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Analysis of the Adherence to the Time of Doctor Visits in the Inpatient Installation

Fitrianti Adnan[1], Yuniar Lestari[1], Rosfita Rasyid[1]

[1]*Study Program in Public Health, Faculty of Medicine, Universitas Andalas, Indonesia*

**Corresponding Author: Fitrianti Adnan*
Email: fitriantiadnan55@gmail.com

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Abstract

One of the national indicators of hospital quality is compliance with doctor's visit time, the achievement of the National Quality Index (INM) at the inpatient installation of Tk. III dr. Reksodiwiryo Padang Hospital in 2023 is 67%. This value is below the quality indicator standards that have been regulated by the Minister of Health Regulation No. 30 of 2022. This study is aimed at analyzing the adherence to doctor's visit time at the inpatient installation of Tk. III Dr. Reksodiwiryo Padang Hospital. The research used the mixed method method, the first stage was quantitative research with stratified random sampling techniques, then qualitative research was carried out with in-depth interviews with 14 informants, field observation and document review. Compliance with the doctor's visit time at the inpatient installation of Tk. III dr. Reksodiwiryo Padang Hospital based on research was obtained at 40%. The causes of non-compliance with doctor's visit time are the lack of the number of organic/permanent specialist doctors and the absence of an alarm to remind the doctor's visit time, the absence of clear regulations related to decrees, SOPs, and doctor's visit policies, the absence of a clear doctor's visit schedule, in addition to the DPJP's lack of understanding of the Regulation of the Minister of Health on visit time and the lack of optimal follow-up from monitoring and evaluating the compliance of doctor's visit time in inpatient installations.

Introduction

Hospitals as institutions in charge of health services are currently undergoing development (Ekasari et al., 2024; Sharma et al., 2024; Hendriyanto et al., 2024). At first, it was socially oriented with adequate management, but along with its development, modern management science, health science and technology and the high need of the community for quality services, currently hospitals have become a very rapidly developing industry but do not neglect its main function as a social function (Kamil, 2012; Kailay & Paposa, 2024). The purpose of the hospital management arrangement is to improve the quality and maintain the standard of health services. Law Number 44 of 2009 concerning Hospitals article 1, paragraph 1 states that "A hospital is a health service agency that provides emergency, inpatient, and outpatient services, as well as providing individual health services in a complete manner". Then in article 3 it is stated that what is meant by the plenary health service is health services which include promotive, preventive, curative, and rehabilitative (Law No. 44 of 2009, on Hospitals, 2009). Hospitals are one of the complex organizations, both in terms of management and services provided. Various fields of discipline and professions are needed to operate a hospital, including doctors, nurses, nutritionists, pharmacists, laboratory analysts, entomologists,

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radiographers, environmental health, accountants, administration, security/security guards, cleaners, parking attendants and others.

In carrying out health services, all human resources in hospitals must synergize with each other in order to create excellent health services to the community (Pangaribuan et al., 2024; Mano et al., 2025; Zhang et al., 2024). One of the most crucial assets in a hospital is human resources. Based on WHO (2011), there are several important issues in health human resources in Indonesia, one of which is the development of health workers currently cannot be met in the needs of health services. Based on the number, quality, and distribution of health workers, it is good, but in terms of meeting the needs of health services throughout Indonesia, it is still not met (Setyawan et al., 2025; Chairunisa et al., 2024; Muharram et al., 2024).

In article 12 of Law Number 44 of 2009, it is stated that "The requirement for human resources for hospitals must have permanent personnel which include medical personnel and medical support, nursing personnel, pharmaceutical personnel, hospital management personnel and non-health personnel". The Law also regulates in such a way as to: 1) Based on the classification of hospitals, the number and type of human resources must be appropriate; 2) Hospitals must have employment data on resources that carry out practices or work in hospital administration; 3) Based on laws and regulations, hospitals can hire non-permanent staff and consultants according to the ability and needs of the hospital.

The law already regulates in such a way that the provisions that must be fulfilled by a hospital. Hospitals in Indonesia should guide these regulations to create hospital services that are in accordance with national standards and meet patients' expectations and satisfaction with health services (Ngatindriatun et al., 2024; Noviyani & Viwattanakulvanid, 2024; Ashidiqi et al., 2025).

Human resources are still a challenge for Indonesia in line with Indonesia's vision in 2025 to make Indonesia a developed country, namely indicators of developed countries can be seen from access to education and health must be easily accessible and equitable for all its people without disparities. In the health sector, the government continues to improve health services to the wider community by establishing various health service programs as well as rules and provisions so that there is an improvement in the quality of health services. One of the rules set to improve health services is the Regulation of the Minister of Health Number 30 of 2022 concerning national indicators of the quality of health services where doctors and dentists practice independently, clinics, community health centers, hospitals, health laboratories and blood transfusion units (Ministry of Health, 2022; Riswati et al., 2024; Setyawati & Pujiyanto, 2025). This Regulation of the Minister of Health is a reference for hospitals in improving their role and function in the community as a comprehensive health service center.

Padang City is the capital of West Sumatra Province. As a center of government, education center, health center, center of economic turnover, the center of health development of Padang City takes an important role in plenary health services in West Sumatra. Padang City has more government hospitals or private hospitals and teaching hospitals when compared to other districts/cities in West Sumatra.

Tk. III dr. Reksodiwiryo Padang Hospital is one of the type C hospitals in Padang City located in East Padang District, which is more familiarly called Army Hospital (RST) by the people of Padang City. This hospital carries out health functions including health services, promotive, curative, preventive, and medical rehabilitation, as well as limited health support continuously in the Korem 032/WBR area in order to support the main tasks of Kesdam I/BB.

