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Factors Influencing Nurse Managers' Protective Disciplinary Exchange with Clinical Nurses: A Qualitative Study

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Abstract

Background

How nurse managers respond to clinical errors can affect patient safety, support for nurses, and the retention of human resources. Protective Disciplinary Exchange (PDE) refers to managers' supportive strategies when responding to nursing errors. However, the factors shaping this approach in the Iranian organizational context remain insufficiently understood. This study explored the factors influencing nurse managers' PDE with clinical nurses.

Methods

This qualitative study used a conventional qualitative content analysis approach in teaching hospitals affiliated with Urmia University of Medical Sciences, Iran. Twenty-two nurse managers were recruited through purposive maximum-variation sampling. Data were collected through in-depth, semi-structured interviews and analyzed concurrently with data collection. Data saturation was reached at interview 20; two additional interviews were conducted to ensure data adequacy. MAXQDA version 10.4.16.1 was used to organize the data.

Results

Two overarching concepts were identified: "Collaborative Ward Climate," which facilitated PDE, and "Perceived Insecurity in the Managerial Performance Position," which hindered it. Together, these concepts comprised 11 categories and 34 subcategories.

Conclusions

Nurse managers' PDE emerges from a tension between supporting nurses, protecting human and managerial resources, and remaining accountable for patient safety. Support for nurses should be accompanied by transparent reporting, learning from errors, and safeguards for patient safety.

Introduction

Conservation of Resources (COR) theory has become an influential motivational framework in organizational psychology and behavior and helps explain how individuals and organizations respond to environmental pressures and challenges. The theory proposes that people strive to acquire, retain, and protect what they value (1). It can be used not only to analyze individual responses to stressors but also as a strategic framework for organizations and managers seeking to strengthen human resources and manage crises (2).

According to COR theory, people invest their resources to obtain additional resources, and those who possess greater resources are generally better positioned to gain more (3). An important principle is that individual evaluations of valuable resources may be less influential than resources considered valuable by the collective. Resource-oriented, multilevel typologies of behavioral tendencies may therefore help researchers predict behavior in organizational settings (1).

One dimension of COR theory concerns the crossover of resources. Crossover is an interpersonal process in which the occupational strain or psychological pressure experienced by one person affects the strain experienced by another person in the same social environment (4). It refers to the reciprocal transmission of psychological states and experiences and functions as a mechanism of resource exchange. By adding an interpersonal level of analysis and focusing on dyads, groups, and organizations, this approach explains how experiences, emotions, and resources are shared within social and organizational contexts (1, 5).

Leader–member exchange is an example of transmission between leaders and followers. It addresses the dyadic social-exchange relationship between supervisors and subordinates and describes how supervisors exchange resources such as social support, control, and self-efficacy with employees to help them perform their work (6). Employees who have high-quality exchange relationships with their supervisors tend to gain more resources. Positive, high-quality social exchanges between managers and employees are important for individual, group, and organizational outcomes (6).

Nursing is widely recognized as a stressful and demanding healthcare profession (3). Nurses are expected to regulate their emotions while alleviating patients' pain and their families' concerns. Stress may adversely affect patient care and contribute to medical errors that harm patients and hospitals (4, 5).

The term "Protective Disciplinary Exchange" was introduced by Baljani and colleagues in 2020 to describe nurse managers' supportive strategies toward clinical nurses when work errors occur. Drawing on leader–member exchange theory, PDE describes a dyadic relationship between nurse managers and clinical nurses intended to support professional performance. Managers may protect nurses' professional standing through reciprocal exchanges to motivate participation in ward activities, acceptance of managerial decisions, and greater effort to maintain patient safety, while seeking to protect both parties' positions. The original study suggested that nurses may make errors despite workplace safeguards and monitoring systems, exposing them to disciplinary action and legal consequences. Managers may also perceive their valued resources as threatened, motivating them to stabilize nurses' positions and, in turn, their own positions through PDE (7).

Nursing errors can harm patients and increase costs by prolonging hospitalization while the consequences of errors are addressed (8). They may also reduce nurses' confidence, prompt patient complaints, undermine trust in healthcare professionals, and contribute to occupational stress, tension, and ethical conflict among nurses (9). Consequently, nursing errors are a concern for policymakers, service providers, and healthcare professionals (10).

