



Patient- and family-centered care for hospitalized children and their parents with a migration background: A qualitative study

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ARTICLE INFO

Article history:

Received 7 January 2025

Revised 6 April 2025

Accepted 11 April 2025

Keywords:

Culturally competent care

Child care

Family nursing

Qualitative research

ABSTRACT

Purpose: To explore experiences and needs of parents with a migration background regarding patient- and family-centered care for their hospitalized child in a Dutch university children's hospital.

Design and methods: A qualitative descriptive design was used with semi-structured face-to-face interviews among parents with a migration background who are proficient in the Dutch language. Thematic analysis was used to analyze the data.

Results: Eleven mothers and four fathers were interviewed. Their experiences and needs were described in four key themes: (1) receiving child-focused care from hospital staff; (2) acquiring support and personal attention to endure hospitalization; (3) engaging in parental participation; and (4) seeking comfort and privacy in the hospital. Parents valued the specialized, child-focused care, and needed additional support and understandable information for parental participation. They need the opportunity to stay close to their child and practice their religion with privacy.

Conclusions: Parents expressed universal needs concerning hospital care for their child, such as receiving high-quality, personalized, child-focused care with attention to their own well-being. Parents had specific needs focused on support in participating in their child's care, receiving understandable language and information, and appropriate private facilities to accommodate religious practices and ensure privacy during admission.

Practice implications: Parents need health care professionals to support them in actively participating in their child's care by using understandable language and facilitating both privacy and religious practices. Further research should include patients and families with language barriers to ensure representation of the patient population.

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Introduction

Hospitalization of a child is stressful for the parents and the child. Beyond the medical complexities, it involves navigating uncertainties, managing emotions, and seeking support from health care professionals. How parents and children respond to these challenges is affected by how the health care professionals take the family system into account (Zdun-Ryżewska et al., 2021).

Patient- and family-centered care (PFCC) is essential during hospitalization, encompassing core elements such as respect and dignity, information sharing, participation, and collaboration (Institute for Patient- and Family-Centered Care, 2017). In pediatrics, PFCC operates on the principle that the family serves as the child's primary source of

strength and support, emphasizing the importance of both the child's and family's perspectives in clinical decision-making. A systematic review of Hodgson et al. (2024) on the effectiveness of family-centered care interventions showed that PFCC interventions can increase patient knowledge, satisfaction with care and with PFCC, participation in care-giving and decision-making, partnership with the health care team, and parent well-being. PFCC is based on mutual partnership, communication, respect, and compassion between health care professionals, patients, and families (Seniwati et al., 2023). This approach aligns with the World Health Organization's (WHO) advocacy for culturally appropriate health care for ethnic minority patients (WHO, 2022).

Nurses and other health care professionals are increasingly faced with the diversity of patients' and their families' ethnic backgrounds due to migration (Spitzer et al., 2019). A systematic review of Lauwers et al. (2024) showed that patients experience inequities and shortcomings in receiving PFCC and diversity-sensitive care competencies, even

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with basic elements such as respect and attention. They reported a study in which patients reportedly feel more isolated and discriminated against in comparison to patients who speak a mutual language.

PFCC is not always guaranteed for families with a migration background. The ethnographic study of Belintxon et al. (2020) showed that nurses were less at ease with first-generation immigrants than with Spanish parents, asking fewer questions and conducting fewer in-depth conversations. The information provided was not tailored to parents with a migration background; it was neither family-centered nor culturally appropriate (Belintxon et al., 2020). This persistent gap in delivering culturally competent care is well-known, indicating a need for widespread adoption of interventions for cultural competence training. As a result, the skills required for culturally competent care remain inadequate in nursing practice (De-María et al., 2024).

In 2015, a Dutch university children's hospital in an urban area known for its large number of migrant citizens (Crul et al., 2019) introduced PFCC as part of medical and nursing care to provide customized care. While PFCC has been widely studied in various health care settings, previous studies have had an insufficient representation of marginalized populations, thereby overlooking the specific needs and challenges faced by migrant families (Hodgson et al., 2024). It is unclear if PFCC effectively takes into account the particular expectations and needs of migrant parents when their child is hospitalized. As a result, the aim of this study was to explore the experiences and needs of parents with a migration background regarding patient- and family-centered care for their hospitalized child in a Dutch university children's hospital.

