

RESEARCH BRIEF

Redesigning orientation for child health nurses: A cultural safety and workforce development initiative

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Abstract

Effective orientation programmes are essential to support newly employed nurses to safely and confidently adjust to specialised clinical environments. Research suggests that structured, equity-focused orientation models enhance workforce retention, clinical competence, and culturally responsive care in paediatric settings.

This article reports on the evaluation and redesign of the nursing orientation programme at Te Whatu Ora-Health New Zealand's Wellington Child Health Service, with a focus on a surgical ward. A staff survey identified knowledge gaps in ward-specific processes, surgical competencies, immunisation systems, hospital IT systems and preceptorship consistency. Using Kurt Lewin's change theory and cultural safety principles aligned with Kawa Whakaruruhau¹, a standardised orientation framework was developed to incorporate ward-specific competency checklists, phased workload orientation guidance and a formalised preceptorship model. Pilot testing demonstrated improved clarity, confidence and professional development among orientating nurses.

Keywords

Nurse orientation programme, preceptorship, paediatric nursing, cultural safety, workforce orientation, phased workload model.

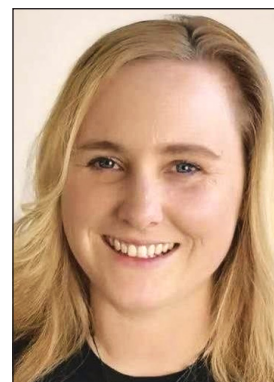
Introduction

Orientation into a new clinical environment is a vulnerable period for nurses, particularly in specialised paediatric settings where patient acuity, engaging with families, and multidisciplinary coordination add layers of complexity. Orientation programmes play a critical role in shaping nurses' professional practice, influencing patient outcomes, and strengthening workforce stability (Ernawaty et al., 2024). Robbins et al (2017) state that a poorly structured orientation programme may contribute to anxiety, reduced confidence and early attrition, whereas structured orientation can support the development of nurses' competence and their commitment to the organisation.

Rising workforce turnover and negative feedback from newly employed nurses at the Wellington Child Health Service prompted



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a review of the existing orientation programme. Between 2023 and 2025, 17 nurses resigned, some departing within three months of starting employment. In informal discussions with nurses hired between 2023 and 2025 about their experience of orientation to the service, the nurses mentioned the challenges of orientation between the service's different specialty wards, as well as inconsistent preceptorship and that they gained limited ward-specific knowledge. A 2024 learning needs assessment at the service identified significant gaps in confidence among nurses regarding paediatric surgical care.

Before the redesign, the orientation programme consisted of a four-to-six-week supernumerary period, with nurses using a generic workbook that was applied across all wards of the service. New staff were assigned a preceptor on a day-to-day basis, but there were no structured weekly expectations, no formalised workload orientation model and no ward-specific skills checklists. Although the duration of the programme was generally acceptable, the absence of structured guidance and consistent preceptorship limited its effectiveness.

Aims

The aims of the project were to:

- 1) Assess new nurses' experiences of the current orientation model.
- 2) Develop a structured and ward-specific orientation framework.
- 3) Strengthen the integration of cultural safety knowledge during orientation.

1) Kawa Whakaruruhau is cultural safety within a Māori context. The term "kawa" refers to protocols or guiding principles that shape culturally appropriate engagement. "Whakaruruhau" means to shelter, protect or safeguard.

Background and context

Internationally qualified nurses and cultural safety

Most new Child Health Service nurses are internationally qualified, and while they are required to complete cultural competency training, online modules alone have limited impact on addressing health disparities experienced by New Zealand's indigenous Māori population (Clubb et al., 2024). Māori children continue to face significant inequities, including lower immunisation rates—only 72.1 percent of Māori babies were fully immunised at eight months in 2020/21, well below the national target of 95 percent (Duncanson et al., 2022). Currently, nurses primarily learn cultural safety through ward practice, but it is not explicitly included in the orientation programme. By embedding cultural safety into orientation, nurses would be better prepared to promote equitable care, support timely immunisations, and align their practice with Te Tiriti o Waitangi² principles, helping to reduce health disparities for Māori children.

Theoretical framework

The project was guided by Kurt Lewin's three-stage change theory: unfreeze, move, and refreeze.

