

# Provider Perspectives on Partnering With Parents of Hospitalized Children to Improve Safety

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**BACKGROUND AND OBJECTIVES:** There is increasing emphasis on the importance of patient and family engagement for improving patient safety. Our purpose in this study was to understand health care team perspectives on parent-provider safety partnerships for hospitalized US children to complement a parallel study of parent perspectives.

**METHODS:** Our research team, including a family advisor, conducted semistructured interviews and focus groups of a purposive sample of 20 inpatient pediatric providers (nurses, patient care technicians, physicians) in an acute-care pediatric unit at a US urban tertiary hospital. We used a constant comparison technique and qualitative thematic content analysis.

**RESULTS:** Themes emerged from providers on facilitators, barriers, and role negotiation and/or balancing interpersonal interactions in parent-provider safety partnership. Facilitators included the following: (1) mutual respect of roles, (2) parent advocacy and rule-following, and (3) provider quality care, empathetic adaptability, and transparent communication of expectations. Barriers included the following: (1) lack of respect, (2) differences in parent versus provider risk perception and parent lack of availability, and (3) provider medical errors and inconsistent communication, lack of engagement skills and time, and fear of overwhelming information. Providers described themes related to balancing parent advocacy with clinician's expertise, a provider's personal response to challenges to the professional role, and parents balancing relationship building with escalating safety concerns.

**CONCLUSIONS:** To keep children safe in the hospital, providers balance perceived challenges to their personal and professional roles continuously in interpersonal interactions, paralleling parent concerns about role ambiguity and trust. Understanding these shared barriers to and facilitators of parent-provider safety partnerships can inform system design, parent education, and professional training.

## ABSTRACT

www.hospitalpediatrics.org

DOI: <https://doi.org/10.1542/hpeds.2017-0159>

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HOSPITAL PEDIATRICS (ISSN Numbers: Print, 2154-1663; Online, 2154-1671).

**FINANCIAL DISCLOSURE:** The authors have indicated they have no financial relationships relevant to this article to disclose.

**FUNDING:** Supported in part by the KiDs of New York University Foundation. The funder had no involvement in the study design, analysis, writing of the report, or decision to submit.

**POTENTIAL CONFLICT OF INTEREST:** The authors have indicated they have no potential conflicts of interest to disclose.

Dr Rosenberg led the study design and analysis, drafted the initial manuscript, participated in the collection and interpretation of the data, and revised the manuscript for key intellectual content; Ms Williams, Ms Ramchandani, Ms Silber, and Ms Schlucter participated in the collection and interpretation of the data and reviewed; Ms Geraghty participated in the study design, interpretation of the data, and review; Drs Sullivan-Bolyai and Rosenfeld participated in the study design, analysis, collection and interpretation of the data, and revised the manuscript for key intellectual content; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.



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Patient and family participation in harm prevention is a widely promoted opportunity to achieve both patient-centered safe care<sup>1-5</sup> through patient error reporting,<sup>6</sup> situational awareness of clinical changes,<sup>7,8</sup> and speaking up about care itself.<sup>9-11</sup> This emphasis on promoting patient-family involvement in hospital safety, also known as patient safety partnership, entails systemic, cultural, and personal changes for patients, families, and providers.<sup>12-15</sup> In pediatrics, this concept includes parent safety partnership.

The translation of these concepts into actual bedside collaborations between US pediatric providers and families to prevent hospital-associated harm for hospitalized children outside of ICUs has not been reported. Understanding expectations and perspectives of providers regarding interpersonal interactions with families about safety, and how these views align with parents', is critical to the successful implementation and dissemination of interventions aimed at reducing harm to patients through family and staff collaboration.

We previously reported on parents' views related to the patient and family safety partnership and identified themes of self-perception as child protector and advocate, parents functioning both independently and interdependently with health care teams to keep a child safe, and variation in parent participation in safety behaviors by personality and/or experience, situation, and perceived risk of child harm with risk of offending the staff.<sup>16</sup>

Our aim in the current qualitative study was to explore the perspectives and experiences of pediatric providers (physicians, nurses, and patient care technicians [PCTs] and/or associates) regarding family-provider partnerships in inpatient safety for hospitalized children. Our ultimate goal was to integrate the parent and provider findings into a shared model of facilitators and barriers around expectations, roles, and communication.