Methods

Study design and sample

This descriptive qualitative study used semi-structured face-to-face interviews with parents with a migration background during their child's hospitalization in one of the pediatric general wards of a Dutch university hospital. These general wards include care for patients under the age of 18 with different conditions. Purposive sampling was used to recruit parents who met the following inclusion criteria: (a) at least one of their parents was born outside the Netherlands, (b) speaking sufficiently proficient Dutch to conduct the interview in Dutch, and (c) having their child hospitalized for a minimum of four days, ensuring they had sufficient experience with hospital care. Based on the meta-analysis of Guest et al. (2020), a target of twelve to fifteen interviews was set, and data saturation was expected to be achieved within this range. The first author (AH), who is also a pediatric nurse, asked general ward nurses to identify eligible parents and seek their consent to receive study information. Eligible and interested parents received written and verbal study information and had at least four hours to decide on participation. If both parents participated, both gave verbal consent and one provided written consent. Interviews were scheduled at the parents' convenience. Maximum variation sampling was used in terms of migration background and different types of hospital admissions. It was possible for parents to participate individually or together.

Data collection

Data collection was accomplished through face-to-face semi-structured interviews using a topic list, see Appendix A. This topic list was developed by the first author and reviewed by members of the research team (MvD, JLF) to ensure feasibility and completeness. The topics were based on the core elements of PFCC and an integrative review concerning the experience of PFCC among parents in a pediatric intensive care unit (Hill et al., 2019). The element 'collaboration', as in policy, professional teaching, and research development, was not included since it was beyond the scope of this study. Collaboration in the delivery of care is covered under 'participation'. In this study, the core elements were operationalized as follows:

- Respect and dignity: how patients and their parents are treated. Topics addressed the cultural background, religion, and experiences of compassion, support, and understanding from hospital staff.
- Information sharing: communication and availability of information to parents. Topics addressed using understandable language and receiving information.
- Participation: empowering parents to be involved in caring for their child. Topics addressed the role of parents as experts and feeling heard.

All interviews started with the opening questions: "How are you?" and "How are you experiencing your child's admission?"

The interviews were held by the first author (AH) and were audio-recorded by a recording device. A quiet room just outside the hospital ward had been made available, but most parents preferred being interviewed in their child's room on the ward, as they wanted to remain close to their child.

Ethical consideration

The Medical Ethics Review Committee of the Erasmus University Medical Center assessed this study as not subject to the Medical Research Involving Human Subjects Act (MEC-2022-0786). Written informed consent was secured from parents prior to each interview. Data collection was treated confidentially and processed pseudonymously according to the General Data Protection Regulation (GDPR). During this study, the first author did not have a nurse-patient relationship with participating parents and their child.

Data analysis

All interviews were transcribed verbatim and pseudonymized (AH). Data analysis started after the first four interviews and continued after every interview. The inductive thematic analysis approach of Braun and Clarke (Braun & Clarke, 2006a, 2006b) was used, supported by ATLAS.ti 22 software (ATLAS.ti Scientific Software GmbH, Version 22, 2021). The transcripts were read and re-read by the first author to get familiar with the data (AH). The first author (AH) open- and axial-coded the interviews after every interview. Members of the research team independently coded the first three interviews (MvD, JLF) and assessed for similarities and differences (JLF, DS). Initial codes were collated into potential themes and reviewed by the research team.

These codes, code groups, and potential themes were discussed among the research team until consensus was reached. The first author's reflections were recorded in memos, which were discussed with the research team (MvD, JLF, DS). The first author used memos for self-reflection, recognizing potential biases and assumptions that could influence data collection and interpretation. To enhance the study's validity, the first author reflected on her role as interviewer and researcher. Subsequently, all researchers (MvD, JLF, DS, HW), who are experts in thematic analysis, independently reviewed and verified the final themes that emerged. Illustrative quotes were selected by the first author (AH) and translated into English by an experienced translator.