During the “unfreeze” stage, gaps in the orientation process were identified through surveys and stakeholder discussions, fostering readiness for change. In the “move” stage, new resources—including a ward-specific workbook and preceptor training—were developed and piloted. The “refreeze” stage, which involves embedding change into routine practice, was initiated but not fully completed due to project timelines. Engaging stakeholders early strengthened the change process by increasing ownership and reducing resistance (Hussain et al., 2018).

Data collection

An online survey was distributed to 52 nurses hired between 2023 and 2025 in two of the three wards of the Child Health Service, which is based at Wellington Regional Hospital. These were the surgical and medical wards. Thirty-eight responses were received (73 percent response rate).

The survey included nine questions, comprising multiple-choice, Likert-scale and open-ended items. Quantitative data were analysed descriptively, while qualitative responses were reviewed thematically to identify recurring concerns and recommendations. Additional data sources included:

- Staff retention records.
- Informal discussions with stakeholders: the nurse educator, associate charge nurse manager, charge nurse manager and current preceptors.

2) Te Tiriti o Waitangi is the core constitutional and ethical mandate requiring New Zealand's health and disability system to honour Treaty obligations, protect Māori rights, and achieve equitable wellness outcomes.

Findings

Orientation duration

Eighty-three percent of respondents reported that a four-to-six-week orientation was appropriate. However, comments emphasised a need for clearer expectations and structure.

Clinical preparedness

Key areas where nurses wanted additional support included surgical preparation (37 percent), referrals to community and outpatient services (42 percent), wound care and post-operative care (50 percent), immunisation and cold chain management (37 percent), enteral feeding devices (30 percent), computer systems and digital documentation (29 percent), and communication with the multidisciplinary team (32 percent). These findings suggest that although nurses were exposed to these tasks during orientation, the programme did not provide sufficient structured competency development to fully support them acquiring these skills.

Preceptorship

Sixteen percent of participants said their primary preceptor did not demonstrate strong ward-specific expertise. Qualitative feedback indicated that inconsistent shift alignment limited opportunities for sustained interaction with designated preceptors, with some participants describing only brief or infrequent contact due to differing rostering patterns. These findings suggest that lack of continuity may have influenced participants' perceptions of preceptor support and ward-specific guidance. This interpretation is consistent with previous research, demonstrating that regular access to experienced and well-prepared preceptors contributes positively to clinical reasoning, confidence and the overall transition experience of new graduates (Spiva et al., 2013). In addition, clear role expectations and adequate preparation have been identified as important components of effective preceptorship and supportive mentoring relationships (Peltokoski et al., 2015).

Cultural safety

Although 87 percent of respondents believed cultural safety was integrated into orientation, it was largely implicit rather than structured. This suggests cultural safety was modelled in practice but not explicitly taught or documented.

Discussion

Programme redesign

The feedback clearly highlighted the need for a more structured and supportive approach to orientation, so instead of just extending the orientation length, we focused on strengthening its structure and clarity. We introduced a new, ward-specific orientation model that was tailored to surgical paediatrics. This model included a ward workbook, weekly learning expectations, a competency checklist with formal sign-offs, and a clear progression of clinical responsibilities.

Phased workload orientation

We introduced a phased workload model to help nurses transition smoothly into their roles. In week 1, nurses had protected time for policy review, familiarisation with equipment, computer training and e-learning. From week 2 onward, their patient allocation gradually

increased, under supervision. The final stage included a one-day rotation to a medical ward for broader exposure. This gradual approach, instead of a sudden shift from supernumerary to a full patient load, helped build confidence and improve retention, as research shows (Chipwanya et al., 2024). This new approach provided nurses with a clear roadmap of what was expected in each week of their orientation. It also gave preceptors a shared framework to guide their teaching, ensuring consistency and clarity. The structure reduced uncertainty for nurses, making it easier for them to understand what was expected of them at every stage of their training. Nurses reported feeling safer and more prepared in practice, thanks to this supportive and structured transition.

Practical resources that support daily work

To streamline daily tasks, we created two central resources: the orientation handbook and the ward workbook. The orientation handbook included hyperlinked policies, computer navigation guidance, referral pathways using the communication tool ISBAR (introduction, situation, background, assessment, recommendation), and immunisation references, reducing time spent searching across multiple systems. The ward workbook offered practical tools such as surgical preparation checklists, wound management competencies, enteral feeding sign-offs, and reflective prompts on cultural safety and whānau-centred care³. Digital tracking allowed monitoring of nurses' progress and early identification of gaps in their learning. We also prioritised blended learning, combining online modules with supervised clinical practice, reflecting evidence that this approach enhances skill development (Mizuno et al., 2025).