## METHODS

We used a qualitative description approach<sup>17,18</sup> with thematic content

analysis<sup>19</sup> to collect and analyze our data. We conducted in-depth interviews and focus groups of pediatric providers, using semistructured guides developed with a patient- and family-centered care framework.<sup>20</sup> The research team included a family advisor (B.S.) and professionals with backgrounds in health services research, qualitative research, and quality improvement; pediatric medicine and nursing; and family engagement. These diverse perspectives helped to ensure objective study design and analysis with unique interpretations of the meaning of the data.

Target participants were providers in a medical-surgical unit of a 109-bed children's service in a Magnet-certified, urban, tertiary-care academic medical center from March 2014 to January 2015. Providers included pediatric specialists and general physicians who care for patients in the inpatient setting and nurses and PCTs who worked exclusively in the acute-care pediatric unit.

## Interview Development

We adapted our original parent<sup>16</sup> semistructured interview guide to elicit providers' perspectives of (1) parents' definition of hospital safety, (2) roles and interactions with families in preventing harm (eg, What do you think the parents' roles should be in protecting their child's safety during hospitalization?), and (3) experiences and reflections on factors affecting parent-provider partnership in safety activities and behaviors (eg, "Have you ever had a family member remind you to wash your hands? How did that go?") (Supplemental Information).

## Subject Recruitment

We purposively sampled for specialty, sex, and seniority. Staff were recruited from a pediatric acute-care unit (by G.G.) at New York University (NYU) Langone Health. Attending physicians were recruited by a physician (R.R.); parents had focused specifically on attending physicians rather than resident physicians as influential in safety and expectations.<sup>16</sup> To assure internal validity, we used purposive sampling to attempt fair dealing, which explicitly seeks a

wide variety of viewpoints and extreme cases. All participants received token refreshments or gift cards and assured confidentiality.

The NYU School of Medicine Institutional Review Board approved this study.

## Data Collection Procedures

Participants were asked to reflect on their individual experiences across their health care careers. The original intent was to use focus groups for all stakeholders to capitalize on building effects. For nurses and PCTs, data were collected in focus groups moderated by the same researcher (E.W.) with 1 of 3 other researchers. Because of challenges in scheduling focus groups for physicians, individual semistructured interviews were conducted by the same experienced nurse researcher (N.R.). Field notes were taken in addition to audio recordings, which were independently transcribed and verified.

## Data Management and Analysis

We used qualitative content analysis with a constant comparison technique, an iterative process<sup>21</sup> in which we aim to transform rich descriptions from participants into pragmatic suggestions. We began with the codes generated from the parent data<sup>16</sup> to develop the provider code list, using ATLAS.ti to manage codes. Two members of the research team reviewed the transcripts independently, submitted notes on initial and new codes and illustrative data, and met routinely to review codes. These codes, and ultimately themes, were discussed and revised periodically at full research team meetings. Previously coded material was then rereviewed by the same 2 members, and codes were reapplied. After 6 physician interviews were analyzed, an additional interview did not offer any new codes or themes relevant to the focused areas of inquiry and thus approximated informational redundancy.

We also used member checking and reviewed our findings with nurse and physician participants to confirm validity.

## RESULTS

Ultimately, the provider sample (N = 20) consisted of 7 pediatric and surgical

specialists (“physicians”), 2 focus groups of 4 and 5 nurses each, and 1 focus group of 4 PCTs.

### Overall Perceptions of Safety

#### *Providers’ Views on Parental Perceptions of Safety*

Providers believed families view safety as trust in overall quality clinical care that avoids mistakes. Providers perceived parents’ primary safety concerns about isolation precautions and communication gaps. Nurses and physicians also believed families were concerned about medication errors, whereas PCTs perceived concerns about cleanliness.

