An Exploration of the Child’s Experience of Staying in Hospital from the Perspectives of Children and Children’s Nurses using Child-Centered Methodology

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ABSTRACT
Globally the needs of children differ to those of adults; consequently, the “voice” of children in health care delivery is paramount to its effectiveness as a service. This qualitative study aims to present a contemporary “slice” of life in four children’s wards in a typical United Kingdom children’s hospital in the 21st century from the perspective of the service user (child) and significant service giver (Registered Children’s Nurse). Phase one of the study involved the development of a child research advisory group (CRAG) with five local primary school children (aged 10–11 years) to assist in the co-production of research questions and data collection tool for child participants – two talking cartoon characters (Sprinkle Cupcake and Ronaldo Football) via an app/iPad. In phase two (main study), hospitalized children (n = 18) and Registered Children’s Nurses (n = 8) were interviewed on one occasion within their ward setting using a semi-structured approach in July 2017. The emerging broad themes (using thematic analysis), were (1) children – the child’s needs, relationships, fears, and concerns, alongside (2) nurses – children’s nursing, job pressures, safe and effective care. Themes were then presented as tensions in that they represent the relationship between variables where the different elements in the relationship are held in tension, such that a change in one impacts upon the other. Similarities between the children and nurse participants include issues with the environment, lack of time to care (nurse), effects of nurse-led interventions, and valued role of play. Differences are largely around the role of the parent. The development and work of the CRAG and use of “tensions” to more effectively present the complexity of the findings are unique to this study. In conclusion, this study contributes to the development of a generalized knowledge base for policy, nursing education, and clinical practice by shedding light in how the complex hospital environment can be challenging for the child and children’s nurse.

Introduction

This paper presents the findings of an empirical study, which explores the child’s experience of an overnight stay in hospital from the perspective of the child and registered children’s nurse. It is organized as follows – background, literature review, theoretical frameworks, study aims and methods, findings, discussion, and conclusion.
Background

It is widely agreed children and young people (CYP) are recognized as significant and unique users of healthcare whose needs differ significantly to those of adults (Carter et al., 2014; Corkin et al., 2012; Glasper & Richardson, 2010; Royal College of Child Health and Paediatrics, 2017; The United Nations Convention for the Rights of the Child, 1989). They also have a comparatively high rate of contact with health services for preventive care or management of acute illness and a high possibility of requiring hospital admission at some time during childhood (Scottish Executive, 2005). Within Northern Ireland (NI), one of the United Kingdom’s four countries report approximately 145,000 Emergency Department attendances each year by children under 16 years (Department of Health, 2016). A proportion of these children would be admitted to hospital and a case for ‘children’ having a voice in respect of an area of health care that clearly affects them is evident within policy and the relating literature. In today’s society there does appear to be an increasing expectation that children and young people should participate in health and social care decisions that affect them (Franklin & Sloper, 2009).

Narrative review: summary

A narrative review enabled the researcher to summarize different primary studies into a comprehensive holistic overview of the topic (Whiteley et al., 2015). It adopted a process of selection using a broad time period, key search terms, and a number of appropriate data bases. Data were initially extracted from each study using a data extraction sheet, which identified the author(s), date and source of publication, study design, key findings, limitations, and recommendations. The extracted data was then added to a summary table and based on this key dominant themes were identified. These provided the foundation for the formulation and the synthesis of a coherent narrative – available as an open access publication (Clarke, 2019). There were 51 papers included in the review. The review, therefore, presents the views of two groups – (1) children who stayed overnight (n = 46) and (2) children’s nurses (n = 5). The main findings of the narrative review are organized thematically.

The views of nurses caring for the child in hospital suggest challenges exist within time restraints (to provide care), communication skills, and an environment, which may isolate and separate the child from their family and other children. The main themes emerging in respect of the hospital experience of children are represented as relating to communication, environment/ward design, play, isolation/separation, and the child’s relationship with family and children’s nursing to be particularly important to the child in hospital.

