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A phenomenological study exploring pediatric hospitalization: The voices of accompanied and unaccompanied hospitalized children

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ABSTRACT

Purpose: Most children go through their childhood without being hospitalized. For a child, being hospitalized may be a disturbing and unfamiliar experience. Pediatric institutions promote parental presence and family-centered care, yet not all parents are able to stay with their children. Holding the child's voice central to the phenomenon, the aim of this study was to explore how parental accompaniment and absence shape a child's hospitalization experience.
Design and methods: A phenomenological study was implemented, and children ages 7–11 years old were included if they were in the hospital for at least 24 h with a parent present or 12 h without a parent present. Deriving from the interviews of children, themes were identified to unearth the meaning of children's lived experiences.
Results: Twelve school-age children shared their hospitalization experiences. The findings of this study are organized around the following themes: (a) participating in care; (b) being on the road to recovery; (c) being a kid, still; (d) being accompanied – having a familiar face; and (e) being unaccompanied – yearning but understanding.
Conclusions: Being in the hospital was not significantly different when parents were absent, but children preferred their parents to stay. Being in the hospital was not a negative experience. Hospitalized children were attentive, independent, understanding, and resilient.
Practice implications: Children in this study illuminate the need to listen to children's voices. Understanding the experiences of hospitalized children provides pediatric nurses with insight on supporting the patients and families they care for.

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Being in the hospital is generally stressful for adults, and even more so for children. Hospitals present many fears and concerns for children with unfamiliar environments, alarms, people, and procedures (Coyne, 2006; Salmela et al., 2010). Pediatric hospital practices have evolved greatly over the years from an affectionless, institutional approach limiting parental visitation to a family-friendly approach encouraging parental presence (Jolley & Shields, 2009). Family-centered care has become the norm, as it is associated with better patient outcomes, better family satisfaction, decreased length of hospitalization stays, and decreased healthcare costs (American Academy of Pediatrics, 2012). A key component of family-centered care is the presence of parents during a child's hospitalization. Yet, not all parents are able to stay at their children's bedside, let alone throughout their hospital stay (Roberts, 2010). Being a child unaccompanied in the hospital represents a context contrary to family-centered care. This study aimed to explore how parental accompaniment and absence shape a child's hospitalization experience.

The historical context of pediatric hospitalizations displayed the evolution of practices to enhance a child's hospitalization stay and mitigate detrimental effects. The research that guided these changes was primarily based on researchers' observations and parents' perceptions of children's behaviors (Davies, 2010). Children's own perceptions of hospitalization are essential to explore and understand; children's views can help shape the planning and delivery of their care. More recently, researchers began to turn their focus to the children themselves, and the voices of hospitalized children have joined the literature.

Children hold both negative and positive views of being in the hospital. Carney et al. (2003) found that children more often identified positive or neutral views of hospitalization as opposed to negative views. Aspects of hospitalization that children identified as positive included perceiving the hospital as a place to get better, being well-informed of what was going to happen, having friendly interactions with staff, being able to maintain social interactions with other hospitalized

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children, and having their parents with them (Carney et al., 2003). Aspects of hospitalization that children identified as negative included perceiving the hospital as scary, not knowing what was going to happen, a loss of control, being in pain, and being away from home (Carney et al., 2003). The negative aspects identified by the children in Carney et al. (2003) study aligned with the findings from Coyne (2006) and Salmela et al. (2010) explorations of hospitalized children's fears. Children voiced concerns about separation from friends and family; being alone; being in an unfamiliar place; being uninformed; different treatments, instruments, and equipment; and having a loss of control (Coyne, 2006; Salmela et al., 2010). While children experienced a range of emotions, they viewed the hospital environment as a place that could be fun as well as threatening (Wilson et al., 2010). Subsequently, children wanted protection when they were scared and wanted companions when they were bored (Wilson et al., 2010). While hospitalized children reported wanting their parents present, no study explored the child's experience when their parent was present or absent. Parental accompaniment and absence present unique contexts when exploring children's hospitalization experiences.

Past literature has reported the emotional responses, behaviors, and effects of hospitalization on accompanied and unaccompanied children. Responses varied by age, but all were augmented when parents were not at their child's bedsides (Brain & Maclay, 1968; Branstetter, 1969; Cleary et al., 1986). Infants cried more, slept more, and spent more time in non-stimulating environments, and toddlers withdrew and played less when unaccompanied (Branstetter, 1969; Cleary et al., 1986; Grant, 1983). Unaccompanied toddlers and pre-schoolers adjusted poorly to being in the hospital, reacting with panic, denial, withdrawal, or other overt signs of emotional disturbance more often than those who were accompanied (Brain & Maclay, 1968). Signs of disturbed behavior continued after discharge for these children as evidenced by clinging behavior, temper tantrums, irritability, nocturnal enuresis, encopresis, and refusal to go outside (Brain & Maclay, 1968). In an oral history of older adults who were unaccompanied preschool and school-age hospitalized children during the 20th century, participants recalled the abandonment, loneliness, and lack of trust they experienced and still experience (Jolley, 2003). Unaccompanied hospitalized children adjusted poorly to being hospitalized and experienced distress both during and after their hospitalization. While the main themes that emerged from our integrative review on unaccompanied hospitalized children were hospitalization as a stressor, nurses' perceptions, and distress, the literature on the phenomenon revolved mainly around the observations of researchers and the reports of nurses (Lulgjuraj & Maneval, 2021). Children's voices were lacking and as the ones living the phenomenon their voices need to be heard. An exploration of accompanied and unaccompanied hospitalized children's experiences was required to foster understanding and thoughtful practice by pediatric nurses and providers.

Methods

The aim of this study was to explore and gain insights into the experiences of hospitalization for young children. A hermeneutic phenomenological study was designed to understand the experiences of hospitalized children and address the following research questions:

1. What is it like for a school-age child to be in the hospital accompanied by a parent/caregiver?
2. What is it like for a school-age child to be in the hospital unaccompanied by a parent/caregiver?

