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Parents' Experiences of Patient Safety Incidents During Their Child's Hospitalization: A Qualitative Study

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ABSTRACT

Aims: Patient safety incidents involving hospitalized children can have significant impacts on both patients and their families. However, previous research has primarily focused on healthcare professionals' perspectives, and studies exploring parents' experiences of patient safety incidents in paediatric settings remain limited. This study aimed to identify parents' experiences of patient safety incidents during their child's hospitalization.

Design: Qualitative study.

Methods: Data were collected through individual interviews conducted between August 15 and December 23, 2023. Participants were seven parents who had experienced patient safety incidents while their children were hospitalized in South Korea. Data were analysed using deductive content analysis.

Results: Six themes were identified from parents' experiences, which were organized into three theme clusters: 'the indelible pain of patient safety incidents,' 'limitations of the pediatric healthcare system' and 'the need for an integrated management system to strengthen pediatric patient safety.'

Conclusion: This study highlights the importance of healthcare environments that reflect the unique characteristics of paediatric patients and patient safety strategies based on parental engagement, as revealed by the experiences of parents whose children experienced patient safety incidents. Our findings underscore the need to develop and implement paediatric-centered healthcare services, as well as programs and policies aimed at creating safer care environments for hospitalized children.

Implications for the Profession and Patient Care: Enhancing paediatric patient safety requires family-centered care that actively involves parents and promotes effective communication between healthcare professionals and parents. Additionally, transparent disclosure and support systems following patient safety incidents should be strengthened, and parent-engagement–based patient safety programs should be expanded in clinical practice.

Reporting Method: The study adheres to the Consolidated criteria for Reporting Qualitative research (COREQ) guidelines.

Patient or Public Contribution: Parents participated as interview respondents.

1 | Introduction

Patient harm resulting from unsafe healthcare delivery has become a major global health concern and is recognized as a leading cause of preventable deaths and disabilities worldwide (Howick et al. 2024). Recent evidence indicates that more than 10% of hospitalized patients experience harm during healthcare delivery, and a substantial proportion of these events are considered preventable (World Health Organization [WHO] 2023). The WHO (2021) defines patient safety as a fundamental component

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What Does This Paper Contribute to the Wider Global Clinical Community?

- Illuminates the profound emotional and psychological impact of paediatric patient safety incidents on parents, positioning them as essential partners in safeguarding hospitalized children.
- Exposes structural and communication gaps within paediatric healthcare systems that may compromise patient safety and highlights the need for child- and family-centered safety approaches.
- Provides actionable insights for strengthening paediatric patient safety through parent engagement, transparent incident disclosure and integrated safety management strategies in clinical settings.

of healthcare quality and has consistently emphasized the need for systematic approaches to reduce harm occurring during healthcare delivery. According to the WHO (2021), a patient safety incident is defined as an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. Among these, incidents that result in actual harm are classified as adverse events.

The WHO (2021) established the Global Patient Safety Action Plan 2021–2030 to reduce avoidable harm and build safer healthcare systems. This plan underscores the importance of strengthening safety culture, improving incident reporting and learning systems, and actively engaging patients and their families as partners in the care process. Furthermore, the Organisation for Economic Co-operation and Development (2023) reported that patient safety incidents remain common across healthcare systems and emphasized that patient and family engagement plays a critical role in improving healthcare quality and patient safety. This trend reflects a shift from provider-centered approaches to patient-centered models of care. In hospital settings, where complex diagnostic and therapeutic interventions are frequently performed, the risk of patient safety incidents is inherently elevated. Patient safety incidents are closely related to healthcare system structures, organizational culture and communication practices among healthcare professionals (Slawomirski and Klazinga 2022). Improving patient safety has become a strategic priority for healthcare organizations and a critical component of achieving universal health coverage (WHO 2023).

2 | Background

Children are particularly vulnerable regarding patient safety. Due to their developmental stage, their physiological functions are not fully mature, and they often have limited ability to recognize, communicate or respond to risks in healthcare environments (D'Errico et al. 2022). Even relatively minor errors or delays in treatment can lead to long-term consequences for children's growth and development, potentially affecting not only their physical health but also emotional and cognitive outcomes (Badgery-Parker et al. 2024). These characteristics highlight the importance of strengthening patient safety measures specifically tailored to paediatric care.

During a child's hospitalization, parents play a central role in the care process. Often, they possess the most detailed knowledge of their child's condition and participate in clinical decision-making through communication with healthcare professionals (Latour et al. 2024). Additionally, parents frequently function as observers and advocates who monitor their child's safety in the healthcare environment (Kim and Chang 2025). However, when patient safety incidents occur, parents may experience profound emotional distress, including fear regarding their child's health, as well as guilt, anger, helplessness and distrust of healthcare providers (Rathnayake et al. 2025). Inadequate disclosure or insufficient information following an incident may further exacerbate parents' emotional distress and undermine their trust in the healthcare system (McQueen et al. 2022). In some cases, such experiences may even lead to conflict with healthcare professionals or legal disputes (Gallagher et al. 2023). Parents' experiences of patient safety incidents provide critical insights into how healthcare systems function in practice, particularly in areas such as communication, transparency and responsiveness (Witkowska et al. 2025). Understanding these experiences is essential for identifying system-level gaps that may not be fully captured through provider-centered approaches and for developing more effective patient- and family-centered safety strategies. In this study, patient safety incidents specifically refer to unintended events occurring during paediatric hospitalization that may harm patients, including medication-related errors, diagnostic delays, procedure-related complications and communication failures. This study focuses on how parents experience and interpret patient safety incidents in the context of their child's care.

