nurses are often socialized into a cultural way of being that motivates their cultural imperative to care for and look after others. Knowing the realities of marked inequities for Māori in their experiences and health outcomes when engaging with the health system (Barton & Wilson, 2008; Wepa & Wilson, 2019) and being subjected to discriminatory practices and racism are added drivers for Māori nurses to ensure whānau are looked after well. Retention of Indigenous nurses, like Māori, is critical because of their advocacy for those experiencing marked health inequities and what (Hunter & Cook, 2020a, 2020b) described as their 'cultural fit'.

4.3 | Cultural loading

Cultural loading was evident in the additional workload Māori nurses have in addition to their own patient allocation because of their perceived cultural knowledge and skills they may have. The Māori nurses in this study call into question the cultural competency of non-Māori nurses' and their avoidance of respectful and effective interactions with Māori. This is despite legislated requirements (s.118(i) Health Practitioners Competency Assurance Amendment Act 2019) making it clear health practitioners in Aotearoa are required to be culturally competent, including being respectful and effective in their interactions with Māori. Nonetheless, it becomes an expectation that Māori nurses will 'sort out' and go beyond their workload for colleagues because of the additional cultural value their non-Māori counterparts do not possess (Wilson & Baker, 2012). This was especially evident

when situations escalated because of their poor or unacceptable treatment. (Hunter & Cook, 2020a, 2020b) highlighted the need for non-Indigenous nurses to reflect critically on inequities and Māori disengagement from health services—we would advocate this also extends to the inequities Māori experience in acute care settings.

Like other studies, it was not unusual for Māori nurses working in acute healthcare services to feel routinely compromised, witness colleagues' discriminatory practices and experience cultural dissonance as they simultaneously stand in two worlds—the world of healthcare and their Māori worlds (Barton, 2018; Hunter & Cook, 2020a, 2020b; Wilson & Baker, 2012; Haitana et al., 2020). Bearing the burden of requests to work with Māori and their whānau, witnessing suboptimal or discriminatory care, and fulfilling intrinsic cultural obligations to care for others, especially Māori whānau, takes its toll on Māori nurses, something Hunter and Cook (2020b) also found. Barton (2018) called nurses' attention to their ethical responsibility to do no harm and for nursing practice to be culturally safe.

Tokenistic use of Māori nurses to bridge the gaps in nursing care, especially when situations have escalated with Māori and their whānau, perpetuates Māori nurses' sense of cultural loading.

The additional work associated with their cultural loading burdens Māori nurses and frequently compromises their cultural integrity, all the while going unrecognized and unregulated. Wilson and Baker (2012) explained the realities of Māori nurses bridging two worlds to resolve the conflict that arises for Māori patients and whānau seeking mental health services. This involved Māori nurses advocating, defending Māori customary practices and interpreting the moves patients and nurses need to make between the non-Māori and Māori worlds. Haar and Martin (2021) described the concept of the cultural double shift that confirms the additional work Māori encounter when simultaneously functioning in both Western and Māori worlds. Māori identity is associated with critical workload pressures, navigating multiple roles and is detrimental to their career and can lead to burnout. Haar and Martin found whakawhanaungatanga, kawenga (responsibilities) and taumaha (additional cultural load) create a sense of intrinsic (cultural imperatives) or extrinsic (imposed by others) responsibility to be engaged in culturally related work. Cultural loading had a two-prong effect on Māori nurses which is their duty of care and deep challenges to their cultural identity. Their compassion to provide equitable care alongside cultural modes of care was mostly exploited. However, lightening the load requires nursing teams to step-up and meet the expectations of the nursing profession, their Te Tiriti o Waitangi obligations and to recognize the importance of cultural modes and hybridity to support Māori nurses to be Māori first.

4.4 | Compromised realities

The blending of Indigenous and Western models of care relies on modes of practice that consider not only cultural imperatives, like whakawhanaungatanga but also the context of whānau realities. Māori nurses in this study indicated that many existing Māori models of care do not appear to be applied in healthcare practice. Incongruence is perpetuated by colonial systems, structures and people that impose a Western lens and understanding of Māori concepts. Māori knowledge and models of care are often aesthetic or non-tangible versus Western models that aim to control and measure. These misinterpretations of knowledge create tensions and conflicts that do not work for Māori and their whānau (Pihama, 2019). The nurses in this study confirmed the importance of understanding and working in the context and realities of whānau to improve Māori health equity in outcomes to ensure they are inclusive of cultural concepts and are applied appropriately.