Theoretical frameworks

Bronfenbrenner (1979) and Arnold (2016) provide a conceptual platform, which would guide the study to ultimately help discover children’s experience of hospital. For example, Bronfenbrenner’s (1979) model can be used to support an understanding of how children adjust to or cope with an environment that is alien to them – both hospital ward/environment and children’s nurse differ greatly to the child’s home and family, while Arnold’s (2016) model provides a vehicle for exploring the challenges of communication.
**Ethical considerations**

This study was granted full ethical approval by the *Office for Research Ethics Committees Northern Ireland*: No 17/NI/8800.

**Aims and methods**

This study aims to

1. Seek the views and feelings of children who had an overnight stay in one of four wards when cared for by a Registered Children’s Nurse.
2. Explore the views and experiences of Registered Children’s Nurses on providing nursing care to children who stay overnight in hospital.
3. Identify any ‘differences’ and ‘similarities’ in the way the child’s hospital stay are perceived by the child and the Registered Children’s Nurse.

**Study design**

A broad qualitative approach was adopted, it therefore took an interpretative, naturalistic approach to its subject matter (child and children’s nurse) within the setting (hospital); attempting to make sense of, or interpret phenomena in terms of the meanings it brings to the person (Jones, 1995).

**Phase 1: child participatory context for study methodology**

Prior to conducting this study, the researcher established a child research advisory group (CRAG) which co-developed child-centered research questions and data collection tool (Clarke, 2020). Five primary school children aged 10 and 11 years – two boys and three girls with experience of hospital agreed to act as a CRAG to this study. The school principal assumed the role of gatekeeper and gained written parental consent and child assent; activity materials were developed and used with the CRAG. Figure 1 depicts the four-stage process.

The children agreed two talking cartoon characters (Figure 2) would be used to collect information from child participants using an iPad.

**Phase 2: sample and setting**

In an attempt to capture the younger child’s voice, child participants were aged six to 12 years (n = 18) who had experienced at least one overnight stay in one of four children’s wards of NI’s regional children’s hospital and those registered children’s nurses (n = 8) who routinely cared for hospitalized children. Children of differing genders, age, cultural backgrounds, medical and surgical intervention, and those with a learning disability participated in this study. Children who were either a first or second admission to hospital or those more frequently admitted to hospital ensured a balanced sample of child respondents. As a nursing group, eight nurses had more than five years’ service with the majority employed full time and under 40 years of age – six were ‘junior’ within their career pathway. One was an Advanced Nurse Practitioner and another ‘dual trained,’ i.e. Registered Nurse (Child) and (Adult).
Figure 1. CRAG: four-stage process.

Data collection and procedure

The ward manager was the Initial contact to inform the children’s nurse, child, and parent/guardian. On reading information relating to the study and a cooling off period, informed consent was freely given by the children’s nurse and parent, along with child assent. In total 26 interviews were conducted ‘face to face’ within the hospital setting, during the first two weeks of July 2017. Both children and nurses were offered a choice when selecting their interview space. Child options were playroom, main ward or single room, sitting on their bed or chair. Even though the CRAG recommended the presence of a parent during the child’s interview, i.e., ‘make them feel safe’, it was optional and the child’s ‘right’ to choose. Most children preferred to have their parent present, with a small number having no preference and their parent respecting their right to choose. Nursing options were family room, manager’s office, or clinical room. Field notes and digitally recorded interviews were anonymized. Infection control measures were upheld by the researcher, i.e., hand washing on entering and leaving a ward and between interviews – the iPad was cleaned between interviews with an antibacterial wipe. Child interviews lasted approximately 10 min and children’s nurse 20 minutes. The approach to interview did however differ for the child (service user) and that of the (adult) children’s nurse (service giver) (Punch, 2002). ‘What to ask’ and ‘how to seek’ the views of children in hospital on was underpinned by an established GRAG. The researcher guided each child participant on how to use the interactive animated software program loaded onto an ‘iPad’ – both characters asking the same questions (Table 1) – each child selected a character.

