

Implementation Barriers of Peer Support for Nurses as Second Victims: A Qualitative Study from the Supporters' Perspective

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Objective: This study aims to explore the obstacles faced by nurses in providing peer support to “second victims” from the perspective of support providers, in order to provide basis and strategic suggestions for medical institutions to construct systematic peer support strategies.

Methods: A descriptive qualitative study design was adopted. The semi-structured interview method was used to formulate an interview outline based on the theory of “Knowledge-Attitude-Practice”, and was conducted in 2024 for 3 months, interviewing 14 nurses who had provided support to the second victim in a tertiary hospital in Shanxi Province, and using the thematic analysis method to analyze the data.

Results: Three themes and eight sub-themes emerged: (1) Disconnection Between Conceptual Awareness and Personal Experience (Cognitive Blind Spots, role confusion); (2) The Triple Barrier to Peer Positive Support (Personal attribution bias, organizational culture constraints, systemic deficiencies); (3) Fragmented practices of support measures (Discrepancies Exist in the Timing of Support Interventions, Limitations in Support Content, Need for Standardized Protocols).

Conclusion: To institutionalize peer support, we propose a tiered approach: (1) awareness training to address cognitive gaps; (2) cultural shifts to reduce fear of accountability; (3) structured programs for sustained implementation.

Keywords: second victim, peer support, qualitative research, nursing adverse events, support barriers, organizational culture

Background

Adverse events in care have a significant impact on patient safety and quality of care. After the occurrence of adverse events, the American scholar Wu¹ found that not only patients will be harmed and become the “first victim”, but also medical personnel will be harmed by medical errors, thus proposing the concept of “second victim”. In 2009, Scott² further refined its definition to mean that a person providing medical care is one of the victims of physical or mental harm caused by an unexpected medical error or patient-related injury. Nurses are considered to be a high-risk group for second victims.² A series of physiological, psychological, and occupation-related second victim syndromes, such as increased breathing, fear, burnout, and loss of empathy, may occur after a nursing adverse event.³ Therefore, it is crucial to provide the necessary support to nurses as second victims.

Studies have shown that peer support can help second victims quickly recover both physically and mentally.⁴ The immediate emotional comfort, empathy based on shared experiences, and non-punitive conversational environment it provides make peer support the preferred and primary form of assistance for second victims.⁵ Currently, there are relatively well-established peer support programs abroad (such as the Scott Three-Tier Intervention,⁶ MITSS Telephone Support,⁷ and the

YOU Matter Team Mutual Aid⁸). However, domestic research on peer support is still in its infancy, and existing studies focus on evaluating the level of peer support for nurses as second victims from the perspective of the supported person (second victim), analyzing its influencing factors,⁶ and exploring the reasons for insufficient support.⁹ A number of domestic studies have shown that the level of peer support received by the second victim is not high, and one survey study shows that the average peer support score of the second victim of nurses is (3.09±0.32), which is significantly lower than the total score of the dimension, indicating that the current peer support is insufficient.¹⁰ Some research attributes the low quality of peer support among nurses to an insufficient supportive atmosphere. Most hospitals in our country are still under a punitive organizational culture, which makes nurses more worried about the consequences of the incident and afraid of being blamed and punished by patients and departments, resulting in nurses shirking responsibility from each other, and peers will not provide support to them.⁹ These studies all start from the single perspective of the supportee, and there is still a lack of in-depth discussion on the internal cognition and behavioral logic of why support providers fail to effectively fulfill their support roles.

The theory of “Knowledge-Attitude-Practice” (KAP)¹¹ divides the change of individual behavior into three continuous processes, namely acquiring knowledge, generating attitudes and forming behaviors, revealing the facilitating relationship between individual cognition, attitude and behavior, which has been widely used in the fields of medicine and behavioral science. This theory has been used to analyze nurses’ adherence to infection control protocols,¹² suggesting that it is suitable for exploring supportive behaviors. Therefore, this study aims to delve into how nurses’ knowledge gaps and attitudinal barriers hinder effective peer support, based on the KAP theory and from the perspective of peer support providers, so as to provide a basis for targeted interventions.

Research Methodology

This study employs a descriptive qualitative research design.

Operationalized Definition of Related Concepts

Second Victim

Any healthcare worker who is directly or indirectly involved in a patient’s unexpected adverse event, unintentional medical error, or patient harm, and who also suffers negative effects thereby becoming a victim.¹³

Peer Support

Refers to supportive behaviors provided by nurse colleagues within the same healthcare institution to the “second victim”.

