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A Quantitative Analysis of the Impact of Emotional Labor on Patient Safety in Healthcare

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Chronicle	Abstract
  Iram Waheed is currently affiliated with Superior College of Nursing, Lahore, Pakistan. **Email:** iramnafees701@gmail.com **Corresponding Author***	This quantitative study examines the impact of emotional labor on patient safety, focusing on how nurses' ability to manage emotions affects healthcare outcomes. Patient safety is a critical global objective, defined by the World Health Organization (WHO) as minimizing harm to patients during healthcare delivery. Ensuring patient safety improves healthcare efficiency, reduces patient harm rates, and strengthens public trust in medical institutions. Emotional labor, a key aspect of nursing, involves managing and expressing emotions as part of professional responsibilities, influencing both patient care quality and nurses' well-being. A cross-sectional research design was employed, utilizing a structured questionnaire to collect data. The study was conducted at SGRH, with a total population of 280 nurses, from which a sample of 184 was selected using Yamane's formula. Convenience sampling was applied to recruit participants. The reliability, validity, and normality of the data were statistically confirmed. Regression analysis revealed a significant relationship (p = 0.000) between emotional labor and patient safety, indicating that nurses' emotional management directly affects patient care quality. The findings highlight the importance of emotional regulation in nursing, as it plays a crucial role in enhancing patient safety. While emotional labor is essential for providing high-quality care, excessive emotional regulation may pose challenges for nurses. Addressing emotional labor through training and institutional support can improve healthcare outcomes. This study underscores the need for strategies that balance emotional demands with patient safety objectives, ultimately contributing to more efficient and trustworthy healthcare systems.

INTRODUCTION

According to the National Academies of Sciences, Engineering, and Medicine, 134 million bad things happen every year in hospitals in low- and middle-income countries because of dangerous medical care (LMICs). About 2.6 million people die because of these things. Raising the quality of medical care all over the world while closing the quality gap between different parts of the world. Washington) Another study found that low- and middle-income countries (LMICs) are responsible for about two-thirds of all bad things that happen because of dangerous treatment, as well as the years lost because of death and disability (also known as disability adjusted life years, or DALYs) (The cost of bad medical care around the world) Another study has estimated that around two-thirds

of all adverse events resulting from unsafe care, and the years lost to disability and death (known as disability adjusted life years, or DALYs) occur in LMICs (The global burden of unsafe medical care). WHO says that patient safety is "reducing the risk of undue suffering from health care to an appropriate standard. "It can also be said that "patient safety" means that a patient doesn't get hurt in a way that could have been prevented. Patient care is the process of working together to make sure that patients don't get hurt by the procedure of receiving health care. In order to improve health care systems and move closer to achieving effective universal health coverage (UHC) in line with Sustainable Development Goal 3, it is important to make sure that patients are safe while receiving secure and elevated quality healthcare (Make sure healthy lives and promote health and well-being for all at all ages) (Systems Approach, as seen on the page for Patient Safety Network). (The Agency for Healthcare Research and Quality, 2019).

Also, it's important to recognize how patient safety affects the reduction of expenses associated with damage and the improved performance of operational efficiency in health care systems. Providing risk-free services will also help people feel better about their own systems of health care and restore their faith in them. (Patient safety—Actions that can be taken on a global scale to protect patients. Report from the Organization's top official. (The World Health Organization, 2019). Emotional labor (EL) is a way of thinking about how to control what you say and how you show how you feel in work relationships. Because of this, it is a very difficult topic that has many different sides. Analysis of the relevant literature shows that there is a strong link between EL policies and the values they support. However, because there are different theoretical perspectives, there are different ways to put this idea into practice. This is why different EL studies have come to different results and conclusions (Hülshegez and Schewe, 2011).

LITERATURE REVIEW

Protecting patients is a key part of providing essential, high-quality health care services. In fact, most people agree that high-quality healthcare facilities should be fully functional, risk-free, and focused on what patients need. Also, for people to get the benefits of getting good medical care, health services need to be timely, fair, coordinated, and good.For patient safety techniques to work well, they need clear rules, a lot of management, data to drive safety improvements, qualified health care experts, and patients who are actively involved in their care. Patient protection is a term that emphasizes safety in health care by preventing, reducing, commenting on, and analyzing errors and other kinds of damage that can be avoided and often lead to bad things happening to patients (Akinlua James., 2019). Patient safety is a relatively new idea in the medical field. It came about because health care systems were getting more complicated and more people were getting hurt in hospitals at the same time.

The goal of giving patients the right medical care is to prevent and lessen the chance that they will face risks, make mistakes, or get hurt. An important part of the punishment is that the person keeps growing by learning from their mistakes and from competing events. (Slawomirski et al., 2019). The goal of the World Health Organization is to improve how patients feel, lower risks and damage, make better health products, and lower the cost of health care (By WHO guidelines). The safety of all patients in a healthcare setting is of the utmost importance, so there needs to be a practical framework for managing drugs that is safe, easy to use, and gives patients information. Kwan, Lo, Sampson, and

Shojania (2013) say that it is very important to make sure that patients are taking all of their medications before switching to other types of treatment. This is similar to the need to reduce safety concerns and get rid of inconsistencies in pharmaceuticals whenever it is possible to do so. So, nurses should pay the most attention to medication errors and add an extra level of quality to care and management to make sure that patients always get the best care and treatment and are never put in danger (Kwan et.al, 2013). This article talks about a common but less often looked at part of care transitions: how to deal with worries about suppositories at this level. The study's goal is to help nurses figure out what their responsibilities are to patients in this area. The safety of giving medications to patients must also be looked at to make sure that an organization has the right tools and resources to give the right number of medications in a safe and correct way. This is to make sure that patient care is not harmed in any way (Dubois et.al, 2013).

