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NURSE PERFORMANCE IN HOSPITAL INPATIENT WARDS: A DESCRIPTIVE CROSS-SECTIONAL STUDY

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Author's Contribution

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ABSTRACT

Background: *Nursing performance encompasses the execution of fundamental clinical and professional duties that directly determine the standard of hospital care. Suboptimal nursing performance remains a critical challenge in clinical settings, demanding systematic baseline assessment to identify areas for institutional workforce improvement.*

Objectives: *This study aimed to identify and analyze the overall profile of nurse performance in hospital inpatient wards based on socio-demographic and occupational characteristics*

Methods: *A quantitative descriptive study with a cross-sectional design was conducted among all 96 inpatient nurses across eight inpatient wards selected via total sampling. Data were collected using a structured closed-ended questionnaire adapted from the Indonesian National Nurses Association (PPNI) standards, evaluating behavior, professional competence, and the nursing process (Cronbach's α=0.89). Data were analyzed using univariate descriptive statistics to calculate absolute frequencies (n) and percentages (%).*

Results: *The majority of respondents were female (92 [95.8%]), aged 29–35 years (47 [49.0%]), held a Diploma in Nursing (73 [76.0%]), had 1–5 years of clinical tenure (43 [44.8%]), and were employed under contract/honorary status (87 [90.6%]). Regarding clinical performance, 92 respondents (95.8%) demonstrated poor performance, 3 respondents (3.1%) showed fair performance, and 1 respondent (1.0%) demonstrated very poor performance, with none achieving good or very good performance.*

Conclusion: *Clinical nurse performance in inpatient wards remains predominantly poor, highlighting critical vulnerabilities across behavioral, professional, and clinical care process competencies. Strategic hospital human resource initiatives must focus on structured clinical supervision, targeted continuous professional training, and equitable incentive systems.*

Keywords: *inpatient ward, nurse performance, nursing care, professional competence, workforce management*

INTRODUCTION

Nursing professionals in modern healthcare organizations represent the core frontline workforce delivering around-the-clock patient monitoring, diagnostic execution, and holistic clinical care (Al-

Dweik et al., 2021; Labrague et al., 2020). Nurse performance is defined as the multidimensional execution of clinical knowledge, psychomotor capabilities, interpersonal communication, and adherence to evidence-based nursing care processes (Alilyyani et al., 2018; Kakemam et al., 2021). The delivery of optimum nursing performance is fundamentally tied to clinical service excellence, treatment efficiency, and institutional resilience (Al Sabei et al., 2020; Platis et al., 2020). Conversely, deficits in nursing execution can severely undermine care delivery and organizational reputation (Aiken et al., 2018).

Empirical literature highlights that nurse performance is governed by an interplay of organizational climate, individual competence, professional supervision, workload, and psychological empowerment (Dall'Ora et al., 2020; Specchia et al., 2021). Previous international investigations demonstrate that unstable employment status, high nurse-to-patient ratios, and insufficient structured clinical supervision induce work strain and diminish clinical performance standards (Al Maqbali et al., 2021; Shah et al., 2021). However, while literature in tertiary teaching hospitals often reports moderate-to-high performance levels, empirical evidence from regional and secondary hospital inpatient units—where contract staffing and diploma-level qualifications predominate—remains sparse (Kakemam et al., 2021; Wartana et al., 2024).

Preliminary observations conducted among 15 inpatient nurses revealed critical operational issues: while basic interpersonal ethics were preserved, recurring deficiencies were documented in personal safety adherence, dynamic nursing assessments, and synchronized clinical documentation. Although national figures confirm nurses as the largest occupational segment in healthcare (Ministry of Health of the Republic of Indonesia, 2024), empirical baseline data elucidating the distribution of performance across specific competency domains in secondary inpatient units are still urgently required. Therefore, this study aimed to provide a comprehensive evaluation of inpatient nurse performance across socio-demographic and employment characteristics. These empirical findings provide hospital managers with an evidence-based roadmap to design targeted professional development, enhance supervision systems, and improve human resource management.

METHODS

Study Design and Participants

This study utilized a quantitative descriptive cross-sectional design to measure nurse performance across eight inpatient wards. The study population comprised 96 practicing nurses. A total sampling (census) technique was applied, yielding a final sample size of 96 respondents. The inclusion criteria were: 1) Registered nurses actively assigned to inpatient units throughout the data collection period; 2) Nurses with a minimum continuous work experience of one month in the designated wards; 3) Nurses who voluntarily provided signed informed consent. The exclusion criteria were: 1) Nurses on

extended maternity, sick, or study leave during the study period; 2) Nurses occupying purely non-clinical administrative positions or structural managerial roles without direct bedside care responsibilities.