Referring to the early history of the establishment of the Tk. III Hospital, dr. Reksodiwiryo Padang was indeed intended for the Indonesian National Army. Along with the development of the times and the demands of the need for health services to the community, this hospital is

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developing continuously so that currently the hospital can serve patients of the general public. Its strategic location makes this hospital high in demand and almost every day the queue for patients is very long. This defines that the community's need for hospital health services at this time is very high.

Based on data from the profile of the Tk.III dr. Reksodiwiryo Padang Hospital in 2021, in its operation, the hospital is currently supported by 596 employees consisting of the Indonesian National Army (TNI), Civil Servants (PNS), Non-Civil Servants (Non-PNS), and Partners (attachment 14). This hospital has a total of 49 specialist doctors, of the 49 specialist doctors only 4 are permanent specialists (TNI and PNS), while the remaining 45 are partner doctors (part timer doctors).

The achievement of the national quality indicators of Tk. III Hospital dr. There are 13 indicators (appendices 15 & 16). In 2022-2024, the indicators that have not been achieved are according to the national standard for the quality of hospital services, namely compliance with doctor's visit time (≥80%) with percentages of 62% (2022), 67% (2023), and 63.6% (2024), respectively. Robbins stated that there are six indicators to measure an individual's performance, namely quality, quantity, effectiveness, punctuality, work commitment and independence at work. One of these indicators is punctuality, the level of activity of completing work within a certain time which has been set as a standard for achieving time in completing work is the definition of punctuality (Robbins, 2006). Compliance with the doctor's visit time is one of the National Indicators of Hospital Health Service Quality as has been strengthened by the Minister of Health Regulation Number 30 of 2022.

Research conducted by Santi Et. Al (2021) in 28 main teaching hospitals, 13 satellite teaching hospitals and 9 affiliated teaching hospitals regarding the achievement of the National Indicators of Health Service Quality in Teaching Hospitals. The total sample is 50 Teaching Hospitals (Anugrahsari et al., 2021). Based on the results of Santi's analysis Et. Al (2021), there are 11 National Health Service Quality Indicators that show significant differences between types of Teaching Hospitals. In achieving 2 (two) indicators, namely compliance with patient identification and compliance with efforts to prevent patients from falling, the Main Education Hospital is better. Satellite Teaching Hospitals are better in achieving 4 (four) indicators, namely outpatient waiting time, adherence to doctor's visiting hours, emergency response time, and patient and family satisfaction. At the Affiliated Teaching Hospital in achieving 5 (five) indicators, namely compliance Clinical pathways, the time of reporting laboratory critical test results, the speed of complaint response time, compliance with the National Formulary (Fornas), and compliance with hand washing. From the results of Santi's research et.al It can be seen that in Satellite Education Hospitals there is a relationship between patient satisfaction and compliance with doctor's visit time which is directly proportional, in the sense that compliance with timely doctor's visit time in health services can provide satisfaction to patients. Compliance with doctor visits at Mardi Waluyo Hospital, Metro City, Lampung Province in 2019 reached 80.96%, Cut Meuthia Hospital, Langsa City, Aceh Province in the first semester of 2022 reached an average of 98.77%, Sidiarjo Regional General Hospital, East Java Province in the first semester of 2023 reached 92.49%, and Bali Med Hospital Denpasar City, Bali Province in the first semester of 2022 reached 87.99%.

Another study conducted by Reyza, (2017) on the Effect of Service Quality on General Inpatient Satisfaction at the Madani Regional Hospital, Central Sulawesi Province by using the determinant dimension of service quality, namely TERRA; Tangible, Emphaty, Responsiveness, Reliability, and Assurance (Pz, 2017). There are three groups, namely those whose performance must be improved (empathy and responsiveness), those whose performance needs to be maintained (assurance and reliability), and those that do not need to be improved (physical evidence) which is the conclusion of this study is generally a variable of service quality in this hospital. In inpatients, the guarantee variable is the variable that has

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the most influence on patient satisfaction. Patients get guarantees from health services carried out by health workers, both doctors and other officers. Therefore, doctors are highly recommended to participate in training activities or seminars related to patient handling and excellent service.

Research conducted by Ulfa Et. Al, (2020) entitled Analysis of Factors Related to Health Service Quality on Inpatient Satisfaction at Hospitals. Dr. Wahidin Sudirohusodo Makassar 2020 who found that the variables of the timeliness of doctor visits and patient satisfaction are interrelated (Mutmainnah et al., 2021). In his research, it was stated that health services must be carried out in the right time and manner by service providers, the availability of the right equipment and drugs, and cost-efficiently. One of the ways that health workers provide to patients is time compliance, this is so that patients better understand and understand the time compliance applied in the hospital (Ghadi et al., 2025). A condition in which everything must be done according to its time is the meaning of time obedience. Compliance with service time can also be interpreted as the length of service provided to patients by the hospital. After conducting a statistical test, the results were obtained that there was a significant relationship between the time compliance variable and patient satisfaction. Ulfa research results Et. Al This is in accordance with the theory that time compliance is a condition in which everything must be done according to its time.

The results of the pre-research conducted by the author at the Tk. III Hospital dr. Reksodiwiryo from the end of December 2023 to the beginning of January 2024 in 6 rooms, taken in each room of 3-4 patients who are hospitalized. The results from 20 patients were 30% of the doctor's time compliance rate.

Based on preliminary data, interrelated theories, supporting previous research results, and pre-research that the author has conducted on 6 (six) inpatient wards, the author is very interested in further research on "Analysis of Compliance Time of Doctor Visits in the Inpatient Installation of Tk.III dr. Reksodiwiryo Padang Hospital". This research will use the concept of a system theory approach, namely output, process and input.

Methods

Based on a mixed-methods design, the current study aimed at explaining the given phenomenon of physician visitation compliance in a more detailed and empirically-based structure. The study began by a quantitative stage that created a background mapping of the levels of visitation compliance at the inpatient unit of Tk. III Reksodiwiryo Padang hospital. This pre-test allowed the researcher to determine the extent of the problem and the difference between wards and the physicians that served there. Further qualitative investigation was thus informed by these quantitative results, in a bid to identify contextual and organizational forces behind the realized numerical trends.