Data saturation was reached after the tenth interview. Two additional interviews were performed to affirm the themes and subthemes and to ensure maximum variation in the sample. Additionally, member checks were conducted, providing parents with the opportunity to review the transcript to ensure the accuracy of the descriptions and interpretations of their experiences (Boeije, 2010). Two parents utilized this opportunity, both agreeing with the content without opting for any adjustments. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) was used to ensure complete and careful documentation of the study (Tong et al., 2007).

Results

Between February 2023 and May 2023, parents of thirty-seven children were invited to participate in this study. Seventeen declined; not all provided a reason for declining, however, most parents indicated that they were experiencing a lack of energy or that the timing was inconvenient related to their child's condition. The children of eight parents were discharged before consent could be sought or an interview could be scheduled. Twelve interviews were conducted; eleven mothers and four fathers participated, with a total of 15 participants. Three interviews were conducted with both parents (Table 1). The duration of interviews ranged from 32 to 105 min (median: 41 min). The mean age of the parents was 36 years (range 22 to 51 years). Parents had diverse migration backgrounds, primarily from Eastern Europe, and most had lived in the Netherlands for more than 15 years. The median length of admission at the time of the interview was 10 days (IQR: 5–18 days).

Four key themes emerged that represented the parents' experiences and needs: receiving child-focused care from hospital staff, acquiring support and personal attention to endure hospitalization, engaging in parental participation, and seeking comfort and privacy in the hospital. Appendix B provides an example of how codes, subthemes, and themes were derived from the interviews using the theme 'Parental Participation'. An overview of all four themes, including corresponding codes and representative participant quotes, is provided in Appendix C.

Receiving child-focused care from hospital staff

Parents experienced that their child received the professional care that was needed and felt as if the child was at the center of care. They valued how nurses considered the child's needs and preferences, which was paramount to parents. They felt that the child-friendly environment, activities of the pedagogical staff, and personal attention paid to the child contributed to a comfortable and homely atmosphere. Parents appreciated extras that were done for the child, including nurses

writing diaries for the babies and the use of distraction from painful or frightening interventions.

"It's actually not a fun place to be, but on the one hand you want to be here because it's quite fun. Because of all the activities that are organized, the things from the pedagogical staff that they bring to keep you busy." (Mother, interview 1).

Parents expressed appreciation for the expertise of the hospital staff and the facilities provided for their child's treatment. Some parents noted that the care they received differed from their experiences in their country of origin, where there is a distinct difference between private and public hospitals, and the quality of care often depends on the financial ability of parents. Additionally, parents mentioned that in this hospital, they tend to have more personal interactions with physicians and have a greater sense of assurance that the care and hospitalization of their child is well-managed. From another perspective, a mother reported increased anxiety due to the waiting period for crucial test results, which would influence her child's prognosis. She indicated a preference for the health care system in her country of origin, where she perceived the results could be obtained more quickly.

"The concerns of most [migrant] people is that they know that abroad everything is done. They worry about: Could I possibly be too late for my child? While there [country of origin], I might hear everything after two days." (Mother, interview 10).

Parents whose child had been previously admitted to a general pediatric ward in another hospital noticed a positive difference in the care provided on a specialized pediatric ward for that particular condition. They especially appreciated the calm way in which the child was approached and the feeling that the staff is really on top of things. Parents of children with complex conditions, such as heart defects or oncological diseases, felt secure thanks to the specialized care for their child. They observed that nurses stayed calm in acute situations and knew exactly how to handle them, which helped build trust in the nurses. The knowledge that other children with similar conditions were also being treated there contributed to their sense of safety. Especially the parents of the children who needed multiple admissions expressed their gratitude for the specialized care.

"A staff meeting where a child is fully discussed and sometimes several times in a day. So much attention that your child gets, and they really take you seriously and we can only appreciate that. I think that's great." (Father, interview 3).

