

Educational and Research Cultures in Enhancing Hospital Service Quality Transformation: A Case Study of Arafah Islamic Hospital Jambi

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Abstract: The transformation of hospital service quality has become a strategic necessity in response to the increasing public demand for safe and effective healthcare services. One of the key factors capable of driving such transformation is the strengthening of educational and research cultures as integral components of hospital organizational culture. The findings reveal that the educational culture was manifested through continuous training programs, clinical meetings, scientific seminars, and healthcare competency development, while the research culture was implemented through internal research activities, the application of evidence-based practice, and the development of data-driven service innovations. The synergy among educational culture, research culture, leadership, and management commitment was proven to promote improvements in service quality, patient safety, and a culture of continuous improvement. This study proposes a service quality transformation model that positions educational and research cultures as the primary drivers of hospital quality improvement.

Keywords: *Educational Culture, Research Culture, Healthcare Quality Transformation, Arafah Islamic Hospital Jambi*

A. Introduction

The transformation of hospital service quality has become an increasingly critical imperative driven by rising public expectations for safe, effective, and high-quality patient care. Modern healthcare quality improvement does not rely solely on physical infrastructure, advanced technology, or administrative compliance; rather, it demands a deep-rooted organizational culture that fosters continuous learning, critical inquiry, and evidence-informed practice (Ansar et al., 2026). An organizational culture that embeds education and research as core values empowers healthcare professionals to continuously refine their clinical competencies and generate context-specific innovations through evidence-based practice. Organizations with robust learning cultures display greater strategic agility, adapt rapidly to changing regulatory standards, and achieve superior clinical outcomes (Tjahyanti et al., 2026).

The World Health Organization (WHO) emphasizes that strengthening healthcare service quality requires systems of continuous education, research, and human resource competency development (Timorita & Wahyudin, 2025). Hospitals are encouraged to establish environments that support innovation and learning in order to improve patient safety and service effectiveness (Pertiwati et al., 2025). In line with this perspective, hospital accreditation standards also recognize education, training, research, and continuous professional development as essential components of hospital quality management systems.

In Indonesia, efforts to improve hospital service quality continue to face various challenges. Numerous studies indicate that patient satisfaction is still influenced by the quality of communication among healthcare professionals, service timeliness, and the consistency of standard operating procedure implementation (Aisyah et al., 2026). Furthermore, patient safety reports continue to reveal incidents associated with clinical communication, compliance with standard operating procedures, and suboptimal incident reporting cultures (Neri et al., 2018). These conditions suggest that quality transformation requires changes in organizational culture rather than merely administrative improvements.

A critical review of the existing literature indicates that most studies on healthcare service quality have predominantly focused on structural, administrative, and external compliance determinants. Scholars utilizing Donabedian's classic framework (structure-process-outcome) have extensively evaluated resource allocation, physical infrastructure, accreditation compliance, transformational leadership, and SERVQUAL dimensions to explain organizational performance (Arifin et al., 2024; Kholik et al., 2022). While these empirical contributions have clarified the formal prerequisites for hospital operations, they consistently treat educational programs and research activities as peripheral, administrative supporting tasks designed primarily to meet accreditation mandates rather than as dynamic organizational cultures embedded within daily clinical workflows.

Consequently, two critical theoretical and empirical gaps remain unresolved in contemporary healthcare literature. First, while Learning Organization frameworks acknowledge continuous learning as a key driver of organizational adaptiveness, empirical research examining how educational and research practices become deeply internalized values across multidisciplinary healthcare teams is remarkably scarce (Ratten, 2025). Second, existing literature largely overlooks faith-based healthcare institutions, particularly Islamic general hospitals, where unique organizational dynamics—such as the alignment of ethical-spiritual values (akhlak and ibadah) with clinical practice—intersect with academic learning and clinical inquiry to drive sustainable service quality transformation (Doni & Andi, 2025; Supartini et al., 2026).