Research Subject

Purposive sampling method was adopted. From May 2024 to August 2024, nurses from a tertiary hospital in Shanxi Province were selected as research objects.

Inclusion criteria: (1) Engaged in clinical nurse work for more than 1 year; (2) self-reported providing support to the second victim; (3) In the past 1 month, Provided support at least once, with each interaction lasting ≥ 30 minutes; (4) Support content covers the solution of psychological or practical problems; (5) Good expression ability and full expression of inner feelings; (6) Signed informed consent. Exclusion criteria: Nurses who are in further education and are not on duty on vacation.

When sampling, follow the principle of maximum differentiation, and try to cover nurses with general demographic characteristics such as different education levels, different working years, and different professional titles to obtain relevant information to the greatest extent. Interviews continued until thematic saturation was achieved (no new themes emerged after 3 consecutive interviews), and finally 14 respondents, the investigator replaced the interviewers’ names with serial numbers N1-N14. General information is shown in [Table 1](#).

Research Methodology

Interview Outline

Based on the Knowledge-Attitude-Practice (KAP) theoretical model, a preliminary interview outline was developed through literature review. Pre-interviews were conducted with two subjects, and the feedback obtained was used to revise

Table 1 General Information of Respondents

Number	Gender	Age	Educational Attainment	Years of Service	Title	Type of Adverse Event	Time from Adverse Event to Interview
N1	Female	36	Junior college	12	Deputy Chief Nurse	Unplanned extubation	2 weeks
N2	Female	27	Undergraduate	5	Nurses	Drug extravasation	3 weeks
N3	Female	30	Postgraduate	6	Nurses	Needlestick injuries	4 weeks
N4	Female	33	Undergraduate	9	Nurse in charge	Errors in executing medical orders	1 week
N5	Male	26	Undergraduate	4	Nurses	Medication errors	2 weeks
N6	Female	34	Undergraduate	10	Nurse in charge	Medication errors	3 weeks
N7	Male	38	Junior college	14	Nurse in charge	Pressure ulcers	4 weeks
N8	Female	35	Undergraduate	11	Nurse in charge	Unplanned extubation	3 days
N9	Female	30	Undergraduate	5	Nurses	Wrong specimen collection	2 days
N10	Female	29	Undergraduate	4	Nurses	Scald	1 week
N11	Female	31	Undergraduate	6	Nurses	Pressure ulcers	1 week
N12	Female	29	Undergraduate	5	Nurses	Drug extravasation	4 weeks
N13	Female	36	Postgraduate	11	Nurse in charge	Medication errors	2 weeks
N14	Male	26	Postgraduate	4	Nurses	Errors in executing medical orders	3 weeks

and refine the interview protocol. For instance, closed-ended questions such as “Did you experience symptoms?” were replaced with open-ended inquiries like “What specific changes or reactions did you have in terms of emotional, physical, or work status after the incident?” to more comprehensively capture nurses’ actual experiences. The final interview outline is as follows: (1) Knowledge: Please talk about your experience of adverse events in nursing work. What specific changes or reactions did you have in terms of emotional, physical, or work status after the incident? How do you understand the impact that an adverse event can have on the healthcare provider? Who do you usually turn to for support when you are struggling? Please describe the specific reason. What do you know about the concept of “second victim of nurses?” (2) Attitude: What is your attitude towards supporting the second victim? What factors do you think might influence you to provide this type of support? (3) Practice: Do you usually take the initiative to support the second victim, or do you only help after the other party asks for help? What are some of the ways you typically support them? What improvements do you think the unit or team can make in supporting second victims?

Data Collection

The researcher had good communication skills, conducted one-on-one in-depth interviews with the interviewees, fully communicated with the interviewees before the formal interview, explained the purpose, significance and process of the research, explained the content and concepts of the interview, collected the general information of the interviewees and signed the informed consent form. The interview was conducted one-on-one in a quiet, separate conference room. During the exchange, audio recording and recording are made, and valuable questions are appropriately asked and supplemented with transcripts. During the interview, there is no guidance, no hint, no evaluation, and the interview time is 20–30 minutes per person, and the interviewee is encouraged to express his or her feelings. Two researchers transcribed the audio recordings into text within 24 hours after the interview, and sorted out the interview notes in a timely manner. Interview records are numbered from N1 to N14 and separate files are created.