A study by Kiguba and colleagues in Uganda found that 18% of healthcare professionals had committed at least one harmful medical error, while 41% had identified errors committed by other healthcare professionals (11). In a 2025 study of medical interns at Iran University of Medical Sciences, 31% reported medical errors that harmed patients during their internship. The researchers concluded that most interns avoided full disclosure of their errors; fear of legal action and concern about being viewed negatively by patients were the main reported reasons (12). Further research is therefore needed to identify effective solutions and improve professional performance and patient safety.

Studies in Iran have examined nursing errors and barriers to error reporting. Nasiri and colleagues (2021) reported that nurses most commonly attributed errors to excessive workload and tasks beyond their capabilities; fear that ward managers would learn about an error and reprimand them was the leading reason for nondisclosure (10). Babakhani and colleagues reported that fear of professional consequences, a weak organizational safety culture, and insufficient feedback substantially reduced nurses' willingness to report errors. They emphasized the importance of a non-punitive environment, timely feedback, and up-to-date training to improve reporting systems, patient safety, and nurses' empowerment (13). However, the factors shaping nurse managers' responses to clinical nurses' errors have not been adequately explored in Iran. This study therefore aimed to identify the factors influencing nurse managers' PDE with clinical nurses.

Methods

Study design and setting

This qualitative study employed conventional content analysis to explore the meaning of the data and was conducted from March 2024 to April 2025. The study setting comprised teaching hospitals affiliated with Urmia University of Medical Sciences, Iran. Eligible participants were nurse managers with at least two years of management experience. Purposive maximum-variation sampling was used to capture diverse demographic and professional characteristics and rich experiences relevant to the study. Participants were selected based on their ability to understand, articulate, and communicate their experiences and after written informed consent had been obtained. In total, 22 nurse managers were interviewed. All interviews were conducted by members of the research team.

Data collection and sampling

Data were collected through in-depth, semi-structured interviews using open-ended questions. This interview approach uses a limited set of predetermined questions to explore experiences or phenomena and allows the interviewer to ask follow-up questions to obtain further information and compare accounts across interviews (14, 15). The researchers sought to prevent their prior assumptions and perspectives from influencing data collection. After introducing themselves to hospital administrators and nurse managers, they explained the study aims, invited managers to participate, obtained written consent, and agreed with each participant on a suitable interview time and location.

With participants' permission, interviews were audio-recorded after assurances that information would remain anonymous and confidential. Each interview began with a checklist of demographic and professional information, followed by the open-ended question: "In the current working conditions, where nurses make errors, what factors influence your efforts to protect and support them?" Probing and follow-up questions were guided by participants' responses. Participants were asked to clarify ambiguous points when needed. Nonverbal information, including facial expressions and emotions such as anger, sadness, emphasis, or tearfulness, was documented in field notes. Interviews lasted an average of 45 minutes. Soon after each interview, the audio recording was reviewed and transcribed verbatim; the transcript was analyzed before the next interview. Interviews continued until data saturation. The final sample comprised 11 head nurses, seven supervisors, and four matrons; eight participants were men and 14 were women. Participants were 40–53 years old; 20 held a bachelor's degree in nursing and two held a master's degree in nursing.

The study was approved by the Ethics Committee of the Islamic Azad University, Urmia Branch (IR.IAU.URMIA.REC.1403.005; the date recorded in the source manuscript was 2023/4/7). Written informed consent was obtained. Participants were informed about the study purpose, voluntary participation, anonymity, confidentiality, and their right to withdraw at any time.

Data analysis

Conventional content analysis followed the stages proposed by Zhang and Wildemuth (16). During preparation, researchers listened to each recording shortly after the interview, transcribed it, read the transcript carefully, summarized the text, and coded an initial sample before coding all transcripts. Words and phrases were treated as units of analysis. Transcripts were read repeatedly and interpretive notes were extracted. As interviews continued, relationships among categories and subcategories became clearer, allowing patterns and central meanings within interviews to be identified. Initial coding decisions and the coding process were discussed, and the results were documented (16). During organization, data were entered into MAXQDA version 10.4.16.1 to condense the material and label similar codes.

After subcategories had been identified and their similarities and differences compared, the findings were prepared for reporting. Trustworthiness was assessed using the five criteria described by Guba and Lincoln (17). Consistent with Granheim and Lundman's approach, analysis proceeded continuously alongside data collection. Words, sentences, and paragraphs were condensed into meaning units in context and assigned abstract codes. Codes were grouped into subcategories and categories according to similarities and differences; finally, an overarching category representing the latent meaning of the data was derived (18). Credibility was supported by spending sufficient time on interviews, reviewing data repeatedly, and consulting the research team and experts. Transferability was supported through maximum-variation sampling and detailed description of the research context (19), while member checking was used to support credibility (19).