Protecting patients from risks related to medication delivery is a big part of a nurse's job and needs their full attention and course to avoid mistakes and other interactions. Because of the way these places work, it is very important for nurses to have access to the latest technological advances. This will help cut down on the number of mistakes made with medications and make it easier for nurses to talk to each other about treatment medications (Peris-Lopez et.al, 2011). Most importantly, a strategy that includes a cross-checking method, a way to avoid distractions, and a clear and concise way to organize drugs must be kept in place to cut down on action-based mistakes and people who rely on their memories (Peris-Lopez et.al, 2011). The hope is that these technologies will go a long way toward meeting secondary patient needs and showing how important nurses are in preventing drug mistakes as much as possible.

METHODOLOGY

Design and Population: Shek and Wu (2018) said that the research paradigm is the way a researcher sees and understands the real world. The type of this study is quantitative. It uses a cross-sectional time frame and a convenience sampling method to get information from 270 Nurses in a certain department at Sir Ganga Ram Hospital. This was done to study the causes and effects of Patient Safety. All of the nurses from Sir Ganga Ram Hospital were part of the group we chose for this study. This was a group of 270 nurses from different departments, such as Emergency, Medical, and Eye Ward. The Taro Yamane was used to figure out the sample size (Yamane,1973).

Measurement: This section has information about the questionnaire that was made to measure the quality of the professionals at Patient Safety. The Emotional Labor Scale (ELS) from Grandy (2002) is a standard index measurement scale that scholars use. This study used the Chinese translation of (Luo,2008). The 25-item professional standards questionnaire was used to measure professionalism (Lombarts et al., 2014).

RESULTS

Demographic Analysis: Based on the table below, 4.1 most of the people were between the ages of 21 and 30. In the same way, 32 of the people who replied were between the ages of 31 and 40. While only 3 of the respondents were between the ages of 41 and 50.
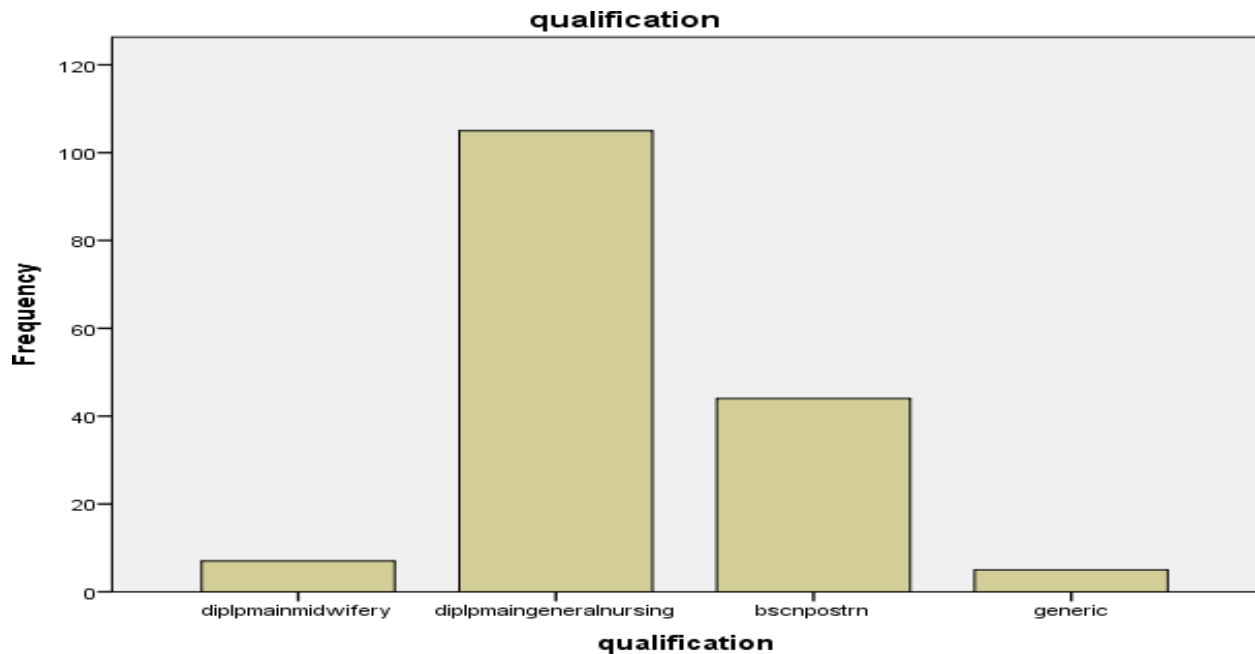
Table 1.