Data Analysis

The analysis utilized Nvivo 12.0 software to manage interview data. Following Braun and Clarke’s thematic analysis approach,¹⁴ the study implemented a six-phase process: familiarizing with data, generating initial codes, searching for themes, reviewing themes, defining/naming themes, and producing the report. After completing transcription, two researchers who were not involved in the project but work in this field conducted group discussions to review the generated codes, ultimately refining and synthesizing the themes. During analysis, if disagreements arose regarding any analytical outcomes, an experienced senior researcher from the research team was invited to participate in deliberation and provide a final decision. Thematic development process exemplification is provided in Table 2.

Table 2 Example of Thematic Analysis Coding Process

Theme	Sub-theme	Condensed Code	Initial Code	Meaning Unit
Disconnection Between Conceptual Awareness and Personal Experience	Cognitive Blind Spots	Lack of conceptual awareness	Unfamiliar with terminology	"I've never heard of the term 'second victim'—this is my first time".
		Experience matching definition	Self-blame and guilt	"I felt terrible after the incident and kept blaming myself".
	Role Confusion	Identity misalignment	Self-identification as perpetrator	"I didn't see myself as a victim; I thought the patient was the victim, and I was the one who made the mistake".

Trustworthiness

To ensure methodological rigor and trustworthiness, this study adhered to the «Consolidated Criteria for Reporting Qualitative Research (COREQ): 32-Item Checklist»¹⁵ to guarantee research design quality. Specific measures included: (1) Triangulation: Two researchers independently read, analyzed, and coded the same interview data, with consensus reached through collaborative discussion to minimize subjective bias; (2) Member Checking: Interview transcripts were returned to respective participants for verification to ensure content accurately reflected their intended meanings; (3) Researcher Training: All researchers received systematic training in qualitative methods and conducted pre-interviews to refine interviewing techniques and procedures prior to formal data collection.

Ethical Considerations

This study has been reviewed by the Ethics Committee of Shanxi Bethune Hospital, batch number (YXLL-2023-047), and the participants informed consent included publication of anonymized responses/direct quotes. To protect participant privacy, we have adopted strict confidentiality measures: the collected data is immediately anonymized, all personal identifiers are removed and interview records are numbered from N1 to N14; electronic data is stored on a dedicated server with password protection; Paper documents are stored in a locked office; Only the project leader and principal investigator have access to the list of raw data containing identifying information.

Results

Theme I: Disconnection Between Conceptual Awareness and Personal Experience Cognitive Blind Spots

79% of respondents (11/14) had never heard of the concept of “second victim” but fit its definition when describing their own experiences.

- N1: After the incident, I was terrified—afraid of being blamed by the head nurse, and worried about losing my colleagues' trust. Sometimes it affected my entire day's work; when I was emotionally drained, I became more prone to mistakes.
- N2: I felt really scared. I was worried about how to explain it to the patient's family, anxious that they might become demanding. I also felt uncertain and overwhelmed by the subsequent process of reporting the adverse event—it was quite complicated and unfamiliar.

Role Confusion

43% (6/14) see themselves as “responsible nurses” rather than “victims”.

- N1: Although my guilt and self-blame stemmed from the adverse event, I never saw myself as a victim. I could only try to comfort myself.

- N4: After the incident, I only felt guilty toward the patient. I always viewed the patient as the victim and myself as the perpetrator. Even when symptoms emerged, I didn't realize they were manifestations of harm, and thus believed I didn't need others' help.

Theme 2: The Triple Barrier to Peer Positive Support

Personal Attribution Bias

36% (5/14) blamed individual error, believing that the cause of the adverse event was the nurse's own, and therefore unwilling to provide support to the second victim.

- N1: This nurse didn't turn the patient over on time, which caused the patient to develop a pressure ulcer. No amount of support can undo this.
- N5: The two liquid packaging bags are similar, and he gave the wrong one, I think it's mainly because he failed to follow medication verification protocols, and I don't want to support him like this.
- N9: He hadn't checked it before, and this time he made a mistake again, and I don't quite understand.

Organizational Culture Constraints

50% (7/14) people avoided support because of the "atmosphere of accountability" and did not dare to provide support to the second victim for fear of being implicated.

- N2: Because our team leader often reports trivial matters to the head nurse, the atmosphere in the entire group has become tense. When mistakes occur, everyone just focuses on protecting themselves.
- N4: Actually, I really wanted to help him speak, and I was a little responsible for the adverse event, but I didn't say it because I was afraid that the head nurse would blame me.
- N9: The incident led to severe consequences. The head nurse demanded to identify which shift's nurse neglected proper skin care, prompting all nurses to hastily deny involvement out of fear of accountability.