Philosophical underpinnings

Phenomenology as a form of human science inquiry aims to discover what an experience or phenomenon is really like (van Manen, 1997). Perception is central to understanding a phenomenon; different emotions or feelings may arise because of one's unique being, time, and space in the experience. Yet, the goal of hermeneutic phenomenology is to go beyond description of each lived experience and provide an interpretive account in order to unearth a phenomenon's eidetic meaning. The eidetic meaning identifies what makes an experience unique and recognizable from other related phenomena; the eidetic meaning is not intended to be a generalization of the phenomenon. This study aimed to elucidate the eidetic meaning of hospitalization for accompanied and unaccompanied children, so that nurses and all healthcare professionals can use these insights when caring for similar children

Setting and sample

A purposive sampling method was used to recruit participants for this study. Participants were intentionally selected from the inpatient acute care units of one children's hospital affiliated with a large metropolitan hospital system in New York. Two groups of hospitalized children were included in this study – hospitalized children with a parent/caregiver by their side and hospitalized children without a parent/caregiver by their side. Parental presence and lack of parental presence have not been defined in the literature, but past literature was used to guide the establishment of criteria for these two groups of children. Children whose parents/caregivers have been physically present for at least a 24-h period during their hospitalization were considered accompanied. Children whose parents/caregivers have not been physically present for at least a 12-h period during their hospitalization were considered unaccompanied for this study. Branstetter (1969), who conducted a study on the effects of hospitalization on different groups of children, identified her 'mother-present' group as hospitalized children whose mothers remained with them day and night. Grant (1983), who reported on the behavior of an unaccompanied infant for a continuous 12-h period, found the infant experienced numerous interactions with staff members and spent a significant amount of time crying, compared to the 4 h the infant's mother was present. Throughout a 12-h period, hospitalized children receive many different interventions and have numerous interactions with various members of their healthcare team. This study aimed to identify the meanings children give to these experiences, especially when in the presence or absence of a parent or caregiver.

Children in middle childhood were the focus of this study opposed to children in early childhood or adolescence. In early childhood, children have a greater dependence on parents, and in adolescence, children have a greater desire for independence. Children in middle childhood are at a point where their social world expands, but parents are still principal attachment figures. For this study, experiences were sought from school-age hospitalized children 7 to 11 years old. Participant inclusion was not limited to a child's type of illness or diagnosis. Children who did not understand and speak English were excluded; language barriers would be a limitation to data collection, and keeping young children engaged using an interpreter would present an obstacle to data collection.

Data collection

"The best way to enter a person's lifeworld is to participate in it" (van Manen, 1997, p. 69). Aligning with van Manen (2017) phenomenological method, children were interviewed during their current hospitalizations in order to investigate the experience as it was lived. Children were interviewed in their hospital room or in the hospital family lounge when the child had a roommate. All interview sessions were coordinated with the healthcare team to take place at a time that did not interfere with the child's care. Parents who were present were welcome to sit in on the interviews. Interviews were audiotaped and later transcribed for data analysis. Interviews lasted from 20 min to 1 h and were conducted over the course of 7 months.

All interviews were conducted by the first author, a pediatric nurse. The process of interviewing children and obtaining experiential descriptions is not an easy task (Irwin & Johnson, 2005). Children at different ages and stages of development may not be able to reflect on experiences beyond an expression of feeling or emotion. Some children may unclearly recall their experiences or only respond in one-word answers. Others may be shy and lack enthusiasm to discuss their experiences with a researcher. To overcome some of these challenges, interviews began with measures to establish trust and promote the child's comfort in conversing in a relaxed, non-threatening environment. To build a rapport with the child before beginning the interview, time was spent playing with the child in an activity of the child's choice, such as drawing, coloring, doing a puzzle, or playing with toys. Children were encouraged to continue in this play during the interview. The interview began with questions to build a relationship with the child and obtain a sense of who the child was. These included questions such as the child's favorite toy, movie, or activity. Once the child was conversing freely the introductory question, “tell me what it is like to be in the hospital,” was asked. The use of this general question was selected to encourage free recollection and allow the child to guide the direction of the interview.

Questions were child-centered and considered the child's level of development. Follow-up questions were used to clarify specific accounts and focus on personal features of the child's description. If the child was having difficulty describing an experience, a “what happens when” question was asked to provide a prompt in the child's description. If the child shared emotions associated with the experience, the child was asked to describe a particular time where those feelings were embodied. If children were reluctant to discuss experiences, they were reassured that there were no right or wrong answers. A list of follow-up questions and prompts was used to help children bring out their experiences when they had difficulty expressing themselves or only responded in one-word answers. These included exploratory questions such as the best/worst part of their day, things that have happened in the hospital, and what they would tell a friend/sibling about being in the hospital. Leading questions were avoided to ensure the child's authentic voice was expressed.

Data analysis

Data analysis was a continuous process. Analysis began with the start of data collection and occurred concurrently to determine when a redundancy of themes was achieved. Findings were constructed relying on thematic analysis and reflective journaling. The journaling process followed each interview and was the starting point of the analysis. Journaling allowed for a direct reflection and immersion into each child's experience. Reflexivity allowed the interviewer to bracket self-experiences, and be conscious of her own attitudes, assumptions, and values, to keep separate from children's experiences. Interviews were transcribed by a medical transcription company, reviewed, and analyzed as they were completed. Thematic analysis was done using van Manen (2017) three phenomenological approaches: 1) the holistic approach, 2) the highlighting approach, and 3) the line-by-line approach.

Starting with the holistic approach, the transcribed text was examined as a whole to encapsulate the overall meaning of the experience in one sentence. Then, using the highlighting approach, sentences that seemed fundamental to and captured the nature of the phenomenon were identified. Lastly, a detailed line-by-line analysis followed to allow for further revelations of the phenomenon. Transcripts were read multiple times, at times alone and at times concurrently with listening to the recordings to thoroughly immerse in the descriptions. Commonalities were identified across transcripts, merged into higher levels of abstraction, reflected on to uncover their meaning, and developed into themes as they related to children's lived experiences. Anecdotes were identified to support the development of each theme and offer readers a more direct access to the lived experiences of children.

Trustworthiness

As identified by Lincoln and Guba (1985), qualitative inquiry is often evaluated for trustworthiness by the principles of credibility, transferability, dependability, and confirmability. In this study, time was spent before and during interviews to develop a relationship and maintain prolonged engagement with each child. Once a redundancy of themes was achieved, an additional child was recruited to confirm data saturation. A doctoral-prepared certified child psychiatric nurse practitioner was consulted as a peer debriefer to review transcripts and themes. Lastly, thick descriptions and phenomenological anecdotes were provided so the reader can evaluate the findings from the voices and stories of the children themselves.

Phenomenological validity

As identified by van Manen (2014), validity in phenomenological inquiry is evaluated by the principles of heuristic questioning, descriptive richness, interpretive depth, distinctive rigor, strong and addressive meaning, experiential awakening, and inceptual epiphany. This study began with wonder as a phenomenon was explored for the first time. The interviewer retained a sense of wonder with each child interviewed. Throughout the study period, the interviewer kept other abstractions of the phenomenon in abeyance and relied on the children's voices. By engaging in journaling of personal experiences, the interviewer focused on how the phenomenon is actually lived by children. The goal of phenomenological work is to arrive at meaning that reveals a phenomenon as an accessible and recognizable human experience (van Manen, 2017). The use of a peer debriefer contributred to the validity of the meaning ascribed to the phenomenon. This text is intended to stimulate wonder and encourage readers to question the meaningfulness of the phenomenon. The findings of this study offer direct, firsthand insight into hospitalized children's experiences. Readers are encouraged to recognize the possible human experience of hospitalized school-age children.