Māori prefer to be looked after by Māori because they know Māori nurses understand their fears and needs (Barton & Wilson, 2008; Wepa, 2015). The conflict between Indigenous and biomedical models shifts Māori nurses unconsciously into the third space creating modes of care as a strategy to improve the health of Māori whānau. The compromised reality is nurses being pressured to address the racist systemic inequities at the expense of their own identity and well-being. Barton (2018) called nurses to address the 'elephant in the room'—that is, their contribution to the Māori health disparities.

Discriminatory practices and racism noted by Māori nurses was their 'elephant in the room' with these able to go unchecked in a dominant biomedical way of practising. The racism, rhetoric and realities for Māori nurses created few opportunities to exercise cultural agency and resist the Western hegemonic practices of colleagues (Wilson et al., 2022). The health system promotes conforming with the dominant structures—as the nurses indicated, some days, it was too hard, so it was easier to go with the flow.

Māori nurses talked about feeling tired, undervalued and unrecognized because of their duty to care for whānau, but their Māori identity and value by the healthcare system are under-recognized. Encountering conflicting spaces meant sometimes they had to disengage with their cultural identity and be identified as another just to continue in their role. Other conflicting realities are structural and included professional precarity, burnout, compromised cultural integrity and the absence of reciprocity for Māori nurses from their colleagues and the health system. As the largest health workforce provider, nurses are well positioned to champion the decolonization and indigenization of systemic processes, yet they work in a system that is discriminatory in nature.

The findings of this article call for policies and practices that improve the capability to engage Māori in respectful and effective ways that endorse their cultural identity, values and practices to achieve a culturally safe environment. Therefore, we make the following recommendations:

- Indigenous nurses have access to regular resourced Indigenous cultural supervision as best practice.
- Workload policies are strengthened to ensure equitable workloads and leadership development for Indigenous nurses.

- Indigenous nurses lead the development of nursing modes of practice for working with Indigenous peoples.
- The non-Indigenous workforce is developed and supported to work more effectively with Indigenous peoples and their whānau in culturally safe ways.

4.5 | Limitations

Despite the small number of participants from the same hospital, no new information indicated data saturation of each theme and confirmed the adequacy of the sample size. This study provides useful insights for workforce planning, improving the equity of Indigenous health outcomes and is aligned with Māori nurses' experiences confirmed by others (Haitana et al., 2020; Hunter & Cook, 2020a; Wepa & Wilson, 2019). However, we do caution readers about the application of this study in other contexts. Furthermore, additional research with Indigenous nurses would be beneficial and add to the small but growing body of knowledge about the Indigenous nursing workforce. We also recognize that some nurses expressed concern about how what they were saying would be perceived by non-Māori nurses but the insights in their kōrero can shape a better practice environment for not only them but patients and their whānau.

5 | CONCLUSION

This study reinforces the need for consideration of Indigenous nursing experiences in workforce planning and ensuring their pressured and invisible workloads are addressed. Continuous cultural loading, compromised realities and the oppression of Māori nurses signpost the existence of systemic racism and importantly lead to burnout and retention issues. Strategies such as cultural supervision, strengthening workload policies that improve equity and enabling Indigenous approaches to care delivery would assist mitigating cultural loading. Further, the development of the non-Indigenous workforce to effectively work with whānau Māori could evolve modes of care that improve respectful, culturally safe and effective engagement and interactions with Māori patients and whānau. Ignoring the cultural double shift has serious employment and well-being consequences. The findings of this research have relevance to other Indigenous groups internationally. Indigenous patients and nurses are critical components of planning nursing care approaches and improving equity in outcomes.

ACKNOWLEDGEMENTS

We thank Julia Slark, Eleanor Maloney and Merryn Gott (University of Auckland) for their contributions early in this research, and Leigh Paparoa (Te Whatu Ora—Health New Zealand Counties Manukau) for assistance in recruitment of participants. Open access publishing facilitated by Auckland University of Technology, as part of the Wiley - Auckland University of Technology agreement via the Council of Australian University Librarians.

FUNDING INFORMATION

We acknowledge the Health Research Council for the funding and support of this research.