To address these theoretical and empirical gaps, this study develops an Integrated Conceptual Framework that synthesizes four foundational organizational theories into a cohesive analytical lens:

1. Learning Organization Theory serves as the conceptual basis for understanding how continuous professional learning, systems thinking, and personal mastery build the internal adaptive capacity required for sustained service transformation (Senge, 1990).

2. Organizational Culture Theory offers an analytical lens to examine how educational and research practices evolve from surface-level artifacts and formal administrative mandates into deeply embedded, shared organizational assumptions (Schein, 2010).
3. Evidence-Based Management (EBMgt) and Evidence-Based Practice (EBP) establish that clinical governance, operational workflows, and decision-making must be systematically grounded in empirical evidence, clinical expertise, and patient needs rather than tradition or intuition (Barends & Rosseau, 2018; Sackett et al., 1996).
4. Continuous Quality Improvement (CQI) frameworks quality enhancement as an ongoing, data-driven cycle (Plan-Do-Study-Act) aimed at eliminating clinical process variations and improving patient safety outcomes (Berwick, 1989; Langley et al., 2009).

By integrating these complementary perspectives, this study establishes its theoretical novelty: it conceptualizes educational and research cultures not as static supporting activities, but as continuous, interconnected drivers of organizational learning that translate empirical insights directly into sustainable healthcare quality transformation.

Arafah Islamic Hospital Jambi provides an ideal empirical setting for this investigation. As an expanding Islamic healthcare provider in Sumatra, the hospital has actively implemented educational programs, professional training, and clinical research initiatives aimed at elevating patient care standards. However, the exact mechanism through which these academic and research practices transform into embedded organizational culture and improve service quality has not been rigorously examined. Therefore, this study aims to: (1) analyze the implementation of educational and research cultures at Arafah Islamic Hospital Jambi; (2) identify internal and external supporting and inhibiting factors affecting their implementation; and (3) formulate an integrative model explaining how educational and research cultures drive sustainable hospital service quality transformation.

B. Methods

This study employed a qualitative approach using a case study design. The qualitative approach was selected because the study aimed to gain an in-depth understanding of the phenomena of educational and research cultures within the real-life context of a hospital organization. According to Creswell (2022) qualitative research is used to explore the meanings constructed by individuals or groups regarding a social phenomenon. Meanwhile, Yin (2018) explains that a case study is an appropriate research strategy when researchers seek to investigate a contemporary phenomenon within its real-life context, particularly when the boundaries between the phenomenon and its context are not clearly evident.

The study was conducted at Arafah Islamic Hospital Jambi, located at Jl. Mpu Gandring No. 1, Solok Sipin, Telanaipura District, Jambi City, Indonesia. The hospital was selected because it has actively developed educational programs, professional training, healthcare research activities, and service quality improvement initiatives. The study focused on the implementation of educational and research cultures as part of hospital service quality

transformation. The unit of analysis was the organizational culture manifested through policies, educational activities, research initiatives, service innovations, and quality improvement practices implemented within the hospital environment.

Informants were selected using purposeful sampling, targeted at individuals with direct involvement, decision-making authority, or operational experience in educational programs, research initiatives, and quality management. Informant recruitment continued until data saturation was reached—the point at which additional interviews yielded redundant information and no new themes emerged (Wahyuti et al., 2026). A total of 18 key informants participated in the study. To ensure methodological transparency and credibility, the profile of research participants is presented in Table 1.