All study participants were asked if satisfied with their responses immediately following their interview and if they would like anything removed from the audio recording. No requests were made. Each parent and nurse had the researcher’s contact details in case they wished to view a summary of the transcription for accuracy. Individual interviews for
children’s nurses were during contracted working hours; the questions listed in Table 2 were partly reflective of previous studies and CRAG. For example, while questions one and three were developed from gaps in the literature, two was based on the findings of
previous studies (Jolley, 2003; Koller et al., 2006). Question four was asked by a previous study (Coyne & Kirwan, 2012) and recommended by the CRAG as it was open and limitless.

Data analysis

Braun and Clarke (2006) thematic analysis framework of six phases was used to guide data collection and analysis. It was selected as commonly adopted by many researchers’, uses a simple framework, with the end result of undertaking thematic analysis is to optimally highlight the most salient constellations of meanings present in the dataset. NVivo Pro version 11 was used to code and recode all interviews. By adopting thematic analysis, participant statements and wishes were identified, and analyzed through the reporting of relationships between variables within the data set. This was achieved by grouping common respondent extracts together, which then created broad themes. Relationships were then established between themes which were then presented as tensions. Tensions within the data appeared to represent a lack of harmony in the relationship between variables. This was also supported by participants’ non-verbal communication, i.e. facial expressions.

Findings

Thematic interpretations from ‘the child respondents’

A first examination of data from the children established some broad themes/sub themes that can be represented as relating to,

- The child’s needs – to be listened to; the importance of their being able to exercise choice; the importance of play.
- Their relationships – parent/guardian, the play specialist, the children’s nurse/ children’s nursing student, other children (in hospital); visitors and pet(s).
- Their fears or concerns – length of stay (in hospital), ward environment and nurse-led clinical procedures and interventions (including pain).

The needs of the child in hospital are represented as a tension due to the things they consider equally of importance when in hospital. Although most children did appear listened to, this study does suggest there may be scope for improvement. James (age 10) when asked if the nurses listen to you, ‘laughingly’ stated, ‘I asked for beans and toast and it took them two days’. Jack’s (age 12) summation of his experience with children’s nurses was typical of most children.
We usually get a lot of different nurses every day but they are helpful and very kind, they are always there if you need anything. They are always there to listen.

The children’s nurses although ‘liked’ by the children did recognize they were ‘busy’. The fundamental right of a child to choose in matters that affect them appeared to be adopted by the nurses in all four wards. A finding from this study did suggest ‘choice’ to have a positive impact on the child’s experience of hospital and for poor communication by the nurse to impact on their experience in a negative way.

All children deemed the role of play important. It relates to the environment, array of activities, access to technology, and the person employed to facilitate play, i.e., play specialist. Sue (age 10) reported the hospital should ‘make the play room bigger’ and there needed to be ‘more for the bigger children, as they too babyish’. The children reported what the ward offered in relation to play, did not meet their needs and they were ‘bored’.

The child ‘relationships’ are represented as a tension due to those people who are of importance to them when in hospital. Hence, a tension between a hospitalized child and those people they consider important occurs because the fact of hospitalization limits access to those people the child holds dear.

Parents (and guardians) were reported by most children as being of great importance in hospital. All but two wanted their parent present at all times. Sam (age 11) for example, felt his mum ‘keeps him company, makes him feel happy, not lonely and safer’. Kim (age 7) said her mum was ‘fun’ with Lara (age 8) stating it would be ‘scary’ if her mum were to leave. The findings may suggest children need some sense of security in respect of the aspects of hospital care that cause them most concern. As parents are seen as offering that security there may be an argument for having them more involved in the care of children whilst in hospital. The same may apply concerning pets, siblings, friends, etc. Examples of who children wanted to see in hospital are presented below.

