ABSTRACT

Introduction Worldwide, our societies are characterised by increasing diversity, which is greatly contributed to by people who have migrated from one country to another. To provide person-centred care, healthcare staff need to consider the personal background, biography and preferences of people with care needs. Little is known about the care preferences of older migrants and minority ethnic groups. The purpose of this planned scoping review is to explore and systematically investigate current research addressing the care preferences of older migrants and minority ethnic groups. In addition, gaps requiring further research will be identified. To the best of our knowledge, this scoping review will be the first to synthesise the literature regarding the preferences in nursing care of older migrants and minority ethnic groups.

Methods A scoping review will be conducted to identify and analyse the care preferences of older migrants and minority ethnic groups (population 60 years or older with various care needs). Based on the research aim, we will systematically search the electronic databases MEDLINE (via PubMed), CINAHL (via EBSCO) and PsycINFO (via EBSCO). We will include literature published in English and German with no restrictions regarding the publication date. The identified records will be independently screened (title/abstract and full text) by two reviewers. Data from the included studies will be extracted by one and verified by a second researcher. We will analyse the identified preferences with an inductive content analysis and will narratively present the review results in the form of tables.

Ethics and dissemination There are no ethical concerns related to conducting this study. We will discuss our results with practitioners in the field of nursing care of older people with migration backgrounds. We will present our results and make them available to the public at (inter) national conferences and in the form of peer-reviewed and practice articles.

INTRODUCTION

It is estimated that there were approximately 281 million international migrants in the world in 2020, which equates to 3.6% of the global population. In January 2020, 23 million people among the 447.3 million people living in the European Union (EU) were non-EU citizens. In the EU, the number of people with migration backgrounds who are over 64 years of age rose from 4.73 million in 2000 to 7.37 million in 2017. Caring for people with migration backgrounds is one of the major public health challenges worldwide. In the future, the number of older people in need of care will grow. With regard to demographic changes, the number of people with migration backgrounds who need care in old age will increase.

Looking into the literature, it turns out that there is no common definition of the term migrant, and it is an unclear concept with varying definitions. Migrant is an umbrella term for people who leave their homes, where they were born, willingly (temporally or for commercial re-use. See rights and permissions. Published by BMJ.

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the long term) in search of employment, or something else, in a different country. Furthermore, a migrant can be defined based on their country of birth, where people with a migration background are living in countries other than their country of birth or their own or their parents’ citizenship. In contrast, ‘immigrant’, not a commonly used term in all countries but frequently used, for example, in North America, refers to all people who are living in a country where they were not born. Immigrants move from their home country to enter willingly and legally another country and apply for permission to enter and live in that country permanently, which will qualify them to work without any restrictions in their new country (permanent residency). On the other hand, undocumented immigrants, non-nationals, who enter or stay in a country without appropriate documents, are foreign-born people who do not possess a valid visa or other legal immigration documentation. ‘Undocumented migrants who lack any identity document usually experience more difficulties in accessing services, in obtaining permits to reside or work, or in returning to their countries of origin’.11

The terms ‘migrant’ and ‘refugee’ are sometimes used interchangeably, but it is important to distinguish between these terms as they are linked to a clear legal definition. A ‘refugee’ is a person who lives outside their country of origin for reasons of feared persecution, conflict, generalised violence or they are at risk of being subjected to serious human rights violations and because their own government cannot or will not protect them from those dangers. Refugees seek safety outside their country and have a right to international protection. An ‘asylum seeker’ is an individual who is seeking international protection and whose claim has not yet been finally decided. Not every asylum seeker will ultimately be recognised as a refugee, but every recognised refugee is initially an asylum seeker. Refugees are defined and protected in international law, and the 1951 Refugee Convention is a key legal document. Not every refugee or asylum seeker will become an international migrant.