To support transferability, the study context and relevant conditions were described in detail. To support dependability, interviews were recorded and transcribed, an interviewee list was maintained, and the data-analysis process was documented and stored electronically and on a flash drive for possible review. Dependability was also strengthened by consistently following the same coding procedure and recording the stages and methods used to combine and condense the data.

Results

The analysis identified two overarching concepts influencing nurse managers' PDE with clinical nurses: "Collaborative Ward Climate," a facilitator of managers' strategies, and "Perceived Insecurity in the Managerial Performance Position," a barrier. The findings comprised 11 categories and 34 subcategories. A positive ward climate, manager–staff relationships, effective communication by ward managers, shared needs between managers and nurses, good nursing performance, alignment between managerial authority and performance, and empathy between managers and nurses represented the collaborative climate. Conversely, conflicting needs, nurses' resistance to managerial authority, errors that impaired ward performance, and patient-safety responses contributed to managers' perceived insecurity and constrained their strategies (Table 1).

Table 1
Concepts, categories, and subcategories influencing nurse managers' Protective Disciplinary Exchange with clinical nurses

Concept	Category	Subcategories
Collaborative Ward Climate (facilitator)	Positive ward climate	Nurses' comfort in approaching the ward manager, which promotes cooperation; friendly relationships between the ward manager and nurses, which help resolve nurses' problems; the manager's good-natured behavior, which encourages staff participation in problem-solving; informal coordination between the head nurse and senior managers when deciding how to respond to staff errors.
	Human relationships between manager and staff	Delegation of authority, which promotes nurses' cooperation in resolving ward problems; consulting nurses, which encourages staff participation in problem-solving; informal manager–nurse relationships, which facilitate cooperation in resolving nurses' problems.
	Relationship-oriented ward management	Friendly manager–physician relationships, which may help managers prevent escalation of nurses' work errors; friendly manager–nurse relationships, which may prevent recurrence of work errors; friendly manager–nurse communication, which may reduce work errors.
	Mutual cooperation and shared needs	Managers' and nurses' shared need to cooperate in managing the ward; nurses' competence in their work roles; nurses' efficiency in caring for patients; the need to support nurses in order to provide patient care.
	Good nursing performance	The unintentional nature of a nurse's error, which encourages managerial support; satisfactory work performance, which may lead a manager to overlook an error; good work performance as a basis for showing respect to the nurse.
	Alignment between managerial authority and performance	Use of nursing-office resources to resolve staff problems; the nurse manager's authority to work collaboratively with staff.
	Empathy between managers and nurses	Empathy with nurses when workload is disproportionate to their capacity; empathy concerning stress arising from family problems; empathy concerning staff members' financial needs.
Perceived Insecurity in the Managerial Performance Position (barrier)	Conflicting situational needs between manager and nurse	Misalignment between the priorities of experienced nurses and ward managers regarding work schedules; misalignment regarding shift types; conflicting needs concerning requests to transfer a nurse.
	Nurses' resistance to managerial authority	Nurses' failure to comply with ward norms, which may lead them to take advantage of the manager; experienced nurses' resistance to managerial decisions, which may create disorder in the ward.

Concept	Category	Subcategories
	Work errors that reduce ward performance	Repeated nursing errors, which reduce ward performance; recurrent conflict involving a nurse, which increases tension in the ward; deliberate nursing errors, which reduce overall ward performance; negligence by a nurse perceived as problematic, which undermines managerial performance.
	Responses to protect patient safety	Physicians' follow-up of nursing errors, which creates difficulties for managers; patients' relatives' follow-up/reporting of nursing errors, which creates difficulties for managers; investigation of patient complaints by the university's deputy for treatment, which creates difficulties for managers.

1. Collaborative Ward Climate

This concept comprised a positive ward climate, manager–staff relationships, relationship-oriented ward management, shared needs and mutual cooperation, good nursing performance, alignment between managerial authority and performance, and empathy between managers and nurses. These behaviors were perceived to help maintain the positions of both nurse managers and clinical nurses.