#### *Providers’ Views on Parents’ and Providers’ Roles in Safety*

In terms of overall stated global safety roles in the hospital, providers viewed parents as “child experts” and “advocates,” the majority of whom “want to be involved.” Providers saw parents’ engagement in safety as both a right and “a bonus” but not a requirement, recognizing that not all families are able to participate.

Providers viewed their own roles in parent safety partnerships as a shared and complementary interdisciplinary responsibility. Specifically, nurses’ safety roles are primary rule-setting, proactive educators and enforcers who educate parents on general and patient-specific safety rules and who orient families to the hospital environment and risks. PCTs viewed their roles as preparing a safe environment and reminding parents about safety rules. Physicians saw their role as providers of “anticipatory guidance” to parents about safety as a “natural extension of what we always do as pediatricians.” For example, a neurologist teaches safety precautions for seizure-related falls while in the bathroom. Other staff viewed attending physicians as enforcers of safety education.

Providers, especially physicians, viewed the health care team as ultimately and professionally responsible for safety as “the ones driving that boat,” although ideally with family collaboration: “The expectation should be that for the most part we are, as a medical team and providers, maintaining

patient safety with or without the parent” (doctor of medicine [MD]).

### Provider Perceptions of Facilitators and Barriers Affecting Parent-Provider Partnerships in Safety

We identified several themes that providers associated with a positive parent partnership about safety (Table 1). One shared facilitator was mutual respect and clear delineation of roles for parents and providers.

An MD stated that parent-driven facilitators included advocacy, including speaking up about situational awareness as a “first line of defense” that honors a parent’s role as the “expert” best equipped to detect subtle changes in behavior and potential side effects in their child:

*“I think parents have a great sense of instinct. And I have always taught the medical students that when the mother says something you better believe it. Because they understand their child’s behavior . . . they really know when things are right versus wrong.”*

Providers also viewed parents as protectors and allies in following hospital rules, like being “our number one resource in safeguarding their child from falls.”

Provider-driven facilitators to partnership were focused on trust gained through consistent good care, empathetic adaptability, and transparent communication of expectations. Demonstrating reliable competence to parents promoted comfort and lessened overall anxiety over hospitalization. Another facilitator was providers’ own empathy and adaptability to recognize each family’s individual capacity for safety and clinical information and not assuming “one size fits all.” Providers further acknowledged that families and individuals differ in their ability to take in information at any given time in a child’s “nerve-wracking” hospitalization. Establishing a comfortable and nonthreatening environment with transparent, realistic goals and consistent verbal and environmental and/or visual cues for involvement and speaking up facilitated partnership, like explicit and routine invitations to participate in

central-line care and family-centered rounds and signage used to support specific safety language for parents.

### Provider Perceptions of Barriers to Parent-Provider Partnerships

We identified barriers to parent-provider collaborations on safety, which were often conflicts between expected and actual roles in the moment of care (Table 1).

Providers noted that a perceived lack of mutual respect of roles or mistrust by either party impeded partnership. To providers, parents are “protecting [their] child from a host of people who are generally well intended,” but at extremes, this can manifest as mistrust and unwillingness to collaborate: “The personality type that doesn’t like the fact that ‘I am being displaced,’ as the father of the child, or the mother, and other people are making the decisions.”

Parent-related barriers to partnership, from the provider perspective, included differences between parent and provider interpretation of events and their significance. For example, parents may perceive medication changes as urgent, whereas providers may not prioritize in the same way.