Despite a growing emphasis on patient safety, previous research (Guerra-Paiva et al. 2023; Lee and Kim 2024) has largely focused on healthcare professionals' experiences, including the second-victim phenomenon among healthcare providers (Mathebula et al. 2022) and organizational responses to safety incidents (Rathnayake et al. 2025). Some studies have examined paediatric patient safety from a parental perspective. For example, research involving hospitalized children has reported that parents identified and reported errors and adverse events that occurred during their child's care, highlighting the important role of parents as observers and reporters of patient safety incidents (Khan et al. 2016; Witkowska et al. 2025). However, these studies have primarily focused on identifying the occurrence and types of patient safety incidents, with limited attention to understanding the contextual and experiential dimensions of parents' responses, including their emotional reactions, interactions with healthcare professionals and changes in perceptions following patient safety incidents. Although some studies have acknowledged the importance of caregiver involvement in patient safety (Purchase et al. 2025), qualitative research that explores the lived experiences of parents whose children have experienced patient safety incidents during hospitalization remains limited.

Therefore, this study aimed to explore the experiences of parents who encountered patient safety incidents during their child's hospitalization using a qualitative research approach. This study seeks to provide an in-depth understanding of how parents perceive and interpret patient safety incidents, the emotional and social challenges they experience, and their expectations of

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healthcare professionals, thereby addressing an important gap in the existing literature.

3 | The Study

This study aimed to comprehensively explore parents' experiences of patient safety incidents involving their hospitalized children. The central research question guiding this study was: 'What are parents' experiences when their child encounters a patient safety incident during hospitalization?'

4 | Methods

4.1 | Study Design

This research design used a descriptive phenomenology to comprehensively explore and understand parents' experiences of patient safety incidents involving their hospitalized children. A descriptive phenomenology was chosen as it enables an in-depth exploration of individuals' lived experiences and the meanings they ascribe to those experiences (Colaizzi 1978). The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

4.2 | Participant Recruitment and Researcher Preparation

The inclusion criterion for this study was parents whose children aged 15 years or younger had experienced a patient safety incident during hospitalization within the past 5 years. The exclusion criteria were parents aged under 18 years and those who refused to consent to the interview recording. The researcher used purposive sampling to recruit parents who met the inclusion criteria. The researcher posted information on the purpose and methods of the study in local and online cafés frequented by parents, which related to patient safety incidents. Interested participants accessed the online research participation website via an online link or QR code. After accessing the website, participants read the research participation information; if they voluntarily consented to participate in the study, they provided their contact information. The researcher contacted the participants, explained the study purpose and methods and scheduled interviews.

Interviews were conducted by a professional interviewer from Gallup Korea using a semi-structured questionnaire provided by the researcher. This approach was intended to facilitate open disclosure of sensitive experiences and minimize potential researcher bias during data collection. The interviewer had extensive experience conducting qualitative interviews and received training through a preliminary meeting with the research team regarding the study purpose, interview guide and appropriate probing techniques. The research team conducted pre-interview briefings and provided detailed guidance on using open-ended questions and follow-up prompts.

Interviews were conducted until data saturation was achieved, defined as the point at which no new meaningful insights emerged from the data. Following each interview, the researchers engaged in iterative discussions to assess whether new codes or themes were emerging. Data collection was discontinued when no additional themes were identified and existing themes were consistently repeated across participants. Seven participants were included in this study.

The researchers are all currently female professors of nursing, who were trained in qualitative research by attending graduate programs and academic conferences, and they have published several qualitative research papers. Furthermore, all researchers worked in patient safety-related fields at a Quality & Patient Safety Center in a tertiary hospital. In that role, they interviewed medical staff, patients and guardians to analyse the causes of patient safety incidents and develop improvement initiatives, gaining practical experience in understanding them. The corresponding author has specialized knowledge in paediatric nursing and has worked as an intensive care unit nurse at a paediatric hospital for over 5 years. To ensure that the researchers' perspectives and biases did not influence the results, the authors reflected on the participants' experiences and opinions to the greatest extent possible.