The quantitative part was based on secondary data that was taken out of institutional records. This type of records included daily visitation activities conducted by technician physicians through routine records. The stratified random sample was used in order to make sure that the sample was a reflexion of the hospitalized patients distribution in 2023. Considering that the hospital received over a thousand inpatients monthly, this stratified method enabled equal representation of each ward and enabled the representation of patient heterogeneity and physician duties at the hospital. Statistical analysis was conducted using descriptive methods aiming at producing a clear description of the level of compliance as between wards and attending physicians. During this stage, rooms with significantly large compliance and those with extraordinarily low rates were located; they became crucial points of further qualitative research.

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After the quantitative analysis was done, the research proceeded to the qualitative phase. This step boosted the understanding of the determinants of compliance difference and the influence of institutional forces on the ability of physicians to make a timely visit. At first, the discussion with a focus group was also scheduled, but the inpatient unit had to cancel the discussion because of the patient load and a lack of available staff. In turn, the researcher adopted the use of the intensive interviews, personal observation, and thorough examination of the relevant documents. Even though the method changed, the purpose of gathering rich detailed accounts with different points of view was preserved.

One patient in each of the chosen inpatient rooms that is, Bagindo Aziz Chan, Rasuna Said, Imam Bonjol and Agus Salim underwent in-depth interviews. The other interviews were made in the form of visiting physicians, nursing staff, administrative staff, members of the medical committee, and representatives of the hospital management on different organizational levels. These discussions allowed the researcher to track the practices of daily visitations, how the physicians timetabled their visits and how the ward employees responded to the delayed visitations.

The interviews were supplemented with observations. The researcher observed the procedure of activities step wise starting with admission of patients, up until the rounding of the physicians. These observational data were able to capture the small but important things like how the staff moved, how they communicated information and how digital systems supported or hindered the process of visitation. The analysis of the documents also supported the research since it presented written sources confirming about the existing regulations, standard operating procedures, visitation schedules, the human resource capacity, and monitoring and evaluation records.

Triangulation was used to provide the credibility of the qualitative findings. The triangulation of the sources allowed comparing the information received through different sources, which hold different positions. Triangulation of methods entailed the cross-validation of data based on interviews, observations and documents. Through the combination of these heterogeneous flow of evidence, the researcher was able to develop interpretations that made sense and were representative of the actual situation in the hospital setting.

The combination of the two methodological steps allowed the research to go beyond shallow descriptions. The quantitative phase helped in shedding light as to the magnitude of the compliance issue whereas the qualitative one helped in shedding light as to the underlying dynamics, as to issues having to do with the human resource, policy ambiguity, the practice of scheduling, and the daily operational realities in the wards. Using this mixed-method design, the research provided a subtle insight into the reasons behind physician visitation compliance in the inpatient unit at Tk. III Dr. Reksodiwiryo Padang Hospital was lower than the national standard.

Results and Discussion

Quantitative Research

The current paper has analyzed 200 documented inpatient physician encounters to determine compliance with one of the nationally prescribed standards of visitation time in a type C hospital in Padang. Visiting the patients daily, all the present physicians had a significant percentage of rounds that went beyond the prescribed time frame, and the overall compliance rates were 40.4%. In disaggregating the data by ward, a more refined trend was observed: timing adherence was the greatest in the Imam Bonjol Ward unit a unit that mainly dealt with surgical recovery cases and has concise and structured care pathways that seemingly enable better scheduling synchronisation. Conversely, adherence was at its peak in the Agus Salim Ward where most visits were done by part-time specialists in the partner that practiced in other

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external organizations whose clinical requirements seemed to determine the order of the inpatient rounds.

These ward level data highlighted the importance of studying the greater staffing arrangement. In Rumah Sakit Tingkat III dr. Reksodiwiryo, the number of specialists who were regarded as organic permanent employees was only four people, and other physicians were partners, who worked on a part-time basis. The difference in time compliance between the two groups was significant and always directed towards a structural, and not an individual, determinant.

A binary logistic regression was designed to determine the combined effects of employment status, outpatient workload, academic engagement, and manual nursing reminders. The model explained 46intof the realized variance in visit timing compliance, and supported the hypothesis that institutional status and workload structure is a sound predictor of whether or not inpatient rounds within the national indicator window.

Table 1. Physician Visitation Time Compliance by Inpatient Ward

Inpatient Ward	Number of Observed Visits	On-Time Visits	Late/Off-Time Visits	Compliance Rate
Imam Bonjol Ward	75	57	18	**75.3%**
Agus Salim Ward	40	1	39	**2.5%**
Bagindo Aziz Chan Ward	45	20	25	44.4%
Rasuna Said Ward	40	3	37	7.5%
Total	**200**	**81**	**119**	**40.4%**

Table 1 describes visit timing compliance in the ward. Timing compliance was most successful in Imam Bonjol Ward with 57 out of 81 visits observed coming on time. The predictability of the surgical orientation of the ward, the more predictable discharge planning, and the focused physician assignment, presumably, eased the more thoughtful arrangement of visits. Other wards, in turn, had lower levels of compliance; Agus Salim Ward provided almost one-third of all delays in visits, thus consolidating a trend of significantly non-uniform visit timing in non-surgical wards.

Table 2. Physician Visit Time Compliance by Specialist Status

Physician Employment Status	Total Physicians	Number of Visits Evaluated	On-Time Visits	Late/Off-Time Visits	Compliance Rate
Organic Permanent Specialists	4	40	36	4	**90.0%**
Partner Part-Time Specialists	45	160	45	115	**28.1%**
Total	**49**	**200**	**81**	**119**	**40.4%**

Most of the visits occurred outside the national indicator timeframe even though at the time of observation, partner part-time specialists recorded the most number of visits (160 visits). Organic permanent specialists had lower visit records but provided considerably better adherence with 36 visits made in the appropriate time range. These results indicate that compliance behavior on a large scale is most affected by institutional affiliation and the possibility of visit sequencing, as opposed to the frequency of visit.