An MD stated that another barrier was the lack of parent availability to participate in safety collaboration because parents may be “distracted and not focused,” or physically absent:

*“If the parent is at the bedside every day and wants to be involved, then we give them more involvement and responsibility, as much as they choose to. But I think there are plenty of patients that do not have anyone at the bedside reliably, so the system has to be in place to protect those children as well.”*

Provider-related barriers to partnering with families regarding safety included inconsistent communication or care. This variability was viewed as a threat to collaboration because “the one thing that upsets parents is lack of consistency. . . when that breaks down, I think it leaves a lot of anxiety” and hypervigilance. Participants, especially nurses, noted that

**TABLE 1** Provider Perceptions of Barriers to and Facilitators of Parent Safety Partnerships for Hospitalized Children

		Provider Perceptions of Factors Impacting Parent-Provider Inpatient Safety Partnerships	
		Facilitators	Barriers
Shared factors	Mutual respect of roles	"I say this to parents sometimes: they are the experts [on their kid, and we are maybe the experts in medical care. But you know your kid the best, so you tell me." (Night RN)	Lack of respect for parent role <p>"[Some] physicians become abrasive and immediately try to contradict the parent. Well, I think you need to be a little bit more of a human being here and understand that it is all natural for the parent to ask what you are doing. Look, it is fair game. I think it is the way they have every right. It is their child. So, I think if you get too sensitive about that, you are not doing your job right." (MD)</p>
Parent factors	Advocacy	"You tell them, you are the advocate for the child [at home], and you are going to be the advocate in the hospital." (MD)	Difference in parent versus provider risk perception <p>"Sometimes you have to be a little stern if they are being a little unreasonable or freaking out about something that is just [normal] . . . "Okay, this is how it is going to be. It's okay." (Night RN)</p>
Provider factors	Parent follows hospital rules on safety	"[The parent's role is to] pay more attention; be more attentive, and try to follow the rules . . . for example, fall precautions. [Patients] need to wear the socks. And you cannot leave [patients] at the bathroom. You can take them there, but you have to stay with them." (PCT)	Parent not available <p>"But they have so much to worry about in addition to [medications] that I don't want them to think they have to double check the label. If they want to, great, but hopefully with the checks and balances we have in place we can really prevent a lot of, the majority of, those errors. If we have to rely on the patient to be that last safety net, we're a little bit in trouble." (MD)</p> <p>"For safety, it's better just to have a parent there at the bedside." (Day RN)</p>
	Gain trust with good care	"Like our oncology patients, I see at first some parents . . . want things done a certain way, and they are not going to change. But I have also have seen some parents kind of let go once they learn the system. And they go from being super nervous, asking a million questions, wanting things exactly when they are due, to kind of letting go a little bit, knowing that everything will get done." (Night RN)	Inconsistencies and errors harm trust <p>"From a parent's standpoint, I am sure they are like, 'Wait, you don't know that neurosurgery was just here? Wait, didn't they tell you?' And then they get panicky: 'So you don't know what is going on?'" (Day RN)</p> <p>"I think most families that are distrusting of nurses, med students, residents; it is more of a multiple incident type of thing or a preconceived perception, as opposed to a one-time major issue." (MD)</p>
Provider factors	Adapt with empathy	"If they are bright-eyed and very anxious, and their tone of voice and their body language . . . you know you are going to be in the room a little longer. You budget your time to manage that, to give them the extra attention that they need and the education that they need." (Night RN)	Lack of provider skills and/or time <p>"I think the biggest concern for me is time. There are just so many things that are going through your mind when you are in a room with a patient: What is my diagnosis? How is my exam? [And] if you have a resident or medical student there, working with them and addressing moms' questions and concerns." (MD)</p>
	Transparent communication of expectations	"You get [parents] that don't know as much who turn to the medical professionals. And then you have the parents who have these kids with chronic conditions, who come in as the experts on their children, as they should be. And run the show . . . "Okay, I want you to do it this way. And this is how I keep my child safe," and are a little bit more in tune with what is not right and what practices they are not comfortable with for their child." (Day RN)	Risk of overwhelming information <p>"Especially the first time a child comes to the hospital, there is so much they are coping with and dealing with that I think that volume of information can be distracting and not even effective, necessarily." (MD)</p> <p>"If we are going to have the parent say, 'I need to see the dosage,' then what is that going to do to [build] trust between the parent and the nurse? . . . I do not think that the attending should tell the parent to distrust the nurse . . . let us just put it this way: the attending-nurse relationship and the nurse-parent relationship would not be helped by this as a trust issue." (MD)</p>

MD, doctor of medicine; PCT, patient care technician; RN, registered nurse.

clinicians' well-intentioned engagement of parents to "protect" a child from other providers (eg, asking parents to "not let anyone touch that wound") is a paradoxical barrier to partnership, creating mistrust. Providers perceived that gaps in care, such as a medication error with harm, may damage a particular relationship as well as future trust in health care.