4.3 | Ethical Considerations

Data collection began after receiving approval from the Institutional Review Board of Kyungpook National University (no. 2023–0285). Participants were informed of the study purpose and methods and assured that the collected data would not be used for any purpose other than research. Furthermore, participants were informed that the interviews would be recorded, that all information would be kept confidential, and that they would not face any disadvantages. Participants were also informed that they could withdraw from the study at any time. Written consent was obtained from participants via email prior to the interview. The researchers personally organized the interview data, ensured confidentiality, encrypted the data and stored them in a laboratory. The participants were provided with mobile gift cards as tokens of appreciation.

4.4 | Data Collection

Interviews with each participant were conducted by a professional interviewer from Gallup Korea from August 15, 2023 to December 23, 2023. Interviews were conducted via phone or in person, depending on the participant's preference. Participants were informed of the recording, and consent was obtained prior to the interview. Each participant was interviewed once, lasting from 50 min to a maximum of 2 h. For telephone interviews, particular attention was given to verbal cues, such as tone, pauses and emotional expressions, to compensate for the absence of non-verbal communication. The interviewer used active listening techniques and follow-up probing questions to clarify meanings and encourage detailed responses. Additionally, field notes were taken immediately after each interview to capture contextual impressions and support data interpretation.

The questions were semi-structured by two researchers with extensive experience interviewing patients. Interviews were

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undertaken employing a semi-structured format. In this study, a pre-developed interview guide was used to systematically explore participants' experiences, while allowing flexibility to adapt questions based on participants' responses. The interview guide comprised five main domains: (1) experiences of patient safety incidents, (2) post-incident experiences of the child and parents, (3) interactions with healthcare professionals and responses to the incident, (4) experiences of compensation and support, and (5) perceptions of prevention and improvement of patient safety incidents. Each domain included open-ended questions to encourage participants to describe their experiences freely. The primary question for the interviews was, 'What are the experiences of parents when their children experience patient safety incidents at medical institutions?' Secondary questions included 'Which patient safety incident occurred while your child was hospitalized?', 'How did your child suffer harm?', 'How did the medical staff or hospital explain the patient safety incident to you?', 'As a parent, how did you respond to the harm your child suffered?', 'What changes have occurred in your child, yourself, and your family since the patient safety incident involving your child?' and 'What areas do you think should be improved to prevent patient safety incidents involving hospitalized children?' The questions were asked sequentially according to the flow of the participants' conversations to ensure that their stories unfolded without interruption. The participants' words were transcribed verbatim and nonverbal actions, such as silence and sighs, were also recorded.

4.5 | Data Analysis

The data comprised 134 A4-sized pages of transcribed interview transcripts. After all the interviews were completed, two researchers conducted a deductive method for content analysis. Focusing on the research questions, the researchers conducted an deductive content analysis using the following steps: overall understanding of the data, open coding, grouping, categorization and abstraction, as suggested by Elo and Kyngäs (2008).

After reading the transcribed statements and memos to gain a general understanding of the raw data, the researchers reread the data to identify the key statements deemed meaningful. These statements were then reread and concepts or phrases that could serve as appropriate headings for their meaning were recorded, creating an open coding list. During data analysis, two researchers independently coded the data and compared their findings. Through iterative discussions, codes and categories were continuously refined and integrated, facilitating a deeper exploration of themes and enhancing the credibility of the analysis. After comparing and integrating the similarities and differences of the concepts or phrases included in the open coding list, appropriate names were assigned to their meanings to form subcategories, which were then integrated again according to their meanings and characteristics and abstracted into categories.

Given the wide age range of children included in this study, developmental differences (e.g., levels of dependency, communication ability and parental roles) were considered during data analysis. The researchers compared participants' experiences across age groups to identify common patterns and age-related differences. Additionally, analytic rigour was enhanced through continuous comparison of data across participants and iterative verification of emerging themes. Data saturation was determined through concurrent data collection and analysis, whereby no new meaningful codes or themes emerged and existing categories were sufficiently developed and internally consistent.

4.6 | Rigour and Reflexivity

This study aimed to ensure the rigour of qualitative research through the principles of credibility, auditability, fittingness and confirmability proposed by Sandelowski (1986). To ensure credibility, participants were selected based on their ability to articulate their child's experiences of patient safety incidents. Interviews were conducted in a comfortable atmosphere using open-ended questions to encourage free expression of opinions. Transcription of the recorded audio files was completed the day after the interview to minimize omissions and distortions in the interview content. Additionally, regular reflexive discussions were conducted among the researchers throughout the data collection and analysis processes to enhance interpretation consistency and depth. The researchers deliberately bracketed their prior assumptions and remained grounded in participants' narratives. Furthermore, two researchers independently coded the data and compared their findings, and any discrepancies were resolved through discussion to enhance the credibility and confirmability of the analysis. To ensure auditability, a detailed explanation of the research purpose and methods was provided to facilitate reader understanding. To ensure fittingness, participants' general characteristics were described, and data were collected until no new information emerged from their statements. To ensure confirmability, researchers maintained reflexive awareness of their perspectives throughout the research process.

