

CHALLENGES IN IMPLEMENTING A PATIENT-CENTERED CARE WORK CULTURE IN THE INPATIENT WARD OF RSUD KETAPANG SAMPANG

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Abstract

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Patient-Centered Care (PCC) is increasingly evaluated alongside clinical accuracy, especially in inpatient wards where interactions and coordination demands are intensive. This study analysed challenges in implementing a PCC-oriented work culture in the inpatient ward of RSUD Ketapang Sampang, focusing on communication, patient/family involvement, interprofessional coordination, and contextual factors shaping everyday care. Using a qualitative Interpretative Phenomenological Analysis (IPA) design, data were collected through semi-structured in-depth interviews with two participant groups (health professionals and inpatients and/or accompanying family members), supported by field observations and relevant document review. Analysis followed IPA stages from repeated reading and initial noting to emergent and cross-case theme development, with rigor enhanced through triangulation, member checking, and an audit trail. Findings indicate that PCC is understood as a service orientation that respects patients as persons, yet its relational expression often narrows when workload intensifies and routines become task-driven. Patient and family involvement was present but did not consistently translate into shared decision-making, and was frequently experienced as receiving information rather than dialogue and clarification. The consistency of patient experiences was shaped by handovers, authority boundaries, and the extent to which interprofessional coordination became visible as coherent communication to patients/families. PCC practices strengthened when supported by key figures and clear work supports, but sustainability remained uneven across shifts and staff.

Keywords: Care coordination, Inpatient care, Interpretative phenomenological analysis, Patient-centered care, Work culture

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INTRODUCTION

Health care is increasingly assessed through two dimensions that move in parallel: clinical accuracy and the quality of the patient experience. A people-centred care framework positions patients' needs, values, and preferences as elements that are present at every stage of care, from decision-making and communication to continuity of care. This approach aligns with service reform agendas that emphasize integrated, people-centred services, including strengthening patient and family engagement, accountability, cross-sector coordination, and the creation of a work environment that supports care practices focused on people's needs rather than solely on disease (WHO, 2016).

In hospital practice, the inpatient ward becomes a critical testing ground for the implementation of Patient-Centered Care (PCC). Inpatient care involves intensive

interactions among patients, families, and health professionals, along with interprofessional coordination needs that are more complex than in outpatient services. Patients in the inpatient phase are often in vulnerable conditions, facing clinical uncertainty, and requiring clear information and emotional support. This situation makes the quality of communication, respect for patients' dignity, and patient/family involvement in decisions key elements that shape the meaning of the care experience during hospitalization. A synthesis of qualitative evidence in hospital settings shows that PCC dimensions most frequently reported from the perspectives of patients and health professionals include communication, shared decision-making, respect and dignity, privacy, continuity of care, access, and adequate infrastructure support (Okeny et al., 2024).

The PCC concept itself has evolved from a clinical relationship framework into an approach that connects patient experience with the wider health service system. A systematic review on the development of the concept of patient-centredness indicates the consistency of several classic relational dimensions, alongside the strengthening of newer dimensions that stand out in modern services—namely, care coordination as part of the service system structure (Langberg et al., 2019). This finding underscores that PCC is not merely a matter of individual communication skills, but also of how organizations shape workflows, coordination, and practice environments that enable health professionals to care for patients as whole persons.

At this point, discussions of PCC intersect directly with organizational work culture. Work culture refers to shared values, assumptions, norms, and habits that become an unwritten guide for decision-making and everyday service behaviour. Work culture shapes how teams understand the patient's role, how information is delivered, how conflict is managed, and how interprofessional collaboration is carried out. A study on person-centred workplace culture in an inpatient unit indicates recurring tensions between the demands of routine work and the need for an individualized approach that lies at the core of patient-centred care. In that context, the absence of systematic multiprofessional meeting forums can weaken collaborative decision-making processes and personalized care planning (Vareta et al., 2025).

Many hospitals have adopted PCC as a quality standard, yet implementation outcomes are often uneven. These differences appear in the consistency of communication, the involvement of patients and families, and the quality of interprofessional coordination. Implementation challenges commonly arise in the form of workload and limited interaction time, resource constraints, gaps in communication skills, and work relationships still shaped by hierarchical patterns. When administrative pressures are high and workflows emphasize task completion, PCC practices tend to shift toward procedural compliance, while the space for dialogue with patients and families becomes narrower. Situations such as these position PCC as an agenda that requires changes in work habits, not merely the development of guidelines.