Systemic Defects

Systemic reasons such as high workload and lack of time and resources further limit the implementation of support behaviors.

- N5: Our department is so busy, we have to work overtime, and when we have a problem, people usually cannot help us.
- N10: Departments are overloaded all year round, and overtime has become the norm every day, so even if a colleague is in trouble, we have little extra energy to provide substantial help.

Theme 3: Fragmented Practices of Support Measures

Discrepancies Exist in the Timing of Support Interventions

Nurse Peers Exhibit Significant Variations in Support Intervention Timing for Second Victims. 43% (6/14) people actively intervene, that is, when the second victim is observed to have some abnormal behaviors or emotional manifestations, they will actively trigger supportive behaviors. 57% (8/14) people responded passively, that is, support was initiated only after the second victim clearly expressed his desire to seek help.

- N1: After noticing that he was depressed and making frequent mistakes, I suggested that he take a break from work and make some adjustments.
- N6: He avoided eye contact, and I judged that he was under too much psychological pressure and asked if he needed help.
- N2, N5: I usually wait for her to confess her mistake and ask for help at work, and then I will help her solve it.

Limitations in Support Content

The content of the support is simple, focusing on emotional comfort, and professional and informational support relies on personal experience. 71% (10/14) respondents provided only emotional support and lacked systematic solutions to

practical problems; There are 50% (7/14) nurses who provide guidance on how to handle the incident; 36% (5/14) nurses assisted the second victim in the reporting of adverse events.

- N4: Just comfort him from the perspective of his peers, after all, I know he will be very self-remorseful and anxious at this time.
- N11: I sued her that this matter can be solved, so don't worry.
- N1: Since I am the nursing team leader, I helped him contact the doctor who placed the indwelling central venous catheter and helped him communicate with the attending doctor and the head nurse.
- N5: He asked me about the adverse event reporting process, and since I did, I reported it for him.

Need for Standardized Protocols

The lack of relevant support training and standard processes in hospitals suggests that the construction of institutionalized interventions is critical.

- N5: The hospital does not pay enough attention to the second victim, and there is no corresponding peer support process to help the second victim get out of trouble.
- N7: I want to help, but I don't know exactly how to do it, and no one has taught us how to support our colleagues.

Discussion

Popularize the Concept from the Individual Level to Eliminate Cognitive Blind Spots

This study found that 11 respondents did not understand the concept of “second victim” in theory, but experienced situations that met this definition in practice. The possible reason for the existence of this cognitive blind spot is that domestic medical institutions have not yet popularized the concept of a second victim, causing nurses to be unaware of the harm caused by adverse events and may not actively seek help, which is similar to the results of Fu Jinping et al.¹⁶ At present, the research on second victims in China is in its infancy, and the understanding of the concept of “second victim” is still shallow,¹⁷ and even care managers have never heard of the concept of second victim.¹⁸ Lack of concept causes nurses to fail to identify themselves or their colleagues as victims after adverse events, leading to self-stigmatization and inhibition of their willingness to seek help. This finding echoes the study of Lim et al¹⁹ which also reveals the long-term psychological burden of acute care nurses due to institutional silence culture, highlighting the critical role of concept popularization in breaking silence and promoting help. In addition, the study also found that some nurses have cognitive biases about the causes of adverse events, tending to blame individuals rather than systemic factors, which undermines their empathy and support for second victims. Studies have shown that the occurrence of adverse events often stems from systemic defects, caused by a combination of factors, and should not be simply attributed to individuals,²⁰ but should be analyzed from the systemic level.²¹ Therefore, healthcare institutions should actively promote awareness and provide training on the concept of the “second victim” and related knowledge, enhancing nurses’ ability to recognize and understand this affected group, thereby enabling more effective peer support.