When people migrate, they bring their mother language, personal and social identity, experiences and religious beliefs to their new home. Migration has contributed to the richness in the diversity of cultures and ethnicities in developed countries. Migrants are often associated with ethnic or religious minorities as well as with asylum seekers and refugees. However, migrants and immigrants are not the only sources of diversity in our societies. Autochthonous ethnic and linguistic minorities or ‘historic minorities’ are an equally important source of ethnic and cultural diversity. The term ‘minority ethnic group’ usually refers to a group of people who share a common cultural identity that differs from the local population (in a particular country). Ethnicity can be understood in terms of a shared culture, often incorporating a common language, geographic locale or place of origin, religion, sense of history, traditions, values, beliefs and food habits and may refer to characteristics of persons, national origin, religion, regional identification and language, among others. Looking more closely at the various examples and definitions, it becomes clear that the use of words in different contexts or the specification of categories within different research studies may blur and might be used with different meanings. Every individual—whether a naturalised full citizen, a new migrant or a member of a dominant indigenous population—has an ethnic location. Regardless of where a person comes from, everyone has roots or connections in terms of culture, kinship and upbringing, and our personal history creates parts of our identity. Minority ethnic groups or cultural minorities may include migrants who become part of established minority ethnic groups in the countries they migrate to. At this point, however, it should be noted that not all migrants are from minority ethnic groups and not all people from minority ethnic groups are migrants. Individuals with a migration background experience multiple stresses, including experiences linked to distinct lifestyles and languages to particular attitudes, values or political beliefs. In addition, migrants face many barriers when accessing healthcare when they migrate from one country to another, both structural, cultural and political, often leading to unmet needs and poor quality of care. Although people from minority ethnic groups experience similar stresses, for example, the minority ethnic group is often recognised but not necessarily accepted by the larger society, which may lead to disadvantages in everyday life situations. Minority identity and acculturation can be understood as a ‘phenomenon’ that happens when groups of individuals from different cultural backgrounds come into continuous first-hand contact with subsequent changes of their original culture patterns of either one or both groups.

Barriers people with a migration background and/or ethnic minority groups experience are related to language challenges, cultural differences, lack of information, sociocultural and economic barriers and policy and resource barriers. Individuals with a migration background as well as people from minority ethnic groups may have different healthcare needs, care traditions and different understandings of illness and treatment than the local population. For example, depending on the country, they are coming from, migrants may provide different perspectives on dementia and have different preferences for care and other expectations, ideas and desires regarding information and self-determination and therefore they have special care needs.

This scoping review employs the term ‘migrant and minority ethnic groups’ as a general phrase that captures the range of groups we will focus on. Although it is clear, this term may not cover the wide range of terms used in studies. A clear separation of certain population groups that were included in studies is often not possible (due to missing information). Furthermore, members of minority ethnic groups could also mean that people with a migrant background are included but remain...
a minority group in the country they immigrated to, or it could mean that indigenous minorities are included in the selected studies. However, for the purpose of this scoping review, we assume that using the term ‘migrant and minority ethnic groups’ can be a useful umbrella term. We focus exclusively on international migrants who are living in another country, different from where they or their (grand)parents (or ancestors) were born and who have a legal migration status (eg, dual citizenship) in the country they moved to. Furthermore, we will focus only on international migrants with a legal migration status in the country they currently live in but not on other types of international migrants (ie, return migrants, circular migrants).

Carpenter et al noticed that older adults with functional limitations need assistance ranging from traditional activities of daily living to more abstract expressions of their personality. This means that each individual, with a migration background or without, as well as people from minority ethnic groups, has a unique idea of care needs and different thoughts and feelings on how those care needs should be met. Knowledge of the individual everyday life preferences of older people in need of care is the foundation of person-centred care, which improves positive care outcomes. Individualised care planning is an important element to maintain the quality of life of older people.

Person-centred care can be defined as ‘providing care that is respectful of and responsive’ to individual preferences, needs and values, and it has a positive influence on the person’s well-being and satisfaction with care. Person-centred care means treating a person as an individual and as an equal partner; it is personalised, coordinated and enabling, which supports people in developing the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and healthcare. Therefore, the knowledge of the individual as a whole person is necessary, involving them—and where appropriate, their family and friends—in helping to assess their own needs and plan their own care.