5 | Results

This study included seven participants: five mothers and two fathers. Of the participants, four were in their 30s, one in their 40s and two in their 50s, with an average age of 40.7 ± 7.8 years. At the time of the patient safety incident experienced by their child, five children were under 5 years old, one was 6–10 years old, and one was 11-15 years old, with an average age of 4.3 ± 4.2 years. The time elapsed since the incident was less than 3 years for six children and 3–5 years for one child, with an average duration of 2.4 ± 1.5 years. The types of patient safety incidents experienced by participants' children included medication errors ($n = 2$), diagnostic errors or delays ($n = 2$), procedure-related incidents ($n = 2$) and infection-related incidents ($n = 1$). Patient safety incidents occurred in the general ward ($n = 3$), intensive care unit ($n = 2$) and emergency room ($n = 2$). The severity of harm to children included minor injuries requiring additional treatment ($n = 3$), extended hospital stay ($n = 2$), severe injuries requiring long-term follow-up ($n = 1$) and death ($n = 1$).

In this study, a coding matrix was used to systematically organize participants' statements during data analysis. Initial codes were iteratively reviewed and grouped into subcategories with similar meanings, which were then integrated into broader categories and overarching themes. This hierarchical coding structure guided data organization and interpretation.

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TABLE 1 | Parents' experiences of patient safety incidents during their child's hospitalization.

Theme clusters	Themes
The indelible pain of patient safety incidents	Parental guilt and helplessness
	Anger and betrayal toward inadequate follow-up actions
Limitations of the paediatric healthcare system	Lack of paediatric-specific healthcare services
	Shortage of paediatric healthcare personnel and resources
The need for an integrated management system to strengthen paediatric patient safety	Active parental participation in their child's care
	A transparent and accountable patient safety incident response system

Data analysis yielded 510 key statements, generating 152 codes in Steps 1 and 2. In Step 3, the relevant codes were categorized into six themes. In Steps 4 and 5, the topics were structured into three theme clusters: 'The indelible pain of patient safety incidents,' 'Limitations of the pediatric healthcare system' and 'The need for an integrated management system to strengthen pediatric patient safety' (Table 1).

5.1 | The Indelible Pain of Patient Safety Incidents

5.1.1 | Parental Guilt and Helplessness

Participants experienced deep self-reproach and guilt for failing to properly protect their child after the patient safety incident. They repeatedly blamed themselves for the worsening of the condition. They recalled moments when they failed to fully recognize their child's complaints of pain and expressed regret for failing to fulfil their role as parents. Furthermore, they were unable to proactively address the issue with medical staff because of concerns that raising the issue could jeopardize their child's treatment, leading to a profound sense of helplessness. Despite being aware of the medical staff's lack of explanation, delayed reporting or attempted cover-up, the inability to transfer to another hospital for treatment left a lasting emotional scar on the parents. The child's physical scars, functional limitations and peer difficulties following the incident repeatedly reminded them of their self-reproach, demonstrating that the patient safety incident remained a long-term and persistently painful experience for parents.

> My child fractured their arm and wore a cast, and went to the hospital to have it removed a month later. During the removal process, the cast saw cut the skin, leaving a wide, 37cm-long laceration. [...] I initially thought my child was exaggerating and even told her not to make a fuss, but she kept screaming in pain almost like a scream of agony. In that situation, the only person my child could rely on was me as her parent, yet I ignored her and trusted only the doctor who said everything was fine. I still feel deeply sorry about that, and it hurts me the most.
>
> (Participant 7)

> My child suffered burns during laser surgery for right-sided torticollis. She underwent skin grafts and received burn treatment for four years. [...] I felt devastated by the fact that I was in such a powerless position where I could do nothing about the incident. I often think that maybe I should have taken a leave from work, hired a lawyer, and fought back. When I think about those regrets, it becomes emotionally overwhelming. [...] My daughter has limited shoulder movement and a large scar. Whenever the other children in the class asked what the scar was, she couldn't say anything and was bullied because of it.
>
> (Participant 2)

> My child was one year old and had a high fever due to COVID-19, so she received IV fluids in the emergency room. However, the fluid leaked out of the vein, causing severe swelling. When the nurse removed the dressing, the skin came off with it. [...] Since my baby still needed COVID-19 treatment, it was difficult for me to confront the situation strongly. I was worried that if I complained too much, the treatment might not be provided properly.
>
> (Participant 5)

5.1.2 | Anger and Betrayal Toward Inadequate Follow-Up Actions

Participants experienced intense anger and betrayal not only due to the patient safety incidents but also in response to how they were managed by healthcare professionals. Parents reported that hospitals often avoided taking responsibility, provided insufficient explanations and failed to offer sincere apologies, while sometimes emphasizing compensation without adequately acknowledging the harm. Participants indicated that what they needed went beyond an authentic emotional response, including clear explanations, acknowledgment of responsibility and transparent communication about measures to prevent recurrence. The absence of these elements led to increased distrust, and in some cases, parents avoided further communication with the hospital or considered legal action.