Ethical considerations

Permission to conduct this study was obtained from the respective university and hospital. The study was approved by the hospital's pediatric research committee, as well as the university's Institutional Review Board. As children are a vulnerable group, this study was designed to minimize risk and create a comfortable, safe environment. Consent and assent were obtained from parents and children, respectively. An impartial witness was present for the consent of the absent parent and the assent of the unaccompanied child. Conversations with children took place in a casual manner and employed child-centered measures to allow the child to speak freely. Children were allowed to skip any question they did not want to answer, take a break and play, or stop the interview entirely at any point. If the child seemed uncomfortable, the interviewer stopped the interview, engaged in more play, and provided support to the child. The child life specialist or social worker was always available if a child were to experience any distress. Attention to the child's comfort and well-being did not differ in relation to the presence or absence of parents. Lastly, pseudonyms and anecdotes were selected carefully to maintain participant confidentiality and anonymity.

Findings

A total of 12 school-age children were interviewed while they were admitted to the hospital and asked about their current hospitalization experience. Two children met the criteria for the unaccompanied group, of which one child was completely unaccompanied throughout his hospitalization. Ten children met the criteria for the accompanied group, of which seven were completely accompanied throughout their hospitalization. The remaining four children had periods where they were both unaccompanied and accompanied. Nine children were hospitalized for acute issues, having had no other hospitalizations in the past year. Three children were hospitalized for chronic issues, having had at least one prior hospitalization in the past year. Children's length of stay at the time of study inclusion varied from 1 day to 20 days.

All of the children were eager and excited to participate in the study. However, based on each child's personality, recall, and comfort level, excitement during the interview varied. All attempts were made to gain access to the lifeworld and experiences of the children. Some children were quick to open up and share stories from their hospitalization; they engaged in conversation and in play with the researcher. Few were quiet or reluctant, requiring frequent prompting to encourage conversation. No child appeared to experience signs of distress during the interview. One child lost all interest in the interview, and thus, his interview was concluded by the interviewer.

The resulting transcripts offered entry into the lifeworld of children and insight into their lived experiences. Both accompanied and unaccompanied children shared their experiences of what it is like to be in the hospital. This phenomenological text was organized around the following themes: (a) participating in care; (b) being on the road to recovery; (c) being a kid, still; (d) being accompanied – having a familiar face; and (e) being unaccompanied – yearning but understanding. Table 1 displays these themes with their subthemes, along with statements made by children that led to the identification of each theme.

Participating in care

A hospitalized child's care team comprises many interdisciplinary members, and children seek to be active members of this team. Participants observed the care they received and could describe not only what had occurred but why. Children were attentive to their care and, at times, even took the initiative in their own care. For example, Mariah was aware that the albuterol she was receiving every few hours was instrumental to her recovery, as she shared:

> *I have to take four pumps, and I have to inhale it. That will help me with my asthma and to open up my lungs. I feel better, but I'm still sick. I feel better. Yeah, this just opens up my lungs and helps me breathe better.*

Despite being uncomfortable with sticking herself to check her glucose levels, Ava expressed a desire to learn the process. She found it beneficial to learn about her newly diagnosed condition and how to make it better, as this helped her realize that it is a condition she can live with.

Children were aware of the adverse effects that could ensue and the undesirable outcomes of care. Axel spoke adamantly as he described his allergy and his desire to know what medications he was receiving. Attentiveness to their own care was paramount to children. Children prudently moved their IV poles with them as they navigated the halls to the family lounge or cautiously observed the cardiac respiratory monitors whenever they alarmed throughout the interview. Children knew which values were acceptable and which were concerning. Leo had learned about the importance of his oxygen saturation and described an experience requiring prompt action by his medical team.

> *It was like super deadly. I felt like I was gonna die because I was just like, my oxygen was low, and I was like 'nooooo.' Once my oxygen even went down to 81. I know, it's bad. And I was just like, 'oh no.' They had to quickly rush up and put the mask on [my] face. It went back to 91, and it went back to the original thing, 95, what it is now.*

Hospitalized children could associate nursing assessments with subsequent interventions, whether a low oxygen saturation prompted supplemental oxygen or a low blood pressure prompted repeat vital sign monitoring. Even when children did not know the expected outcome, they were still observant of the care they were receiving. Rose and Celine both had ultrasounds done, and neither knew what it would entail. They described their fascination as they kept turning towards the screen to watch along with the technicians. However, not knowing what was going to happen also worried children. Celine described the apprehension she felt with not knowing:

> *...very scary. Wouldn't it be scary to you if someone was doing something, and you don't know what they're doing? You don't know if they're gonna do this to you, maybe stab you, I don't know, maybe make you fall asleep.*

Worry emanated when children were not kept informed, and knowing brought comfort to children. Celine's meaning of her experience transformed when she recognized what her test entailed as she shared, "*...it was fun.*" Children sought insight into providers' actions before they were performed, feeling a sense of security when kept informed, as described by Leo:

> *It's like if something bad were to happen, they would care about you. And whenever they want you to move to a different room, they'll actually observe, they observe your health patterns and wait two hours before doing it. And they tell you, and they tell you in hindsight two hours before. Yes, before they do it. They don't just be like, alright, get up now, walk all the way over downstairs to the 5th floor. They go like, here, this is what we're going to do. I just feel like I have a sense of like, I know what's gonna happen.*

Being on the road to recovery

Children understood that sickness prompted them to the hospital, and they recognized the hospital as a place where they will get better. Participants described their initial presentation to the hospital and shared how much better they felt at the time of our interview. Leo's condition had warranted intensive unit level care, and he articulated the progression he saw in his own health. "*I couldn't, earlier I couldn't walk. I could barely even talk. Now, it's just like someone saved me. The hospital workers, they saved me.*" Leo had been transferred out of the critical care unit and was now on an inpatient floor. He explained he knew he was improving because the doctors and nurses no longer needed to provide constant care.

Children attributed their recovery to the nurses and doctors. Almost all shared the importance of listening to what the doctors and nurses say to do. Children were grateful that providers were there to help them, make them feel better, and make them healthy again. Children viewed nurses and the healthcare system in a positive light. Jayce shared, "*doctors are there for you. Nurses are there for you. Your family is there for you. Everyone is there for you.*" Axel described his perception of nurses as.