The term preference can be used broadly to describe an individual’s tendency to consider something as (un) desirable in a particular circumstance. More specifically, Van Haisma et al described a stated preference as ‘an expression of the attractiveness of an option that serves to fulfill a person’s needs, is determined based on one’s values and directs behaviours to achieve goals’. A preference for a specific activity or choice is determined by one’s broader ‘value system and behavioural goals and reflects the daily expression’ of how an individual would like their needs to be met. In detail, preferences can be understood as ‘an integral measurement tool to operationalise more abstract constructs (ie, needs, values, goals) of individuals’. Van Haisma et al propose a ‘Preference-Based Model of Care to articulate the mechanisms by which preferences affect care outcomes’, where preferences are the essence of person-centred care. The focus of the proposed model lies on the older person and their needs. Individuals transform needs consciously or subconsciously into values, goals and preferences that guide how individuals want to have their needs met, which results in preferences or goals that then serve as the driving force behind behaviour.

van Haisma et al pointed out that preferences cover a broad range of behaviours and activities related to daily life, such as ‘leisure activities, caregivers and care, social engagement, and activities of daily living’.

Currently, little is known about the care preferences of older migrants and people from different minority ethnic groups. To date, there is no systematic overview of the various care preferences of older migrants and people from minority ethnic groups. The lack of familiarity with the healthcare system, different perceptions, cultural and language barriers often result in lower use of healthcare services, and unknown care preferences hinder and inhibit person-centred care.

Our interest lies in the identification of existing preferences regarding care in general, including nursing care but also other healthcare areas.

In this paper, we report the protocol for our scoping review. The aim of the scoping review is to (1) systematically identify the care preferences of older migrants and people from minority ethnic groups who receive care services and support in a variety of settings as well as those who might be in need of care in the future, (2) display the existing research landscape in visual formats and (3) identify gaps requiring further research to inform people with migration backgrounds and from minority ethnic groups, practitioners, nursing caregivers, policy makers, researchers and funding organisations and to help identify future research requirements and priorities.

**METHODS AND ANALYSIS**

Scoping reviews are an innovative review method of synthesising evidence that is particularly useful when the research question is too broad to conduct a ‘traditional’ systematic review. Scoping reviews are an approach to define the scope of a body of literature on a given topic and give a clear indication of the volume of literature and studies available, as well as an overview (broad or detailed) of its focus. The scoping review is a first step towards systematically mapping existing research findings that can help to answer a broad-based research question, to gain knowledge in a broad field, to identify gaps in the literature and research and to map existing data from a variety of sources. The scoping method aims to search broadly for literature and is more iterative and reflexive than a systematic review; it is therefore possible that the inclusion and exclusion criteria will be refined and updated during the review process. In contrast to systematic reviews, as defined by the Cochrane Collaboration, for scoping reviews, it is not necessary to produce a critically appraised result and detailed information about narrow questions or to analyse the strength of evidence.
of the included studies, since its purpose is not to provide recommendations for interventions.\textsuperscript{49} The results can be analysed and presented using narrative and visual formats of the identified research and description of gaps.\textsuperscript{46}

The main purpose for conducting scoping reviews is to identify and map the available research.\textsuperscript{43}\textsuperscript{45}\textsuperscript{44} Arskey and O’Malley published the first methodological framework for conducting a scoping study and provided four specific purposes why a scoping review may be conducted.\textsuperscript{45}\textsuperscript{44} Levac \textit{et al} further advanced and extended this original framework.\textsuperscript{44} At that time, there was no universal definition of scoping reviews or a commonly acknowledged purpose or indication of how to conduct them. In 2015, a methodological working group of the JBI produced formal guidance for conducting scoping reviews,\textsuperscript{47} which was updated by Peters \textit{et al}.\textsuperscript{48}

We chose the scoping method for this review because we would like to provide the first broad and systematically structured overview of the different types of care preferences related to older migrants and people from minority ethnic groups with various care needs. To our knowledge, this has not been done before. Therefore, it is necessary to include different types of study designs to obtain a broad understanding of the research on the specific topic. If an update of the inclusion and exclusion criteria is needed during our review, the protocol will be updated, and the reasoning behind the changes will be made clear to ensure transparent reporting and avoid potential bias.