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21_30years	126	78.3	78.3	78.3
31_40		32	19.9	19.9	98.1
41_50		3	1.9	1.9	100.0
Total		161	100.0	100.0	
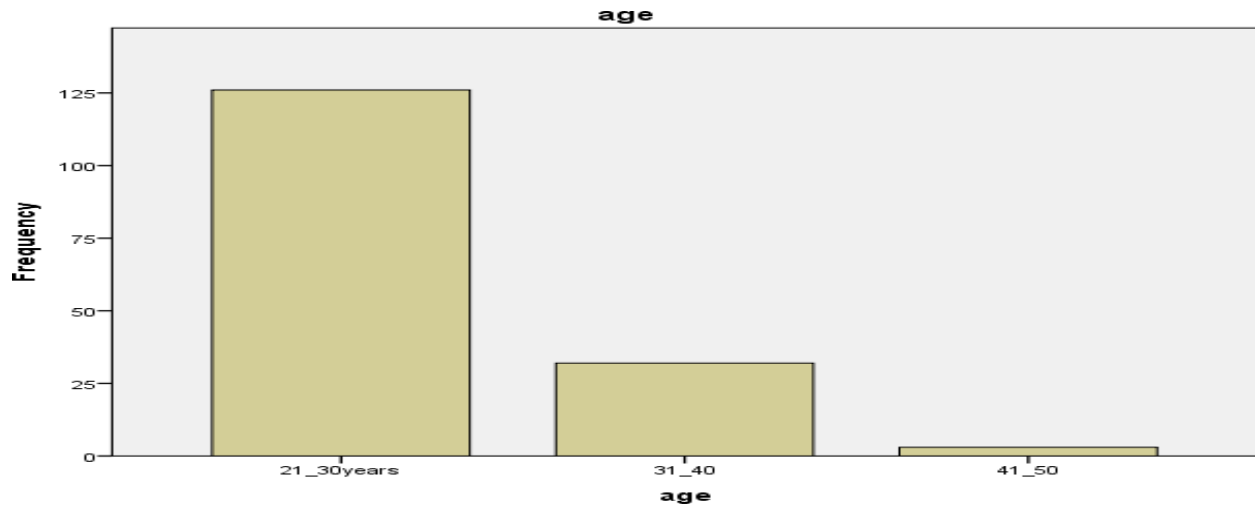
Figure 1.
Age

Qualification

As per table 4.2 major of respondents have diploma in nursing similarly, 44 of respondents found to have BSN post Rn. Whereas only 7 respondents have

Figure 2.
Qualifications

Diploma in midwifery and 5 respondents found to have generic.

Qualification

As per table 4.2 major of respondents have diploma in nursing similarly, 44 of respondents found to have BSN post Rn. Whereas only 7 respondents have diploma in midwifery and 5 respondents found to have generic.
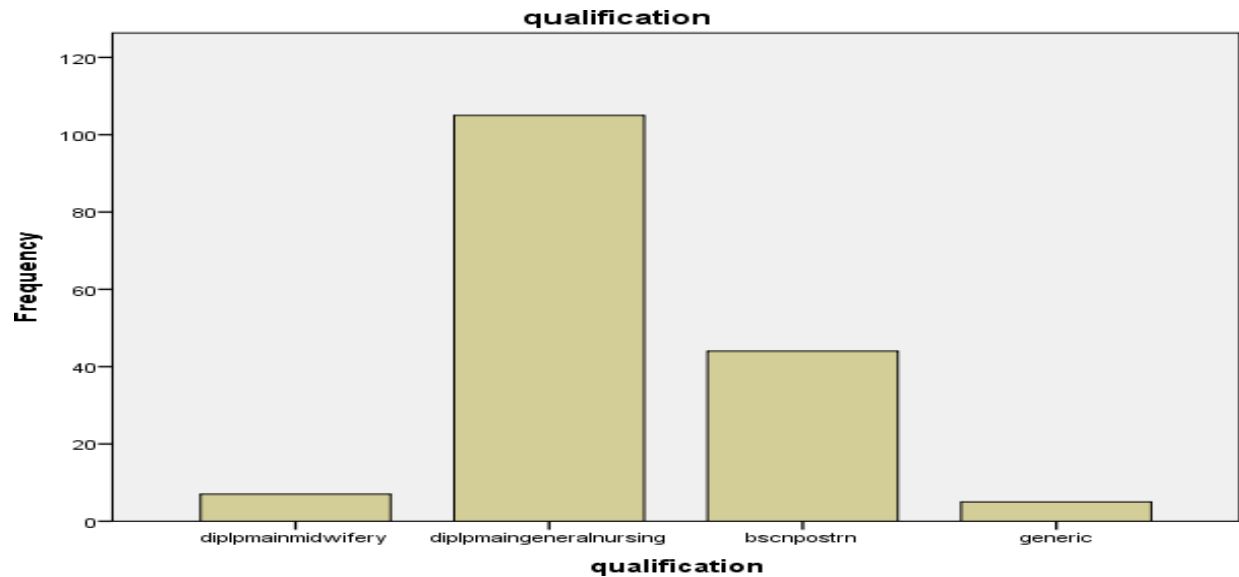