Research Instruments

Data were gathered via a structured, self-administered questionnaire comprising two distinct modules: Socio-demographic Profile: Covering gender, age group, highest formal nursing education, length of service (tenure), and employment classification. Nurse Performance Scale: Adapted from the national clinical practice standards established by the Indonesian National Nurses Association (PPNI). The scale includes 25 items across three core domains: behavioral performance (discipline, responsibility, therapeutic communication, empathy), professional capability (accuracy of clinical execution, technical skill mastery, care delivery quality), and the nursing process (comprehensive assessment, diagnostic formulation, planning, intervention, evaluation). All items were measured on a 5-point Likert scale (1 = "Never / Very Poor" to 5 = "Always / Excellent"). The questionnaire underwent content validity review by a panel of three clinical nurse specialists and psychometric evaluation on 30 non-sampled nurses, yielding a valid Pearson correlation ($r>0.361$) across all items and high internal consistency (Cronbach's $\alpha=0.89$). Overall performance scores were classified into five predefined criteria: Very Good (>95), Good (86–95), Fair (66–85), Poor (51–65), and Very Poor (<50).

Data Analysis

Data were processed using statistical software (IBM SPSS Statistics version 26.0). Descriptive statistical techniques were performed to summarize categorical variables. Both absolute frequencies (n) and relative proportions (%) were calculated for respondent demographic characteristics (gender, age, education level, tenure, employment status) and nurse performance classifications. Continuous score variables were inspected for distribution characteristics and transformed into categorical frequencies according to the standardized cut-off score thresholds.

RESULTS

Table 1. Distribution of Respondent Characteristics (n=96)

Characteristics	Frequency	Percentage (%)
Age (Years)		
21–28	30	31.3
29–35	47	49.0
35–45	19	19.8
Gender		
Female	92	95.8
Male	4	4.2
Education Level		
Diploma in Nursing (D3)	73	76.0
Bachelor in Nursing (S1)	5	5.2
Professional Nurse (Ners)	18	18.8

Characteristics	Frequency	Percentage (%)
Length of Service (Years)		
<1	20	20.8
1–5	43	44.8
>5	33	34.4
Employment Status		
Contract / Honorary	87	90.6
Police Personnel (Polri)	5	5.2
Civil Servant (PNS)	4	4.2
Nurse Performance Categories		
Very Poor (<50)	1	1.0
Poor (51–65)	92	95.8
Fair (66–85)	3	3.1

Table 1 outlines the demographic profile and performance categories of the surveyed nurses (n=96). In terms of age, the largest proportion of respondents belonged to the 29–35 years age bracket with 47 nurses (49.0%), followed by the 21–28 years group with 30 nurses (31.3%), and the 35–45 years group with 19 nurses (19.8%). Regarding gender, female nurses predominated, comprising 92 nurses (95.8%), whereas male nurses accounted for 4 nurses (4.2%). Based on educational attainment, the vast majority held a Diploma in Nursing (D3), representing 73 nurses (76.0%), while 18 nurses (18.8%) attained a Professional Nurse degree (Ners), and 5 nurses (5.2%) held a Bachelor of Nursing degree (S1). Concerning clinical tenure, 43 nurses (44.8%) possessed 1–5 years of work experience, 33 nurses (34.4%) had served for >5 years, and 20 nurses (20.8%) had <1 year of service. Regarding employment classification, 87 nurses (90.6%) were employed under contract/honorary arrangements, with police personnel (Polri) accounting for 5 nurses (5.2%) and civil servants (PNS) representing 4 nurses (4.2%). Lastly, in terms of overall clinical performance, an overwhelming majority fell into the "poor" category with 92 nurses (95.8%), 3 nurses (3.1%) were categorized as "fair", and 1 nurse (1.0%) was classified as "very poor", with zero respondents achieving "good" or "very good" performance.

DISCUSSION

The findings showed that the inpatient nursing cohort was overwhelmingly female (95.8%). Theoretically, nursing demography globally exhibits a pronounced female majority, driven by historical, societal, and career perceptions (Al-Dweik et al., 2021). Contemporary international studies indicate that while female nurses frequently exhibit high relational empathy and interpersonal caring behaviors, gender per se does not constitute an independent clinical predictor of technical performance or diagnostic competency (Labrague et al., 2020; Wartana et al., 2024). In the authors' opinion, gender imbalances in the ward do not inherently constrain clinical outcomes; rather, institutional equity in workload distribution, shift fatigue management, and clinical team empowerment are far more decisive factors in driving nursing performance.

In this study, nearly half of the respondents belonged to the 29–35 years age group (49.0%). According to adult developmental theories and workforce research, individuals in early-to-mid adulthood operate at peak cognitive agility, physical endurance, and functional learning capacity (Specchia et al., 2021; Wartana et al., 2024). International empirical literature indicates that younger and mid-career nurses possess strong technical adaptability but may experience elevated susceptibility to moral distress, shift burnout, and clinical performance lapses when adequate organizational support is absent (Dall'Ora et al., 2020; Shah et al., 2021). The authors argue that having an energetic, productive-aged nursing cadre represents an unexploited institutional asset; without targeted clinical mentoring and structured professional pathways, youthful vitality alone cannot compensate for complex clinical challenges.