Table 3. Reported Individual DPJP Compliance Patterns

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Compliance Group	Number of Physicians	Visit Timing Behaviour Reported
0% adherence	2	Never visited within the indicator timeframe, both partner specialists
100% adherence	2	One organic permanent specialist and one partner specialist with lower outpatient load
Unquantified variable adherence	10	Rounding time varied due to outpatient priority pattern, travel distance, and academic duties
Total DPJP evaluated	14	

The table below draws a conclusion on the visitation time patterns of the fourteen DPJPs discussed in the paper. The data show a bimodal distribution with the highest level of compliance and the highest level of delay; the rest of DPJPs are of fluctuating schedules that do not have a uniform time structure. Notably, all DPJPs upheld daily rounding even though adherence to irregular timing was not observed, which supports the fact that the main concern of the study was the timing of visits and not the frequency of visits.

Table 4. Logistic Regression Predictors of On-Time Visitation Compliance

Predictor Evaluated	Odds Ratio (OR)	95% Confidence Interval	p-value	Interpretation
Organic permanent specialist employment	8.9	3.8–20.7	<0.001	Strong positive predictor of on-time visits
High outpatient clinical burden (>30/day)	0.23	0.11–0.44	<0.001	Strong negative predictor of compliance
Active academic or institutional engagement	0.31	0.14–0.61	0.002	Reduces likelihood of on-time visits
Manual nurse reminder support	2.1	1.03–4.29	0.041	Moderately improves visit timing adherence

The current regression model estimated the probability-adjusted impact of the systemic and role predictors of visit timing compliance. The strongest positive predictor proved to be organic employment status. Conversely, overlaps between outpatient workload and academic duty were linked to a huge drop in odds of compliance. Despite a slight change in likelihood, when provoked by the implementation of the manual reminders by the nursing staff, these interventions were unable to completely undermine the structural outpatient-first sequencing of visits, in particular among specialists of the partner.

Taking everything in aggregate, the results demonstrate that the major issue is not the lack of physician visits but the ongoing problem of how to fulfill them within the time frame stipulated nationally. The physicians who came to their daily clinical roundings could also fulfill their professional duties, and the nursing team confirmed that bedside communication was always constructive, empathetic, and decision-oriented. The reviews of treatment plans were made systematic, patient concerns were thoroughly discussed about and interprofessional collaboration taking place during rounds (though frequently later than advised) was evidence of active clinical engagement. Therefore, the main problem is not whether physician visits take place but whether they can be performed in time in a context in which the majority of the specialists that attend to patients are not full-time clinicians of the institution.

This kind of contextual view is important because the staffing feature in the hospital creates a de facto hierarchical situation in the allocation of physician time. The partner specialist, with

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constituting the majority of deputy physician- journals (DPJs), works in various institutions and has an unequally larger workforce on outpatient grounds hence making a habitual inpatient visit last in their clinical schedule. Their rounds do not commonly fall within the window of early visitation, not because they are unwilling but since the inpatient rounding is ordered after they have completed their main ambulatory responsibilities. Organic permanent specialists, on the one hand, outnumbered, however, demonstrate that physicians who are structurally based in the institution have a significantly higher probability of aligned visit timing. This has been observed to suggest that obedience is not so much an expression of professional discipline but rather of institutional identification and work centralisation.

The conversation no longer concerns individual performance measures but the context of system configuration and clarifies the positive feedback of infrastructure on visible behavior. Without built-in digital alerts or an automated sub-acute rounding roster, timing of visits would be discussed upon by the nursing staff, the human memory and the ability of individual physicians to adjust cross-institution schedules. The nursing staff helped alleviate this shortage through the use of real-time communication through WhatsApp and telephone that slightly increased the likelihood of timely visits but did not completely overcome the structural gap created by physician mobility and outpatient-first duty structure. In such a way, although communicative channels are still operational, the institution does not have systemic timing governance processes that can make compliance a realizable communal goal as opposed to an ideal individual one.

On a larger scale, the results reflect a real-life experience of quality indicators and the realities of functioning clinical ecosystems. The assumption of national benchmarks is that timely physician visits take place in institutions in which inpatient care is a core workflow; this assumption is not consistent with hospitals that are operating on a model based on partner-employed specialists. In this kind of setting, quality metrics are useful in evaluating the operational viability, but not clinical commitment. Even though compliance with the indicator was not optimal in a number of wards, interpersonal feedback provided by physicians reveals that patients continued to have positive views of the rounds, communication channels remained functional, and treatment discussions still took place at the bedside. In turn, the compliance data must not be viewed as the sign of clinical disengagement but must be viewed as the sign of pragmatism in the scheduling of a distributed specialist work force.

The findings therefore support a redefinition of the consequences of compliance, which puts emphasis on the fact that the identified shortcomings are as a result of a system being limited by lack of availability of full-time specialists, increased workloads of an outpatient, lack of automated coordination of rounding to the hospital information system, and overlaps in extrinsic academic duty that cause physicians to shift their time allocation instead of reducing the number of visits. This fact suggests that improving the compliance of national indicators in inpatient services does not require changes in the behavior of physicians in terms of rounding, but rather involves systematic reorganization of the system, according to which the sequence of rounding is determined, and new tools help clinicians to follow the time norms in the rhythm of their daily work. In this way, the results reflect a clinical reality, as well as an operational insight, offering a realistic compliance framework which is a real representation of the hospital inpatient care dynamics.