Acquiring support and personal attention to endure hospitalization

The uncertainty of hospitalization and what the future may hold felt like a heavy burden on parents. However, they recognized the importance of support and attention not just for their child, but for themselves as well, as it helped them navigate this challenging time. Parents of children who required multiple admissions felt that the medical and nursing staff took the time to truly get to know their child. They sensed that the medical and nursing staff were genuinely involved and undoubtedly valued this relationship. They received personal attention and care, and their needs were considered and actively inquired about. The physicians and nurses made an effort to inquire about their feelings, offer comfort, ask about their home and work situations, and greet them in the hallways as if they were familiar faces. This attention created a sense of family for them.

"I'm happy, I see familiar people. I just feel like home." (Mother, interview 4).

Parents whose children were admitted for a short period or for the first time did not mention that kind of personalized connection with the hospital staff. They felt that the support and attention provided

Table 1
Demographic characteristics of the participating parents.

N	15 parents*
Gender, n	
Female	11
Age parent, mean (range)	36 (22–51)
Age child, n	
< 1 month	2
1–12 months	3
> 1–4 years	3
> 4–12 years	1
> 12 years	3
Continent of origin, n	
Eastern Europe	5
South Europe	2
North Africa	2
North and South America	2
Asia	4
Number of years in the Netherlands, n	
5–14	5
15–24	3
≥ 25	3
Length of hospital stay in days, n	
≤ 7	5
8–21	5
≥ 22	2
Previous hospitalization, n	
Yes	4
Religion, n	
Muslim	10
Christian	3
None	2

* 15 parents in 12 interviews.

did not extend to their own needs, such as postpartum care or emotional support. Postpartum care, for example, was not available in the same ward where the child was admitted, which meant that mothers needed to leave their child. In addition, some parents felt that the nurses did not fully acknowledge how intense and overwhelming their child's hospitalization was for them. They perceived that some of the nurses felt these were routine and predictable admissions. For example, with children undergoing a major cranial operation, where a significant skull wound is visible, their eyes swell up, and the child is unable to see through their eyes for a few days. These parents required more support to care for their child.

"Then I hear someone say, we get cranio-children [children with a major cranial operation] twice a week. So, it seems like they are used to everything. It might be the most normal thing in the world for them, but not for me. I'm the mother. This is the first time in my life that I'm going through something like this." (Mother, interview 7).

Most parents expressed that they gained strength from their faith to endure hospitalization. They felt supported by the nurses to practice their religion and perform rituals that were important to them.

"I think everyone needs some kind of grip. It doesn't matter what you believe in. It's just something you can fall back on. It's something that gives you strength." (Mother, interview 12).

Engaging in parental participation

Most parents experienced their role as being a partner with the nursing team and emphasized the need for a collaborative approach to care. They considered it obvious to provide parental care, such as washing and feeding, to the child themselves, while expecting nurses to handle medical procedures. However, parents' experiences varied depending on their child's age and condition during the hospitalization. Parents of newborns emphasized that they needed more help in providing parental care for their child, as they were still getting to know their new role as parents for a first-born or for a sick child. These parents experienced a barrier to providing parental care when their child's condition was fragile. When children had a significant wound, for example after a cranial operation, parents who initially felt capable of performing parental care might hesitate or feel overwhelmed by the sight of their child being physically altered. In those cases, they preferred to leave these responsibilities to the nursing staff. However, it was sometimes unclear to parents how these responsibilities were divided, making them unsure whether it was appropriate for them to remind the nurses about administering medication, which deepened their uncertainty about their role and their ability to care for their child.

"Nine times out of ten, I'm the one who does call, shouldn't you guys do the checks? [...] It's my child, sure I have to take care of her, but if I'm in a ward like that, they should be in control of the care for my child." (Mother, interview 7).

There were differences between wards regarding parents' experiences with parental participation. Parents from two wards stated that they did not receive an invitation to participate in ward rounds, while parents admitted to the other two wards mentioned being offered the opportunity to participate several times a week. Parents valued the opportunity to ask questions and receive information immediately. They emphasized their need for comprehensive information sharing as a crucial part of collaboration between nurses, physicians, and parents. This included detailed information about the child's condition, an upcoming surgery, or the child's treatment options.