Reinvent Culture at the Organizational Level to Reduce Fear of Accountability

Six respondents positioned themselves as “responsible nurses” rather than “victims” after the incident. It reflects the deep-rooted “patient first” culture and punitive accountability mechanisms in the medical industry²² on the psychology of nurses. At the same time, this role shift dilemma reveals that KAP’s “knowledge” stage is not merely about awareness but also reframing identity—from “responsible nurse” to “second victim”. This suggests that in a stigmatized environment, adjustments to the KAP model are necessary. In this cultural atmosphere, nurses are often forced to internalize responsibility for fault, believing that expressing their pain is a manifestation of “selfishness” or “shirking responsibility”. At present, although some hospitals have implemented the principle of non-penalty reporting,²³ there are still hidden penalties, which still make nurses concerned about supporting their peers.⁹ Some respondents even chose to remain silent for fear of being implicated, leaving the second victim isolated. This organizational culture not only hinders peer support but can also exacerbate burnout and turnover tendencies among nurses. This aligns with the findings of Kappes et al²⁴ whose study delineated the coping trajectories of ICU nurses as second victims. In the help-seeking phase, nurses may

refrain from seeking support from colleagues or supervisors due to the influence of a pervasive punitive culture within their work environment. Therefore, to break this constraint, efforts must begin at the organizational level by genuinely implementing a non-punitive reporting system and improving the hospital safety culture.¹⁷ Only when the organizational culture shifts from “blame” to “learning” can nurses feel more comfortable seeking and providing support.

Develop Intervention Strategies at the System Level to Standardize Support Behaviors

This study found that peer support measures provided by nurses to second victims exhibited significant fragmentation. Firstly, there was a divergence in the timing of support intervention. Six nurses actively intervened with the second victim, but may ignore the victim’s autonomy due to over-intervention, while eight nurses chose to respond passively, but may hide their pain because the second victim is afraid of accountability and there is a risk of delayed support. Therefore, standardized interventions after an incident are essential to balance autonomy and timeliness. The second is the limitation of support content. The interview results showed that the support measures were mainly emotional comfort. Although emotional support can alleviate the psychological pressure of the second victim to a certain extent,²⁵ this single support method often fails to meet the deep needs of the second victim for incident handling and career reconstruction. The third is the lack of institutionalized interventions. Unlike established support programs abroad,^{6–8} our participants lacked training – indicating that institutionalized interventions are critical. Therefore, domestic medical institutions can refer to international experience and combine local cultural characteristics to construct systematic intervention strategies. Given China’s hierarchical culture, peer support programs may require top-down buy-in from nursing leadership to address concerns about accountability.

Limitations

There are certain limitations to this study. First, the interviewees are all from the same tertiary A hospital, and the representativeness and diversity of the sample are limited, and it is necessary to expand to medical institutions of different levels and regions in the future to improve the validity of inference. Secondly, it is necessary to be wary of the impact of social expectation bias on the results, that is, respondents may overestimate their willingness to support and underestimate their actual unwillingness to support or avoid behaviors due to professional identity or moral pressure. In addition, this study did not conduct long-term follow-up evaluation of supportive behaviors after the occurrence of the event, which is difficult to reveal the dynamic changes and sustained effects of supportive attitudes and behaviors in the temporal dimension. In the future, longitudinal design can be introduced to investigate the evolution paths of supporting behavior and psychological mechanisms at different stages.

Conclusion

Based on a descriptive analysis of knowledge, attitudes, and practices regarding peer support for second victims among 14 nurses, this study reveals that following adverse nursing events, peer supporters’ ability to provide effective assistance is constrained by insufficient conceptual understanding, organizational blame culture, and systemic barriers. Unlike Japan’s “error disclosure” culture, which emphasizes non-punitive reporting and proactive systems, Chinese healthcare institutions tend to prioritize outcome-based accountability.²⁶ This discrepancy exacerbates the stigma risk faced by second victims in China and helps explain the pervasive fear of responsibility observed in this study. The National Quality Forum has outlined safety practices to reduce medical errors and patient harm, explicitly stating that nurses should receive timely and systematic support after adverse events.²⁷ Therefore, to advance peer support from its current spontaneous state toward an institutionalized phase, future efforts should adopt a multi-tier strategy: popularizing the concept to eliminate cognitive gaps, reshaping organizational culture to reduce blame fears, and implementing structured protocols to standardize support behaviors.

Data Sharing Statement

To access the data in this study, please contact the author Yanan Zhang (Email:1554950092@qq.com).

Ethics Approval and Consent to Participate

This study was approved by the Institutional Review Board of Shanxi Bethune Hospital of China (YXLL-2023–047) and conducted in accordance with the Declaration of Helsinki. All methods were performed in accordance with the recommended guidelines and regulations. The purpose and significance of the study were explained to the participants, and only those who agreed to participate were interviewed after obtaining written informed consent. The participants informed consent included publication of anonymized responses/direct quotes.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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