> *...nurses doing they work like they always do. They just work and try to make me feel better. They try to make other patients feel better...That's what the hospital was invented for. The hospital's make you feel better. When they hook IV up to you and you have to feel blood, but it's gonna, it's gonna hurt bad but you're gonna feel better at the end.*

The road to recovery was not easy for children, as they reflected on care that was often uncomfortable. Noah had a rectal tube placed when he was first admitted. He acknowledged that the rectal tube relieved his pain, but it was not a pleasant experience.

> *With the tube, I didn't feel that pain anymore. I didn't feel the pain anymore because the intestines were untwisted, so it felt good, but kinda hard to sleep because the tube was like, twisted around itself and making it uncomfortable. It's hard to look at because there was brown stuff in there and it's nasty...they took it out, which hurt a lot. And they said it*

Table 1
Identified themes.

Themes	Subthemes	Comments by Children
Participating in Care	Paying attention to care	*- I keep turning my head to see what the inside of my body looked like.* *- I also had to get like more oxygen, because it was low when I sleep and right now my oxygen is 97 and I'm not using the oxygen thing right now.* *- Like when they do my blood pressure, when it's black it's okay and when it's red, it's not okay.* *- I want to learn how to do it … but I'm a little weirded out by it, but still, I think it's gonna be easier when I learn how to do it so I'm not hurting myself.*
	Knowing what's going to happen	*- Definitely learning about it helps because it's not like this thing. It's an actual condition and you can help it and make it better, so you're not stuck wondering if the needles will come out of your arms.* *- [If] they give me amoxicillin, I'm telling them not to because I don't wanna get sick. That's what makes me throw up*
	Apprehensiveness with unknowing	*- I get scared and I say what are you gonna do? They come one day, they come one at a time to take me to the bed and they couldn't tell me where I'm gonna go.* *- Wouldn't it be scary to you if someone was doing something and you don't know what they're doing?*
Being on the Road to Recovery	Nurses and doctors are here to help	*- Now, it's just like someone saved me. The hospital workers, they saved me.* *- They just work and try to make me feel better. They try to make other patients feel better…That's what the hospital was invented for. The hospital's make you feel better.* *- It's gonna be okay because there's doctors here with you. They're gonna help you feel better. You shouldn't be scared.* *- Nobody will bother me here, just some doctors and nurses. Well, technically, they just like do their thing. I don't mind. I pause like, my games or toys, I pick them up and put them somewhere and then just do what they told me to do.*
	Enduring the uncomfortable	*- They put like 200 IVs in me, 99.9% of them missed…super painful. I was like, what, if you wanted me to bleed and die you could've just left me at home.* *- … So, my aunt, my dad, and the doctors all. I was on the chair, so like I was crumbled up in a ball. Everybody was just like holding me down.* *- Since I've never done this before, I've never like in real life had known someone with this condition, I feel a little bit alien. Like kind of weird, in other worldly, but I'm getting used to it, so that's good.*
	Getting better	*- They also shouldn't be worried, and that they'll be good and fine. And by the end of the day, when you're out of the hospital, you'll be okay.* *- I may not be doing good, but I'm doing certainly better than when I first came in here.*
Being a Kid, Still	Like home	*- I do what I usually do at home.* *- It's not that bad, like you have entertainment, TV, your phone, your iPad, your computer. Sometimes you can ask them if you can go outside. You have, sometimes you have your own room, or you share a room, etcetera. There's really stuff to do in the hospital.*
	Unlike home	*- Doctors and nurses come in the room, and I don't get my beauty sleep.* *- There's tape on me, when I have to peel it off, then it's gonna hurt me because it's like pulling me. Then these wires that are on me, one is to check my chest, the heartbeat and breathing and stuff like that. I do not like being attached to them because I can't really move.* *- It's kind of annoying with all the hospital noise. It's a lot.* *- I shared a room with a baby. I tried to ignore her, but I couldn't. She was just crying and crying over and over again.*
	Play	*- And if the playroom's open, I just go to the playroom and have fun.* *- I wish they had that was more for, that's more entertaining for kids, like a playroom where there's just all sorts of games…A room where there's just toys, and kids can just come and play instead of just being in their room all day.* *- If I see them in the playroom, I would play with them.*
	Relationships with caregivers	*- He always come in my room and play with me.* *- She's my best friend.* *- They like talk to me, I talk back, and then boom, we're friends. We're friends forever.*
Being Accompanied - Having a Familiar Face	Companionship	*- The best part is that she's here with me, that she's my mom.* *- I'm a minor in the hospital. I can't stay by myself.* *- Because I get to spend a lot of more time with my mom than I usually do.*
	Comfort	*- I like when my mom stays with me because she comforts me and talks to me. We watch a movie together. We talk about things we like or what we're gonna do when I get out of the hospital.* *- …Your family is there for you. Everyone is there for you.*
	Concern	*- Because like every little thing, where like, you just sit and space out, mom would ask you if you're okay. And which I like that, but it's like kind of tiring. Because like every little thing, where like, you just sit and space out, mom would ask you if you're okay.* *- My dad said, 'are you okay?' A lot of times, every day, he's saying, 'are you okay?'*
	Care	*- So, it's nice to not have to like watch, have to practice, like poking yourself with a needle as long as there's someone there to help you.* *- I like how she helps me along the way. Like the time I had to pee when I had the tube in, I had to turn over and mom would put the container there to make sure I peed.* *- She's here for me like every time when I'm like hurt or sick.*
Being Unaccompanied - Yearning but Understanding	Wanting their family	*- Not sad, but when she leaves, I don't want her, I don't want her to leave.* *- To be in the hospital? It's like you always want someone you know to be there…* *- It's still like, the same a bit, just, just not like, I'm just not really with my mom. It makes me feel like upset a bit because it's like, I want my mom still.*
	Sharing their parents	*- But she has to leave 'cause she has to take care of the kids to wake up to go to school…She does that, we do that.* *- Sometimes in the day she leaves to check up on my sister and refill the stock of their food.*

> *wouldn't hurt that much, but it ended up feeling like something was taken out of me that wasn't supposed to be tooken out. After it made sleeping a lot more better. I felt really good because now I can walk around freely and hug mom better.*

Necessary interventions could be painful and anxiety producing for children. Leo described his frustration with the multiple attempts made to obtain IV access, "*they put like 200 IVs in me, 99.9% of them missed…super painful. I was like, what, if you wanted me to bleed and die you could've just left me at home.*" While children understood the rationale for different treatments and interventions, acceptance was not always easy. Children cried and sometimes fought when they did not want something. Rose articulated her fight against getting a nasal swab to test for COVID-19.