"I see medical care as a tandem bicycle. As parents, we need to pedal alongside the health care professionals. They can't do it on their own."

"We are responsible too and must actively participate in the process." (Father, interview 3).

Parents mentioned that the use of language played a central role in sharing information about the child's condition or treatment plan. Some parents found the use of medical jargon during these rounds somewhat stressful. One father addressed that they did not fully understand the physician, after which the physician rephrased and used other words, which improved their understanding. Although the parents were proficient in the Dutch language, language barriers were still experienced. Two mothers had a partner who did not speak Dutch, and they felt responsible for translating. This burdened both parents, as the father could not communicate with the staff during admission, and the mothers felt they could not leave the hospital because the fathers were unable to express what the child needed. A professional interpreter by phone for general care and conversations was suggested by them as a desirable solution, though it was not offered during the hospitalization thus far.

Parents experienced occasional miscommunication with the nurses and physicians, long waiting times for the nurses to respond to an alarm, and negative experiences with a physician. Despite these issues, they responded with tolerance and understanding, recognizing that such challenges are part of the health care experience and accepting that they are sometimes unavoidable.

"I had one bad experience. But I understand they were very busy there. They lost my first [breast]milk. I brought the bottles to them, and they forgot to freeze it. I thought this was under control and didn't check it myself. Now I understand that I must check that myself. It's a sad story. But I also understand why it happened." (Mother, interview 6).

Seeking comfort and privacy in the hospital

Parents emphasized the impact of the hospital environment while enduring admission, highlighting the importance of staying close to their child. To support this, the hospital provides meals for parents, allowing them to remain on the ward without needing to leave. Parents appreciated that the hospital had a variety of food options, including halal food, which made some parents feel at home and aligned with their lifestyle and religious beliefs, which were important to them.

"Having halal food available makes me feel a bit safe and a bit at home. If you have a different background, you are somewhat limited, you can't eat everywhere, that is not possible. For a child, that is quite difficult." (Mother, interview 2).

Parents mentioned that different types of rooms were available: single-occupancy room, multi-bedded room, and family room. Due to hospital rules and space limitations, only one parent is officially allowed to room in with the child in the single-occupancy and multi-bedded rooms. However, some parents mentioned that exceptions were made during their admission, allowing both parents to stay together, which parents highly appreciated. Most parents were satisfied with the single-occupancy room, as it provided private space with access to their own bathroom. Conversely, some parents of children in a multi-bedded room found the lack of privacy and the challenges of sharing the space with others difficult to manage. Family rooms, which are available in only one of the wards, allowed both parents to stay with their child. These rooms, noted for their spacious and neat appearance, were especially valued by parents.

"I was surprised by the lack of privacy. I would never have thought that I have to stay here with more people in the room, having to take others into account. For instance, now with breastfeeding, I take everything into account. Whereas you should just be able to be at ease." (Mother, interview 5).

Parents felt that even in a private room, the sense of privacy was lacking when the entrance door had a window, which made it more difficult to follow the practices of their religion. They mentioned that a nurse or physician did not always ask permission to enter the room, so that an uncovered Muslim mother could suddenly be confronted with the near presence of a man. However, these mothers could put it into perspective, indicating that good care was their priority and that in a hospital where many cultures come together, it is challenging to accommodate everyone's needs perfectly.

"I very often say to my husband: you had better stay here to sleep. For you it's easier, because I have to deal with my headscarf, I have to deal with my clothes, constantly. And you just put on your pyjamas and you lie down, and done. For me, I have to worry about everything." (Mother, interview 1).

"You wear your headscarf all the time, of course, that is a little bit inconvenient. You also want to be a little bit free. Now they come into the room at once, which also makes me want to be prepared. But I also pray in the room, and then the nurse came once. That is fine, I don't mind, I just continue my prayer." (Mother, interview 2).