Qualitative Research

The qualitative aspect of the given research examined trends of coordination of inpatient visits, professional duty flow, operational limitations, and interprofessional perceptions of the physician rounds. Although the initial aim was to determine adherence to visit schedules with the help of a national quality indicator, interviews and own observations revealed that the adherence of physicians to visiting patients was not questioned. Primary physicians (DPJPs)

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were visiting on a daily basis and bedside interaction was always active, compassionate, and cooperative. However, matching the timing of visits with the official national measure was in many cases inhibited by the freedom of physicians, outpatient patient engagement, and the lack of ward-level scheduling systems. These findings indicate compliance stories are not as much affected by personal volition as by systemic attainability of timing co-ordination through a multi-institutionalized physician workforce model.

Having cross-read stories of the main stakeholder groups, the rounding process can be characterized as an outpatient-first duty sequence among the majority of the partner specialists, thus scheduling the inpatient rounding later in the afternoon or in the early evening. The adaptation of nurses to this rhythm on a regular basis was through the use of manual reminders and the expression of satisfaction by the patients in the quality of the doctor-patient interactions despite unreliability of the rounding times. The replacement of the ideals of structured scheduling with negotiated and real-time coordination was observed in wards and categories of DPJP uniformly, making it a salient qualitative theme of the study results.

Table 5. Ward-Level Qualitative Themes on Physician Visit Dynamics

Inpatient Ward	Description Reported in Article	Visit Pattern Noted	Summary of Timing Intersection Challenge
Ruang Imam Bonjol	Post-surgical patients with shorter average length of stay	Rounds occur mostly in the morning	Scheduling intersection more attainable due to structured care pathway
Ruang Agus Salim	Internal medicine cases managed by partner specialists	Visits after 14.00 almost every day	Inpatient rounds placed after outpatient clinics at other hospitals
Ruang Bagindo Aziz Chan	Mixed medical cases with no fixed rounding schedule	Rounding time varies widely	Timing decided based on DPJP availability rather than ward roster
Ruang Rasuna Said	Academic-involved DPJPs with high outpatient volume	Morning or late-afternoon visits	Academic duties and clinics compete with timing indicator overlap

Rounding story analysis of the ward helps understand how operational design influences visit rhythms in a profound way. In Imam Bonjol Ward, the early start of patient interactions can be explained by both the presence of timely arrival of the clinicians and easier predictability of the clinical trajectory of a patient cohort. The teams of postoperative care usually have clear schedules, with regard to the periods of evaluation, possible therapeutic changes and the probable dates of discharges. These inherent time parameters allow the clinicians to set an earlier inpatient round, hence the less conflict with auxiliary tasks. Even though the interaction between nurses and physicians is informal, the clinical environment in the ward provides a quasi-structured schedule structure, which helps to conduct prior interactions with patients.

There is a shift of the Agus Salim Ward, and the story is changed into the distribution of clinical activities, instead of predictability. Partner specialists are still making rounds daily, but their schedule is much less frequently aligned with the fixed indicator periods because they have an outpatient responsibility in other facilities that is their major day-to-day affair. The interviews with nurses supported the idea that their clinicians made inpatient rounds when the polyclinic tasks were also finished, which makes afternoon appointments their general rather than a special trend. The same fluctuations were noted in Baginda Aziz Chan and Rasuna Said Wards, where rounding times were defined as fluid goals that were negotiated basing on the availability rather than institutional instructions. These cross-ward changes ensure that non-adherence to timing procedures is not as much a question of deliberate deviation as the fact of overlapping feasibility limits, which adds to the qualitative meaning of the research.

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Table 6. Individual DPJP Temporal Compliance Perceptions

DPJP Category	Narrative from Article	Timing Behaviour Trend	Scholarly Interpretation
2 Non-compliant DPJPs	Visited patients daily, but never within indicator time	Rounds after 14.00 consistently	Indicators conceptualized under full-time attachment assumption, not mobility model
2 Fully compliant DPJPs	Always rounded in the morning	Consistent on-time intersection	Lower case-load allowed higher timing alignment feasibility
10 Variative DPJPs	Timing not numerically logged individually	Fluctuative, depending on duties	Variability structured by clinical and academic role collision feasibility

At individual attending physician level, the stories showed strong dichotomies which could not be explained by differences in clinical presence but instead by the ability to intersect in the duty. The two DPJPs who have not followed the prescriptive protocols were not absent or dormant, but instead the day workload of the two was entirely determined by the outpatient services in various institutions, therefore making sure that inpatient rounds were scheduled after and not before the outpatient services. It is interesting that this non-compliance is structured. Their timing arrangements were predictable but they were always out of sync with the designated time windows of indicators. Bedside observations still revealed substantive clinical discourse and decision-making; however, the encounters are hardly ever matched with predestined timing indicators.

On the contrary, the DPJPs that followed the protocol to the fullest extent had lower patient census in the ambulatory settings and had comprehensive knowledge of the national rounding time requirements. The associated narrative changes to a narrative of structural constraint to structural empowerment, in which the centralisation of work and compliance with organisational policies helped to schedule earlier rounds easier. The other ten DPJPs had value changes that could not be measured individually, instead the article viewed these changes as necessitated by task distribution, mobility as well as conflicting professional activities. Most importantly, this fluctuation in the timing did not reduce the frequency of visit that were daily and consistent in all DPJPs.

The above findings highlight that heterogeneity of adherence does not undermine the methodological quality of the study but instead it increases the interpretation depth. They do not deny that the time of visits is not always decided by the intentions of physicians but rather conditioned by the professional context, order of workload duties and system of coordination.