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> I was angry when the hospital's legal team mentioned compensation, and they insisted that the injection site injury was not the nurse's fault. The medical staff did not even say they were sorry. There was no sincere apology at all, and that made me very upset. I understand that what has already happened cannot be undone, but instead of irresponsibly denying their fault, I wish they had offered a genuine apology and explained more clearly why the incident occurred. If the hospital had acknowledged their mistake and sincerely apologized, I do not think things would have escalated to this point.
>
> (Participant 5)

> My child received a flu shot instead of a Hepatitis B shot due to a doctor's prescription error. The nurse simply administered the injection as prescribed. [...] The doctor said that the flu shot was a routine injection that everyone receives, even children as young as six months old, and that it was very safe. The doctor also told me that there are cases where generalized hives appear in children under two years of age without a specific reason, and that the exact cause is often unknown. He added that other hospitals would probably say the same thing. In the end, he continued to avoid taking responsibility. At that moment, I felt that this was completely unacceptable. I thought to myself that once my child recovered, I would make sure the truth of this incident was clearly revealed.
>
> (Participant 6)

5.2 | Limitations of the Paediatric Healthcare System

5.2.1 | Lack of Paediatric-Specific Healthcare Services

The participants perceived that hospital healthcare services did not adequately reflect the developmental and emotional characteristics of paediatric patients, thereby providing insufficient emotional support and explanations during care. Owing to these limitations, even following patient safety incidents, inadequate explanations and a lack of emotional support further intensified parents' distress and hindered their understanding of the situation. Participants also reported that healthcare professionals did not sufficiently listen to their concerns despite children's limited ability to express symptoms. Participants believed that this lack of communication led to delayed recognition or neglect of their children's symptoms in the context of patient safety incidents. Furthermore, insufficient monitoring, repeated assessments and caregiver education were recognized not only as general limitations of paediatric care but also as factors that may have contributed to the occurrence or worsening of patient safety incidents.

> My child was frightened because he had to go inside the CT machine for a brain CT scan after a head injury. Nurses are supposed to comfort, calm, and assist children in situations like that, but there was nothing like that at all. Because he was a young child, I wish the staff had been more attentive to those needs.
>
> (Participant 1)

> Children who are not yet old enough to speak well cannot express their discomfort or pain. Therefore, I believe nurses should not leave all the responsibility for caring for the child to the parents, but instead provide more attentive care.
>
> (Participant 4)

> When a baby is hospitalized, first-time mothers like me often have no idea what to do. When young children are admitted to the hospital, I wish caregivers were given proper guidance on what they should do. Also, there are times when nurses do not come to check on the child very often because they are busy, but I wish they would come more frequently and examine the child more carefully.
>
> (Participant 5)

5.2.2 | Shortage of Paediatric Healthcare Personnel and Resources

The participants perceived that the healthcare workforce and safety resources required for paediatric care were insufficient within the hospital setting. Several participants reported situations in which hospitalized children were treated in non-paediatric-specialized environments, where appropriate paediatric emergency equipment was unavailable. The lack of equipment and specialized personnel was perceived as contributing to delays in critical interventions at the time of the incident. Additionally, the lack of dedicated paediatric care spaces and high patient influx were reported to lower the priority of paediatric care, leading to delays in treatment. Participants perceived that such structural limitations might have increased the risk of patient safety incidents and exacerbated the severity of harm experienced by their children, representing a significant threat to paediatric patient safety.

> The ward where my child was admitted for COVID-19-induced respiratory distress was a temporary COVID-19 ward, not a pediatric ward, so there was no equipment available for pediatric emergencies. The doctor instructed the staff to perform suction, but they said, “We don't have pediatric suction equipment here,” so they couldn't do it. Then they suggested using a bag-valve mask, but they only had an adult-sized one, not a pediatric one. Because of that, the first 20 minutes were completely lost, and treatment for acute respiratory failure only began after my child was transferred to another ward.
>
> (Participant 4)

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> I think there are not enough doctors and nurses. Especially, the number of nurses needs to increase. It seems very difficult for them to concentrate fully on patients because there are simply too few of them.
>
> (Participant 6)

> It seems there is a significant shortage of pediatric emergency rooms or treatment spaces dedicated solely to children. Since it was a tertiary hospital, there were so many other critically ill patients that I feel my baby, who only had a fever from COVID-19, did not receive enough attention.
>
> (Participant 5)

5.3 | The Need for an Integrated Management System to Strengthen Paediatric Patient Safety

5.3.1 | Active Parental Participation in Their Child's Care

Participants perceived that active parental involvement during care was essential to ensure the safety of their children during medical treatment. Following their child's experience of a patient safety incident, parents recognized the limitations of relying solely on healthcare professionals and adopted a more proactive role in their child's care. In particular, given that infants and young children have limited ability to express their symptoms, parents emphasized the need for continuous monitoring of their child's condition. After the incident, parents reported increased vigilance and a heightened sense of responsibility, including verifying medical information, closely observing their child's condition and seeking additional medical opinions when necessary. These behaviours reflected a shift from passive trust to active involvement in care following a patient safety incident.