> *It wasn't that bad, but I was crying. I was crying because I don't like iVs that much. You don't want to hear about the COVID test. It was, basically like, first I don't like stuff going up my nose, so I was crying already. They kept holding me down, but then I jumped up out the seat. No, before I jumped up out the seat, I actually kicked the doctor. And then I jumped up out my seat and tried to go on the floor. Then, they had held me down more, then she just stuck it up my nose. I'll try to, I try to hit her again or kick her again but then she, she stuck it up my nose. Because I don't like stuff going up my nose and they kept holding me when I told him not to. Well, my aunt kept holding me when I told them not to. So, my aunt, my dad, and the doctors all. I was on the chair, so like I was crumbled up in a ball. Everybody was just like holding me down.*

Rose understood and was able to rationalize the necessity of both in-erventions, but understanding did not ease the experience for her. However, she explained that she endured it and was now one step closer to her surgery, recovery, and going home. Acceptance was more common than resistance. Children realized that the care they found uncomfortable, frustrating, or annoying was also instrumental to their improving health and desired outcome of going home. They accepted it nd took initiative when they could.

> *When I scrape myself, or like cut myself and there's blood, the first instinct I have to do is to wipe it off. So, it really bugs me when you have to [prick finger] and just wait for it to come out, push more, and then you have to slide onto the little stick. And sometimes you don't, we don't do it right, so you have to do it again and it's kind of annoying. I mean, technically it's not considered self-harm to poke yourself with a needle, but then I keep getting Sleeping Beauty flashbacks to a long time ago, so there's always that factor of thinking you're gonna go to sleep for a 100 years…Honestly, since I've never done this before, I've never like in real life had known someone with this condition, I feel a little bit alien. Like kind of weird, in other worldly, but I'm getting used to it, so that's good.*

Ava found it uncomfortable to check her sugars before meals as it necessitated actions and provoked feelings that were unnatural to her. Despite the feelings she had towards doing her fingerstick, she faced them head-on, and expressed a desire to learn how to do it independently.

Being a kid, still

Being in the hospital is a change from the normal routine and environment for the young child, but many children are not opposed to it. "*It's not that bad*" was a common response amongst participants when asked what it is like to be in the hospital. Although some children had difficulty articulating their thoughts further, others shared that they were able to keep their home routine in the hospital. Celine shared, "*I do what I usually do at home.*" Being able to partake in play and activities as they would at home was pleasing to children. Rose described all that was available to her even while she was in the hospital.

> *It's not that bad, like you have entertainment, TV, your phone, your iPad, your computer. Sometimes you can ask them if you can go outside. You have, sometimes you have your own room, or you share a room, etcetera. There's really stuff to do in the hospital.*

However, children still missed home. Both accompanied and unaccompanied children missed their families. Visits from family members brought joy to children. Noah described how much his sister's visit meant to him.

> *The best part was when my sister came. She visited and comforted me, and it felt really good. It felt like a part of me that was missing just came back because I've been living with Isabella for all I can remember. Because when she came it just means so much to me because she brought like my phone for more entertainment. She got me balloons, she got me a teddy bear that would be her and I would hug her whenever I go to sleep. Yeah, it's usually like a good comforting memory where every time I would have a dream I, I would, I would think about her and me playing together.*

Children also described times they were bothered with being in the hospital. If it was unlike their home, their usual routine, or presented a burden, children expressed their dissatisfaction with it. Leo found the hospital boring because he could not connect with his friends and shared, "*it just feels weird being here. It feels like I shouldn't be here.*" Children were annoyed by the frequent nighttime awakenings. Having a roommate was not always a fun experience. Axel shared his experience with his different roommates, "*I had a patient in my room, but he was annoying. He was annoying because he kept whining. A big roommate, then I have it. For a whiney roommate, no, I can't take it.*"

Being attached to medical equipment, such as a cardiac monitor or IV pump, or having a device in place, such as a rectal tube, presented additional nuisances for children. Children's movement and mobility were subsequently restricted, which is unfamiliar for the young child. Having an IV board on their arm forced children to always keep their arms straight. Ava described the constant beeping of the IV pump whenever she would bend her arm and the difficulty managing the IV tubing to make her way to the bathroom. During our interview, she was not receiving any fluids through her IV and emphasized, "*…now I'm unhooked, free.*" Children sought to be disconnected from their IVs and not in isolation so they could do the things they enjoyed.

> *I just like to play around. If I'm not on isolation, I just walk around. And if the playroom's open, I just go to the playroom and have fun. If the playroom was open right now, I woulda went. Yeah, but when the playroom is open, I'm on it.*

Play was central to many participants' experiences and being able to play in the hospital was a positive attribute of children's experiences. Mariah, who was in isolation, was not aware of the playroom and so described her hospitalization experience as boring.

> *I wish they had that was more for, that's more entertaining for kids, like a playroom where there's just all sorts of games. Just board games. Just a room like where people entertaining people. Clowns can come and just make kids laugh or help like feel a little better and have some more fun. A room where there's just toys, and kids can just come and play instead of just being in their room all day.*

Mariah desired an opportunity to play and have fun in the hospital like the other participants were afforded and described a room she didn't know existed. The playroom offers children the opportunity to be kids, play, socialize, and continue to do what they enjoy, even while in the hospital. Many children recognized the playroom as the best part of the hospital. Children were able to leave their hospital room and even play with others in the playroom. Rose shared an experience she had with another child:

> *Sometimes kids ask questions and like the nurses will tell them or the child specialist will tell them that's rude to ask them something. Like, why are you here? I don't think it's quite rude 'cause sometimes I want to ask them what happened, but I know that's rude to ask someone. But I don't want to go assuming why they are here.*

Rose and the other child displayed a childlike inquisitiveness by their mutual desire to know why the other was in the hospital. Children sought connections while in the hospital so that they were not lonely or bored. While most children sought this connection within the hospital, Leo wanted to retain his connections outside the hospital. He was concerned with the lack of Wi-Fi connection he had in the hospital and explained he subsequently had to play games on his iPad by himself, whereas the internet would enable him to play with his friends. Isolated from his friends both physically and virtually, Leo described his being in the hospital as boring.

While children were in the hospital, they formed relationships and friendships with their nurses and caregivers as they would with other children. Jayce knew many of the nurses and doctors by name and described a special bond he had with them as they had cared for him since he was an infant. He also made new relationships during this admission and shared, "*…they like talk to me, I talk back, and then boom, we're friends. We're friends forever.*" Children recognized and appreciated when nurses and providers took time to play with them and interact with them beyond their roles. These nurses stood out to children as they fondly shared stories about their favorite nurses. Whether it was making paper airplanes or hanging drawings on their hospital windows, children explained the joy they felt when nurses spent time with them.