_I want to go home be with my dog._ (Kerry, age 12)

_To see my brother and sister (and friends) during hospital._ (Fred, age 6)

_‘My friends live far away so it would be hard - to see them’._ (Sam, age 11)

Similar to play, time with the play specialist was deemed essential, and more so for the younger children in hospital. Eva, (age 8) and Max (age 7) when asked, is there anything else that would help children in hospital? Both replied the ‘play therapist’.

The children also described the children’s nurse in simple terms, for example ‘nice’, ‘helpful’, ‘friendly’, ‘funny’ ‘love them all’ and ‘children friendly’. Opposing views were given, David (age 11) reported the nurses as ‘a bit mean’ as they ‘stabbed him with needles’. David was aware ‘they had to do it’. One younger child Kim (age 7) reported on liking the nursing student as ‘she has more time to spend with me’.

While some children appeared informed around the ward’s access policy (visiting) and others not, access did appear to impact upon their experience of being in hospital. Ten children spoke of separation – they expressed sadness when reflecting on the people and pets they missed. Beth age 9 missed her ‘brother and my cat’, and ‘the wee ones’ (siblings), she wished they ‘were allowed to come in and visit’. Family, pets and friends are fundamental to the child’s world, as they create a sense of normality and help the child feel safe.
Child relationships when in hospital are represented as tensions; this is due to the fears or concerns the child considers to be of importance when in hospital. Hence, a tension between a hospitalized child and their fears or concerns, which they consider important, occurs because they are in hospital. Thus, the elements in the relationship – hospitalization and fears or concerns are held in tension. In respect of fears and concerns.

Length of stay appeared to matter more to those children who had been in hospital for a longer period i.e. weeks to months rather than the ‘norm’ of a few days. Luke (age 10) stated, ‘it’s bad being away from home for so long’.

The ward environment was also reported as important to the child in hospital in terms of how their needs were met. Children spoke of the ward layout and to where they were positioned as mattering to them most. Hospital food had mixed reviews, it was more important to those ‘fasting’ or on a restricted diet. Max (age 7) offered other insights into his experience,

*The toilets are a wee bit smelly and I don’t have a tray (breakfast tray) and then I will get the bed messy and I feel bad then, as the cleaners have to clean it up.*

Kate (age 6) was of an alternative view, as she liked her side room – it was personalized and looked like a bedroom. Orla (age 12) who was allocated a bed space in the main ward (nightingale design), spoke negatively of the heat, the smell, noise, and pain as her experiences of hospital. She also reported to hearing the nurses talking at night. Eva (age 8) whose bed space was in a bay of four bed spaces provides additional insights into sleeping in hospital.

*This isn’t anybody’s fault but what’s annoying whenever I was trying to go to sleep last night, I couldn’t really and it was not this person fault …….. because that baby over there (in the same bay) was crying but it’s not their fault.*

Some of the worst things of being in hospital as a child related to clinical interventions such as needles (injection), pain, operations, and a hospital environment where the ward was not considered fit for purpose. Clinical procedures made the children feel sad and scared. David (age 8) and Fred (age 6) both named ‘needles’ one of their worst things. In summary, the children in this study mostly had strong views; they did voice their opinions when given the opportunity.

**Thematic interpretations from ‘the children’s nurse respondents’**

A first examination of data from children’s nurses established some broad and themes that can be represented as

- Children’s nursing – love children’s nursing; communication; the hospitalized child and nurse/parent conflict.
- Job pressures – inadequate staffing levels and visiting access.
- Safe effective care – environment, knowledge deficit; inadequate play and new regional hospital.