Figure 3.
Qualifications

Experience: As per table 4.3 major of respondents have experience 1-3 years similarly, 49 of respondents found to have 4-6 years' experience. Whereas only 7 respondents have experience of 7-9 years and 12+ years' experience have 8 respondents
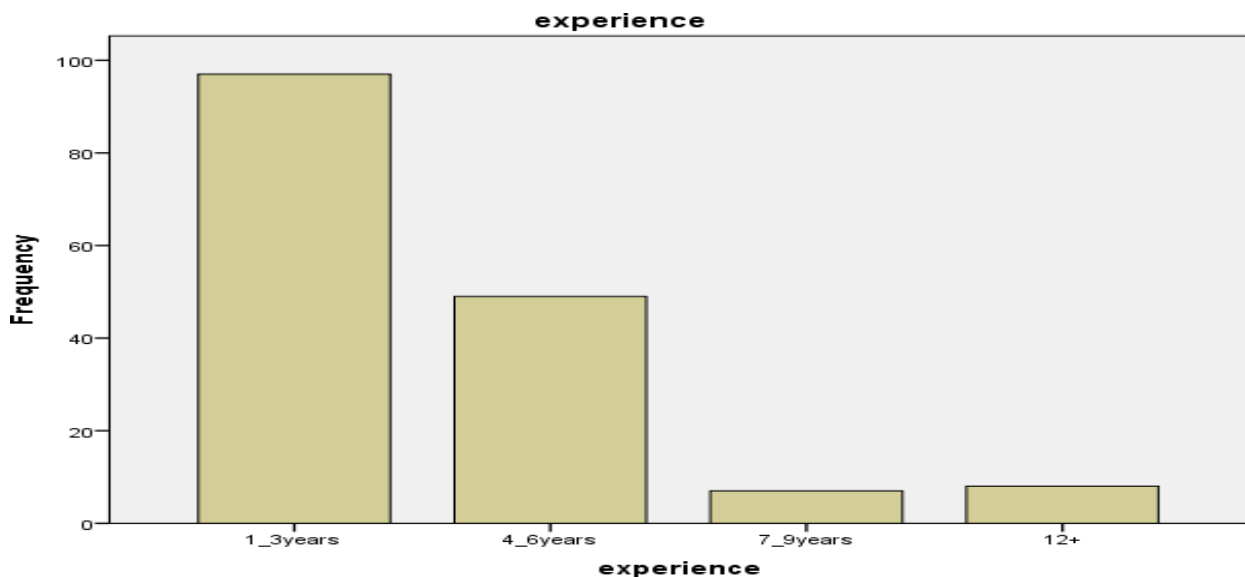

Figure 4.
Experience

Nature of Employment: As per table 4.4 major of respondents have permanent job similarly, 8 of respondents found to have contractual job. Whereas only 6 respondents have other job.

Table 2.
Nature of Employment

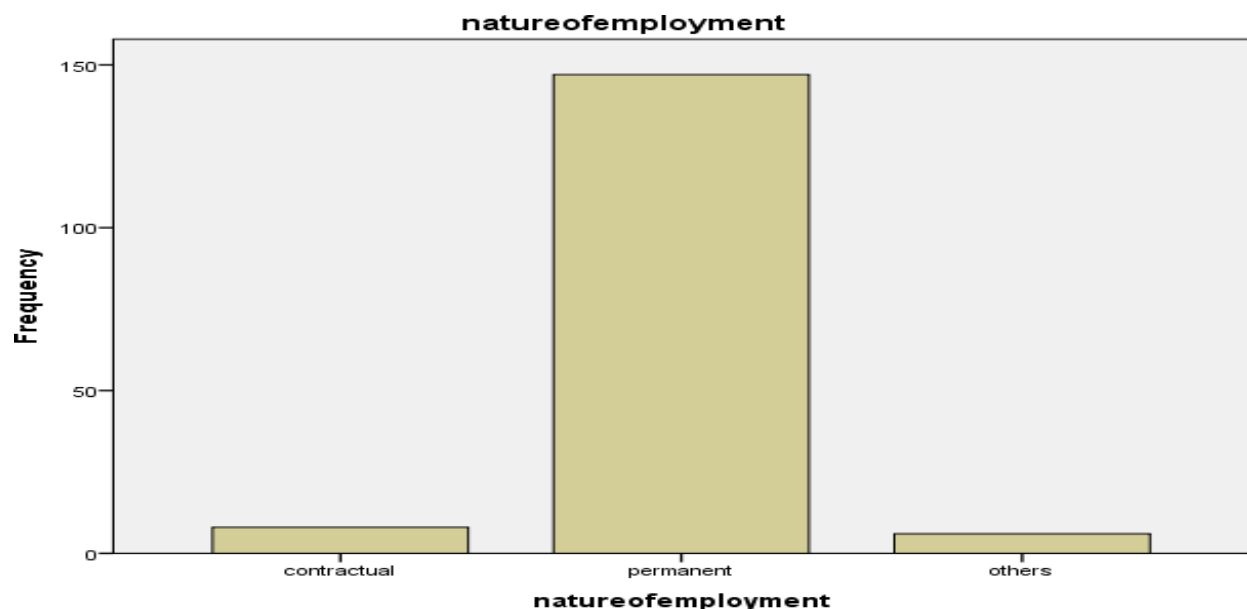|		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Contractual	8	5.0	5.0	5.0
	Permanent	147	91.3	91.3	96.3
	Others	6	3.7	3.7	100.0
	Total	161	100.0	100.0	

Figure 5.
Nature of Employment

Duty Shift: As per table 4.5 major of respondents perform morning shift during data collection similarly, 62 of respondents performed evening shift. Where are 26 respondents perfumed night duty during data collection?

Table 3.
Duty Shift

		Frequency	Percent	Valid Percent	CumulativePercent
Valid	Morning	73	45.3	45.3	45.3
	Evening	62	38.5	38.5	83.9
	Night	26	16.1	16.1	100.0
	Total	161	100.0	100.0	