Being accompanied – having a familiar face

Accompaniment by parents/caregivers offered hospitalized children an experience that was unlike the unaccompanied hospitalized children. Just the mere physical presence of a parent was significant to children. Grayson explained the best part about his parents being in the hospital was "*…being with my mom and dad. My dad cannot be here, but at 12pm, he's coming to see me.*" Grayson was aware of the visitation policy that allowed for a second visitor and was looking forward to his dad coming back. Having a parent present gave children a companion in the hospital. Jayce shared the joy of having his mom by his side, "*the best part is that she's here with me, that she's my mom. She's here for me like every time when I'm like hurt or sick.*" Mariah believed that she could not be alone in the hospital; she sought a constant companion.

> *I'm a minor in the hospital. I can't stay by myself. If my mom has to go somewhere, one of the visitors have to come. If there's no visitors available to come, a doctor will probably have to stay with me.*

Having someone to play with or someone to talk to was enjoyable for children. For Celine, her mom's presence and the time spent with her in the hospital was very meaningful. Celine shared that the best part of her mom being in the hospital was that they could eat together and went on to explain that her mom is typically at work. Being in the hospital gave Celine the chance to spend her days with her mom.

The presence of a parent provided children with comfort, especially during painful interventions. Parents acted as a protector; they couldn't stop the intervention from happening, but children attributed their parent's presence to better outcomes. Children shared how their mother's voice, touch, or presence made a painful experience better for them; parents were able to distract children from the hurt they anticipated. Ava and Noah described the comfort and helping hands their parents offered them:

> *…Honestly, it's comforting. So, it's nice to not have to like watch, have to practice, like poking yourself with a needle as long as there's someone there to help you. So, you don't accidentally cut yourself and send the syringe flying across the room.*

> *She comforted me when I heard about the surgery. I started to cry because I didn't want stitches on my belly. So, mom told me not to cry and she hugged me. Yeah, she did comfort me. And that's what I like about her being here.*

Parents were able to comfort and ease their children's worries. However, accompanied children explained there were times their parents also worried. Grayson recognized his dad's concern through his repeated questioning. "*My dad said, 'are you okay?' A lot of times, every day, he's saying, 'are you okay?'*" At times, parental concern was too much for children. Time spent alone in the hospital gave children a break from a parent's concern, which Noah found peaceful.

> *To take care of myself, has been pretty nice because, you know, moms would usually ask you repeatedly if you were okay. And which I like that, but it's like kind of tiring. Because like every little thing, where like, you just sit and space out, mom would ask you if you're okay.*

By being present, parents were afforded the opportunity to partake and assist in their child's care. Whether it was administering enteric feeds, doing carbohydrate counting, or assisting with activities of daily living, parents took a leading role. Children recognized and appreciated this help. Noah's mom gave him M&Ms. to mask the taste of the medicines he did not like and assisted him with the urinal when he had the rectal tube. Mariah's mom helped her when she felt weak and Hannah's mom answered the doctors' questions when she did not know the answers. Accompanied children looked to their parents first for help.

Being unaccompanied – yearning but understanding

Children want their parents to be with them in the hospital so that they are not alone. Children who were unaccompanied spoke about times their parents visited. Unaccompanied children treasured these visits, acknowledging the value of these visits; "*…so, I don't be by myself.*" Children missed their parents and longed for them to stay in the hospital, but they understood the need for their absence. Axel and Noah acknowledged the need for their parents to leave their side:

> *Not sad, but when she leaves, I don't want her, I don't want her to leave. But she has to leave 'cause she has to take care of the kids to wake up to go to school…She does that, we do that. She don't like being here, and I don't like being here either.*

> *Sometimes in the day she leaves to check up on my sister and refill the stock of their food…To be in the hospital? It's like you always want someone you know to be there because you know, you can't really trust people unless you've been with them for a few days knowing they'll take care of you.*

Unaccompanied children recognized that their parents had competing obligations and they needed to share their parents. Yet, being in the hospital was not much different when parents were absent. Jayce had spent time alone in the hospital and shared, "*it's still like, the same a bit, just, just not like, I'm just not really with my mom. It makes me feel like upset a bit because it's like, I want my mom still.*" It was not distressing for children to be in the hospital unaccompanied. Axel explained that he had an infant as a roommate during his hospitalization, who was often unaccompanied and crying. "*You know what happens when they whine? They cry. They cry because their mom leaves. And my mom left and I ain't crying.*"

Discussion

This study was the first to explore the phenomenon of unaccompanied and accompanied hospitalized children from the lens of the children themselves. The United Nations Convention on the Rights of the Child (1989) recognized the need to make children's voices heard. This study revealed the voices and experiences of school-age hospitalized children. The act of giving voice to children recognizes that children's opinions and experiences matter. Children's voices are instrumental in guiding nursing practice, yet their voices are often not heard. This study revealed that children were both welcoming and willing to share their stories and experiences with an outsider.

Participants of this study granted access into their lifeworld. Their experiences allowed for the identification of what gives meaning to being an unaccompanied and accompanied hospitalized child. From speaking with hospitalized children and immersing into their experiences, it was evident that children embraced their hospitalization experiences in a positive light. Being in the hospital was a similar experience for unaccompanied and accompanied children. All children gave voice to their participation in care, being on the road to recovery, and still being a kid. However, the presence or absence of parents differentiated the two groups of children. Accompaniment offered the hospitalized child that which the unaccompanied child yearned for – companionship, comfort, concern, and care. While children may have different experiences depending on various physical, psychosocial, and cultural factors, this phenomenological study revealed what makes the hospitalization experience unique for accompanied and unaccompanied hospitalized school-age children.

Participants were attentive to nurses' and providers' actions and wanted to participate in their care. Being in the hospital was not a passive experience for children; it involved knowing, observing, and doing. The desire for better communication and wanting to know what providers were doing supports the findings from Coyne and Kirwan (2012) study on hospitalized children's wishes. These children sought information and involvement to have an active role in their own care. This shared desire of hospitalized children to participate in their own care aligns with the normal childhood developmental behaviors of seeking independence during a time of dependence.