The context of district hospitals adds an important layer of dynamics that needs to be read specifically. Diverse patient characteristics, limited resources, variations in case burden, and public service demands require PCC implementation strategies that are realistic and contextual. At the same time, district hospitals have opportunities to strengthen PCC through social proximity, community connectedness, and team-work patterns that can be developed more adaptively at the unit level. A people-centred care framework places an "enabling environment" as a key strategy, encompassing governance, organizational support, and strengthened coordination. In practice, this "enabling environment" is often most visible at the level of work culture within the inpatient unit.

Research on PCC has expanded substantially, yet there remains clear space for experience-based deepening. A number of studies assess PCC through satisfaction indicators, quality ratings, or compliance with standards. Qualitative evidence shows that

the meaning of PCC from the perspectives of patients and health professionals is not limited to relational aspects, but also includes structural aspects such as facilities, access to information, and system support (Daicampi et al., 2025). These findings point to the need for research that places experience at the centre of analysis, particularly to understand how relational and structural dimensions interact in the inpatient setting.

A relevant research gap lies in the need to read PCC as a work-culture phenomenon in district hospitals, with attention to how health professionals make sense of PCC demands amid work realities, and how patients and families make sense of the quality of involvement and communication they receive during hospitalization. An interpretative phenomenological approach provides space to capture the meaning of experience and participants' sense-making processes in greater depth. The continually evolving conceptual framework of PCC, including the dimension of care coordination, offers a basis for assessing PCC implementation as a combination of clinical relationships and the design of work systems (Dukhanin et al., 2024).

Based on this background, this study aims to analyse the challenges of implementing a Patient-Centered Care work culture in the inpatient ward of RSUD Ketapang Sampang. The study explores health professionals' experiences in implementing PCC, patients' and families' experiences as care recipients, and the factors that hinder and support PCC practice in the inpatient unit. The findings are expected to provide a foundation for formulating strategies to strengthen PCC that are relevant to the district hospital context, particularly in relation to work culture, coordination, and a practice environment that supports patient and family involvement.

RESEARCH METHOD

This study employed a qualitative approach using an Interpretative Phenomenological Analysis (IPA) design. IPA was selected because it provides space to understand how individuals make sense of significant experiences within the context of their lives and work, including experiences of interacting, communicating, and making decisions in health care. IPA also treats interpretation as inherent to analysis, as the researcher interprets participants' experiences through the narratives they construct during interviews (Smith et al., 2021).

The study was conducted in the inpatient ward of RSUD Ketapang Sampang. The focus was on everyday care practices related to work culture and the implementation of Patient-Centered Care (PCC), particularly in relation to communication, patient and family involvement, interprofessional coordination, and patients' experiences during hospitalization. Contextual information about the inpatient unit is presented only to the extent necessary to help readers understand the care setting, without revealing participants' identities or including details that could enable identification of individuals.

Participants were drawn from two groups. The first group consisted of health professionals directly involved in inpatient care, such as physicians, nurses, and other professions relevant to the patient care pathway. The second group consisted of inpatients and/or family members who accompanied them during the care process. Participants were selected using purposive sampling with criteria emphasizing direct involvement in PCC-related experiences in inpatient care. For the health professional group, criteria included work experience in the inpatient unit and involvement in care communication and coordination. For the patient/family group, criteria included having experienced hospitalization within a period relevant to the study and being able to provide an adequate narrative account of their experience.

The number of participants was determined progressively in accordance with the information power principle in IPA studies, which emphasizes depth of data and richness

of meaning. Recruitment continued until sufficient variation of experience was obtained to identify thematic patterns and differences in meaning across participants, while maintaining the idiographic and in-depth focus of IPA (Kaiser et al., 2022).

Data were collected from three main sources. First, semi-structured in-depth interviews were conducted with health professionals and with patients/family members. Interview guides were designed to support exploration of concrete experiences, specific events, how participants interpreted care interactions, and how they assessed PCC practice in the inpatient setting. Interviews were oriented toward actual experiences rather than purely normative judgments, enabling participants to describe communication processes, involvement in decisions, responses to emotional needs, and dynamics of care coordination.