1.1. Positive ward climate

A positive ward climate included nurses feeling comfortable approaching the ward manager, a manager's good-natured manner encouraging staff to solve problems, and informal coordination between head nurses and senior managers when responding to staff errors. Participants described workplaces where nurses helped one another beyond their formal duties and informally discussed concerns with the ward manager. They considered this comfort and openness important for cooperation.

I have behaved in a way that nurses tell me directly when they have a problem. If they administer the wrong medication, they inform me so that I can quickly notify the physician and something can be done for the patient. (Ward manager, female nurse, 39 years old)

Head nurses also described informal coordination with senior managers when deciding how to respond to staff errors.

I modeled my behavior on the hospital director. When minor errors occur, she does not rush into a decision. I follow the same approach. (Hospital matron, woman, 44 years old)

1.2. Human relationships between managers and staff

This category included delegation of authority, consultation with nurses, and informal relationships that encouraged staff to help solve ward problems. Managers reported that staff had a degree of autonomy

and that this promoted cooperation in resolving problems.

“The nurses in my ward feel comfortable and have autonomy. I do not interfere with every minor task. I intervene when an error causes harm to a patient or damages ward property. (Ward manager, woman, 45 years old)”

1.3. Relationship-oriented ward management

Participants described friendly relationships with physicians as helping managers resolve some staff problems without escalating them. They also believed that friendly relationships with nurses encouraged disclosure of errors and could prevent their recurrence.

If one of my staff members makes a work-related error, I ask the physician to let me resolve it myself rather than escalating it to the hospital director or matron. They value me, accept my request, and overlook some problems. (Ward manager, man, 40 years old)

“Our friendly relationship means we feel comfortable with one another. If a problem or error occurs in the ward, they tell me and do not hide it. (Ward manager, female nurse, 45 years old)”

1.4. Mutual cooperation and shared needs

This category reflected shared needs in ward management, nurses’ competence, efficiency in patient care, and the view that patient care requires managers to support nurses. Managers said nurses felt responsible for care quality and for the ward manager’s position and were willing to cooperate.

My staff feel responsible for the quality of the ward’s work and are not indifferent. They do not want an error to occur and then have me apologize to a particular physician because of it. (Ward manager, man, 42 years old)

Managers also described experienced nurses as having a shared interest in managing the ward and preventing errors.

I value an experienced nurse for her work. During evening and night shifts, she is responsible for the shift and uses her experience to prevent errors and protect patients. (Hospital matron, woman, 46 years old)

1.5. Good nursing performance

Good performance facilitated PDE when errors were unintentional, the nurse’s overall performance was satisfactory, and the nurse took the error seriously. Managers described comforting nurses when an error appeared accidental, based on the understanding that human error can occur.

After hearing the nurse’s explanation, I honestly felt that the error was unintentional. Instead of punishment and additional stress, I told her that I, the matron, and the hospital director knew about it and that it had been accidental, but that she should be more careful. (Hospital supervisor, woman, 45 years old)

A history of good performance and efforts to correct an error also influenced managers' responses and could lead them to overlook an individual mistake.

From the explanation, I realized the nurse had not made the error intentionally. When she noticed it, she removed the infusion before handing over the patient and documented everything in the nursing report. She had not been indifferent to the patient's condition. (Hospital supervisor, woman, 50 years old)

Managers emphasized that nurses who acknowledged an error and sought to correct it were more likely to receive support.

If a nurse makes a mistake through inexperience or unintentionally, explanations can help. But explanations do not work when the mistake is deliberate. A nurse who does not want to repeat an error comes to me immediately, explains what happened, and asks for a chance to correct it; we also want to ensure it does not happen again. (Ward manager, man, 40 years old)

1.6. Alignment between managerial authority and performance

Managers described the authority available to the nursing office as a resource for resolving staff problems and supporting reciprocal protection. They used their formal authority to address concerns within their remit, such as work schedules, before problems escalated to higher levels of management.

I solve staff problems within my authority because otherwise the matron may intervene in ward affairs. Why should I ignore staff concerns? I know the work schedule matters to every nurse, and when it falls within my authority, I use that authority to resolve the problem. (Head nurse, woman, 50 years old)

1.7. Empathy between managers and nurses

Empathy concerned mismatches between workload and nurses' capacity, stress arising from family problems, and staff members' financial needs. Managers repeatedly noted that workload could exceed a nurse's capacity and that recognizing this shared difficulty helped them adopt supportive strategies.