Another barrier to partnership was the providers' lack of, or variability in, skills, prioritization, and time related to engaging parents on safety.

A final barrier to partnership was clinicians' concerns about overwhelming families with too much information about safety risks, which might then burden families and promote fear, guilt, or anxiety, including hypervigilance. Absolute transparency on all possible safety risks was viewed as unfeasible or

counterproductive: "We don't want to scare patients when they come into the hospital, but hospitals are dangerous places."

### Balancing Communication and Concerns

In addition to themes of perceived barriers to and facilitators of parent safety partnerships, themes related to the challenges of balancing personal and professional roles and communication emerged (Table 2).

### Shared Challenges

Parents and providers constantly balance their own roles with those of the other. Providers reported balancing a respect of parent wishes to minimize an adversarial relationship with providers' own professional expectations, practice, and responsibilities. Providers described tensions that emerge when parental

autonomy of "knowing what is best for my child" clashes with provider clinical expertise, like safe sleep in the hospital.

### Unique Provider Challenges

Providers reported varying abilities to balance professional equanimity with "human instinct" and also respond defensively to parents' perceived challenges to competence. Although some providers struggled, others were less threatened. One PCT said, "Some of [the parents] do remind you, 'Oh, you did not put on your mask.' I say, 'Oh, thank you. . .you reminded me.' Because that is part of keeping ourselves safe and the patients safe, too, so it doesn't bother [me]."

Maintaining professional equanimity despite aggressive or disrespectful language or actions by parents was recognized as a difficult balancing act at times.

**TABLE 2** Themes From Providers Related to Balancing Communication and Concern in Parent-Provider Interactions Involving the Safety of Hospitalized Children by Stakeholder

Balancing Theme		Exemplar Quote
Shared factors	Balance parents' expertise and/or advocacy with clinician's safety expertise	"You kind of have to adapt to what the patient and the family come in requesting and needing and what they are comfortable with. I think that is just the role." (Day RN) "The goal is to have them as part of the team, not force them into an adversary position [in which a parent says], 'I don't really want that drug, can we stop it sooner?' . . . But there is always the personality type that doesn't like the fact that 'I am being displaced,' as the father of the child or the mother. And other people are making the decisions." (MD) "I don't think we can substitute our diligence and our responsibilities to parental control." (MD)
Provider factors	Balance defensive reaction with professional role  Balance human response to disrespectful language with professional role	"Maybe [I would be offended] for a quick second. But then, they're right. If that is what is going to make them feel better, I would wash my hands 5 times for them if I had to." (Night RN) "[Some] physicians become abrasive and immediately try to contradict the parent. Well, I think you need to be a little bit more of a human being here and understand that it is all natural for the parent to ask what you are doing." (MD) "It makes us nervous when people write things down because you feel like they are documenting so they have something to use against you. But if I were a patient, or when I was a patient, I had to write everything down . . . So if we encourage them to write down the changes, that is good." (Day RN) "[Parents] need to speak up and let us know in a way that keeps the child safe. Hopefully it is cooperative, collaborative, and not antagonistic." (MD) "The parents may not be very diplomatic about how they go about trying to help their kid. But we still, I think we do our best to help them advocate for their kid." (Night RN) "If [parents] say it kindly, we are going to receive it better. If they give it to you with a snide attitude, or make comments, or say it rudely, yes, it is going to be offensive. And you are going to take offense, and you may have a little bit of a chip from that . . . I have no problem with [parents saying], 'Hey, listen. This is how I do it at home. Would you mind doing it this way?' Sure, of course, please! I would rather you tell me how you do it." (Day RN)
Parent factors	Parents balance which concerns to escalate	"I think for many of these parents, it's like, which battle do you pick today? And I think that really culminates because we may see them for 12, 13 h, but they are with their child for 24 plus. They are in that bed when we are not there." (RN)

MD, doctor of medicine; RN, registered nurse.