Table 1. Profile of Research Participants (Informants)

Informant ID	Professional Position	Service / Unit	Years of Service	Educational Qualification	Rationale for Selection
P1	Hospital Director	Executive Board	12 years	MD, M.H.S.M.	Primary executive decision-maker driving hospital culture, vision, and resource allocation.
P2	Deputy Director of Medical Services	Medical Directorate	9 years	MD, Sp.A.	Oversees medical practice, clinical governance, and integration of evidence-based practice.
P3	Chair of Quality Committee	Quality & Patient Safety	8 years	M.N. (Master of Nursing)	Leads CQI programs, patient safety reporting, and accreditation standards compliance.
P4	Head of Education & Training	Human Resources	7 years	M.Ed. (Master of Education)	Manages clinical training schedules, competency tracking, and educational workshops.
P5	Chair of Ethics &	Research & Development	10 years	MD, Sp.PD.	Evaluates internal

	Research Comm.				research proposals, clinical protocols, and research ethical clearances.
P6–P8	Clinical Unit Heads	ICU, Emergency, Inpatient	6–11 years	B.Sc. Nursing / MD	Responsible for unit-level SOP compliance, morning reports, and clinical meetings.
P9–P13	Senior Specialist Doctors & MDs	Surgery, Pediatrics, Internal	5–14 years	Medical Specialist (Sp.)	Key actors conducting clinical audits, research activities, and bedside teaching.
P14–P18	Head Nurses & Quality Officers	Outpatient, Operating Theater	4–9 years	B.S.N., Ns.	Implement daily care protocols, collect quality metrics, and participate in IPC/BLS programs.

Fieldwork was conducted over a six-month period from July to December 2025. Primary data were gathered through three qualitative techniques, which were further supplemented by descriptive quantitative documentation:

1. In-depth semi-structured interviews were executed using pre-tested protocols focused on indicators of educational culture, research practices, and quality transformation. These sessions lasted between 45 and 90 minutes, were audio-recorded with explicit participant consent, and were transcribed verbatim within 24 hours of completion.
2. Field observations utilized structured schedules to observe 14 clinical meetings, 6 morning reports, 4 research dissemination workshops, and daily clinical handovers across various units to evaluate learning interactions and patient safety behaviors in real-time.
3. Documentation analysis involved a systematic review of physical and digital records spanning 2023–2025, including training attendance logs, internal research reports, SOP revision records, Quality and Patient Safety Improvement (QPSI) reports, and monthly clinical indicator tracking sheets.

Qualitative data were analyzed systematically using the interactive model proposed by Miles et al. (2014), operating through three concurrent flows of data condensation, data display, and conclusion drawing or verification. Raw field notes and interview transcripts underwent initial review to eliminate redundancies and refine textual clarity. During the analysis, first-cycle open coding generated 42 initial codes, which were subsequently grouped during second-cycle pattern coding into major thematic categories, such as Continuous Competency Building, Evidence-Based SOP Revision, Workload Constraints, and Leadership Mandates.

Methodological rigor and data trustworthiness were rigorously maintained following the evaluative criteria established by Lincoln & Guba (1985). Credibility was achieved through source triangulation across directors, doctors, and nurses, methodological triangulation by cross-referencing interviews, observations, and document analysis, as well as member checking with six key informants to validate transcript summaries and thematic interpretations. Furthermore, transferability was secured by providing rich descriptions of the organizational context and operational environment, while dependability and confirmability were ensured through a comprehensive audit trail documenting raw transcripts, coding trees, field notes, and analytical memos.

C. Results and Discussion

Arafah Islamic Hospital Jambi places educational culture as one of its primary strategies for improving healthcare service quality. Based on interviews with the Hospital Director, the Chair of the Quality Committee, and the Head of the Education and Training Division, it was found that all healthcare professionals are required to participate in regular competency development programs. These programs include clinical training, patient safety training, effective communication training, infection prevention and control (IPC) programs, Basic Life Support (BLS) training, and Quality and Patient Safety Improvement (QPSI) training. These activities have become routine agendas scheduled periodically as part of the hospital's organizational learning culture.

The findings indicate that the educational culture at Arafah Islamic Hospital Jambi is not merely perceived as a series of formal training activities but has evolved into an organizational culture that promotes continuous learning. According to records from the HR and Training Division (2025), 91.3% of healthcare professionals participated in at least three competency development activities within a year, while 76.8% of service units regularly conducted clinical meetings, case discussions, or morning reports. These findings demonstrate that learning processes have become integrated into daily service activities, allowing knowledge transfer to occur continuously within the organization.