When every patient has four drug infusions, a nurse may not have time to check on a patient more than once at medication time. I would struggle too. Put yourself in the nurse's place; then you will have a more reasonable expectation. (Hospital supervisor, woman, 52 years old)

There are conflicts on almost every shift. A patient's relative was upset because the medication scheduled for 8 a.m. had not been given by 10:30. I explained that 48 patients were admitted to the ward and there were only four nurses. How many patients does each nurse have? Put yourself in the nurse's place and ask whether you could administer every medication exactly on time. (Hospital supervisor, woman, 49 years old)

2. Perceived Insecurity in the Managerial Performance Position

This concept comprised conflicting needs between managers and nurses, nurses' resistance to managerial authority, work errors that reduced ward performance, and responses intended to protect patient safety. Based on managers' perceptions and experiences, these factors constrained their use of PDE.

2.1. Conflicting needs between managers and nurses

Subcategories included differences in priorities regarding work schedules, shift types, and requests to transfer nurses. Managers viewed requests for support that conflicted with managerial priorities as a barrier to their protective strategies.

Some experienced nurses want to be in charge of a shift, but they must pay full attention to every patient. A shift leader cannot neglect a critically ill patient. If age or excessive relaxation leads a nurse to overlook a patient, I have to assign work according to my priorities and the needs of the ward. (Hospital matron, woman, 48 years old)

A patient's relative comes to the nursing station because the patient is in pain. I repeatedly ask the nurse to check on the patient, but because of the workload the nurse does not administer the analgesic, and the relative becomes angry. In such cases, I cannot defend the colleague because the nurse has made an error and failed to prioritize tasks. (Ward manager, woman, 43 years old)

Managers also emphasized that nurses must assess patients' stability and dependence on medical equipment, such as intravenous catheters or intubation. When a patient is critically ill, preserving life must take priority over disputes about whose duty it is to provide care.

A patient had a cardiac arrest during handover. The evening-shift nurse expected the night-shift nurse to manage the critically ill patient, while the night-shift nurse said the patient had to be stabilized before handover. When the family complained, there was no basis for defending the colleague. (Hospital matron, woman, 50 years old)

2.2. Nurses' resistance to managerial authority

This category included nurses' noncompliance with ward norms, which managers perceived as enabling others to take advantage of them, and experienced nurses' resistance to managerial decisions, which was perceived to create disorder. When nurses collectively departed from the ward manager's agreed care procedures, managers considered this an obstacle to protective action.

I told them they had independently ignored the written work allocation. They were supposed to use the case method, but divided the patients' tasks among themselves: one documented the records and another performed clinical tasks. The nurse who did not administer the medication did not tell the other nurse. They must follow the ward manager's instructions and must not change the approved allocation. I deducted the performance payment of both. (Head nurse, man, 47 years old)

Managers said that when nurses opposed their decisions, they often interpreted this as disorder and felt less able to protect the nurse; in some cases, they sought to have the nurse transferred to prevent further problems.

2.3. Work errors that reduced ward performance

This category included repeated errors, repeated conflicts, deliberate errors, and negligence by nurses perceived as problematic. Managers argued that repeated errors damaged ward performance and made it difficult to continue protecting the nurse.

The nursing office spoke with the nurse first and asked for another chance, which I accepted. Unfortunately, the errors happened again. This time I filed a report and again requested a transfer. The office had to move the nurse because I had documented that the nursing office would be responsible for the consequences of further errors. The nurse was transferred to the emergency department. (Ward manager, woman, 44 years old)

Repeated conflict was said to increase tension in the ward and threaten the manager's position. Managers distinguished unintentional errors, which might be addressed supportively, from deliberate errors, which they considered unacceptable and not appropriate to overlook.

The patient said that enoxaparin had not been given. I asked whether the patient was sure; the patient said it had been administered the previous night but not that afternoon. I checked the schedule and found the same nurse, who had also been deliberately negligent on the previous shift. I filed a written report. The nurse had performed poorly in the previous ward as well, so the service placement was not extended. (Ward manager, woman, 41 years old)

Some nurses were described as having a poor work history and being viewed by managers as problematic. Their negligence was seen as undermining managerial performance.

We had an experienced permanent nurse who had previously worked in the emergency department. She did not interact well with colleagues, created tension, argued with patients' relatives and interns, and did not listen to the head nurse. Warnings and deductions were no longer sufficient; the ward manager had reached the limit and requested that the nurse be transferred. (Hospital matron, woman, 46 years old)

2.4. Responses to protect patient safety

This category included physicians' follow-up of nursing errors, complaints raised by patients' relatives, and investigations of patient complaints by the university's deputy for treatment. When physicians closely monitored clinical care and would not accept errors, overlooking a nursing error became more difficult and constrained managers' PDE.