**Children’s nursing** was found to be held in tension because of how their nursing role impacted upon their health and well-being. Hence, a tension between the roles of
a children’s nurse occurs because the fact of caring for children in hospital does impact upon the nurse’s health and well-being. Whilst well supported by their employer, all reported having experienced a significant level of stress when commencing their first post as a children’s nurse. One nurse reported, ‘It is difficult at times but very rewarding, I wouldn’t change to do anything else’ … (RNC7). One respondent expressed a distinct motive for choosing children’s nursing:

Children’s nursing really stood out … I find it’s great that people can do adult nursing but I find that was not for me. I sometimes think a child is different; they have all these needs whether they are sick or well. (RNC7)

Although children were reported by one children’s nurse as ‘sort of challenging, they don’t understand things, not always compliant and you just have to play with them a bit. Kids aren’t going to do just what you say’ (RNC4). The typical view of the child in hospital was positive; all appeared to adopt a child centered approach.

A key part of the children’s nursing role was communicating through information giving and by listening to the child, parent/guardian, wider family and other health professionals. Communication challenges seemingly added to the pressures of the job and impacted on their health and well-being especially when time was limited.

I have always said to the girls (nurses) …. a booklet with like basic words in every language, you know it would be great. (RNC8)

The level of communication between the nurse and child, and nurse and parent appeared to cause frustration to the nurse and ultimately impacted upon the level of care they could provide. All nurses had observed the distress invoked by hospitalization on children, they spoke candidly of the ‘fear’, ‘sorrow’ and ‘pain’ a child may experience in relation to clinical interventions. One nurse explained,

‘Virtually every intervention will cause a child upset, you know we are all strangers to a child coming into ‘their space’; it must be very threatening and frightening to have things done them that no one has done before which most children do not understand! That challenge is always trying to put the child at ease I suppose that is the big one in paediatric nursing to put the child at ease and make the experience as good as it can in that situation. … (RNC2)

Parents held a partner role in that they provided much of the child’s basic care. That said, some parents were considered a challenge, i.e., demanding and needy. Extracts on the children’s nurses’ views of parents were,

(Parents) …. can be both or either really. People’s expectation of what is achievable is out of control and I do think it is particularly bad in children’s (nursing); there is no such thing now as no, everybody thinks everything is possible and everything is achievable … (RNC2)

We rely on them to do a lot of the traditional nursing, like the feeding and changing … like they are invaluable to the care of the patient but I do think we do have parents who are very challenging. When people (parents) are anxious they do not build the same rapport, so how a parent is, has a big impact! (RNC1)

Alongside tensions between parent and nurse, all nurse respondents were aware of the continual presence of a parent/guardian and its effect on the child’s experience in hospital. One respondent, who reported valuing a time when caring for the child without the parent
stated, ‘I would imagine from the perspective of the child to have the parents here, it is better’. . . (RNC2)

The job pressures the children’s nurse encountered when caring for the child in hospital are represented as a tension due to tensions between job pressures and the ability to care for the child in hospital. Thus, the elements in the relationship – the job pressures and caring for the child in hospital are held in tension. All nurses reported to be under paid and of significance to children’s nurses and regular to have no nurse available to cover sick leave. The standard nurse to child ratio on a routine ward was reported as 1:4 and to go over their allocated bed numbers to meet demand. Health care assistants acted, as ‘floaters’ and nursing students were supernumerary. One children’s nurse offers a perspective around the job pressures of time and staffing.

More time for us to spend with the patient, but maybe that is more for me. Staffing is a huge challenge and the lack of staff . . . I mean the care that you give to children that you are looking after on a daily basis, the level of care when you are under a lot of pressure. You can be so busy that you could miss something with a child sometimes. You are going to ‘eyeball’ a child who has become unwell, as sometimes parents do not realise the importance of things and flag them up with you, that is definitely a challenge. (RNC3)

A final tension in this theme was reported between the nurse wanting to support the child and family in hospital, and the clinical concerns of looking after sick children who may be put at risk by open access to the wards. Here a change in one impacts the other. One nurse respondent who felt they were compassionate reported that not all children’s nurses appeared to be distressed when having to be strict about limiting access. One insight around the issue of access was given by RNC7:

Obviously, children are not allowed on the ward and cause a lot of issues on the ward as parents will say he has been in for a week, so why can his brother not come in? We explain and sometimes we have to tell them to leave, they can come to this wee (parent) room or play room. That is where the challenge begins as they are not meant to have any other children coming in and out to visit; it is at the ward manager’s and consultant’s discretion. If the child is very sick then no, but not allow for one and not another. It is in the patient information and on ward door, you do feel horrible but you have to think of the other children and they can bring in lots of bugs. You do hate having to do it.