Some religious parents wished to pray regularly, giving them peace and strength to go on. Although parents knew there is an official prayer room in the hospital, most parents prayed in their child's room. Some parents wished to have a prayer mat in their room, while others were content with a towel or jacket.

"During prayer, I can talk to God. That does make me feel really good. Where I can find my peace, then. Perhaps that is what helps me persevere, that I can get through it [hospitalization]." (Mother, interview 11).

Fig. 1 illustrates the core elements of PFCC and how they relate to the key themes identified in this study. The upper panel shows the core elements of PFCC (Institute for Patient- and Family-Centered Care, 2017). In the middle white panel, three key domains—Child, Parents, and Hospital Environment—are distinguished. The lower panel presents the four themes from our study: Child-focused care, Support and attention, Parental participation, and Comfort and privacy.

Parental participation, and Comfort and privacy. The coloured arrows connect themes to the core PFCC elements, demonstrating how theoretical principles translate into practice.

Discussion

Main findings

Overall, parents with a migrant background expressed positive experiences about the child-focused and specialized care provided in our university children's hospital. Their experiences and needs varied based on the complexity of their child's hospitalization, as well as their own experience and support in caring for their child. Parents of children with long-term admissions, characterized by increased uncertainty about their child's condition, reported a stronger sense of connection with health care professionals compared to parents of shorter, routine admissions, who felt they needed more support and engagement than they received. Of note, parents' backgrounds may have influenced their expectations and perceptions. Some parents' perceptions may have been influenced by health care practices in their country of origin, such as faster access to secondary and tertiary care or a more limited or more extensive engagement of parents. These differences may have led to uncertainty about their role and the level of engagement expected from them. Another challenge faced by these parents was the loss of privacy, particularly when sharing a room or when they wished to practice their religion. Despite encountering these challenges during admission, parents generally responded with understanding and tolerance, prioritizing their child's well-being over their own.

Our study showed that the needs of parents in relation to the care of their hospitalized child were similar between both migrant and non-migrant parents, including receiving high-quality, personalized, child-focused care with attention to their own well-being. These needs seem universal for any parent with a sick child, which aligns with conclusions from other studies (Adama et al., 2022; Zdun-Ryżewska et al., 2021).

Previous literature has highlighted disparities in the delivery of PFCC in pediatric care, with migrant families often receiving less culturally competent care and comprehensive care compared to non-migrant