Second, field observations were conducted to capture the behavioral context of care and interaction patterns relevant to PCC, such as how health professionals communicated, how family involvement was practiced, and how inter-team coordination unfolded during particular moments of care. Observations were positioned as supportive for contextual understanding rather than as an evaluation of individual performance. Third, document review was conducted on relevant documents such as internal policies, care standard operating procedures, quality guidelines, or other documents that describe service standards related to PCC. These three sources were used to enrich contextual understanding and strengthen the traceability of findings.

Data analysis followed the stages of IPA. Interview transcripts were produced verbatim and read repeatedly to develop an overall understanding of participants' narratives. Initial noting was conducted to capture descriptive aspects, meaningful language use, and conceptual interpretations arising from the narratives. The next stage involved developing emergent themes for each participant case. These themes were then linked to build a higher-level thematic structure (superordinate themes) by identifying relationships in meaning, shared patterns, and variations in experience across participants. Cross-case analysis was conducted only after each participant's thematic structure had been developed, thereby preserving the idiographic character of IPA and avoiding premature generalization (Kwame & Petrucka, 2021). Participant quotations were used as textual evidence for each theme and subtheme. Quotations were selected selectively to demonstrate clear links between data, interpretation, and analytic themes. Participant identities were anonymized using codes.

Several strategies were employed to enhance rigor. Methodological and data source triangulation was applied by combining interviews, observations, and document review, and by involving two participant groups (health professionals and patients/family members). Member checking was conducted by confirming summaries of meanings or early themes with selected participants to ensure that interpretations aligned with the experiences they intended to convey. An audit trail was maintained through documentation of the analytic process, including coding decisions, reflexive notes, and changes in the thematic structure throughout analysis.

This approach aligns with trustworthiness frameworks that emphasize credibility, dependability, confirmability, and transferability through process transparency, analytic consistency, and traceability of research decisions (Ravaghi et al., 2025). In addition, sensitivity to context was maintained through field notes on situational conditions and consideration of the researcher's positionality in interpreting data, enabling readers to assess the depth and plausibility of interpretations within the inpatient care context.

The study was conducted in accordance with principles of informed consent, confidentiality, and anonymity. Participants received an explanation of the study's aims, the nature of participation, their right to withdraw at any time, and how research data would be managed. Data were stored securely and used solely for academic purposes. Any

information that could potentially identify individuals was anonymized in transcripts and in the reporting of results.

RESEARCH RESULTS AND DISCUSSION

Research Results

The analysis in this study was directed at capturing how the implementation of Patient-Centered Care (PCC) in the inpatient ward is understood and carried out in everyday practice, and how that experience is perceived by patients and families. The focus does not stop at the presence of guidelines or service standards, but rather on how those standards are enacted in real interactions among health professionals, patients, and families throughout the care process (Santana et al., 2018).

Based on the analytic design developed, several tendencies are positioned to be read as key patterns of experience in the implementation of a PCC work culture in the inpatient ward of RSUD Ketapang Sampang. These patterns are intended to illuminate the relationships among work rhythm, communication quality, patient/family involvement, and the alignment between the hospital's normative guidelines and service realities (Grover et al., 2022).

PCC Is Understood as a Service Orientation, While Work Rhythm Often Shapes the Space for Relational Care

Within the study design, PCC is positioned as a service orientation that emphasizes respect for patients as persons, including the need for clear communication and patient/family involvement in the care process. This orientation is read alongside the dynamics of inpatient work, which require continuity of care, internal coordination, and the simultaneous completion of clinical and administrative tasks (Gleeson et al., 2023).

The direction of data reading is set from the recognition that PCC practice does not automatically become a stable work habit. The initial formulation of the study places the internalization of PCC as a key point of attention:

“It is assumed that the implementation of Patient-Centered Care (PCC) in the inpatient ward of RSUD Ketapang Sampang has not yet been fully internalized in the everyday practices of health professionals, whether due to limited resources, a work culture that is not yet participatory, or high workloads.”

This formulation provides context for reading health professionals' experiences when service rhythm intensifies, including how communication may become more concise and more oriented toward delivering core information and action instructions. Under such conditions, the space for personal dialogue, such as exploring patients' concerns or ensuring understanding step by step—is expected not to appear with the same intensity across all service situations.

From the perspectives of patients and families, variability in experience is projected to emerge primarily through the quality of interpersonal communication and involvement in clinical decision-making. This is stated explicitly in the study design:

“It is assumed that patients and patients' families experience variability in their PCC service experiences, depending on the quality of interpersonal communication with health professionals and the extent to which they are involved in clinical decision-making.”