Children did not always like being in the hospital, but their experiences were not viewed by them as negative. Similarly to the findings reported by Carney et al. (2003), their perceptions were surprisingly positive. Children described being in the hospital as “not that bad.” They wished to share with other children positive and uplifting messages – “You'll be okay.” “Be brave.” “Believe in yourself.” Childlike spirits emanated from their shared stories and their behaviors during the interviews. Whether hiding under the covers, making witty comments, being fascinated by the audio recorder, or turning the tables to ask questions, children remained resilient. They did not let being in the hospital impede their childlike ways. Many children in this study and others (Wilson et al., 2010) have recognized play and the playroom as the best part of the hospital. Play holds an essential role in a child's life and development. Play can also have additive therapeutic effects for the hospitalized child who may be bored, lonely, or apprehensive. Pediatric institutions take children's developmental needs into consideration when designing their hospital environment. Many institutions include designated playrooms to allow children play areas away from clinical areas, family lounges to allow areas to gather outside the hospital room, and pull-out beds to facilitate rooming-in of parents. In addition, pediatric institutions employ child life specialists, art therapists, and music therapists to help children cope with illness and hospitalization. They also collaborate with outside organizations to permit volunteers access to spend time with children. A hospital environment is where individuals are treated to return to a state of health. Pediatric institutions often go further to offer children a place where their overall well-being is considered.

Children's being in the hospital was not significantly different when parents were absent, but children preferred that their parents stay. Children's desire to have parents present aligned with the conclusions drawn from Björk et al. (2006) observational study on children's behaviors while hospitalized. The presence of a parent/caregiver offered children a source of constant support, which children recognized and appreciated. Unaccompanied children desired the same but acknowledged they needed to share their parents. Accompanied children were able to maintain an emotional and physical attachment with their primary caregiver. While unaccompanied children's physical attachment with their primary caregiver was disrupted, they held unto their emotional attachment.

The meaning unaccompanied hospitalized children ascribed to their experiences was not characterized by additional stressors, disturbed behaviors, or distress. This finding is contrary to much of the literature on the phenomenon that reported on the distress of the unaccompanied hospitalized child (Lulgjuraj & Maneval, 2021). However, past literature derived largely from nurses' shared experiences and researchers' observations. The unaccompanied hospitalized children in this study displayed understanding, not distress. With the sociocultural changes of the last century, a shift in social norms, and changes in family dynamics, being apart from parents for long periods of time may not be unusual for a young school-age child. The number of working mothers with children under the age of 18 increased from 47% in 1974 to 71% in 2007 (Galinsky et al., 2013), and in 2020, approximately 60% of families with children had both parents employed (Bureau of Labor Statistics, 2021). More than 70% of children 3 to 5 years old received nonparental care in 2016 and spent an average of 30 h per week in nonparental care (De Brey et al., 2021). With two working parent households, single-parent households, and children in daycare, children are experiencing separation from parents before they get to the hospital. The fear of separation from parents and being alone reported in past studies (Coyne, 2006; Salmela et al., 2010; Wilson et al., 2010) was not a fear reported by accompanied or unaccompanied children in this study.

Negative emotions were not characteristic of children's experiences. Few children discussed their worries in the hospital, which revolved around the unknown. The findings of this study reveal that children's experiences were characterized by apprehension, not fear. Unfamiliar procedures and interventions made children apprehensive in that they worried something bad would result. Once children understood what was happening, the apprehension of the unknown was gone. Children didn't fear the actual procedures, as Coyne (2006) and Salmela et al. (2010) found in their studies. An experience first described as “very scary” changed to “it was fun” when it became clear what was occurring. Children in this study turned towards the unfamiliar with a desire to know rather than turning away in fear. Acceptance of procedures was more common than resistance.

While the reason for a parent's absence varies, children in this study were unaccompanied due to their parent's competing obligations. There are emotional stressors and psychosocial burdens for a parent to have a child require hospitalization. With other children and responsibilities, parents are left with a decision to make. Roberts and Messmer (2012) reported that many nurses in their phenomenological study were judgmental of absent parents. Absent parents in this study left their child to be cared for in the hospital while they returned home to care for their other children. Children view this absence as sharing their parents with siblings, but a parent's absence can also be viewed as a trust in the healthcare system. Both parents and unaccompanied children trusted the healthcare providers who cared for them when parents could not be present. Unaccompanied children display a mature understanding of their parent's absence, and nurses can support parents by communicating understanding and empathy.

Pediatric nurses play an essential part in the life of the hospitalized child. While children recognized the nurse's role in their physical care, many also discussed the psychosocial role of the nurse. Both accompanied and unaccompanied children formed relationships with their nurses and found joy when the nurses engaged with them beyond their prescribed nursing role. The descriptions children shared of their nurses align with the findings from Petronio-Coia and Schwartz-Barcott (2020) exploratory study on children's descriptions of approachable nurses; approachable nurses are happy, playful, creative, competent, and willing to talk and listen to children. The children in this study reinforced this description of the approachable nurse as they described relationships with nurses that enhanced their hospitalization experience. Nurses who recognized the spirit of the child and allowed the child to simply be a child stood out to children. Zengerle-Levy (2006) found that this was typical behavior of pediatric nurses in their study of caring for unaccompanied children. Pediatric nurses were engaged in helping the child heal holistically, as they practiced being a parent-minded nurse, sustained human connections, received the patient as a child, and renewed the spirit of the child (Zengerle-Levy, 2006). Children in this study reinforced the importance of these findings when mining meaning from their own experiences. However, Livesley (2005) found that nurses who cared for unaccompanied children experienced additional emotional labor and tension. The importance of setting professional boundaries by differentiating between being a nurse and being a parent emerged (Livesley, 2005). Yet, children in this study were not looking for someone to take over their parents' role; they solely sought a companion, someone with whom to have fun.

Phenomenological inquiry allowed for an entry into, and understanding of children's lived experiences. Further research is needed to explore the meanings of hospitalization that children identified in this study. Future research exploring children's perception and desire for autonomy and participation in their own care would provide needed insight into implementing child-centered care within pediatric institutions. Further exploration of children's perspectives of their relationships with nurses and other caregivers will advance our understanding of the significance of the pediatric nurse/provider role, both when children are accompanied or unaccompanied. Accompanied children valued the comfort, care, and companionship their parents offered them, while unaccompanied children longed for accompaniment in the hospital. Exploring ways to offer unaccompanied hospitalized children companionship and comfort, such as implementing volunteers to stay with children or using today's technology to connect children with absent parents, can provide unaccompanied children with a different degree of the accompaniment they yearn for.

This study only explored the experiences of hospitalized children ages 7–11 years old; further research is needed to explore the lived experiences of accompanied and unaccompanied hospitalized children at other ages and stages of development. In addition, retrospective studies examining children's hospitalization experiences once they are discharged can provide further insight into the effects of both accompanied and unaccompanied children's experiences. Continuing to explore the experiences of unaccompanied hospitalized children is recommended, as the literature on this unique group of children remains scant.