Table 7. Nurse Coordination Perception Toward Rounds

Professional Group	Narrative Expression Reported	Field Practice Notes	Interpretation
Nurses	Remind physicians manually before rounds	Reminders mostly sent via WhatsApp or calls	Support reactive and compensatory, not system-driven
Physicians	Daily rounding obligation fulfilled	Visits vary in timing due to distributed duty flow	Not absence of visits but delayed sequence

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Nursing Coordinator System	No ward roster or embedded HMIS alarm	Schedule negotiated informally across wards	Compliance misaligned due to lack of scheduling governance tools

The coordination narrative captured in this table reinforces the structural nature of visit timing. Nurses repeatedly confirmed that doctors never skipped patient rounds, yet reminders were always delivered manually rather than driven through scheduling governance. WhatsApp groups and phone calls acted as real-time negotiation channels that nurses relied on to track doctor availability rather than doctor obligation delivery, which already occurred every day. Nurses described this process naturally, without frustration toward physicians, because clinically, patient visits did happen. Yet from an indicator measurement perspective, this coordination mode was always compensatory worked out at the moment rather than set by design.

This table transitions our narrative focus toward the heart of the inpatient coordination challenge. The system did not lack a rounding routine, it lacked a rounding schedule system that would allow indicator time intersections to become realistically collective rather than aspirationally individual. Doctors moved through a clinical ecosystem that demanded nonlinear scheduling across institutions, and nurses compensated using available communication tools even when those tools did not statistically replace systemic solutions.

Implementation Of Physician Visitation Compliance From Input Factors

In the implementation of doctor visit compliance from input factors in the inpatient installation of Tk. III Reksodiwiryo Padang Hospital, the input components in this study include policies, human resources, facilities and infrastructure.

Implementation Of Compliance With Doctor Visits Related To Policies

Based on the results of the research, reviewed from a policy perspective, the implementation of compliance with the visit of inpatient installation doctors at Tk. III Hospital dr. Reksodiwiryo Padang refers to the Minister of Health Regulation No. 129 of 2008 concerning the minimum service standards in hospitals and the Minister of Health Regulation No. 30 of 2022 concerning national indicators of the quality of health services where doctors and dentists practice independently, clinics, Public Health centers, hospitals, health laboratories, and blood transfusion units as well as information from the Medical Committee.

A policy is a series of actions proposed by an individual, group, or government in a given environment, taking into account the obstacles and opportunities that exist to achieve a specific goal. A policy is also a set of actions that have a clear purpose, executed by an individual or group to solve a specific problem (Muadi Sholih, MH Ismail, 2016).

This policy includes various forms of regulations, government decrees, directors' decrees, instructions, circulars, guidelines, and standard operating procedures (SOPs) related to the compliance of inpatient doctor visits and must be implemented in the hospital environment.

Implementation Of Compliance With Doctor Visits Related To Human Resources

Based on the results of the study, it was reviewed in terms of human resources, the implementation of compliance with the inpatient installation doctor visit of Tk. III Hospital, dr. Reksodiwiryo Padang, was inadequate because most of the specialist doctors were partner doctors. Based on the document review of the availability of human resources in the inpatient installation of Tk. III Hospital, dr. Reksodiwiryo Padang, it was found that there was a severe shortage of specialist doctors.

There are 71 doctors consisting of 22 general practitioners, namely 2 doctors with TNI status, 2 doctors with civil servant status and 13 people with partner doctor status, as well as 49 specialist doctors including 2 people from the TNI, 2 civil servants, and 45 people with partner

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doctor status. These specialists and some doctors generally act as doctors who visit patients at the inpatient installation of Tk. III Dr. Reksodiwiryo Padang Hospital. These doctors have backgrounds as general practitioners, specialist doctors and subspecialist doctors.

The main factor in the implementation of the policy is human resources. Human resources include individual potential, both physical and non-physical, which includes experience, expertise, skills, and interpersonal relationships (Arifin, S., 2016). As the organization develops, various complex challenges in HR management can arise, so an effective management system is needed to handle this aspect (Hasibuan, 2009).

Based on research conducted by Hamdan (2023), one of the problems encountered in the Inpatient Installation section is irregular doctor's visit times. This is due to the lack of available doctors, which can result in the schedule of doctor visits in conditional inpatients (Hamdan & Setiawati, 2023).

The effectiveness of human resources in an organization is influenced by several main factors, such as the recruitment process, placement, training, and employee development (Kombertonggo, 2008).

Implementation Of Compliance With Doctor Visits Related To Facilities And Infrastructure

Based on the results of the study, it was reviewed in terms of facilities and infrastructure for the implementation of the compliance of the inpatient installation doctor visit of the Tk. III dr. Reksodiwiryo Padang Hospital for doctor visits that are available by hospitals such as SIMRS, laptops, computers and the internet. The doctor has his own break room and is equipped with supporting facilities. However, there is no reminder to visit a doctor yet.

Facilities and infrastructure play a supporting role as supporters and implementers in the implementation of policies. Both can also be interpreted as equipment owned by an institution to assist employees in carrying out their duties (Arifin, S., 2016). In an organization, facilities and infrastructure are part of material input. Facilities function as tools that speed up and make work easier. In the business world, in addition to an expert workforce, the availability of materials or materials is also very necessary because the two are interrelated. Workplaces, equipment, transportation, and funds are very important supports to ensure smooth tasks.

Implementation Of Compliance With Doctor Visits Related To Process Factors

In the implementation of doctor visit compliance at Tk. III dr. Reksodiwiryo Padang Hospital, the output components in this study include the administration of patient admission in hospital, visite schedules, doctor visits, and monitoring and evaluation.

Patient Admission Administration

Based on the results of the study, it was reviewed from the administration of patient admission at the inpatient installation of Tk. III Hospital, dr. Reksodiwiryo Padang, the process of going through patients with outpatient polyclinics, clinics, and emergency rooms. The administrative process of inpatient admission consists of the process of admitting inpatients including registration and processing of patient data.

According to Rivortus, in improving the quality of patient admission administrative services, it is necessary to implement careful planning, prepare clear SOPs, and utilize an integrated information technology system (Rivortus F. G, Purwani P, 2024)i .