Safe effective care in respect of children’s nursing, the following are highlighted: environment, knowledge deficit; inadequate play and new regional hospital. These are represented as a relationship due to tensions between the hospital environment and the ability to care for the child when in hospital. Hence, a tension between the environment occurs because of the fact of providing safe and effective care. Thus, the elements in the relationship – the environment and safe and effective care are held in tension. The environment appeared important to the children’s nurse and a base to build a positive experience for the child in hospital. It was challenging across all four wards and due to the high turnover of child patients of differing ages. Opposing views of the optimal ward layout are clearly presented below by three nurses.

The environment is wrong here and even coming into some of the wards they [the wards] are old and tired and not child friendly. (RNC2)

I think ours is quite well laid out and everybody is coming and going and it is basically one big straight corridor. You usually know where to find people. (RNC6)
You can have an older kid maybe a 10-year-old with two screaming babies and I don’t think that is fair. If you have a couple of babies’ together mummies are more accepting . . . I think for a child it is not great to be put beside a very sick infant where we maybe have to run in and intervene doing suctioning and such things. (RNC1)

The nurses also thought the children needed to have more fun. Play, playroom, and play specialist were deemed essential to the child’s experience of hospital from the RNC’s perspective. All nurses acknowledged the challenges of caring for children with complex health care needs. A quote contextualizes one nurse’s view of the perceived gap in relation to mental health nurse education.

The challenge for any paediatric nurse is we have no psychiatric training and there are no facilities here . . . . . They are put into the general population of paediatric patients and yet they do not fit in . . . . . . It has got worse in the last year or two and we are not giving that care, and it is the same with the ‘anorexic children’. There again within a discipline and an even smaller grouping as you know needs very specific training and coping mechanisms for yourself. We are so out of our depth, we really have no idea. (RNC2)

**Similarities and differences between child and children’s nurse respondents**

Both children and nurses reported the ward environment to be an influencing factor on the child’s experience of hospital – children of the same age are also thought best cared for together as they are more tolerant of each other. A mix of single rooms and small bays of bed spaces appear to be most favored. In addition, access to age appropriate toys, play specialist alongside the ‘blue uniform’, which was reported to advocate a pending clinical procedure with the potential to incite distress (nurse and child) and pain (child). Although a lack of time to care for children was reported by all nurses, a number of children were aware nurses were very busy and the nursing students had more time. Even though there was a mutual respect between the child and children’s nurse, the communication of information needed improved. Differences then arose around the role and value of the parent and visiting access.