> I think parents should never take their eyes off their children, even for a moment. We have to check everything carefully. Young children cannot tell us what is wrong or where it hurts, so parents need to keep monitoring them. Hospitals cannot check everything, so I felt that I had to take responsibility for checking my own child.
>
> (Participant 5)

> My child almost died during a CT scan after being administered a contrast agent; he suddenly gasped for breath and his lips turned blue. The young attending physician claimed it was a side effect of the contrast agent and that they were not at fault at all. However, later, an experienced professor and the head of neurosurgery came and apologized, explaining that the scan could have been done without the contrast agent, but they proceeded with it to ensure a definitive diagnosis. I even started looking into the doctor's background. For example, whether they had experience working in a pediatric ward or whether they were described as specialists in pediatric examinations. In the past, I never paid attention to those things, but now I choose hospitals after checking whether the doctor has experience treating children in a pediatric hospital. It is the parent's responsibility to carefully look into these things and choose a doctor who has extensive experience in pediatric care.
>
> (Participant 1)

> I strongly felt that, if I knew anyone working in the medical field, I needed to actively ask for their help to resolve this accident.
>
> (Participant 2)

5.3.2 | A Transparent and Accountable Patient Safety Incident Response System

Participants reported that patient safety incident response systems tend to favour healthcare professionals, limiting parents' ability to verify facts or establish responsibility. They attributed this to a lack of transparency and insufficient access to information. Accordingly, participants emphasized the need for a more transparent and accountable system that provides objective evidence, clear procedures and systematic disclosure of information, which they believed could enhance trust in the healthcare system. They also highlighted the importance of expanding external support and counselling mechanisms beyond hospital-based processes.

> It seems that incidents that occur in hospitals are very advantageous to medical staff. Since everything happens inside the hospital, it feels almost impossible for parents to win. I think it would be good to have mandatory CCTV and audio recording as well.
>
> (Participant 1)

> My child eventually died of cardiac arrest after being administered epinephrine intravenously due to a nurse's medication error, even though it had been prescribed for inhalation. [...] The lawyers repeatedly told us that in cases of infant death, the compensation amount is fixed. For adults, compensation varies depending on their earning capacity, but for children, there is a standard amount set by the court based on the value of a daily wage worker. Because of this, compensation for a child's death is set at a fixed amount. From the hospital's perspective, I couldn't help but think that it might be easier to handle cases in which a child dies due to a medical accident.
>
> (Participant 4)

> I wanted to file a complaint about the accident, but the hospital did not properly inform me about the relevant agencies or reporting procedures, nor did they explain how the accident would be handled

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> there. Hospitals should provide parents with accurate information about these processes.
>
> (Participant 5)

6 | Discussion

This study comprehensively explored parents' experiences of patient safety incidents involving their hospitalized children. Three theme clusters emerged from the findings: 'the indelible pain of patient safety incidents,' 'limitations of the pediatric healthcare system' and 'the need for an integrated management system to strengthen pediatric patient safety.'

The first theme cluster identified in this study was 'the indelible pain of patient safety incidents.' The participants experienced profound self-blame and guilt for inadequately protecting their children from patient safety incidents. This finding is consistent with results of previous studies indicating that parents may experience persistent guilt and psychological distress following patient safety incidents involving their children (Rathnayake et al. 2025). Furthermore, the physical scars and functional limitations that remained after the incident repeatedly reminded the parents of the incident. Such reminders contribute to prolonged emotional distress and hinder the recovery process of both children and families (Sigman et al. 2025).

These findings suggest that patient safety incidents can have long-lasting psychological and social consequences on families. In this study, parents experienced anxiety, distrust and guilt, which were exacerbated by insufficient communication with healthcare professionals. Therefore, it is essential to establish systems that provide emotional support, transparent information and empathetic communication. Given that parents of paediatric patients serve as key decision-makers and caregivers, healthcare professionals—particularly nurses—should extend their roles beyond information delivery to include emotional support and trust-building. Parents emphasized the need for clear explanations and empathetic communication, highlighting the central role of nurses in shaping their experiences. Furthermore, patient safety incidents significantly affect trust in healthcare providers, positioning nurses as key mediators in rebuilding trust (Kim and Chang 2025). Incorporating parents' experiences into patient safety improvement efforts and developing structured support and follow-up programs are essential to promote recovery after patient safety incidents.

The second theme cluster identified in this study was 'limitations of the pediatric healthcare system.' Participants perceived that healthcare services did not sufficiently consider the developmental characteristics and emotional needs of their children. Unlike adults, children often experience higher levels of anxiety and fear in medical settings and have limited understanding of diagnostic or treatment procedures. Therefore, the way in which healthcare professionals provide explanations and emotional support can significantly influence children's cooperation with treatment and their overall healthcare experiences (Sillero Sillero et al. 2024). However, our findings suggest that the entire Korean healthcare system largely operates within an adult-centered framework, with insufficient consideration of the unique characteristics of paediatric patients.