Strengthening preceptorship

Preceptorship was formalised to provide more consistent support for new nurses. There are clear selection criteria for preceptors, and an eight-hour education session, defined role expectations and structured supervision tools. Additionally, a goal of 60 percent shift alignment was instituted to ensure that preceptors and new nurses worked together regularly. While full alignment wasn't always possible due to roster constraints, the structured preparation and tools improved consistency in preceptorship. As a result, preceptors reported feeling more confident in their role of guiding new nurses through their orientation.

Making cultural safety explicit

Cultural safety was explicitly integrated into the orientation process to emphasise its importance in nursing practice. This included reflective prompts within the workbook, structured orientation discussions and encouragement of reflective journaling. The orientation was also aligned with Kawa Whakaruruhau principles, signalling that cultural safety is not just an add-on, but an essential and integral part of everyday nursing practice. These changes reinforced the message that cultural safety is a core value that nurses must uphold in their care.

3) Whānau-centred care is a collaborative healthcare model in Aotearoa New Zealand that treats the collective family unit (whānau) as the core decision-maker and focus of well-being, rather than focusing isolated attention on an individual patient.

Implications for nursing education

Pilot evaluation

The redesigned orientation programme was piloted with two newly hired nurses on the surgical ward over eight weeks. Feedback from the nurses and preceptors, together with educator observations, suggested that expectations were clearer, learning was better organised and competency tools useful. Preceptors appreciated the shared structure, as it provided a framework to guide their teaching, rather than relying on memory or informal methods. While there were still challenges, particularly with roster alignment, the overall experience was much more positive, compared to that of previous cohorts.

The findings confirmed that an effective orientation programme is about more than just its duration—it is about having clear structure, good mentorship and clear expectations. A modular, ward-specific approach works well for nurses at different experience levels and aligns with current best practices in orientation-to-practice (Kim et al., 2025). Embedding cultural safety in the programme enhances accountability and aligns with national equity goals. Recognising frameworks like Kawa Whakaruruhau encourages reflective, culturally responsive practice. While continuity in preceptorship can be a challenge in high-acuity environments, structured training and competency tools help make mentorship more effective, even when perfect roster alignment isn't possible.

Reflections as a nurse educator

This project reinforced something simple yet powerful: structure creates psychological safety. When nurses know what is expected and how they are progressing, their anxiety decreases. When preceptors understand their role and have tools to support teaching, mentorship improves. When cultural safety is visible and discussed, equity becomes part of everyday practice rather than an abstract concept.

Orientation is not just about skills. It is about belonging. In paediatric settings, where families entrust us with their most precious people, confident and supported nurses are essential.

Limitations

The project faced some limitations, but several strategies were implemented to overcome them. To overcome budget-driven limits on roster flexibility, the team developed a sustainable, balanced scheduling model that pairs consistency with adaptability. To ensure this approach remains viable over time, the assistant charge nurse manager directly collaborates with the rostering staff to oversee ongoing implementation. A key part of this long-term strategy is the reliable allocation of one to two preceptors per shift, ensuring their schedules align at least 60 percent of the time with the nurse they are mentoring, without exceeding budgetary boundaries.

Another limitation was the reliance on nurse educator capacity to sustain the programme. To mitigate this, printed worksheets and skill sign-off sections were incorporated so that other proficient nurses could verify competency, particularly when preceptors/nurse educators were unavailable. These resources were standardised across wards and periodically reviewed by the nurse educator to ensure they remained accurate and relevant. Looking ahead, future

evaluations will include workforce indicators like retention rates and competency outcomes to better assess the long-term effectiveness of the programme.

Conclusion

The redesign of the Child Health Service nursing orientation programme demonstrates that structured, ward-specific and culturally grounded orientation improves orientation experiences for paediatric nurses. Integrating phased workload orientation, competency-based resources and formalised preceptorship strengthens clinical preparedness and supports workforce stability. For paediatric services navigating increasing complexity and workforce challenges, investment in structured orientation is foundational to delivering safe, equitable, and high-quality care for children and whānau.

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