Department

As per table 4.6 major of respondents perform duty in emergency department similarly, 59 of respondents performed duty in medical department. Where are only 8 respondent performed duties in eye department?
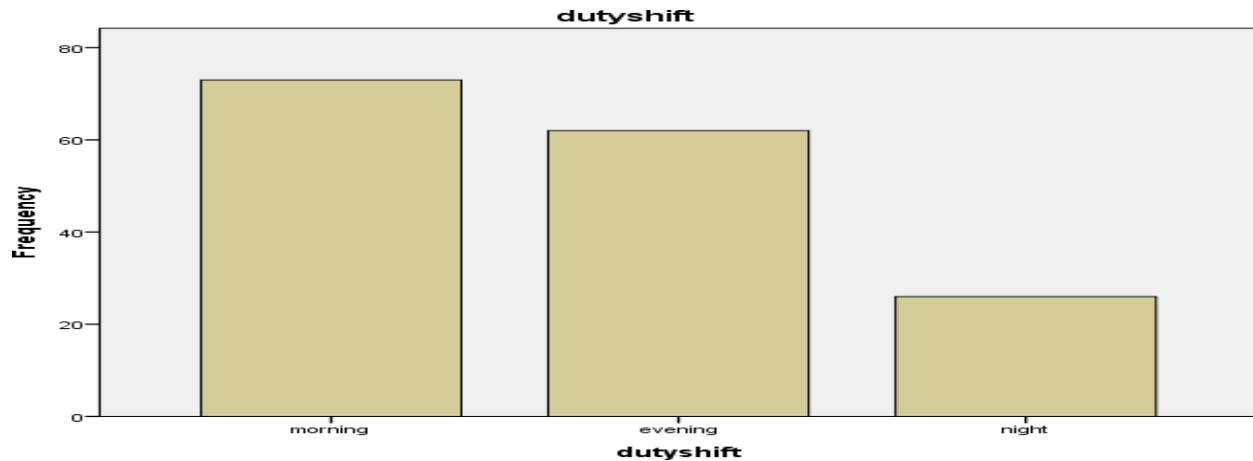
Figure 5.
Duty shift

Figure 6.
Department

Table 4.
Department

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Medical ward	59	36.6	36.6	36.6
	Emergency	94	58.4	58.4	95.0
	Eye ward	8	5.0	5.0	100.0
	Total	161	100.0	100.0	

DESCRIPTIVE ANALYSIS

Table 4.7 shows the average, lowest, and highest values for the PS-related items. Mean and standard deviation can go up to a maximum of 2.9359 and 1.49189, respectively. According to Table 4.6, all of CF's Skewness and Kurtosis values range from -2 to +2. It says that there is no problem with the normality of the data.

Table 5.
Compassion Satisfaction

	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std.Er	Statistic	Std.Err
ps1	161	1.00	5.00	4.0497	.78103	-1.283	.191	2.937	.380
ps2	161	1.00	5.00	3.1988	1.25907	-.306	.191	-1.228	.380
ps3	161	1.00	5.00	4.1180	.76957	-1.455	.191	3.724	.380
ps4	161	1.00	5.00	4.1491	.77630	-1.240	.191	2.477	.380
ps5	161	1.00	5.00	3.2981	1.21370	-.315	.191	-1.116	.380
ps6	161	1.00	5.00	4.1677	.74361	-1.759	.191	5.827	.380
ps7	161	1.00	5.00	3.7081	1.08766	-.901	.191	-.057	.380
ps8	161	1.00	5.00	3.4099	1.08669	-.431	.191	-.896	.380
ps9	161	1.00	5.00	3.8323	1.00770	-1.141	.191	.968	.380
ps10	161	1.00	5.00	3.4907	1.07307	-.744	.191	-.451	.380
ps11	161	1.00	5.00	3.8199	1.01789	-1.251	.191	1.152	.380
ps12	161	1.00	5.00	3.5280	1.02507	-.746	.191	-.333	.380
ps13	161	1.00	5.00	3.9441	.90311	-1.384	.191	2.177	.380
ps14	161	1.00	5.00	4.0621	.88522	-1.108	.191	1.099	.380
ps15	161	1.00	5.00	4.0311	.75351	-1.294	.191	2.847	.380
ps16	161	1.00	5.00	3.3727	1.08294	-.519	.191	-.784	.380
ps17	161	1.00	5.00	3.6957	1.00650	-.773	.191	-.136	.380
ps18	161	1.00	5.00	3.3665	1.09937	-.541	.191	-.895	.380
Valid (listwise)	161								

N Minimum Maximum Mean

Table 6.
Compassion analysis

Minimum Maximum Meazzz   Std   **Deviation Skewness Kurtosis.**

	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Error	Statistic	Error
el1	161	1.00	5.00	3.5280	1.21482	-.447	.191	-.742	.380
el2	161	1.00	5.00	3.6398	1.25774	-.645	.191	-.542	.380
el3	161	1.00	5.00	3.1366	1.30143	-.309	.191	-.989	.380
el4	161	1.00	5.00	3.5155	1.08458	-.278	.191	-.922	.380
el5	161	1.00	5.00	2.4596	1.33226	.329	.191	-1.250	.380
el6	161	1.00	5.00	3.2733	1.21443	-.328	.191	-1.044	.380
el7	161	1.00	5.00	3.4783	1.32800	-.496	.191	-.807	.380
el8	161	1.00	5.00	3.1180	1.09760	-.409	.191	-.575	.380
el9	161	1.00	5.00	3.6149	1.06690	-.398	.191	-.499	.380
el10	161	1.00	5.00	3.2050	1.19435	-.359	.191	-.862	.380
el11	161	1.00	5.00	2.1739	1.26770	.786	.191	-.607	.380
el12	161	1.00	5.00	3.4410	1.22905	-.384	.191	-1.000	.380
el13	161	1.00	5.00	3.1677	1.24617	-.382	.191	-.955	.380
Val(listwise)	161								

Reliability Analysis: Reliability was used on its own, and Cronbach's alpha was used to figure out how much it was worth. Reliability to use and replicate each construct by different researchers under different conditions to get reliable results. If the value of Cronbach's alpha is close to 1, the structure is more reliable, and if it is not close to 1, it is less reliable.