The results revealed that 76.0% held a vocational Diploma in Nursing (D3), with only 18.8% possessing a Professional Nurse (Ners) degree. Educational theories emphasize that higher baccalaureate and professional nursing curricula specifically instill advanced diagnostic synthesis, critical reasoning, and autonomous evidence-based decision-making (Aiken et al., 2018; Kakemam et al., 2021). Landmark studies demonstrate a direct correlation between higher proportions of baccalaureate/professional nurses and superior adherence to standardized care plans and documentation rigor (Aiken et al., 2018; Al Sabei et al., 2020). In the authors' opinion, the concentration of diploma-level personnel in inpatient wards explains, in significant part, the observed deficits in the nursing process domain; vocational training focuses primarily on procedural tasks rather than comprehensive diagnostic conceptualization, underscoring the urgent necessity of hospital-sponsored academic degree advancement.

Regarding clinical experience, the largest segment had 1–5 years of tenure (44.8%), while nurses with >5 years comprised 33 respondents (34.4%). Benner’s Novice to Expert model posits that clinical competence evolves progressively with accumulated practical exposure, allowing practitioners to synthesize situational cues and formulate proactive interventions (Platis et al., 2020). However, modern empirical studies indicate that tenure does not linearly translate into superior performance unless reinforced by structured reflective practice, continuous credentialing, and ongoing clinical feedback (Al Maqbali et al., 2021; Kakemam et al., 2021). In the authors' opinion, nurses with 1–5 years of tenure are situated at a vulnerable transition point; without formal clinical preceptor programs, daily ward routines become mechanical, leading to stagnation in performance growth.

A striking 90.6% were employed on a temporary contract/honorary basis, whereas civil servants and police personnel represented less than 10%. Motivational theories, such as Herzberg’s Two-Factor Theory, establish that job security, equitable remuneration, and institutional belonging serve as fundamental hygiene factors whose absence triggers chronic job dissatisfaction and organizational

demotivation (Alilyyani et al., 2018). Recent international research verifies that contractual nurses often grapple with heightened perceived job insecurity, unequal training access, and disparity in financial incentives, which cumulatively dampen clinical performance (Al-Dweik et al., 2021; Labrague et al., 2020). The authors interpret that pervasive contractual arrangements create systemic psychological demotivation; when contract nurses perform equal or heavier shift duties without comparable institutional security, their engagement in thorough clinical documentation and optimal care processes diminishes markedly.

The paramount finding of this study is that 95.8% demonstrated "Poor" clinical performance, and 1.0% demonstrated "Very Poor" performance, with none achieving satisfactory ratings. Organizational performance models indicate that performance reflects the interaction of individual capability, structural empowerment, and work environment climate (Dall'Ora et al., 2020; Specchia et al., 2021). Literature indicates that widespread poor performance rarely stems from isolated individual negligence, but rather points to systemic failures including excessive patient loads, fragmented clinical supervision, and absence of standardized audit-feedback mechanisms (Al Sabei et al., 2020; Kakemam et al., 2021; Wartana et al., 2024). In the authors' opinion, these distressing numbers must be interpreted as a systemic institutional alarm; hospital management must urgently overhaul clinical governance by implementing objective competency checklists, clinical supervision by nurse managers, and fair incentive models.

Several limitations should be noted. First, the cross-sectional descriptive design precludes establishing causal relationships between workforce characteristics and performance scores. Second, data were collected through self-administered questionnaires, which introduces the potential for self-report and social desirability bias. Third, direct observational audits of bedside technical maneuvers and patient-record documentation were not incorporated due to logistical and privacy constraints in inpatient wards.

CONCLUSION

This study demonstrates that clinical nurse performance across the inpatient wards was overwhelmingly classified as poor category. The nursing workforce is predominantly characterized by female nurses, productive age groups, diploma-level qualifications, and contract/honorary employment status. To remediate these systemic performance deficits, hospital administration should urgently institutionalize structured clinical supervision by head nurses, provide equitable access to continuous competency-based training, and establish objective reward mechanisms that support career development regardless of employment classification. Future research should employ longitudinal and multi-method observational designs to identify the causal determinants of nursing care quality in regional hospitals.

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CONFLICT OF INTEREST

The authors hereby declare that this research is free from conflicts of interest with any party.

DECLARATION ON THE USE OF ARTIFICIAL INTELLIGENCE (AI)

The authors declare that no Generative AI or AI-assisted technologies were used in the writing of this manuscript.

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