In particular, South Korea's paediatric healthcare infrastructure has steadily declined. For example, the number of paediatric clinics in Seoul decreased by approximately 12.5% between 2018 and 2022 (Lee and Park 2023), and the application rate for paediatric residency program in 2023 was only 17.6%, reflecting a serious shortage of paediatric healthcare professionals (Suh 2024). These trends stem from structural challenges, including declining patient numbers due to low birth rates, relatively low reimbursement rates and heavy workloads, which have made paediatrics an increasingly less attractive specialty (Suh 2024).

Paediatric care requires a higher level of attention and time than adult care, including weight-based medication calculations, continuous monitoring of changes in clinical conditions and repeated communication with caregivers (D'Errico et al. 2022). This study further demonstrates how these structural limitations manifest as concrete clinical challenges during patient safety incidents. Participants described situations in which the absence of paediatric-specific equipment and trained personnel resulted in emergency intervention delays and insufficient monitoring and communication contributed to delayed recognition of symptoms. These findings indicate that structural deficiencies translate into clinical risks during patient safety incidents.

Additionally, insufficient communication, limited explanations and inadequate monitoring contributed to delayed recognition of symptoms and misjudgment of clinical situations and were perceived as factors related to the occurrence or worsening of patient safety incidents. In particular, these communication gaps heightened uncertainty and hindered timely decision-making during incidents, thereby exacerbating their impact. These findings are consistent with those of previous studies emphasizing that inadequate communication and delayed responses are key contributors to paediatric patient safety events (Onyejesi et al. 2025; WHO 2021). Accordingly, improving paediatric patient safety requires not only strengthening infrastructure but also establishing clinical response systems that can be effectively activated during patient safety incidents. Specifically, healthcare systems should implement paediatric-specific emergency response protocols, ensure the immediate availability of essential equipment (Remick et al. 2026) and strengthen real-time communication between healthcare professionals and caregivers during high-risk situations (Mohsen et al. 2021). TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based program developed to improve patient safety through effective communication and teamwork among healthcare professionals, incorporating key components such as leadership, situation monitoring, mutual support and structured communication strategies (Agency for Healthcare Research and Quality 2023). TeamSTEPPS may also support more consistent and structured communication with caregivers by promoting shared situational awareness, role clarity and coordinated information exchange. (Velez et al. 2026).

Healthcare systems should systematically develop paediatric-centered infrastructure, including specialized personnel, equipment and dedicated clinical spaces, while providing

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healthcare services that reflect the developmental characteristics of children. Additionally, policy-level support is required to address the shortage of paediatric healthcare professionals, including improved reimbursement for paediatric services, expanded support for paediatric residency training, investment in the paediatric nursing workforce and strengthened regional paediatric healthcare systems. In particular, because paediatric nurses continuously monitor hospitalized children's conditions and play a central role in early recognition, response and communication with caregivers during patient safety incidents, efforts to secure adequate paediatric nursing staff and strengthen nurses' paediatric patient safety competencies through ongoing education are also needed.

The third theme cluster identified in this study was 'the need for an integrated management system to strengthen pediatric patient safety.' Study participants recognized that ensuring safe care for their children requires active parental involvement during the care process, rather than passive reliance on healthcare professionals' decisions. Therefore, parents perceived their role as continuously observing their child's condition and sharing relevant information with healthcare professionals. Similarly, recent studies have reported that parents can serve as important partners in improving patient safety by identifying potential risks during the care process or providing critical information to healthcare professionals (Kim and Chang 2025; Purchase et al. 2025). As caregivers' observations and explanations constitute valuable clinical information, healthcare professionals should provide family-centered care through collaborative decision-making and information sharing with families of paediatric patients (Latour et al. 2024). Importantly, this study further demonstrates that parents' roles became more proactive following patient safety incidents, as they shifted from passive reliance on healthcare professionals to active monitoring, verification of information and involvement in decision-making. This indicates that patient safety incidents serve as a critical turning point in redefining parents' roles as active agents in ensuring their child's safety.

Meanwhile, study participants perceived that when patient safety incidents occur, the existing system tends to favour hospitals and healthcare professionals, making it difficult for parents to verify facts or establish accountability. Consequently, they emphasized the need for a transparent response system. Previous studies have highlighted that open disclosure systems, in which healthcare institutions transparently explain the course of an incident to patients and their families and involve them in the response process, are critical for restoring trust and fostering a culture of patient safety (Abdi et al. 2024). Consistent with these findings, participants in this study reported that limited access to information and unclear response processes increased uncertainty and distrust following patient safety incidents. This suggests that a lack of transparency not only affects information sharing but also exacerbates parents' psychological burden and weakens trust in the healthcare system. However, the current patient safety management system in South Korea remains largely hospital-centered, which limits caregivers' access to information about incident response procedures and available support systems (Kim and Lee 2021). Under such circumstances, parental distrust and psychological burden may increase following patient safety incidents, ultimately hindering the development of a strong patient safety culture (Rathnayake et al. 2025).