## Unique Parent Challenges

Providers perceived that families “choose their battles” and balance concerns about enduring safety risks to their child with voicing their concerns to avoid being perceived as difficult. One MD said, “You’re asking people who feel vulnerable to speak up about something when they’re totally at the mercy of who’s assigned to them, and they are going to be reticent.”

## DISCUSSION

In this qualitative US study of inpatient pediatric acute-care providers, we identified perceived facilitators, barriers, and balancing domains impacting bedside collaborations with families regarding a hospitalized child’s inpatient safety. These themes, developed from daily clinical interactions, were primarily focused on roles, expectations, and related conflicts. Providers viewed hospitals as intense environments for both parents and providers caring for sick children, suggesting that each individual’s personal management of internal and external hierarchies, or power differentials, and threats to roles in and out of the hospital can cause uncertainty and mistrust.

With our findings, we begin to describe and explain the complex, intense relational situations with hierarchies and varying expectations about being a provider for, or parent of, a hospitalized child. Social scientists emphasize the importance of understanding social roles and their impact on interaction. Role theory, a sociology paradigm, seeks to clarify the deeper reasons for a cluster of expected behaviors and attitudes (roles) that individuals develop for themselves and others, although these roles may be dynamic and conflicting.<sup>22,23</sup>

Because the importance of roles paralleled findings in our study of parent perspectives,<sup>16</sup> we conclude that role theory may be a helpful framework for integrating the findings from both groups. Parents and providers both struggled with interpreting their expected roles in the many interpersonal interactions during a hospital stay (Fig 1).

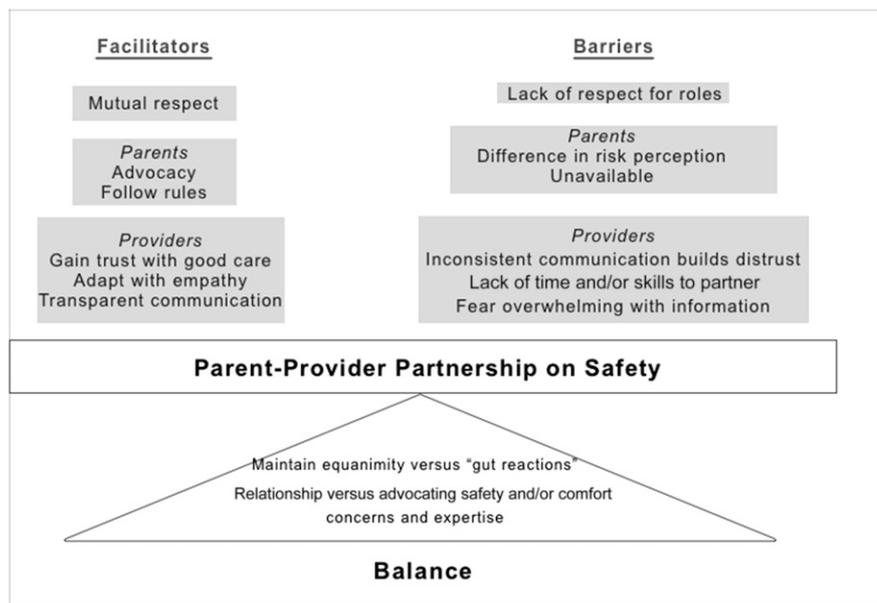
Parents and providers both play the role of child expert, advocate, and protector at different times during a child’s hospitalization. For example, the concept of a parent as a “child expert,” although freely used as a stated ideal for the parent role by both parents and providers, is ambiguous:

the parent is expert at recognizing a child’s “not acting right,” and providers, by profession, training, and experience, are expert at recognizing lethargy as a mental status change that can represent many underlying causes.