Based on research conducted by Fadlun, the administration of patient admission in inpatient facilities involves several important steps to ensure that the process runs smoothly. This includes verifying patient data, filling out forms, submitting documents, and placing patients in appropriate rooms (Fadlun, 2019).

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The implementation of patient admission administration at the inpatient installation of Tk. III Hospital dr. Reksodiwiryo has run smoothly and according to procedures. The use of electronic medical records is one of the supports for the smooth implementation of administration in hospitals.

Visit Schedule

Based on the results of the study, it was found that the doctor's visit schedule at the inpatient installation of Tk. III dr. Reksodiwiryo Padang Hospital was carried out based on an agreement between the DPJP and the medical committee. Scheduling a visit consists of the process of scheduling a doctor's visit, including scheduling and sending notifications to doctors and patients.

Based on research conducted by Marsha, one of the causes of low adherence to doctor's visit time is the lack of commitment to visit on time. This lack of commitment is due to the fact that most of the DPJPs who work in hospitals are partner doctors (Chairissy et al., 2024).

Non-compliance with doctor's visit time occurs because the doctor is also a teaching staff for medical students and also has an obligation to carry out health services at his main workplace first before becoming a partner doctor. In addition, the distance and travel time from home or hospital where the main workplace of the DPJP is also another obstacle so that for efficiency, the DPJP comes to the hospital and visits after 14.00.

Visit Doctor

Based on the results of the research of doctor visits at the inpatient installation of Tk. III Hospital, dr. Reksodiwiryo Padang, the implementation varies from morning, afternoon and night. A doctor's visit includes the doctor's visit, including examining the patient, making decisions, and prescribing or other orders.

According to research conducted by Marsha, a doctor's visit to see the development of the patient who is responsible is the definition of a doctor's visit. Doctor visits are carried out in the treatment room by visiting, examining and communicating directly with patients (Chairissy et al., 2024).

In the implementation of doctor visits, there is a good communication process between doctors and patients, this is a form of empathy. With good communication, there will be a strong doctor-patient bond that can also increase patient satisfaction.

Monitoring and Evaluation

Based on the results of the research, monitoring and evaluation related to the compliance of doctor visits at the inpatient installation of Tk. III Hospital, dr. Reksodiwiryo Padang was carried out by the hospital's PMKP section. Monitoring and evaluation include the process of monitoring and evaluating the timeliness of doctor visits, including the measurement of waiting time and visite time.

Based on research conducted by Shafira Permatasari to improve the quality of hospital health care providers, they can conduct periodic monitoring and evaluation. Monitoring and evaluation can be carried out by increasing supervision of the compliance of health workers using quality indicators (Permatasari et al., 2023).

According to Syahputri, the monitoring process for the implementation of all activities in the organization is supervision that aims to ensure that every task carried out runs according to the previously set plan (Syahputri, R. B., Haryati, R., Handayani, 2024).

The process related to the compliance of doctor visits at the inpatient installation of the Tk. III dr. Reksodiwiryo Padang Hospital administration ran smoothly according to the procedure, the visit schedule was based on the agreement between the DPJP and the medical committee, the

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implementation of the visite varied from morning, afternoon and night. The DPJP conducts an average visit every day. Monitoring and evaluation are carried out by the hospital's PMKP section.

Implementation Of Doctor Visite Compliance From The Output Factor

In the implementation of doctor visit compliance at Tk. III Dr. Reksodiwiryo Padang Hospital, the output components in this study include internal factors, external factors, human factors and technological factors.

Internal factors are characteristics or attributes that originate within an individual or organization, which can influence behavior, decisions, or outcomes. Based on the results of the study reviewed from internal factors, the compliance of doctor visits at the inpatient installation of Tk. III dr. Reksodiwiryo Padang Hospital is influenced by the availability of the number of organic doctors. With the availability of sufficient doctors, it can result in an increase in doctor visitation compliance because they have enough time to do doctor visits. The number of organic specialists at Tk. III Dr. Reksodiwiryo Padang Hospital is only 4 people and partner doctors are 45 people. Internal factors such as physician availability, time management ability (determination of task priority scale), communication between doctors and nurses (effective communication) and health information systems.

Characteristics or attractions that come from outside the individual or organization that can influence the behavior of decisions or outcomes are external factors. External factors include the number of patients, the condition of the patient (critical patients need intensive attention), adequate facilities and infrastructure, and clear service policies and standards. Based on the results of the study reviewed from external factors, the implementation of the compliance of the inpatient installation doctor of Tk. III dr. Reksodiwiryo Padang Hospital is not affected by the number of patients, patient conditions, and infrastructure. The doctor always comes to carry out visits every day. In terms of policy, there are no clear policies and service standards to support the compliance of doctor visits in inpatient installations.

Based on the results of the study reviewed from human factors, the implementation of the compliance of the inpatient installation doctor of Tk. III Hospital dr. Reksodiwiryo Padang is like a motivation to do a good visit, but the commitment to compliance with the visit at the installation is not optimal.

Based on the results of the study reviewed from human factors, the implementation of the compliance of the inpatient installation doctor visit of Tk. III Hospital dr. Reksodiwiryo Padang has used SIMRS. The nurse calls or WA a specialist doctor to remind the visit time because there is no application to remind the visite schedule.

Based on research conducted by Hamdan, one of the problems encountered in the Inpatient Installation section is irregular doctor's visit time. This is due to the lack of medical personnel (doctors) so that there are various schedules of doctor visits in inpatients (Hamdan & Setiawati, 2023).

According to Marsha, internal factors such as the availability of doctors; resulting in increased physician visitation compliance because physicians have sufficient time to perform visits to patients, time management capabilities (determining the priority scale of tasks), communication between doctors and nurses (effective communication, for good cooperation) and health information systems (Chairissy et al., 2024). Effective patient data management can help doctors access patient information easily and quickly, such as reminders of patient visit times and alerts of patient conditions. External factors include the number of patients, the condition of the patient (critical patients require intensive care from a doctor), adequate facilities and infrastructure, and clear service policies and standards. The human factor is the doctor's motivation and commitment to the punctuality of the visit as well as the doctor's ability

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to manage time and the ability of the nurse to support the implementation of the doctor's duties such as providing information on the visite schedule. Technology factors support hospital services, such as SIMRS (sister hospital management information), mobile applications for visit schedules and visite reminder systems.