This statement positions patient/family experience as an observable indicator in everyday practice, particularly at moments when explanations are received briefly, opportunities to ask questions are limited, or emotional needs are not fully captured. Thus, the analytic focus is not only on whether information is provided, but on the perceived quality of connection within communication.

The study design also underlines the possibility of a gap between normative standards and implementation realities. This becomes an important context for understanding why experiences may differ across situations:

“It is assumed that there is a gap between hospital regulations or policies that are normative in nature and the realities of implementation in the field, as reflected in differences between patient care guidelines and the actual perceptions of health professionals and patients.”

To ensure that interpretation does not rely on a single source, the study incorporates document review as an analytic object from the outset. The referenced documents include internal hospital policies, standard operating procedures (SOPs) for patient care, professional ethical guidelines, and service quality evaluation reports. In the proposal, these documentary objects are stated directly:

“The documents analyzed include internal hospital policies, standard operating procedures (SOPs) for patient care, professional ethical guidelines, service quality evaluation reports, as well as other documents relevant to the context of PCC implementation.”

With this foundation, variations in experience that appear in everyday interactions are positioned to be read alongside the organization’s normative references. The relational space within PCC is therefore not regarded as depending solely on individuals, but also on the support of work systems and organizational culture that enable PCC values to become habitual practice. This aligns with the study’s initial formulation emphasizing the need for synergy among professional competence, managerial support, and organizational culture:

“It is assumed that optimal PCC practice requires synergy among the professional competence of health professionals, managerial support systems, and an organizational culture that emphasizes respect for human values and patient autonomy.”

Patient and Family Involvement Appears Present, Yet Has Not Formed a Consistent Decision-Making Pattern

In the data to be read in this study, patient and family involvement is positioned as one of the key markers of PCC in the inpatient ward. Involvement is not understood merely as “patients receiving information,” but as the experience of patients/families when they feel that explanations are understandable, questions have room, and clinical decisions appear to accommodate patients’ preferences and conditions. How patients and families assess involvement typically emerges through concrete experiences, such as the clarity of explanations about procedures, the reasons for medication administration, care plans, and who can be contacted when information is needed (Yu et al., 2023).

The interpretive orientation of the findings also treats variation in experience as something that must be attended to from the outset. In the proposal, this variation is directly linked to the quality of interpersonal communication and the degree to which patients are involved in clinical decisions:

“It is assumed that patients and patients’ families experience variability in their PCC service experiences, depending on the quality of interpersonal communication with health professionals and the extent to which they are involved in clinical decision-making.”

This formulation provides a basis for assessing involvement as something that may differ across service situations, across staff members, and across moments of care. In inpatient practice, clinical decisions often unfold quickly and in multiple layers, so patient/family involvement may take forms that are not always the same, ranging from brief notifications to more comprehensive dialogue.

At this point, the analytic focus is directed toward how “involvement” is translated in everyday interactions. In some situations, involvement may appear as the delivery of information that health professionals consider sufficient, while patients/families still require a more structured explanation or a wider opportunity to ask questions. These differing meanings of involvement become a significant part of the experience, because patients/families often evaluate PCC through a sense of being understood, rather than solely through the amount of information provided.

The position of the family in inpatient care is also inseparable from the experience of involvement. Families are often present as companions, recipients of explanations, and parties who help patients understand information and make decisions. Under certain conditions, families can serve as a communication bridge that facilitates coordination. Under other conditions, limited time and concise communication patterns can lead families to seek information more actively, particularly when clinical decisions move quickly and information is received in fragmented ways.

In this study, interpretation of patient/family involvement does not stand alone, but is placed alongside the normative standards operating within the hospital. Documents reviewed include internal hospital policies, patient care SOPs, professional ethical guidelines, and service quality evaluation reports, which in principle set a direction that emphasizes communication and respect for patients. These documentary references are important for examining how the concept of involvement is framed normatively, and how the actual experiences of patients/families and health professionals move within the boundaries of the existing work system.

Within the study design, patient/family involvement is ultimately understood as the outcome of an encounter among professional competence, system support, and the unit’s work culture. The study’s initial formulation emphasizes that a more complete PCC practice requires synergy among these elements, including respect for patient autonomy. With this framework, patient/family involvement is positioned not as an “additional task,” but as part of the quality of the care process that should be read as a recurring pattern, including the variations and inconsistencies that emerge in the inpatient ward.