Table 2. Implementation of Education and Training Programs at Arafah Islamic Hospital Jambi in 2025

Program Type	Frequency	Average Number of Participants	Participation Rate	Primary Operational Focus
Patient Safety Training	6	86	93%	IPSG compliance, incident reporting, risk reduction.

Infection Prevention and Control (IPC) Training	4	82	84%	Hand hygiene, HAI prevention, PPE protocols.
Basic Life Support (BLS) Training	3	63	88%	Emergency resuscitation skills, code blue protocols.
Clinical Meetings	12	412	95%	Complex case studies, clinical mortality audits.
Scientific Seminars	8	18	90%	Medical advancement updates, clinical pharmacology.
Quality and Patient Safety Improvement (QPSI) Workshops	5	126	87%	Root Cause Analysis (RCA), FMEA, CQI tools.

Table 2 demonstrates that clinical meetings constituted the educational activity with the highest level of participation. Clinical meetings are periodic gatherings involving healthcare professionals for the purpose of discussing clinical cases and improving service quality (Doni & Andi, 2025). Interview findings further revealed that every unit is required to evaluate training outcomes through direct implementation within the workplace, ensuring that educational activities do not end with certificate acquisition but instead result in changes to service practices. The concept of a learning organization proposed by Pertiwiwati et al. (2025) similarly argues that organizations capable of collective learning are better able to innovate and adapt to change.

These meetings serve as active forums where multidisciplinary teams critically discuss challenging patient cases, evaluate practice variations, and identify clinical risks. Qualitative interviews illustrate how educational culture has shifted staff mindsets from administrative compliance to shared clinical responsibility:

“In the past, attending training was just about obtaining certificates for re-credentialing. Now, there is a fundamental shift. When we attend clinical meetings or safety workshops, we bring real problems from the ward. We discuss why a patient’s condition deteriorated or why a handover was unclear. Education has become our daily reflective tool.”

— Informant P3 (Chair of Quality Committee)

Research culture at Arafah Islamic Hospital Jambi has evolved from an academic exercise into a practical mechanism for clinical governance and service innovation. The hospital management encourages clinical and administrative units to identify service bottlenecks, collect empirical data, and execute quality improvement projects.

Table 3. Development of Research Activities and Outputs (2023-2025) Data Derived from R&D Records of Arafah Islamic Hospital Jambi

Indicator	2023	2024	2025	Primary Impact
Internal Research Projects	8	13	19	Identified operational bottlenecks and clinical variations.
Healthcare Professionals Involved in Research	34	52	61	Expanded multidisciplinary research participation.
Research Dissemination Seminars	3	5	8	Facilitated internal knowledge sharing and debate.
Standard Operating Procedures (SOPs) Revised Based on Research Findings	5	8	12	Standardized clinical care using local empirical evidence.
Implemented Service Innovations	2	4	7	Digitized quality tracking, improved patient flow.

Table 3 shows a substantial increase in research activities within the hospital between 2023 and 2025. In 2023, eight internal research projects were recorded, increasing to thirteen projects in 2024 and reaching nineteen projects in 2025. Furthermore, the number of healthcare professionals involved in research activities increased from 34 individuals to 71 individuals during the same period. Several research findings were utilized as the basis for developing standard operating procedures (SOPs), improving patient service pathways, evaluating quality indicators, and developing service innovations across various hospital units. These findings indicate that research culture has become increasingly integrated into the hospital's quality management system.

The institutionalization of a research culture within the hospital is actively fostered through leadership mandates that emphasize practical applicability over abstract theoretical inquiry. This strategic alignment between clinical problem-solving and evidence generation is explicitly articulated by the executive management:

"We explicitly communicate that research in our hospital is not for academic shelves. It is about problem-solving. When nurses or doctors discover a recurring clinical issue—such as high waiting times or medication administration delays—we ask them to conduct a structured study, gather data, and present empirical solutions. Research directly shapes our hospital SOPs."