Physicians are very sensitive about certain tasks, so ward and shift managers supervise them closely. If a nurse delays even slightly, the physician may humiliate the nurse, who will then be more careful next time. (Ward manager, woman, 48 years old)

Managers also reported that patients' relatives were often involved in conflicts with nurses, monitored care, and reported perceived errors to physicians or senior hospital managers.

Patients and their relatives in this ward are informed and do not easily overlook nurses' mistakes. They tell me or the physician that a nurse gave the wrong medication or could not obtain a specimen. (Ward manager, woman, 45 years old)

The university's deputy for treatment, which follows up patient complaints, was also perceived as limiting managers' ability to protect nurses. Patients and relatives could submit complaints to the hospital complaints office, after which the deputy for treatment would investigate and potentially create difficulties for managers seeking to shield staff from consequences.

I apologized to the patient's relative so that the complaint would end. If the relative does not agree, the complaint form will be sent to the deputy for treatment and the nurse may face serious consequences. (Hospital supervisor, woman, 39 years old)

Discussion

This study found that a positive ward climate, manager–staff relationships, effective communication, shared needs, good nursing performance, appropriate managerial authority, and empathy facilitated PDE. In contrast, conflicting needs, nurses' resistance to managerial authority, errors that reduced ward performance, and responses intended to protect patient safety were associated with managers' perceived insecurity and constrained their strategies. Perceived insecurity indicates that managers' strategies may not always sit comfortably within formal legal duties and can come into tension with patient-safety advocates. In this reciprocal exchange, some nursing errors may be overlooked or some nursing care needs may be assigned low priority, potentially resulting in missed care.

The findings are consistent with Bäckström and colleagues (2025), who reported positive outcomes associated with collaborative leadership structures and cooperation among healthcare team members (21). Curșeu and colleagues (2025) similarly noted that healthcare providers adapt collaborative leadership to complex clinical settings and that it is more effective when accompanied by trust, psychological safety, and coordination (22). A systematic review by Alzate-Moreno and colleagues (2025) found that although physicians and nurses recognize the importance of interprofessional collaboration in caring for critically ill patients, it is not yet routine practice (23). Slåtten and Lien (2022) also found that interdepartmental collaboration, managerial support, and care quality positively influence nurses' perceptions of organizational attractiveness (24). Retaining nursing professionals amid global shortages requires greater attention to organizational oversight and support throughout disciplinary processes (25).

In this study, a collaborative ward climate facilitated nurse managers' efforts to protect clinical nurses during disciplinary situations. This finding aligns with a flexible approach to error management, in which informal and timely responses may help maintain quality. Researchers adopting a flexible approach

argue that individuals, teams, and organizations should be able to respond to errors quickly and informally (26). A supportive environment can influence whether nurses report or conceal work-related errors (27).

Perceived insecurity in managers' positions was a barrier to protecting clinical nurses. Managers could feel insecure because of possible complaints from physicians, senior hospital managers, or patients' families after an error. They recognized that errors may have lasting emotional consequences for nurses and can disrupt workplace relationships or lead to severe disciplinary action. They therefore engaged in exchange strategies both to protect nurses and to preserve their own positions. Abbaszadeh and colleagues (2021) similarly found that after errors in emergency departments, nurses may focus on protecting patients, although contextual factors can lead them to prioritize self-protection. A supportive environment may help nurses protect patients while also coping with their own vulnerability (28).

Li and colleagues (2025) identified personal factors, conflicts in managerial roles, and organizational support challenges as barriers to nurses seeking support as second victims of patient-safety incidents. Facilitators included accessible support systems and diverse forms of assistance. Although support can facilitate recovery, second victims may remain reluctant to seek it actively (29). Cabilan and Kynoch (2017) emphasized that managers' support after nursing errors should address nurses' negative emotions. Disclosure decisions may be influenced by nurses' perceptions of the error, patient harm, available support, previous responses to errors, and the process of reconciliation with the system (30). Rezaee Moradali and colleagues (2025) described protective exchange strategies as contingent communication strategies that nurse managers may use to preserve human resources and stabilize their own and clinical nurses' positions (31). Such support may reduce nurses' concerns about workplace difficulties, including work–family and work-related conflict.