**Discussion**

This part of the paper considers how the findings of this study relate to existing literature and theory, its strengths, limitations, nursing education, and policy. Comparable to the small number of previous studies which explored the perspective of both groups (Coyne, 2006; Jackson-Brown & Guvenir, 2009; Jolley, 2003; Koller et al., 2006), this study reported a lack of time to care for the child to be an issue for the nurses, as it posed a challenge in providing quality care to all children admitted to hospital. When considering Arnold’s (2016) theoretical framework the findings may suggest a lack of time by the nurse to impact on communication, for example, time pressures may not enable the nurse to adopt the transactional model or in some cases the basic linear model of communication – this may have led to the child’s needs not being sought or met. For example, restricted visiting or beans and toast! In addition, all nurses failed to highlight (during the interview) that not all hospitalized children can read. With the children’s nurses considered busy by both groups of participants, and a minimal number of play specialists who worked part time, the children in hospital spoke of being lonely and bored. Previous studies have reported similar
findings (Coyne & Kirwan, 2012; Edwards, 2009; Forsner, Jansson, & Soerlie, 2005; Pelander & Leino-Kilpi, 2010). When focusing on the child’s perspective of hospital similar to other studies they did not like the smell (Carney et al., 2003; Coyne & Kirwan, 2012), the noise (Carney et al., 2003; Coyne, 2006), and they found it hard to sleep at night and especially when babies cried or when night staff talked. While the environment did cause disruption for the children in this study, the overall findings did differ to Edwards (2009) in that the children did not appear to feel powerless or uncertain about their experience, overall they felt listened to and to have choice around their care. That said, the importance of family and friends was similarly reported by Edwards (2009). In relation to Bronfenbrenner’s (1979) theory on the child’s microsystem and mesosystem – this study found children who had been in hospital for months or who had regular admissions appeared to add the children’s nurse to their microsystem. This outcome occurred as a result of the developing relationship between the child and the nurse, as the child came to trust the nurse.

The unique strengths of this study lie within the development and work with the CRAG and the use of ‘tensions’ to more effectively present the complexity of the findings. The CRAG was instrumental, independent, and less bias because they were ‘ordinary’ school-children rather than an established advisory group. The analysis process does not end with presenting the findings as themes but more comprehensively as tensions between variables that impacts upon each other and ultimately on the children and children’s nurses. This approach appears to be new to the literature. The views given from both groups of participants on the child’s experience of hospital offer a more in-depth understanding than that found within the existing literature. Limitations include inclusion of those English speaking and the potential influence of both the researcher and parent on the data collection process, findings of this study, i.e., researcher may create a power imbalance, and the parent may affect their child’s interview.

Policy makers need informed especially around staffing levels and hospital design as the information may guide policy to meet the needs of all types of children and children’s nurses. The layout of a ward is important to a child’s sense of well-being in hospital, with most preferring a more private space that looks and feels less clinical. For example, the children appeared to prefer individual rooms and small bays, with children of the same age cared for together, using facilities that meet the needs of all children and their families. The children reported to want a social place where they could play and chat with friends, with access to toys and technology during the day and evening. One children’s nurse reported the need to protect high dependency beds as a step down to the ward environment.

Educational issues were also highlighted – one senior nurse was very concerned about knowledge deficits in mental health while others spoke of the challenges in caring for children with complex healthcare needs. Within the spectrum of communication, the value placed by the child on the presence of their parent alongside the tension between the children’s nurse and parent from the perspective of the nurse may need addressed by nurse education. Nurse educators may also need to question if children’s nurses are prepared with sufficient knowledgeable on models of communication as this study found being listened to and given choice to impact positively on the child’s hospital experience. It secondly provides further evidence on how the environment and the nurse’s lack of time may impact on the developing child and their experience of hospitalization. The role of play and play specialist also appeared as core content within children’s nursing curricula as it mattered greatly to the children and nurses.
Essentially, the ‘voice’ of children in health care delivery is paramount to its effectiveness as a service (Royal College of Nursing, 2014). The child remains central to this study – they appeared pleased the consultation was about them and all smiled when introduced to Sprinkle or Ronaldo (some children had to see both). Both types of respondents hoped their participation would invoke change.

**Conclusion**

In summary, this study contributes to current knowledge by shedding light on the ways in which being in the complex hospital environment can be challenging for the child and children’s nurse. It therefore reflects a contemporary “slice” of life in four children’s ward in a typical UK children’s hospital in the 21” century. It is fitting the last words are from one of the children – Sam (age 11) was clear and able to articulate his experiences of being in hospital. It is hoped the study will help make things better for children like Sam (and the children’s nurses), who explained what his wish would be to make things better when in hospital:

*_Probably bring my house into hospital. I have been in hospital a couple of times and wanted a new hospital like home.*

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