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15609.

DATA AVAILABILITY STATEMENT

No data is available due to ethical constraints and the risk of identifying participants.

ORCID

Ebony Komene https://orcid.org/0000-0002-2271-7438
Debra Gerrard https://orcid.org/0000-0002-5756-2907
Bobbie Pene https://orcid.org/0000-0002-0264-0074
Jenny Parr https://orcid.org/0000-0003-2365-1394
Cath Aspinall https://orcid.org/0000-0001-6682-7770
Denise Wilson https://orcid.org/0000-0001-9942-3561

REFERENCES

Barton, P. (2018). The elephant in the room: Nursing and Māori health disparities. *Kai Tiaki Nursing New Zealand*, *24*, 17–19. https://www.nzno.org.nz/resources/kai_tiaki

Barton, P., & Wilson, D. (2008). Te Kapunga Putohe (the restless hands): a Maori centred nursing practice model. *Nursing Praxis of New Zealand*, *24*, 6–15. https://www.nursingpraxis.org/242-te-kapunga-putohe-the-restless-hands-a-maori-centred-nursing-practice-model.html

Brockie, T., Clark, T. C., Best, O., Power, T., Bourque Bearskin, L., Kurtz, D. L., Lowe, J., & Wilson, D. (2022). Indigenous social exclusion to inclusion: Case studies on Indigenous nursing leadership in four high income countries. *Journal of Clinical Nursing*, *32*, 610–624. https://doi.org/10.1111/JOCN.15801

Chalmers, L. (2020). Responding to the State of the World's Nursing 2020 report in Aotearoa New Zealand: Aligning the nursing workforce to universal health coverage and health equity. *Nursing Praxis in Aotearoa New Zealand*, *36*, 7–19. https://doi.org/10.36951/27034542.2020.007

Clark, T. C., Best, O., Bourque Bearskin, L., Wilson, D., Power, T., Phillips-Beck, W., Graham, H., Nelson, K., Wilkie, M. L., Lowe, J., Wiapo, C., & Brockie, T. (2021). COVID-19 among Indigenous communities: Case studies on Indigenous nursing responses in Australia, Canada, New Zealand, and the United States. *Nursing Praxis in Aotearoa New Zealand*, *37*, 71–83. https://doi.org/10.36951/27034542.2021.037

Cormack, D., Stanley, J., & Harris, R. (2018). Multiple forms of discrimination and relationships with health and wellbeing: Findings from national cross-sectional surveys in Aotearoa/New Zealand. *International Journal for Equity in Health*, *17*, 26. https://doi.org/10.1186/s12939-018-0735-y

Cram, F., Te Huia, B., Te Huia, T., Williams, M. M., & Williams, N. (2019). *Oranga and Māori health inequities 1769–1992*. Ministry of Health.

Fournier, C., Blanchet Garneau, A., & Pepin, J. (2021). Understanding the expanded nursing role in Indigenous communities: A qualitative study. *Journal of Nursing Management*, *29*, 2489–2498. https://doi.org/10.1111/jonm.13349

Haar, J., & Martin, W. J. (2021). He aronga takirua: Cultural double-shift of Māori scientists. *Human Relations*, *75*, 1001–1027. https://doi.org/10.1177/00187267211003955

Haitana, T., Pitama, S., Cormack, D., Clarke, M., & Lacey, C. (2020). The transformative potential of Kaupapa Māori research and indigenous methodologies: Positioning Māori patient experiences of mental health services. *International Journal of Qualitative Methods*, *19*, 160940692095375. https://doi.org/10.1177/1609406920953752

Health Quality & Safety Commission (HQSC). (2019). *A window on the quality of Aotearoa New Zealand health care 2019*. HQSC. www.hqsc.govt.nz

Hunter, K., & Cook, C. (2020a). Indigenous nurses' practice realities of cultural safety and socioethical nursing. *Nursing Ethics*, *27*, 1472–1483. https://doi.org/10.1177/0969733020940376

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

Mika, C., & Stewart, G. (2017). Lost in translation: Western representations of Māori knowledge. *Open Review of Educational Research*, *4*, 134–146. https://doi.org/10.1080/23265507.2017.1364143

Moyle, P. (2014). A model for Māori research for Māori practitioners. *Aotearoa New Zealand Social Work*, *26*, 29–38. https://search.informit.org/doi/10.3316/informit.661443030329449

Mullane, T., Harwood, M., Warbrick, I., Tane, T., & Anderson, A. (2022). Understanding the workforce that supports Māori and Pacific peoples with type 2 diabetes to achieve better health outcomes. *BMC Health Services Research*, *22*, 672. https://doi.org/10.1186/s12913-022-08057-4

Nursing Council of New Zealand. (2019). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2018–2019*. Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand.