The present findings suggest that PDE, when used appropriately, may help move responses beyond purely punitive action. However, if it results in overlooking errors, concealment, or reduced accountability, it conflicts with patient-safety principles. Supportive management should therefore be combined with transparent reporting, learning from errors, and clear safeguards to ensure that patient safety remains the priority.

Limitations

This study was conducted in teaching hospitals affiliated with one university of medical sciences; transferability to other settings should be considered in light of organizational and cultural differences. The data reflect nurse managers' experiences and did not directly capture the perspectives of clinical nurses, physicians, or patients. Although the analysis was discussed within the research team, the researchers' assumptions may have influenced interviewing and interpretation.

Conclusion

This study identified factors influencing nurse managers' supportive responses to nursing errors. High-quality and safe care requires a better understanding of the factors shaping managers' perspectives and decisions about errors. The findings offer useful insights for nursing services, hospital managers, and policymakers developing clinical and institutional approaches to nurses' work-related errors. They also highlight a central challenge: when responding to an error, managers must balance the protection of their own position and that of the nurse against patient safety, and consider how missed care will be identified and addressed.

Abbreviations

PDE
Protective Disciplinary Exchange
COR
Conservation of Resources

Declarations

Ethics approval and consent to participate

The study was approved by the Ethics Committee of Islamic Azad University, Urmia Branch (IR.IAU.URMIA.REC.1403.005). Written informed consent was obtained from all participants. Procedures for obtaining informed consent were approved by the abovementioned institutional ethics committees. All methods were performed in accordance with the relevant guidelines and regulations (Declaration of Helsinki).

Consent for publication

Not applicable.

Competing Interests

There was no disclosed conflict of interest by the author(s).

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Author Contribution

All the authors contributed to the conception and design of the study and also in writing the manuscript. M.R.M and E.B contributed to the design, data acquisition, analysis, and interpretation and wrote the first draft of the paper and final version of the manuscript. E.B was the research supervisor and contributed to the conception, design, and interpretation of the results and critically reviewed the manuscript. He revised and approved the final manuscript. M.R.M interpreted and revised the analyzed statistical data. In addition, M.R.M and E.B reviewed and revised the manuscript. All the authors approved the final manuscript.

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Data Availability

Given the qualitative nature of the data and the need to protect participant confidentiality, raw interview data are not publicly available. Supporting data may be reviewed upon reasonable request, subject to confidentiality and ethical requirements and after coordination with the authors and the relevant ethics body.

References

1. Hobfoll SE, Halbesleben J, Neveu J-P, Westman M. Conservation of resources in the organizational context: The reality of resources and their consequences. Annual Rev organizational Psychol organizational Behav. 2018;5:103–28.
2. Durand R, Hawn O, Ioannou I. Willing and able: A general model of organizational responses to normative pressures. Acad Manage Rev. 2019;44(2):299–320.
3. Hobfoll SE. The influence of culture, community, and the nested-self in the stress process: Advancing conservation of resources theory. Appl Psychol. 2001;50(3):337–421.
4. Bolger N, DeLongis A, Kessler RC, Wethington E. The contagion of stress across multiple roles. J Marriage Fam. 1989:175–83.
5. Brough P, Muller W, Westman M. Work, stress, and relationships: The crossover process model. Australian J Psychol. 2018;70(4):341–9.
6. Epitropaki O, Martin R, Thomas G. Relational leadership. The nature of leadership. 2018:109 – 37.
7. Baljani E, Memarian R, Vanaki Z. Protective disciplinary exchange: A qualitative study into nurse managers' supportive strategies for nursing error management. Nurs Midwifery Stud. 2020;9(3):135–41.