Validity Analysis: Instrument for patient safety and emotional labor was tested to establish validity. Table 10 shows that KMO value is above .50 and Bartlett's test must be significant (p<0.05). So, the whole set criteria was fulfilled and instrument for patient safety and emotional labor is valid.

Table 7.

Variable of study

Variable of study	No of items	Cronbach's alpha
Patient safety	18	.770
Emotional labor	13	.600

Table 8.

Validity analysis

Variables	KMO	Approx.	Df	Sig
Patient safety	.751	538.278	153	.000
Emotional labor	.654	206.030	78	.000

Table 9.

Correlation

		ps	El
Ps	Pearson Correlation Sig. (2-tailed)		
	N	1161	
El	Pearson		
		.284**	1
	Correlation		
	Sig. (2-tailed)	.000	
	N	161	161

**. Correlation is significant at the 0.01 level (2-tailed)

Table 10.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.284ᵃ	.081	.075	.42892	1.768

a.   Predictors: (Constant), el
b.   Dependent Variable: ps

Table 11.

ANOVA

Model		Sum of Squares	Df	MeanSquare	F	Sig.
1	Regression	2.574	1	2.574	13.989	.000ᵇ
	Residual	29.252	159	.184		
	Total	31.826	160			

a. Dependent Variable: ps
b. Predictors: (Constant), el

Table 4.9 provides the values for R, R-square, and adjusted R-square, which are respectively.081,.075, and.085. The corrected R-square value of.075 shows that the model explained minimal variability and that only 37.5% of the overall change in turnover intention is explained by the ideal. According to what is shown in Table 10, the level of significance for Hypothesis 1 is p0.05. According to Table 11, even a little shift of only one percent toward negative leadership may have a significant impact on employee happiness. It indicates that a boss who is disruptive has a significant and negative influence on work satisfaction. Regarding the first hypothesis, given that the models

provide favorable and significant results, it is permissible to accept it. Job satisfaction has a tendency to decrease when there is a greater prevalence of poor leadership.

Table 11.
Coefficients

Model		Unstandardized Coefficients		StandardizedCoefficint		Sig.
		B	Std. Error	Beta		
1	(Constant)	2.932	.217		13.487	.000
	EI	.250	.067	.284	3.740	.000

a. Dependent Variable: ps

CONCLUSION

In this overview and analysis of the results of the current research, we will focus on. The present research not only provided a summary but also drew conclusions based on the most important findings from the previous study. There includes a comprehensive discussion of research issues and aims. Along with discussing the theoretical and practical consequences, this chapter also offered an explanation for why some research findings were deemed noteworthy while others were deemed unimportant. The limitations of the study as well as suggestions for additional research are included at the end of the article.

DISCUSSION

This part is where we'll talk about what we've learned from the current research. To start, I will look at how this study showed a link between professionalism, reasonable structures, and hospital nurses' ability to keep patients safe. I will also talk about the worries that make it hard for nurses to keep patients safe. Also, professionalism had a direct effect on systems thinking and an indirect effect on patient safety knowledge through systems thinking, both of which supported the research hypotheses. (Han & Roh, 2020; Jin & Yi, 2019)). It is important for nurses to have the chance to take part in activities related to continuing education. Educational interventions that are in line with the Patient Safety Course Guide published by WHO in 2011 can help improve patient safety skills (Lee et al., 2021) The first part, "emotional control strength in profession," talks about how nurses try to get to know their patients and keep their emotions in check while they work.

Nurses do emotional work because they want to make their patients feel safe and at ease. They also control their emotions or work through emotional problems with patients to build good rapport, which helps create an invisible link between the nurse and the patient (Gray 2009). Also, nurses try to see things from the patients' points of view and feel empathy for them (Kim et al. 2014). The second part is called "patient-focused emotional defeat," and it refers to what nurses do to make sure they don't let the bad feelings they get from interacting with patients control how they act. Nurses try to hide the private feelings they have at work so they don't upset their patients or slow them down. Among these feelings are a sense of being wrongly suspected or of being weak, as well as anxiety (Kim et al. 2014) The third part is called "emotional trick by rules," and it refers to the practice of nurses exaggerating feelings they don't really have or forcing themselves to have nice facial expressions or ways of talking to make a good impression on their patients. Society has a lot of ideas about what nurses should be like and how they should care for people. These ideas range from thinking nurses should be like

Florence Nightingale to thinking they should be like mothers. Because of these ideas, nurses are forced to use their feelings on the job (Gray 2009). This research will have a number of important effects. It makes it possible to change the way observations about emotional labor are made and shows how nurses use their emotions in a therapeutic and professional way when caring for patients. Also, it was found that how happy patients were with the Results variables was strongly linked to how happy nurses were with their jobs, both in terms of the parts of their jobs that were missing and how happy they were with their jobs overall. Studies done not too long ago by De Simone et al. (2018) and Zaghini et al. back up these results (2020). In particular, both of these studies showed that the nurses' job satisfaction was linked to how happy their patients were. Because nurses are paid more if they provide good care [48], it makes sense that if patients are happier with the results of their concerns, nurses will feel better about their jobs. The number of medication errors had a negative effect on this part of patient satisfaction. On the other hand, the nurses' satisfaction with captainship showed a positive relationship with patients' Outcomes factors, which describe the goals of treatment and satisfaction with conclusion and care. It seems likely that patient outcomes will improve if, for example, nurses learn more about how their nurse controller's lead.