Pene, B., Aspinall, C., Wilson, D., Parr, J. & Slark, J. (2021). Indigenous Māori experiences of fundamental care delivery in an acute inpatient setting: A qualitative analysis of feedback survey data. *Journal of Clinical Nursing*. https://doi.org/10.1111/jocn.16158

Pihama, L. (2019). Colonisation, neoliberalism and Māori education: Herbison Invited Lecture, NZARE Annual Conference 2017. *New Zealand Journal of Educational Studies*, *54*, 5–19. https://doi.org/10.1007/s40841-019-00130-7

Pipi, K., Cram, F., Hawke, R., Hawke, S., Huriwai, T. M., Mataki, T., Moeke-Maxell, T., Morgan, K., Tuhaka, H., Tuuta, C., & International Research Institute for Māori and Indigenous Education (IRI). (2004). A research ethic for studying Māori and Iwi provider success. *Social Policy Journal of New Zealand*, *23*, 141–153. https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/index.html

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

Statistics New Zealand. (2019). Māori population estimates: At 30 June 2018. Statistics New Zealand https://www.stats.govt.nz/information-releases/maori-population-estimates-at-30-june-2018

Te Aka Whai Ora. (2022). *Establishment plan*. Te Aka Whai Ora. https://www.teakawhaiora.nz/assets/Uploads/MHA-specific/D2786-Te-Aka-Whai-Ora-Establishment-Plan-6.pdf

Waitangi Tribunal. (2019). *Hauora – Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry: WAI 2575 Waitangi Tribunal Report 2019*. Waitangi Tribunal. https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/

Warbrick, I., Wilson, D., & Boulton, A. (2016). Provider, father, and bro-Sedentary Māori men and their thoughts on physical activity. *International Journal for Equity in Health*, *15*, 22. https://doi.org/10.1186/S12939-016-0313-0

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

Wepa, D., & Wilson, D. (2019). Struggling to be involved: An interprofessional approach to examine Māori whānau engagement with healthcare services. *Journal of Nursing Research and Practice*, *3*, 1–5. https://doi.org/10.37532/jnrp.2019.3

Wilson, D., & Baker, M. (2012). Bridging two worlds: Māori mental health nursing. *Qualitative Health Research*, *22*, 1073–1082. https://doi.org/10.1177/1049732312450213

Wilson, D., & Barton, P. (2012). Indigenous hospital experiences: A New Zealand case study. *Journal of Clinical Nursing*, *21*, 2316–2326. https://doi.org/10.1111/j.1365-2702.2011.04042.x

Wilson, D., Barton, P., & Tipa, Z. (2022). Rhetoric, racism, and the reality for the Indigenous Māori nursing workforce in Aotearoa New Zealand. *The Online Journal of Issues in Nursing*, *27*, 1–20. https://doi.org/10.3912/OJIN.Vol27No01Man02

Wilson, D., Heaslip, V., & Jackson, D. (2018). Improving equity and cultural responsiveness with marginalised communities: Understanding competing worldviews. *Journal of Clinical Nursing*, *27*, 3810–3819. https://doi.org/10.1111/jocn.14546

Wilson, D., Mikahere-Hall, A., & Sherwood, J. (2021). Using indigenous kaupapa Māori research methodology with constructivist grounded theory: Generating a theoretical explanation of indigenous womens realities. *International Journal of Social Research Methodology*, *25*, 375–390. https://doi.org/10.1080/13645579.2021.1897756

SUPPORTING INFORMATION

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

How to cite this article: Komene, E., Gerrard, D., Pene, B., Parr, J., Aspinall, C., & Wilson, D. (2023). A tohu (sign) to open our eyes to the realities of Indigenous Māori registered nurses: A qualitative study. *Journal of Advanced Nursing*, *79*, 2585–2596. https://doi.org/10.1111/jan.15609