8. Mohsenpour M, Hosseini M, Abbaszadeh A, Shahboulaghi FM, Khankeh H. Nursing error: an integrated review of the literature. Indian J Med Ethics. 2017;2(2):75–81.
9. Vaismoradi M, Vizcaya-Moreno F, Jordan S, Gåre Kymre I, Kangasniemi M. Disclosing and reporting practice errors by nurses in residential long-term care settings: a systematic review. Sustainability. 2020;12(7):2630.
10. Vahednasiri A, Eini S. The causes of nursing errors and effective factors in non-reporting of errors from the perspective of nurses in the hospitals affiliated to maragheh university of medical sciences. Nurs Midwifery J. 2021;19(9):716–24.
11. Kiguba R, Waako P, Ndagije HB, Karamagi C. Medication error disclosure and attitudes to reporting by healthcare professionals in a sub-Saharan African setting: a survey in Uganda. Drugs-real world outcomes. 2015;2(3):273–87.
12. Rafiezadeh M, Noroozi M, Hashemi A, Tehrani SS. Attitudes of General Medicine Students (Interns) Towards Medical Error Disclosure at Iran University of Medical Sciences, 2022–2023. Iranian Journal of Medical Ethics and History of Medicine; 2025.
13. Babakhani H, Khazir Z, Ghiasi Nejad AH, Hamedi A, Khani Jeihooni A. Evaluating the Report of Medication Errors and Barriers Faced by Nurses in Teaching Hospitals. J Hosp Librariansh. 2026;26(1–2):60–75.
14. Cresswell JW, Plano Clark VL. Designing and conducting mixed methods research. 2011.
15. Polit DF, Beck CT. Is there still gender bias in nursing research? An update. Res Nurs Health. 2013;36(1):75–83.
16. Wildemuth BM. Applications of social research methods to questions in information and library science. Bloomsbury Publishing USA; 2016.
17. Guba EG, Lincoln YS. Competing paradigms in qualitative research. Handb qualitative Res. 1994;2(163–194):105.
18. Graneheim UH, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: A discussion paper. Nurse education today. 2017;56:29–34.
19. Elo S, Kääriäinen M, Kanste O, Pölkki T, Utriainen K, Kyngäs H. Qualitative content analysis: A focus on trustworthiness. SAGE open. 2014;4(1):2158244014522633.
20. Birt L, Scott S, Cavers D, Campbell C, Walter F. Member checking: a tool to enhance trustworthiness or merely a nod to validation? Qual Health Res. 2016;26(13):1802–11.
21. Bäckström M, Engström Å, Lundvall L-L, Leijon-Sundqvist K, Jonsson K. Unspoken synergy: Team interdependence with radiographers in trauma alerts-An interview and observational study of trauma teams. Radiography. 2025;31(5):103097.
22. Curșeu PL, van Rijswijk J, Schruijer SG. Collaborative and shared leadership dynamics in healthcare action teams: A systematic literature review. J Healthc Leadersh. 2025:877–99.
23. Alzate-Moreno RM, Calderón-Breñosa RB, Rodríguez-San Miguel RK. Interprofessional collaboration in the clinical sessions of an intensive care unit: perception of nurses and doctors. A systematic

review of the literature. Enfermería Intensiva (English ed). 2025;36(1):100488.
24. Slåtten T, Lien G. Frontline nurses' appraisal of organizational attractiveness and the role of management support, interdepartmental collaboration climate and service quality of care. Int J Qual Service Sci. 2022;14(2):197–216.
25. Papinaho O, Häggman-Laitila A, Pasanen M, Kangasniemi M. Disciplinary processes for nurses, from organizational supervision to outcomes: A document analysis of a regulatory authority's decisions. J Nurs Adm Manag. 2022;30(7):2957–67.
26. Goodman PS, Ramanujam R, Carroll JS, Edmondson AC, Hofmann DA, Sutcliffe KM. Organizational errors: Directions for future research. Res Organizational Behav. 2011;31:151–76.
27. Ghezeljeh TN, Farahani MA, Ladani FK. Factors affecting nursing error communication in intensive care units: A qualitative study. Nurs Ethics. 2021;28(1):131–44.
28. Abbaszadeh A, Borhani F, Ajri-Khamesloo F, Afshar PF, Tabatabaeifar SM, Ajri-Khameslou M. Explaining the process of dealing with nursing errors in the emergency department: A grounded theory study. Int Emerg Nurs. 2021;59:101066.
29. Li Q, Zhang Y, Gao Z, Deng Z, Wu Q, Lu W, et al. Barriers and facilitators of nurse second victim of patient safety incident actively to seek support: a qualitative study. BMC Nurs. 2025;24(1):848.
30. Cabilan C, Kynoch K. Experiences of and support for nurses as second victims of adverse nursing errors: a qualitative systematic review. JBI Evid Synthesis. 2017;15(9):2333–64.
31. Rezaee Moradali M, Baljani E, Shahrifar M, Ranjbar Hajiabadi N. Nurse Managers' Strategies to Support the Practices of Clinical Nurses: A Qualitative Content Analysis. J Qualitative Res Health Sci. 2025.

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