Several studies have shown that the way nurse managers run their departments is linked to how happy nurses are with their jobs. Research from the past has also shown a link between how happy nurses are with their jobs and how well their patients do. It's important for nurses to have an organizational base so they can keep learning, join a professional system, and follow a code of ethics. All of these things help to move professionalism forward (Ageiz et al., 2021) This study also laid the groundwork for more research to find out how common emotional labor is among nursing experts and the things that go along with it. This makes it even more likely that a program that helped nurses learn how to deal with their feelings while doing their jobs will end. Along with professionalism, the idea of systems has emerged as a key predictor of patient safety competence in our research. Complaints from the past back this up (Mahsoon & Dolansky, 2021; Rizany et al., 2018). Helping nurses learn how to use systems thinking in their work would improve both patient safety and the quality of care (Dolansky & Moore, 2013). This part is where we'll talk about what we've learned from the current research. To start, I will look at how this study showed a link between professionalism, reasonable structures, and hospital nurses' ability to keep patients safe. I

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Research from the past has also shown a link between how happy nurses are with their jobs and how well their patients do [65, 61]. It's important for nurses to have an organizational base so they can keep learning, join a professional system, and follow a code of ethics. All of these things help to move professionalism forward (Ageiz et al., 2021) This study also laid the groundwork for more research to find out how common emotional labor is among nursing experts and the things that go along with it. This makes it even more likely that a program that helped nurses learn how to deal with their feelings while doing their jobs will end. Along with professionalism, the idea of systems has emerged as a key predictor of patient safety competence in our research. Complaints from the past back this up (Mahsoon & Dolansky, 2021; Rizany et al., 2018). Helping nurses learn how to use systems thinking in their work would improve both patient safety and the quality of care (Dolansky & Moore, 2013).

THEORETICAL CONTRIBUTION

The present study has different Contributions to theory. The current allegations provide a theoretical basis for developing patient safety competency interference for nurses, which could improve patient safety and the quality of care in hospitals. So, these interventions should focus on building professionalism, systems thinking, coaching, and

experience in patient safety. This will directly or indirectly improve the ability of hospital nurses to keep patients safe. The current findings provide a theoretical basis for developing patient safety competency standards for nurses, which could improve patient safety and the quality of care in hospitals.

- The visible actions of the medical staff's emotional labour have a doubtful effect on the organization's recognition, which has a positive effect on illegal pro-organizational.

- The emotional labour of the medical staff's face acting has a negative effect on UPB, and the organisational identity helps decide the outcome of dynamic face acting behaviours and unethical pro-organizational

- The deep emotional labour of the medical staff has an easy effect on the identity of the organisation, which has an easy effect on unethical pro-organizational behaviour.

- The emotional labour of the medical staff's work on the ocean has an easy effect on UPB,

PRACTICAL CONTRIBUTION

In addition to its theoretical value, the study has some real-world implications for health care. Hospitals should give their medical staff positive education, direction, and coaching to help them deal with deep behaviors of emotional labor. They should help people feel good about what they've done and teach their medical staff how to think like professionals and how to read a patient's mood. They should also teach their medical staff how to use scientific techniques and design to control their emotions. This would prevent the loss of human capital caused by the passive satisfaction of surface emotions and reduce the UPB in the medical service.

LIMITATION

Limitations should be clear when figuring out what the results of this study mean. Self-reporting was used to get the information. So, a future study should think about getting information from more than one place. A sampling method that was easy to use was used. In future studies, other factors, like patient safety, good behavior, and how well the treatment works, should also be taken into account. Data from a doctor or other paramedics should be trusted. So, future studies should look at probability illustrations to make the conclusion about patient safety stronger.

CONCLUSION

Our study showed important things about patient safety and health care skills. Professionalism and systems judgement had a direct or indirect effect on nurses' ability to keep patients safe. These causes are very important for making sure that patients are safe. The emotional labour extent for nurses that was made in this study is a valid and reliable way to match the emotional labor that nurses go through when taking care of patients with numerical values. To get the skills and knowledge they need to do their jobs safely, nursing students need to learn in ways that are both interesting and hands-on.

DECLARATIONS

Availability of data and material: In the approach, the data sources for the variables are stated.

Authors' contributions: Each author participated equally to the creation of this work.

Conflicts of Interests: The authors declare no conflict of interest.

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REFERENCES

Adhikari, N. K. (2013). Patient safety without borders: measuring the global burden of adverse events. *BMJ quality & safety*, 22(10), 798-801.

Ageiz, M. H., Elshrief, H. A., & Bakeer, H. M. (2021). Developing a professionalism manual for nurse managers to improve their perception regarding professionalism and professional identity. *SAGE Open Nursing*, 7, 23779608211026174.

Laurance, W. F., Carolina Useche, D., Rendeiro, J., Kalka, M., Bradshaw, C. J., Sloan, S. P. ... & Scott McGraw, W. (2012). Averting biodiversity collapse in tropical forest protected areas. *Nature*, 489(7415), 290-294.

Leape, L. L., & Fromson, J. A. (2006). Problem doctors: is there a system-level solution?. *Annals of Internal Medicine*, 144(2), 107-115.

Leape, L. L., Brennan, T. A., Laird, N., Lawthers, A. G., Localio, A. R., Barnes, B. A., ... & Hiatt, H. (1991). The nature of adverse events in hospitalized patients: results of the Harvard Medical Practice Study II. *New England journal of medicine*, 324(6), 377-384.

Leape, L. L., Lawthers, A. G., Brennan, T. A., & Johnson, W. G. (1993). Preventing medical injury. *QRB. Quality review bulletin*, 19(5), 144-149.