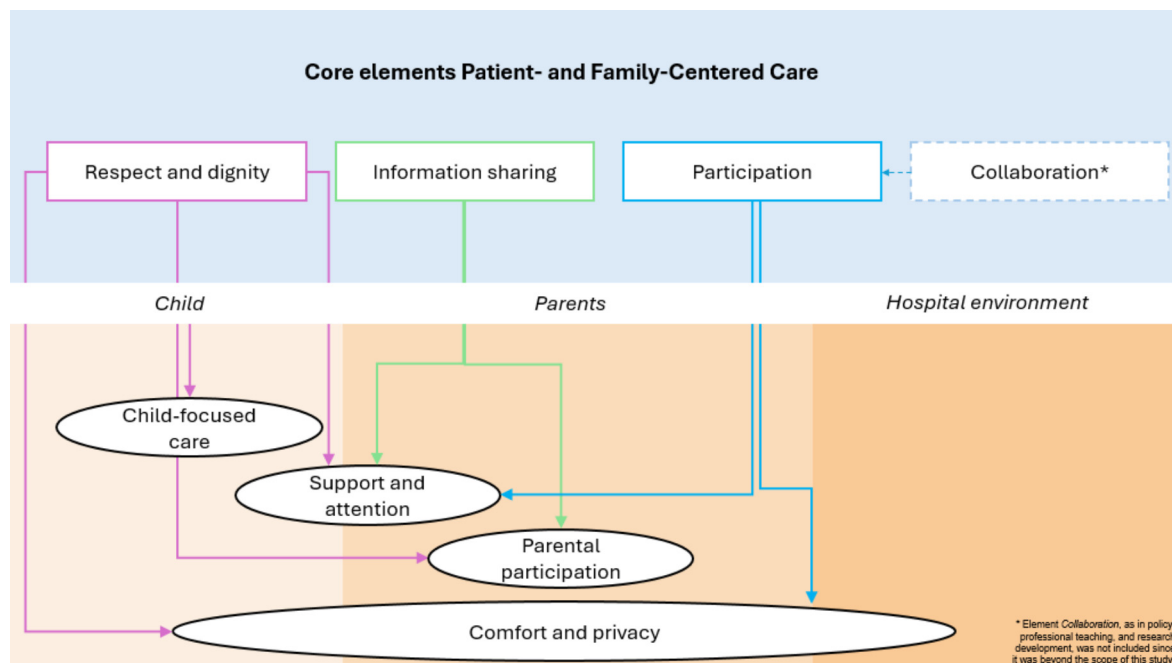


Fig. 1. Conceptual model of the core elements of Patient- and Family-Centered Care and their relationship to the key themes identified in this study.

families (Morgan et al., 2023; Slopen et al., 2024). These studies raised concerns about whether parents in our hospital participating in this study felt similarly. However, our findings indicate that participating parents did not perceive differences in treatment based on their migration background. Rather, they felt that their experiences of PFCC were influenced by other factors, such as their child's specific care needs, whether they were admitted to a private or shared room, the complexity of the child's admission, and whether it was a short-term or long-term admission. Other factors may have contributed to disparities in PFCC delivery within our hospital that could not be identified through parental experiences. Previous studies indicate that nurses face challenges in involving families in treatment processes. These challenges include that nurses believe that only they are responsible for a child's care, their legal accountability, and that parents first need to be assessed to determine if they can be involved in the child's care. Additionally, some nurses perceive the constant presence of family members as overwhelming, particularly when families ask frequent questions (Seniwati et al., 2023). While our study did not reveal these issues, further research may be necessary to explore whether challenges like these impact the effective delivery of PFCC.

The need for support regarding parent participation in PFCC in our study was consistent with previous reviews of non-migrant parents' experiences (Adama et al., 2022; Power & Franck, 2008). Parents needed staff to provide them with an enabling environment to provide hands-on support for basic care. This was also mentioned by parents in our study, who needed assistance with tasks that seemed to be routine for nurses but overwhelming for parents. Parents differed in their comfort levels with taking care of their child independently, without assistance from the nurse. For example, cranial surgery may seem like a routine procedure to the nursing staff but can be very overwhelming for parents. Observing their child with a severe cranial wound, where the child's eyes are so swollen that the child cannot see, brings a lot of emotions. The importance of clear information and interpersonal parent-staff interaction is also described in other studies (Adama et al., 2022; Petersson et al., 2023). It appeared that parents were unable to specifically articulate their expectations and needs concerning information or help with parental care. Therefore, nurses and physicians should actively address parents' expectations, needs, and abilities to participate in care. The level of participation of parents may depend on their general habits, their experiences in their home country, or their cultural practices. Some parents in our study valued being more involved compared to what they are used to in their home country. In contrast, one mother highlighted a concern regarding the diagnostic process of her daughter's illness, which she felt was prolonged compared to what she was accustomed to in her home country. This delay heightened her anxiety and dissatisfaction, as she feared it might lead to unnecessary delays in treatment. A policy letter from Seibel and Arsenijevic (2022) highlighted that migrants, in particular, face difficulties in navigating the health care system, leading to potential negative impacts on their overall well-being. Additionally, migrant patients frequently perceive longer waiting times for specialized care compared to their natives. Such challenges can lead to perceptions of unfair access and a lack of trust in the Dutch health care system (Seibel & Arsenijevic, 2022). Therefore, nurses and physicians need to ask parents about their expectations and previous experiences and support them in dealing with potential challenges in navigating the health care system. This approach can help reduce misunderstandings and improve trust.