Most hospitals have problems in meeting the standards of inpatient doctor compliance because the specialist doctors working at the hospital are partner doctors. Partner doctors are doctors who are not tied to the hospital concerned, but are authorized to practice and use hospital facilities for a certain period of time and use a letter of agreement (Klau, R. G., Fahmi, M. S., Utami, 2022).

With the availability of doctors at Tk. III Dr. Reksodiwiryo Padang Hospital, the compliance of doctor visits increases because doctors have enough time to visit patients.

Based on research conducted by Rizqa Auliyah Shifah Sagalay, doctors must always be present on time according to the predetermined schedule to visit patients in order to achieve compliance in doctor visits. Seniority includes the timeliness of the doctor's arrival and the timeliness provided for each patient. This is so that doctors can give optimal attention to each patient, thereby increasing patient safety and satisfaction. (Rizqa Auliyah Shifah Sagalay, Medina Elly Vanda, 2024).

Related to the output of this study, it was found that there was non-compliance with the doctor's visit at the inpatient installation of Tk. III Dr. Reksodiwiryo Padang Hospital. The cause of this non-compliance is the lack of the number of organic specialists. Another cause of non-compliance with the doctor's visit time is that there is no reminder/alarm system for the visit time schedule in the SIMRS application.

There are many partner doctors who are busy as educators in the S1 (medical profession), Sp1, Sp2, S2, and S3 programs as well as faculty meetings and service and action meetings outside the RST. In addition, the number of patients in outpatient clinics is too large, causing delays in visitation times.

In other cases, there are partner specialist doctors who obediently conduct visits at inpatient installations on the grounds that he understands the rules from the Minister of Health Regulation No. 30 of 2022 concerning INM Hospitals in the indicators of compliance with doctor visits in inpatient installations and the number of patients is not too much. One more person who is in the compliant category is an organic doctor (a permanent specialist doctor at the hospital).

Purpose Tree on Doctor Visite Compliance

The goal tree is to show how problems can be overcome which starts from solving the root of the problem so that the goal is achieved, namely optimal compliance with doctor visits at the inpatient installation of Tk. III Dr. Reksodiwiryo Padang Hospital. The goal tree for the compliance of doctor visits at Tk. III dr. Reksodiwiryo Padang Hospital can be seen in figure 1.

To increase the compliance of doctor visits at Tk. III Dr. Reksodiwiryo Padang Hospital, it is necessary to increase the number of organic specialists, schedule visit times and establish regulations regarding doctor visit times.

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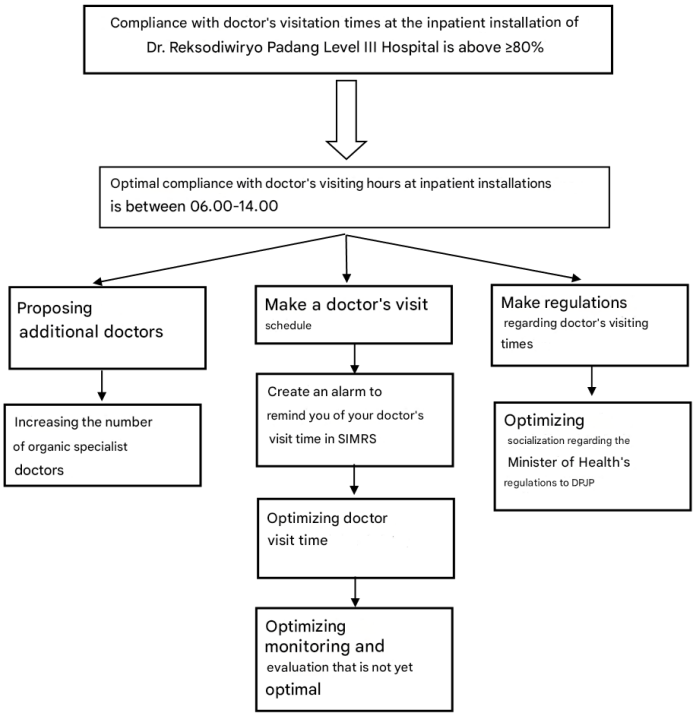

Figure 1. Goal Tree About The Compliance Of Doctor Visits At Tk. III Dr. Reksodiwiryo Padang Hospital

Conclusion

Compliance with the doctor's visit time at the inpatient installation of Tk. III dr. Reksodiwiryo Padang Hospital obtained a doctor's visit compliance rate of 40.4%. The low rate of adherence to doctor visits is due to the fact that some specialist doctors carry out visits after 14.00. Non-compliance with doctor's visits at the inpatient installation of Tk. III dr. Reksodiwiryo Padang Hospital related to input factors is caused by the absence of clear regulations regarding decrees, SOPs, and policies for compliance with inpatient doctors' visits. The availability of the number of organic specialists is only 4 people. Non-compliance with the doctor's visit at the inpatient installation of Tk. III Dr. Reksodiwiryo Padang Hospital related to the process factor was caused by the absence of a clear doctor's visit schedule. Compliance with average doctor visits is below standard, one of which is due to the DPJP's lack of understanding of the Regulation of the Minister of Health's rules on doctor visit times. Follow-up of monitoring and evaluation of visitation compliance that is not optimal. Non-compliance with doctor visits at the inpatient installation of Tk. III dr. Reksodiwiryo Padang Hospital related to output factors is caused by the lack of the number of organic/permanent specialists and the absence of an alarm to remind the doctor's visit time.

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