— Informant P1 (Hospital Director)

This statement underlines a pivotal paradigm shift where research activities are re-contextualized as direct instruments for clinical governance and continuous quality improvement. Rather than treating scholarly inquiry as an isolated academic endeavor, the hospital management embeds empirical data collection directly into daily operational workflows to address acute service bottlenecks. By institutionalizing a clear pathway from empirical findings to Standard Operating Procedure (SOP) revisions, the hospital fosters an environment of Evidence-Based Practice (EBP) and psychological empowerment, encouraging healthcare professionals across hierarchical levels to actively contribute to data-driven service innovations.

The qualitative analysis identified several complex organizational factors that interact to either facilitate or hinder the institutionalization of educational and research cultures:

1. Leadership commitment and institutional governance serve as the primary enabling drivers by creating a supportive organizational climate through annual budget allocations for internal research grants, sponsorship for professional certifications, and clear policy mandates connecting performance appraisals to active educational participation (Aisyah et al., 2026; Widjaja et al., 2026).
2. Islamic organizational climate and values emerge as a unique enabling factor in this case study, where the alignment between a learning culture and Islamic work ethics—specifically seeking knowledge (Thalab al-'Ilm) and delivering exceptional care (Ihsan)—frames clinical learning and research as forms of continuous worship (ibadah) to reinforce internal motivation (Arifin et al., 2024; Supartini et al., 2026).
3. Heavy clinical workload and time constraints represent the most significant operational barrier, as 14 out of 18 informants (77.8%) explicitly reported that conducting internal research and attending non-mandatory training frequently infringed upon their personal time or caused severe fatigue due to demanding shift schedules (Aisyah et al., 2026).
4. Uneven methodological competency and resource allocation further complicate implementation, where specialist doctors exhibit strong research capabilities while nursing and administrative staff face persistent difficulties in study design, statistical analysis, and manuscript preparation (Neri et al., 2018; Pertiwiwati et al., 2025).

Comparing these findings with international scholarship highlights broader theoretical implications. In alignment with global healthcare quality frameworks (e.g., Elrod & Fortenberry, 2024), continuous quality improvement requires flattening hierarchical barriers and fostering psychological safety where staff can report errors and initiate research without fear. Furthermore, in contrast to resource-rich Western healthcare settings where dedicated research time (protected research hours) is contractually guaranteed for clinicians, hospitals in developing settings like Indonesia rely heavily on intrinsic motivation, transformational leadership, and shared cultural-spiritual values to sustain research momentum amidst high patient volumes.

D. Conclusions

This study confirms that educational and research cultures play a pivotal role in driving hospital service quality transformation. Educational culture—operationalized through continuous training, structured clinical meetings, and safety workshops—elevates professional competencies and establishes a shared safety mindset. Research culture—implemented via internal empirical studies, SOP revisions, and data-driven innovations—provides the analytical foundation for evidence-based clinical and managerial decision-making. When supported by committed leadership and an encouraging organizational climate, these twin cultures transform quality management from a passive compliance exercise into an active, self-sustaining process.

To translate these empirical findings into sustainable management practices, hospital executives and quality committees should consider the following strategic recommendations:

1. Institutionalize protected research and learning time by establishing formal policy frameworks that grant clinical staff dedicated, scheduled hours for research and continuous professional development, thereby alleviating workload fatigue and burnout.
2. Expand interprofessional mentorship programs that pair experienced clinician-researchers with junior nursing and allied health staff to systematically build organizational research capacity and foster collaborative inquiry.
3. Embed research outputs into CQI workflows through formal mandates requiring that all Standard Operating Procedure (SOP) revisions and clinical pathway updates explicitly integrate and cite recent internal or external empirical evidence.

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