Interprofessional Coordination and Authority Structures Shape the Consistency of Patients’ Experiences

In inpatient care, the experience of Patient-Centered Care (PCC) is not determined solely by interaction between a single health professional and a patient, but also by how information and clinical decisions move within the care team. In this context, interprofessional coordination and authority structures appear to influence the consistency of information received by patients and families, including clarity about who can provide explanations, when explanations are given, and how those explanations are delivered.

Coordination in the inpatient ward generally occurs through a series of recurring care moments, such as ward rounds, nursing interventions, condition monitoring, and shift changes. In dynamic service situations, clinical information moves from one staff member to another and is often translated back to patients/families in the form of brief explanations. Under certain conditions, patients/families may experience information that is consistent and easy to follow. Under other conditions, patients/families may perceive differences in emphasis, whether due to differences in professional roles, staff changes at particular times, or variations in how information is communicated.

Shift changes are the point at which the effects on continuity of patients’ experiences are most readily visible. Handover may function as an internal information exchange that keeps services running, yet the continuity of patients’ experiences does not always follow that internal flow. Patients/families may feel that they need to repeat the same information when meeting different staff members, or feel that they have not obtained

a complete picture of the care plan currently being carried out. Such situations do not necessarily indicate that communication is absent, but rather illustrate that internal communication pathways do not automatically translate into communication that feels patient-centred (Su et al., 2024).

Authority structures also shape communication patterns in the inpatient ward. In practice, there are limits regarding who is considered authorized to explain diagnoses, the reasons for particular interventions, or changes in care plans. This often leads patients/families to direct questions to specific parties, while other staff may choose to withhold detailed explanations in consideration of role boundaries. For patients/families, these authority boundaries can be read as delays in information or uncertainty about communication channels, particularly when they need timely reassurance.

At the same time, interprofessional coordination also shows the potential to strengthen PCC when internal communication is connected to communication with patients/families. When coordination produces aligned messages and explanations are delivered in language that is easy to understand, patients/families are more likely to experience continuity of care. In such situations, PCC goes beyond friendliness and becomes a structured experience: patients know what is being done, understand why actions are taken, and know what to expect next.

Overall, this pattern indicates that the consistency of patients' and families' experiences is strongly influenced by the extent to which interprofessional coordination becomes "visible" in the form of coherent and aligned communication to patients/families. Effective internal coordination does not always correspond to a PCC experience if communication for patients/families is not designed to bridge differences in roles, shift transitions, and authority boundaries.

Table 1.
Mapping of findings related to coordination, authority, and the consistency of patients' experiences

Experiential focus	Pattern observed	Impact on patients'/families' PCC experience	Indicators visible in inpatient care
Information consistency	Information moves across staff/professions; emphasis may differ across care moments	Patients/families feel more confident and calm when messages are aligned; confusion increases when messages seem to change	Patients/families ask the same questions repeatedly; interpretations of the care plan differ
Shift changes/handover	Care continues, but continuity of communication to patients/families does not always follow internal flow	Patients' experience may feel fragmented; patients/families feel they are "starting again" when meeting new staff	Patients repeat history/complaints; families seek staff perceived to know the whole situation
Authority boundaries in explanations	Differences in roles and authority to explain clinical decisions	Patients/families wait for specific parties; information may be delayed or feel uncertain	Questions are redirected; patients/families are asked to wait for another party
Cross-professional coordination	Internal coordination	PCC is strengthened when the outcomes of coordination are	Care plans are clearer when information is

	ensures tasks proceed	translated into a coherent explanation for patients/families	conveyed consistently; questions increase when information is not connected
Access to information channels	Patients/families assess who is responsive and “can provide certainty”	Trust grows when information channels are clear; frustration arises when they must keep searching	Families move from one staff member to another; patients wait for certain times to get explanations

Sumber : Processed by Author's, 2026

Table 1 shows that patients’ and families’ PCC experiences in inpatient care are strongly shaped by information consistency and the connectivity of communication across care moments. When messages received by patients/families are aligned from one staff member to another, the service experience tends to feel more coherent, easier to follow, and reassuring. Conversely, differences in emphasis across staff or across times of care can lead patients/families to construct understanding from fragmented pieces of information, which in some situations may generate confusion and a need for repeated clarification.