According to role theory, the result of this dynamic double occupancy in the same role is ambiguous of the boundaries between parents and providers, which can create discomfort, tension, or outright conflict.<sup>22,23</sup> In the inpatient setting, at its most benign, this friction can result in shared self-conscious vigilance to maintain a balance between maintaining a relationship and assertiveness. At its worst, role conflict may cause mutual mistrust and lack of collaboration in the interest of child safety.

The health care system is made up of real individuals who are balancing their own conflicting and competing roles of parent, provider, professional, employee, and finally simply being a person in an intense environment with many layers of power imbalances and gaps between idealized and actual roles. In our research on dual perceptions, we underscore the importance of removing generalizations, labels, and assumptions from both parents and providers to develop effective partnerships between patients, families, and providers. Otherwise, mismatches between perceived, desired, and actual roles may lead to parent dissatisfaction and unease and to provider burnout. Recognizing the human challenges for providers of current models of care, with our results, we also support expansion of the Triple Aim (better care, better health, and lower cost) to include a fourth: better provider work environment and patient involvement.<sup>24</sup>

In our empirical findings of parent-provider perceived roles about safety collaboration, some elements of literature-derived models of adult patient engagement<sup>25-27</sup> are reinforced: patient and surrogate self-efficacy and advocacy<sup>28</sup> and previous experiences; provider engagement, such as empathy and openness; and system engagement, such as patient-centeredness and capacity.<sup>29,30</sup> Further development of a unique pediatric and family engagement model of safety may benefit from integrating



**FIGURE 1** Visual of integrated parent and provider perceptions of barriers, facilitators, and balancing themes related to parent-provider safety partnerships for inpatient, acute-care, pediatric patients.

role theory to strengthen existing patient engagement models as well as family nursing<sup>31</sup> and patient- and family-centered care frameworks.

Future application of this work could be focused on resolving gaps in capacity and skills for both families and providers regarding role negotiation, self-efficacy, communication, and relationship building and systems issues, including culture and expectations.<sup>32</sup> Specifically, consistent written and verbal outright delineation of realistic roles and expectations at the start of every encounter may reduce ambiguity; providers cannot expect to tell parents they are the experts and then question parents' expertise and label them "challenging." Rather, focusing on building trust with families through regular active listening by all clinicians, despite time constraints, will likely reduce time needed to resolve conflicts and potentially decrease harm. The ambiguity and a dynamic nature is intrinsic to any human relationship, but the open capacity to recognize, address, and manage these roles is a critical professional skill that requires institutional support.

For example, findings from recent work by Khan et al,<sup>6,33</sup> suggests that it is possible to develop family-centered structured communication systems with parents of hospitalized children that are associated with significant improvements in safety.

This study is limited by its single-site nature and a smaller sample size, although this is not unusual in focused qualitative description studies, and we aimed for diversity in provider experience, specialty, sex, and race. Because focus groups are the level of measure of subjects, a large number of focus groups for nursing staff would have increased confidence in saturation for this category of respondents. Future researchers could build on this work in the development of mixed methods and survey studies to test generalizability and expand the clinician pool to include trainees, who may spend even more time with families than attending physicians.

## CONCLUSIONS

In exploring provider perspectives on their roles in safety partnerships

regarding hospitalized children, we found that balancing personal and professional roles is a significant challenge itself for parents and providers that likely contributes to a complex safety culture. Future multisite studies are needed to confirm these findings and develop strategies that promote resilience and skills for providers and trainees, who wish to care for patients and families effectively, and in partnership, and for families, who must negotiate changes in role from home to hospital.

## Acknowledgments

We thank Dr Patrick Brady for comments on the article. We also thank the NYU Sala Institute for Child and Family Centered Care and the participants in this study for their time and honesty.

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DOI: 10.1542/hpeds.2017-0159 originally published online May 1, 2018;

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