Our study stresses the impact of the hospital environment on parents during hospitalization, while other studies primarily focus on a calm and safe environment for the child's recovery (Hill et al., 2019; Poole et al., 2024). Our study emphasized that even in a private room, where privacy is assumed, this is not always sufficient for religious parents who would like to pray regularly. Health care professionals must realize this to support parents with the burden of hospitalization and ensure that it remains an ongoing topic of discussion throughout hospitalization. Conducting an accurate anamnesis that includes parents'

needs regarding their religion and culture should be documented in the electronic patient file and considered throughout the admission.

Strengths and limitations

A key strength of this study is that it offers insights into the experiences of parents with a migration background during their child's hospitalization and illustrates that PFCC is not a one-size-fits-all approach. By focusing on this underrepresented group, our study provides valuable perspectives that can inform more inclusive health care practices. The study is further strengthened by researcher triangulation, in which the first author was supported throughout the entire process by experts in qualitative research.

Nonetheless, this study had a few limitations. First, the study sample is drawn from a single academic hospital, which limits the transferability of the results. Second, we interviewed parents who were proficient in Dutch to conduct a first exploration of parents' experiences and needs. Experiences and needs of parents with language barriers were not included and need to be explored in future research. Third, selection bias might play a role, since we might have missed parents with unpleasant experiences, especially considering the considerable number of parents who declined to participate. This could potentially bias the findings towards more positive experiences. Additionally, mainly mothers participated in the study, which does not fully represent both parents' experiences. However, it reflects that mothers are more often present in the ward than fathers. Finally, parents may have been inclined to provide socially desirable answers because the first author works in the hospital. Also, she does not have a migration background, which can create cultural dissonance and cultural misunderstanding.

Implications for practice and research

To ensure that PFCC is effectively integrated into clinical practice, it is recommended to evaluate potential barriers within the own setting and develop strategies to optimize the involvement of families in a way that aligns with professional responsibilities. Providing tailored care for patients and parents with a migration background, health care professionals could benefit from education in culturally competent care. In addition, fostering a diverse health care workforce and appointing nurse champions promotes inclusive attitudes, ultimately improving culturally sensitive care.

Beyond education and awareness, culturally competent PFCC also requires practical adaptations, including facilitating religious practices, dietary preferences, and culturally sensitive approaches to end-of-life care. By integrating these considerations into clinical practice, health care professionals can ensure that PFCC is inclusive and responsive to the diverse needs of all families.

To successfully foster a diverse health care workforce, it is crucial to gain insight into factors that influence the recruitment and retention of nurses with a migration background in various settings. This insight can inform the policies aimed at creating an inclusive work environment. In addition, future research should include patients and families with a migration background, particularly those facing language barriers, to gain a more comprehensive understanding of their experiences and needs. This can ultimately enhance the inclusivity and quality of care. To minimize biases caused by the use of translation tools, it may be beneficial to involve multiple interviewers who are native speakers. Strengthening inclusiveness in research will contribute to the development of evidence-based strategies that enhance the quality and accessibility of PFCC for all patients and families.

Conclusion

This study explores experiences and needs of parents with a migration background regarding patient- and family-centered care for their hospitalized child. Parents expressed universal needs concerning

hospital care for their child, such as receiving high-quality, personalized, child-focused care with attention to their own well-being. Parents had specific needs focused on support in participating in their child's care, receiving information in understandable language, and appropriate private facilities to accommodate religious practices and ensure privacy during admission. Further research should include underrepresented populations and explore strategies, including workforce diversity, to improve the inclusivity and effective implementation of PFCC in clinical practice.

CRedit authorship contribution statement

Anne Heijboer: Writing – review & editing, Writing – original draft, Visualization, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Jeannette L. Falkenburg:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Heleen Westland:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Denise Spoon:** Writing – review & editing, Writing – original draft, Formal analysis. **Monique van Dijk:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

We declare that there are no conflicts of interest related to this research, and all authors have no financial or personal relationships that could influence the interpretation of the findings or bias the presentation of information in this manuscript.

Acknowledgments

We would like to express our gratitude to the parents who participated in this study. We also extend our thanks to Ko Hagoort, our editor.

Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.pedn.2025.04.013>.

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