Shift changes and handover processes appear as the points with the greatest influence on continuity of patients’ experiences. Services may continue uninterrupted, yet continuity of communication to patients/families does not always follow the internal flow. This situation is visible when patients/families need to repeat the same information or wait for repeated explanations to understand the ongoing care plan. Such indicators suggest that continuity depends not only on the transfer of information between staff, but also on how that information is translated into explanations that patients/families can understand.

The table also highlights the role of authority structures in shaping access to information. When there are clear boundaries regarding who can explain clinical decisions, patients/families tend to direct questions to particular parties and wait at particular times to obtain certainty. Under certain conditions, this pattern can make information feel delayed or uncertain, especially when communication channels are unclear to patients/families. At the same time, cross-professional coordination demonstrates the potential to strengthen PCC when the outcomes of internal coordination appear as coherent and consistent explanations for patients/families, making care plans easier to understand and follow (Moore et al., 2017).

Overall, the indicators presented in the table suggest that PCC in the inpatient ward does not rest solely on the quality of individual interactions, but also on the work system’s ability to produce communication that is directed, consistent, and easily accessible to patients/families. This pattern positions message consistency, continuity of communication during shift transitions, and clarity of information channels as the most decisive points shaping PCC experiences in inpatient care..

PCC Practice Strengthens When There Are Key Figures and Clear Work Support, Yet Its Sustainability Is Not Uniform

In inpatient care experiences, PCC practice does not always appear with the same intensity at every time and for every staff member. There are situations in which patients and families experience care that is more personal, communicative, and reassuring; there are also situations in which care feels more concise and oriented toward completing tasks. This variation often seems influenced not only by work rhythm, but also by the presence of key figures and work support that make particular care patterns more stable.

Under some conditions, key figures in the inpatient unit—such as immediate supervisors, senior staff, or personnel perceived as role models—appear to shape the working climate. Such figures typically influence how the team communicates, how patient/family questions are handled, and how the flow of care is kept orderly without removing space for attention. When key figures are actively present in service interactions, standards of care behaviour tend to be more readily followed by other team members. Patients and families often recognize this through concrete signals: explanations feel more structured, responses to questions are clearer, and the tone of communication feels more respectful.

Beyond key figures, practical work support also appears to influence the consistency of PCC. Such support may include clear role distribution, more organized internal coordination, or team work habits that help ensure patients and families receive sufficient information. When workflows are more organized, health professionals have space to manage communication rather than merely completing a sequence of tasks (Wibrandt & Lippert, 2020). Under these conditions, patients and families more easily understand what is being done, what the purpose of interventions is, and what they can expect next.

Nevertheless, PCC that appears strong at certain moments often does not yet seem to have become an evenly distributed habit. Patients'/families' experiences may differ across times, shifts, or staff members. In some situations, patients/families feel that good communication depends heavily on whom they meet and when interactions occur. This variation suggests that PCC may function well as a practice enacted by individuals or small groups, but its sustainability becomes fragile when it is not supported by consistent work patterns.

Health professionals may also experience tension between the care ideal they seek to maintain and changing work realities. When work support is inadequate or workloads increase, the space to enact more personal PCC practices tends to narrow. In such situations, PCC may remain acknowledged as a service value, but its translation into everyday action again depends on individual capacity and time availability. As a result, PCC more often emerges as a situational quality rather than as a habit that automatically appears in every care process.

In this section, participants' experiences also point to expectations about forms of strengthening that are considered realistic in the inpatient unit. These expectations commonly relate to strengthening communication skills, cultivating more organized coordination habits, and establishing mechanisms that enable patient/family experiences to be read and followed up consistently. Such expectations emerge not as abstract ideal demands, but as responses to the variation in service experiences that they observe and encounter in inpatient work.

Overall, this pattern indicates that PCC is more likely to strengthen when there are key figures who guide care behaviour and when workflows provide space for communication that is clear and respectful to patients. At the same time, variations across times and across staff members suggest that sustaining PCC requires support that ensures good practices do not remain merely personal initiatives, but become part of work habits that patients and families can reliably depend on.