To conduct this scoping review, starting in November 2021 and scheduled to end in June 2022, we follow the iterative framework for scoping studies developed by Arksey and O’Malley,\textsuperscript{45} which was further modified by Levac \textit{et al}.\textsuperscript{44} This framework has six different stages: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, (5) collating, summarising and reporting the results and (6) consulting. In addition, we followed the Preferred Reporting Items for Systematic Review and Meta-analysis Protocols guidelines for reporting this protocol\textsuperscript{49} (online supplemental table 1).

### Stage 1: identifying the research question

In the context of a pilot study focusing on the translation and psychometric testing of an instrument for assessing the preferences for everyday living of older people in various care settings,\textsuperscript{50–53} it has become clear that migrants and people from minority ethnic groups have not been taken into consideration in the perspective of older adult care recipients. In this context, the research team, coauthors of this review, discussed questions regarding the

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<th>Table 1</th>
<th>Eligibility criteria</th>
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<td><strong>Criteria</strong></td>
<td><strong>Definition</strong></td>
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<td>Population</td>
<td>We will include studies with a population of older (≥60 years)\textsuperscript{62} international migrants with a legal status,\textsuperscript{30} and people from minority ethnic groups with various care needs across care settings without restrictions to specific countries. Migrants are defined based on their country of birth (people with a migration background are living in countries other than their country of birth).\textsuperscript{8} We will not exclude studies where a caregiver, professionals or a family caregiver report about preferences of the elderly (proxyreported). We will exclude studies that focus on people receiving palliative care and/or with a focus on end-of-life preferences of older migrants and people from minority ethnic groups, because this topic is already under research.\textsuperscript{63}</td>
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<td>Concept of interest</td>
<td>We will consider studies that describe the various care preferences of older migrants and people from minority ethnic groups. In this context, terms are also considered relevant when they are related to the term preferences. We will therefore search broadly, including other common terms and synonyms for preferences, which we found with an initial limited search. This approach will increase the probability of finding the most relevant literature, as well as the literature that does not use the term preferences in the title and abstract to define their research findings. In the full-text screening, not only the term “preferences” is relevant for inclusion or exclusion. All of the following terms will be used: Preferences, Care expectations, Care wishes, Care needs, Values, Demands</td>
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<td>Study design</td>
<td>Because the objective is to identify existing care preferences of older migrants and people from minority ethnic groups in the literature, the searches will focus on peer-reviewed scientific empirical research papers. All kinds of studies will be included. We will exclude discussion papers or mission statements, conference abstracts and editorials.</td>
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<td>Others</td>
<td>We will include studies published in English and German. There will be no restrictions on publication status or date, but we will exclude preprints.</td>
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population of diverse groups. Our discussion especially focused on older migrants and ethnic minorities and what care preferences they have. Afterwards, we carried out an explorative literature search to identify a systematic overview of the currently described care preferences of older migrants and ethnic minorities. However, no systematic overview could be identified. Based on this, we defined the following research question for our scoping review: ‘Which care preferences of older migrants and people from minority ethnic groups are described in the literature?’

Stage 2: identifying relevant studies
We started our literature search in November 2021 with a scheduled end in June 2022. We conducted a literature search to identify the described care preferences of older migrants and people from minority ethnic groups in the following electronic databases: MEDLINE (via PubMed), CINAHL (via EBSCO) and PsycINFO (via EBSCO). Our search string was developed for MEDLINE (via PubMed) (online supplemental table 2) and adapted for the other two databases according to RefHunter V.5.0.23. An initial limited search of MEDLINE (via PubMed) was undertaken to generate a first insight. We identified other key terms in addition to preferences, as the papers used analogies to describe the topic, for example, needs, beliefs, values, expectations and wishes.