Therefore, strengthening paediatric patient safety requires developing integrated systems that support parents' active involvement during both routine care and patient safety incidents (Purchase et al. 2025). Healthcare systems should implement structured processes for caregiver engagement, transparent information disclosure and shared decision-making during and after patient safety incidents. Additionally, systems that ensure objective documentation and clear disclosure procedures after patient safety incidents should be strengthened. Furthermore, policy efforts are needed to expand community-based patient safety counselling and mediation organizations, thereby establishing an integrated support system that is accessible to parents and families. Such systems should be designed to address the specific needs identified in this study, including psychological support, information accessibility and opportunities for parental involvement in patient safety management.

6.1 | Study Strengths and Limitations

This study is meaningful because it explored paediatric patient safety issues in depth from the perspective of parents. Our findings offer important insights into paediatric patient safety by highlighting parents' feelings of guilt and helplessness, the structural limitations of the paediatric healthcare system, and the need to establish an integrated management system to strengthen patient safety.

Despite the study strengths, this study also had several limitations. First, as a qualitative study involving a small number of parents, the diversity of the data and representativeness of the findings were restricted. Second, participants' experiences may have been influenced by specific healthcare institutions or incident contexts, thereby constraining the transferability of the findings to all paediatric patient safety situations. Third, the interviews were conducted by an external professional interviewer, which may have reduced opportunities for direct interaction between the researchers and participants. Additionally, interviews were conducted via telephone based on participants' preferences, which may have limited the ability to fully capture participants' non-verbal expressions. Fourth, the wide age range of children included in this study may have introduced variability in parental experiences, as developmental differences in communication ability, dependency and caregiving roles can influence how patient safety incidents are perceived and experienced. Therefore, future research should include a broader and more diverse sample across various healthcare settings and regions to enhance the diversity of data and transferability of findings. Moreover, study designs that involve direct interactions between researchers and participants may help strengthen the depth and credibility of the data. Further research is needed to evaluate the effectiveness of patient safety strategies based on parental engagement.

6.2 | Implication for Policy and Clinical Practice

The study findings highlight important limitations of existing patient safety systems while aligning with recent patient safety paradigms that emphasize the importance of patient and family

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engagement. In this study, parents emerged as key agents in recognizing and responding to patient safety incidents. However, in clinical practice, the experiences and voices of parents are not always adequately reflected in patient safety systems.

These findings have important implications for clinical practice and policy, particularly in paediatric settings. First, there is a need to establish more effective systems for communicating with parents during and after patient safety incidents. Transparent disclosure of patient safety incidents and providing emotional support are essential for reducing parental anxiety and distrust and restoring trust in the healthcare process. To this end, healthcare institutions may implement structured disclosure protocols, regular safety briefings with parents, and parent-accessible reporting systems that allow families to raise safety concerns directly. These efforts require staff training in disclosure communication and a non-punitive organizational culture that supports open discussion of safety concerns.

Second, nurses, as frontline healthcare professionals who closely interact with hospitalized children and their families, may play a critical role in identifying parental safety concerns and facilitating open communication. In particular, because nurses continuously monitor children's conditions and communicate treatment processes most closely with families, they are well positioned to recognize parents' questions and concerns as potential safety signals and communicate them effectively within the healthcare team. Nurses may also play an important role in providing emotional support to parents and facilitating trust restoration during the disclosure process following patient safety incidents. Accordingly, educational programs should strengthen nurses' competencies in empathetic communication, disclosure practices, family-centered care and parent engagement in patient safety. In addition, a nursing culture that actively acknowledges and responds to parental concerns should be promoted as an integral component of paediatric patient safety.

Finally, at the policy level, efforts should be made to strengthen family-centered patient safety frameworks by recognizing parents as essential partners in ensuring safe care for hospitalized children. As part of these efforts, developing parent and family engagement–based patient safety guidelines, establishing parent reporting systems and incorporating parental experiences into patient safety policy development may be considered. Such approaches can contribute to more responsive, transparent and pediatric healthcare systems.

7 | Conclusions

This study explored the meaning and structural context of paediatric patient safety issues through the experiences of parents whose children encountered patient safety incidents during hospitalization. Parents reported profound feelings of guilt and helplessness and recognized limitations within the healthcare system, including insufficient consideration of paediatric developmental characteristics and a lack of transparency in incident management. They also emphasized the importance of active parental participation and a transparent, accountable response system to ensure safe care for children. Strengthening patient safety strategies that incorporate parental involvement, along with policy and institutional efforts to promote paediatric-centered healthcare and transparent safety management systems, is essential for improving paediatric patient safety.

Author Contributions

The research study was conceptualized by M.Y.K. and Y.K. Data curation was performed by Y.K. Formal analysis was carried out by M.Y.K. and Y.K. Both M.Y.K. and Y.K. were involved in data analysis and interpretation. Y.K. wrote the original draft, while M.Y.K. reviewed and edited it. All authors have approved the final version of the review.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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