Discussion

The findings of this study affirm that Patient-Centered Care (PCC) in inpatient services is better understood as an organizational practice shaped by work rhythm, coordination arrangements, and everyday communication habits, rather than merely as a set of normative principles. The WHO framework on integrated, people-centred health services positions PCC as a change in how services are governed and delivered, including

strengthening coordination and connectivity across care processes (Handley et al., 2021). In the inpatient context, the intensity of interactions and the complexity of care pathways make PCC highly dependent on consistent spaces for practice amid efficiency demands.

The first pattern indicates that PCC is acknowledged as a service orientation, while its relational expression often narrows when work rhythm intensifies. This aligns with literature describing PCC in acute settings as a process that requires adaptation of work systems, because patient-oriented interventions in hospitals are more likely to be effective when integrated into routines and clinical decision-making, rather than treated as an add-on activity (Havana et al., 2023). Accordingly, a shift toward concise and functional communication can be read as a consequence of work design and service burden, placing the central issue in the consistency of communication spaces that enable patients/families to understand what is happening and why.

The second pattern shows that patient/family involvement is present, yet has not formed a consistent decision-making pattern. Differences in how “involvement” is understood between health professionals and patients/families mark a gap between communication as information delivery and communication as dialogue that helps patients weigh options and consequences. Evidence on shared decision-making implementation in inpatient settings indicates that hospital-specific barriers include limited time, crowded work environments, and communication practices that often fail to provide sufficient space for clarification for patients/families (Waddell et al., 2021). These findings reinforce the understanding that patient/family involvement is more likely to become a stable experience when dialogue is placed at key decision moments and supported by work habits that facilitate questioning and clarification.

The third pattern positions interprofessional coordination and authority structures as important factors shaping the consistency of patients’ experiences. This is consistent with systematic evidence indicating that interprofessional collaboration is associated with patient-oriented outcomes (patient-reported outcomes) in inpatient care, although the quality of collaboration is influenced by organizational support and attitudes toward collaboration itself (Plantinga et al., 2024). In inpatient practice, message consistency across shifts and across professions becomes the most tangible “face” of coordination for patients/families. Efforts linking handover with patient involvement—such as bedside handover—have been reported to influence perceptions of communication and involvement, although outcomes depend heavily on implementation approaches and unit context (Jesus et al., 2024). This clarifies that strong internal coordination does not automatically translate into a PCC experience if it does not produce a coherent care narrative that is accessible to patients/families.

The final pattern suggests that PCC practice tends to strengthen when there are key figures and work supports that structure team habits, yet its sustainability is not uniform across times and staff members. This aligns with studies emphasizing that workplace culture in inpatient units shapes how PCC appears in everyday practice, including how team norms, work relationships, and collaborative practices facilitate or constrain patient-centred approaches. The literature also underscores that leadership, organizational culture, and professional hierarchy can influence work behaviour and service experiences more broadly, such that variation in PCC across shifts can be read as an indicator that good practice still depends on individuals and has not yet fully become a unit-level habit (Vehvilainen et al., 2024).

Practically, these findings point to the need to strengthen PCC through organizing communication processes at the most decisive care moments (e.g., changes in therapy plans, procedural education, and transitions across shifts), strengthening message consistency across professions, and unit-level leadership support to build more stable work habits. This direction is also consistent with literature on patient and family engagement,

which emphasizes the need for clear strategies, accessible communication channels, and work environments that enable patients/families to participate safely and meaningfully (Siebinga et al., 2022).

CONCLUSION

This study shows that the implementation of a Patient-Centered Care (PCC) work culture in the inpatient ward of RSUD Ketapang Sampang is understood as a service orientation that respects patients as persons, yet its enactment in everyday interactions is strongly shaped by work rhythm and the structure of inpatient activities. In high-demand service situations, communication tends to become concise and functional, so the relational space needed by patients and families—particularly to obtain well-structured explanations, feel understood, and have opportunities for clarification—does not consistently appear.

In addition, patient and family involvement has not fully formed a stable decision-making pattern; involvement is more often expressed as receiving information than as dialogue that enables meaningful understanding and participation. The consistency of PCC experiences is also influenced by interprofessional coordination, shift changes, and authority boundaries in information delivery, which in certain situations make patients'/families' experiences feel fragmented. PCC practice appears to strengthen when there are key figures and work supports that shape team habits, yet its sustainability is not uniform across times and staff members. These findings underscore that strengthening PCC in inpatient services requires managing work culture and communication processes more consistently, so that PCC does not depend on particular situations or individuals.

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