Stage 3: study selection
Following the electronic database search, all identified records will be collated and imported into the review management software Covidence and automatically checked for duplicates, which will be removed. The titles, abstracts and full texts of the identified records will be screened independently by a minimum of two reviewers (VP-N, MR-M and DP) in Covidence against the eligibility criteria (table 1). The results of these two screening processes will be discussed between the two reviewers. If there are any differences in the extractions, they will be discussed. If no consensus can be reached, a third reviewer (MR) will be involved.

Stage 4: analysing and charting the data
Data extraction tables will be created using a table in word (table 2) and will include the following columns: study characteristics such as research type (study design/methodology) and setting (healthcare context, country of origin and study period); population characteristics (sample size, age, sex); aim of the study and characteristics of the preferences. Data extraction from the included studies will be performed by one researcher (VP-N) and verified by a second researcher (MR-M). After finishing this extraction process, the same two reviewers will check every item of the extracted data for consistency. If there are any differences in the extractions, they will be discussed. If no consensus can be reached, a third reviewer (MR) will be involved.

Stage 5: collating, summarising and reporting the results
The included articles will be subsequently analysed using qualitative content analysis through an inductive approach. A combination of in vivo (ie, verbatim) and descriptive coding (ie, summarising the meaning of the extracted text into a word or short phrase) will be used to analyse the included studies.

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<th>Table 2 Data charting framework</th>
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<td><strong>Domains</strong></td>
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<td>Care preferences details/results of the study</td>
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We will summarise and report the extracted data (table 2) via tabular forms. We will report general aspects of the identified preferences (eg, type, referred topic) in the form of tables. More specific information about the identified preferences will be outlined in a descriptive narrative summary and visualised in the form of a mind map. For this purpose, we will collate and summarise the identified terms according to the type of preferences.

Stage 6: consultation
The development of the scoping review will follow an interactive process, and all members of the team will be consulted during all steps. Since stage 6 is described as being in parallel to the other stages,43 we will discuss our results with practitioners and family caregivers from the field of nursing care of people with migration backgrounds and/or people from minority ethnic groups after completing stages 3, 4 and 5. In addition, when discussing our findings, we will involve a person from the patient advisory board of the DZNE (Deutsches Zentrum für Neurodegenerative Erkrankungen e.V.) and/or a person with a migration background who receives care in one of the previously included settings (eg, adult day care). Here, we will discuss the identified preferences, which preferences were underrepresented and the research gaps. In addition, a discussion among the research team members will take place after each stage to evaluate the current approach, the results, and the need for further adjustments of the procedure.

Patient and public involvement
We will involve a practitioner who works with people with a migration background and/or people from minority ethnic groups. Furthermore, we plan to involve two family caregivers of older migrants and/or people from minority ethnic groups and a representative from the patient advisory board of the DZNE. Furthermore, coauthorship will be discussed with the representative from this patient advisory board. Their involvement is planned for stage 6 consultation to discuss the results of our scoping review.

ETHICS AND DISSEMINATION
For our review, there are no ethical concerns. Ethical approval is not required because we do not intend to involve a vulnerable population and their family members/caregivers or other professional staff members in our planned scoping review. We will present our results at (inter)national conferences and publish them in journals for practitioners and peer-reviewed journals. In addition, we will identify possible gaps in the current research landscape and incorporate them into possible future projects.

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Contributors VP-N wrote the initial draft of the protocol. MR-M, DP, HT-G and MR revised the manuscript. MR-M, DP and MR assisted in the identification of the electronic databases and reviewed the keywords and the search string. MR and HT-G are supervisors of this project. All authors read and approved the final manuscript.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

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