Leka, S., Jain, A., & World Health Organization. (2010). Health impact of psychosocial hazards at work: an overview.

Lives, S. S. S. (2009). WHO guidelines for safe surgery 2009. *Geneva: World Health Organization*.

Livingstone, D. N. (2005). Science, text and space: thoughts on the geography of reading. *Transactions of the institute of British geographers*, 30(4), 391-401 Castledine, G. (1998). Nursing professionalism: is it decreasing?. *British Journal of Nursing*, 7(6), 352-352.

Mahsoon, A. N., & Dolansky, M. (2021). Safety culture and systems thinking for predicting safety competence and safety performance among registered nurses in Saudi Arabia: a cross-sectional study. *Journal of Research in Nursing*, 26(1-2), 19-32.

Mcclelland, G., & Smith, M. B. (2016). Just a routine operation: a critical discussion. *Journal of Perioperative Practice*, 26(5), 114-117.

Mello, M. M., Kachalia, A., Roche, S., Niel, M. V., Buchsbaum, L., Dodson, S., ... & Sands, K. E. (2017). Outcomes in two Massachusetts hospital systems give reason for optimism about communication-and-resolution programs. *Health Affairs*, 36(10), 1795-1803.

Naresh, V., & Lee, N. (2021). A review on biosensors and recent development of nanostructured materials-enabled biosensors. *Sensors*, 21(4), 1109.

Nasca, T. J., Philibert, I., Brigham, T., & Flynn, T. C. (2012). The next GME accreditation system—rationale and benefits. *New England Journal of Medicine*, 366(11), 1051-1056.

National Academies of Sciences, Engineering, and Medicine. (2018). Crossing the global quality chasm: improving health care worldwide.

Omura, M., Levett-Jones, T., & Stone, T. E. (2019). Evaluating the impact of an assertiveness communication training programme for Japanese nursing students: A quasi-experimental study. *Nursing open*, 6(2), 463-472.

Peris-Lopez, P., Orfila, A., Mitrokotsa, A., & Van der Lubbe, J. C. (2011). A comprehensive RFID solution to enhance inpatient medication safety. *International journal of medical informatics*, *80*(1), 13-24.

Schnipper, J. L., Nieva, H. R., Mallouk, M., Mixon, A., Rennke, S., Chu, E., ... & Leaders, M. S. (2022). Effects of a refined evidence-based toolkit and mentored implementation on medication reconciliation at 18 hospitals: results of the MARQUIS2 study. *BMJ Quality & Safety*, *31*(4), 278-286.

Shojania, K. G., & Thomas, E. J. (2013). Trends in adverse events over time: why are we not improving?. *BMJ quality & safety*, *22*(4), 273-277.

Shojania, K. G., Burton, E. C., McDonald, K. M., & Goldman, L. (2003). Changes in rates of autopsy-detected diagnostic errors over time: a systematic review. *Jama*, *289*(21), 2849-2856.

Sikka, R., Morath, J. M., & Leape, L. (2015). The quadruple aim: care, health, cost and meaning in work. *BMJ quality & safety*, *24*(10), 608-610.

Slawomirski, L., Auraaen, A., & Klazinga, N. S. (2017). The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level.

Urbach, D. R., Dimick, J. B., Haynes, A. B., & Gawande, A. A. (2019). Is WHO's surgical safety checklist being hyped?. *BMJ*, *366*.

Van Essen, D. C., Smith, S. M., Barch, D. M., Behrens, T. E., Yacoub, E., Ugurbil, K., & Wu- Minn HCP Consortium. (2013). The WU-Minn human connectome project: an overview. *Neuroimage*, *80*, 62-79.

Vickers, N. J. (2017). Animal communication: when i'm calling you, will you answer too?. *Current biology*, *27*(14), R713-R715.

Virdi, G., & Murray, O. (2015). Patient safety in spinal surgery: from scene of injury to discharge. *Orthopaedics and Trauma*, *29*(6), 393-398.

Weled, B. J., Adzhigirey, L. A., Hodgman, T. M., Brilli, R. J., Spevetz, A., Kline, A. M., ... & Wheeler, D. S. (2015). Critical care delivery: the importance of process of care and ICU structure to improved outcomes: an update from the American College of Critical Care Medicine Task Force on Models of Critical Care. *Critical care medicine*, *43*(7), 1520-1525.

West, C. P., Dyrbye, L. N., Rabatin, J. T., Call, T. G., Davidson, J. H., Multari, A., ... & Shanafelt, T. D. (2014). Intervention to promote physician well-being, job satisfaction, and professionalism: a randomized clinical trial. *JAMA internal medicine*, *174*(4), 527-533.

West, C. P., Dyrbye, L. N., Sloan, J. A., & Shanafelt, T. D. (2009). Single item measures of emotional exhaustion and depersonalization are useful for assessing burnout in medical professionals. *Journal of general internal medicine*, *24*(12), 1318-1321.

Wilson, P. M., Brooks, F., Procter, S., & Kendall, S. (2012). The nursing contribution to chronic disease management: a case of public expectation? Qualitative findings from a multiple case study design in England and Wales. *International journal of nursing studies*, *49*(1), 2-14.

World Health Organization. (2019). Patient safety: global action on patient safety. *Seventy- second World Health Assembly A*, *72*.

Zaghini, F., Fiorini, J., Piredda, M., Fida, R., & Sili, A. (2020). The relationship between nurse managers' leadership style and patients' perception of the quality of the care provided by nurses: Cross sectional survey. *International journal of nursing studies*, *101*,