Practice implications

The findings of this study have implications for hospitalized children, pediatric nurses, and all pediatric providers. The children in this study displayed a desire to be active participants in their own care. It is vital that pediatric nurses and providers support children to participate in their care. Updating children on their plan of care, educating them on tests or procedures, informing them of interventions before they occur, and allowing them to partake in their own care when practicable promotes the young child's autonomy. Allowing children the opportunity to ask questions or voice concerns gives the children a voice in their care. Taking these measures can help mitigate the apprehension that participants shared when they were left not knowing what was going to happen.

Pediatric institutions today have adapted and implemented the principles of family- centered care. The concept of child-centered care has recently emerged and has begun to challenge the current care delivery system. Instead of the family being the unit of care, the child is placed at the forefront of care, thinking, and practice (Coyne et al., 2018; Ford et al., 2018). Child-centered care gives children a voice in their care and considers the child's perspective in consideration and collaboration with their family (Coyne et al., 2018). Ford et al. (2018) concluded that child-centered care does not need to compete with family-centered care but rather complement it. Understanding the lifeworld of the child and hearing the child's voice is central to child-centered care. The findings of this study support the need to do so. It is common practice today for healthcare institutions to outline and inform patients of their bill of rights. The Association for the Care of Children's Health (ACCH) created the *Pediatric Bill of Rights*, a document outlining the rights that children should be afforded (ACCH, 1996; Mott, 2014). Pediatric nurses are in a position that allows them to advocate for and uphold these rights, including children's rights to respect, information, support, and choice (ACCH, 1996).

Although not in their usual state of health, children desired to continue in their childlike ways and be a kid while hospitalized. Play and connection with others trumped boredom and isolation. Hospitalized children may benefit from additional Child Life interventions and diversionary activities, especially when on isolation precautions. Children valued it when nurses or providers take the time to spend time and play with them beyond conducting their necessary assessments and interventions. Pediatric nurses are participants in the child's lifeworld and are in a position to meet this need for their patients. Refraining from imposing an adult perspective on children's life worlds better allows nurses and healthcare providers to enter the child's lifeworld and meet children where they are. Participants also did not enjoy having their movement restricted when connected to a cardiac monitor or receiving IV fluids. By disconnecting children when these interventions are no longer necessary, nurses give children the freedom they seek. We need to allow children to be simply a child while still receiving the care they need.

Having parents at the child's bedside had many implications for the hospitalized child, as parents provided companionship, comfort, concern, and care for the child. Encouraging parents/caregivers to remain with their hospitalized children provides children with the benefits accompaniment offers and enables nurses to best execute the principles of family-centered care. However, it is important to understand that not all parents may be able to always stay with their children. The findings of this study show that being unaccompanied in the hospital is not distressing for the child. Being empathetic and withholding judgment of absent parents also promotes a better relationship between nurses, patients, and parents. It is important that children know why their parents are not able to stay with them, as having this understanding was central to unaccompanied children's being in the hospital. Unaccompanied children yearn for their parents, but it was okay for parents to step away from their bedside. While parents are not physically present, nurses can offer the unaccompanied child ways to connect with their parents and family, either by calling or video means.

This study reminds us of the need to listen to children's voices, and actively seek out their perspectives on their hospital experiences. This study showed that children are willing to open up to an outsider about their feelings and their experiences if they are given the opportunity. Hospitalized children desire support in many different ways. Giving children a voice and validating their emotional responses is one way to do so.

Limitations

This study is the first to bring the voices of unaccompanied and accompanied hospitalized children to the literature and highlights the importance of promoting child-centered care. However, several limitations were identified. The findings of this study are specific to only the lived experiences of the children within the context of this study, particularly those of children of one age group, hospitalized at only one pediatric institution. While findings are not intended to be generalized, pediatric nurses and providers may recognize these children's experiences as possible experiences their patients may have (van Manen, 1997). This study is also limited to the interpretive lens of the interviewer, who, as a pediatric nurse, was looking into the lifeworld of children from an adult perspective. However, measures were taken to ensure the trustworthiness of the data and minimize researcher bias. A doctoral prepared child specialist and an expert in phenomenology reviewed the data and concurred with the thematic analysis

As with all phenomenological research, the eidetic meaning is not intended to be universal or final. Readers are encouraged to always turn towards the lived experience itself, as no interpretation is ever complete and no revelation of meaning is ever final. Phenomenological inquiry focuses on perception and relies on participants' accounts of an experience. Inherent in perception is the limitation of one's opinions, assumptions, and values. Readers are encouraged to recognize this limitation and retain their phenomenological inquiry as they read this text.

A total of 12 children were interviewed, yet only one child who met the criteria for the unaccompanied group of children was interviewed while still unaccompanied. Unaccompanied experiences were also sought from the group of accompanied children if they discussed times of being alone in the hospital. Therefore, the findings related to unaccompanied hospitalized children are limited to what this small group of children shared. Reaching the unaccompanied group of children and consenting absent parents was a challenge. The ongoing COVID-19 pandemic and surges that occurred while data collection was in progress presented additional limitations and challenges as hospital system dynamics changed. Less than usual unaccompanied hospitalized children were identified throughout the study duration, and when unaccompanied children were identified, consenting absent parents was difficult. When the unaccompanied child presented, many families seemed to distrust the healthcare system, which discouraged parents from consenting. Despite these limitations, this study allows pediatric providers to learn from the children they care for.

Conclusion

While a child's being in the hospital typically revolves around an ailment, the children in this study revealed that hospitalization is more than treating a physical condition. Hospitalized school-age children's autonomy, understanding, inquisitiveness, imagination, and resilience were revealed through their shared lived experiences of being in the hospital. Although accompanied hospitalized children and unaccompanied hospitalized children present contrasting contexts to the phenomenon, being in the hospital was not significantly different amongst children. Children sought to participate in their care, accepted care as a means to recovery, and remained in their childlike ways. While accompanied children had the additional support of a parent or caregiver that unaccompanied children yearned for, unaccompanied children's experiences were not characterized by additional distress in this absence. Contrary to past literature, this study validated the importance of entering children's lifeworld and listening to children's voices. Understanding unaccompanied and accompanied hospitalized children's experiences is paramount to the practice of pediatric nurses and all pediatric providers, as this understanding offers providers insight into how to support the patients and families under their care.

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Diana Lulgjuraj: Conceptualization, Methodology, Investigation, Writing – original draft, Visualization, Funding acquisition. **Rhonda E. Maneval:** Methodology, Validation, Writing – review & editing, Supervision.

Declaration of Competing Interest

None.

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