

Implementation of Training in Improving *Hospitality Services* At Dr. R. Goeteng Taroenadibrata Purbalingga Hospital

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Abstract

This study aims to analyze the implementation of training programs in improving hospitality services at RSUD dr. R. Goeteng Taroenadibrata Purbalingga. The study is motivated by the need to enhance hospital service quality, which should not only focus on medical aspects but also on non-medical aspects such as friendliness, empathy, and effective communication with patients and their families. A qualitative descriptive approach was employed involving 13 informants consisting of hospital employees, health workers, and non-health staff. Data were collected through in-depth interviews, observation, and documentation, and were analyzed using the interactive model of Miles and Huberman, which includes data reduction, data display, and conclusion drawing. The findings indicate that hospitality training has been conducted regularly, covering interpersonal communication, service excellence, and the development of patient-friendly attitudes. The implementation of the training has increased employees' awareness of patient-oriented services. However, several challenges remain, including limited training duration, lecture-dominated learning methods, unequal training opportunities for all staff including outsourced workers, and limited post-training evaluation to measure behavioral changes. Therefore, this study recommends improving interactive training design, expanding participant coverage, and strengthening continuous evaluation to ensure sustainable improvements in hospital hospitality services.

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1. INTRODUCTION

The quality of public health services has become an increasingly critical concern in the management of hospitals, particularly in the context of growing patient expectations and intensifying institutional competition. Healthcare delivery is no longer evaluated solely on the basis of clinical outcomes; patients and their families now assess the totality of their care experience, encompassing the responsiveness, empathy, and communicative competence of every staff member they encounter throughout their visit. This shift in patient expectations has prompted healthcare institutions to adopt principles drawn from the hospitality industry, recognizing that the emotional and psychological dimensions of service are as consequential to patient well-being as the technical quality of medical treatment itself (Berry and Bendapudi, 2007).

Hospitality in healthcare refers to the capacity of an institution and its personnel to create an environment that is welcoming, respectful, and emotionally supportive for patients and their accompanying families. Unlike conventional hospitality settings, the

hospital context introduces a distinct layer of complexity: patients arrive not as willing consumers of a leisure experience but as individuals in states of physical vulnerability, anxiety, and uncertainty. This condition makes the quality of human interaction during care encounters particularly consequential. Research consistently demonstrates that patients who feel respected, listened to, and emotionally supported during hospitalization report higher satisfaction, exhibit greater adherence to treatment plans, and experience measurably better recovery outcomes (Crick and Spencer, 2011). The cultivation of hospitality values within healthcare personnel is therefore not a cosmetic organizational concern but a substantive quality and safety imperative.

Training represents one of the most direct and strategically significant instruments through which healthcare organizations can develop and institutionalize hospitality competencies among their workforce. Mangkunegara (2013) defines training as a structured learning process aimed at enhancing employees' knowledge, skills, and attitudes in ways that are directly applicable to their professional roles. In the healthcare context, training programs focused on hospitality equip personnel with the interpersonal and communicative capabilities necessary to manage diverse patient interactions with professionalism and empathy. Effective training thus bridges the gap between the technical preparation that healthcare workers receive through formal education and the relational competencies demanded by patient-centered care environments.

Despite its recognized importance, the implementation of hospitality training in Indonesian public hospitals remains underexplored in the academic literature. The majority of existing research on hospital human resource development in Indonesia tends to focus on clinical skills training, accreditation compliance, and performance management systems, with comparatively limited attention devoted to the role of hospitality-oriented training as a strategic lever for service quality improvement. This gap is particularly consequential given the distinct organizational and cultural context of Indonesian public hospitals, which must simultaneously navigate regulatory obligations, resource constraints, and rising patient expectations in a post-pandemic healthcare environment.

RSUD Dr. R. Goeteng Taroenadibrata Purbalingga serves as the research setting for this study, representing a regional public hospital that has made deliberate efforts to integrate hospitality training into its human resource development agenda. The hospital provides an informative case for examining how training design, delivery, and participant targeting are operationalized in a real institutional context, and what structural factors facilitate or impede the internalization of hospitality values among healthcare personnel. By analyzing the training implementation through seven dimensions proposed by Mangkunegara (2013), namely type of training, training objectives, training materials, training methods, target participants, trainer qualifications, and training duration and frequency, this study offers a comprehensive evaluative framework that extends beyond surface-level program description.

This study aims to evaluate the implementation of training in improving hospitality services at RSUD Dr. R. Goeteng Taroenadibrata Purbalingga through a qualitative descriptive approach. The findings are expected to contribute to the theoretical development of hospitality-oriented human resource management in healthcare settings, while providing practical recommendations for hospital managers, human resource practitioners, and health policymakers seeking to strengthen service quality through targeted and strategically designed training interventions.

2. RESEARCH METHODS

]This study uses a qualitative approach with a descriptive method to obtain an in-depth picture of the implementation of training in improving hospitality services at dr. R. Goeteng Taroenadibrata Purbalingga Hospital. The selection of informants was carried out by purposive sampling with a total of 13 people consisting of medical employees, non-medical employees, and outsourced personnel involved in services to patients. Data were collected through in-depth interviews, observations, and documentation studies related to the implementation of training and hospital service policies. The data analysis process uses the Miles and Huberman interactive analysis model which includes three stages, namely data reduction, data presentation, and conclusion/verification. The validity of the data is maintained through the triangulation technique of sources and methods, by comparing the results of interviews, direct observations, and official documents to ensure the accuracy and consistency of the research findings

3. RESULTS AND DISCUSSION

3.1. Results

This study examines the implementation of training in improving hospitality services at RSUD Dr. R. Goeteng Taroenadibrata Purbalingga using a qualitative descriptive approach. Data were gathered through in-depth interviews with key informants comprising physicians, nurses, midwives, administrative officers, security personnel, and cleaning staff. Analysis was guided by seven training dimensions proposed by Mangkunegara (2013): type of training, training objectives, training materials, training methods, target participants, trainer qualifications, and training duration and frequency.

The hospital has designed and implemented various training programs targeting both medical and non-medical personnel, primarily centered on interpersonal values empathy, courtesy, and professional service ethics rather than solely technical competencies. Programs are delivered in the form of seminars, briefings, and thematic workshops covering effective communication, premium service embodying the 3S principle (*Senyum, Salam, Sapa*), emotional management, and patient interaction etiquette. The training is predominantly organized by the internal education and training (*Diklat*) unit, reflecting a need-based approach wherein sessions are triggered by operational dynamics and internal evaluation outcomes rather than a fixed calendar. While the design reflects a systematic institutional commitment, the findings reveal persistent inconsistencies in implementation: not all staff units have equal access to training, particularly support units such as cleaning services, which had not participated in formal hospitality training at the time of data collection.

The overarching objectives of the training are well-articulated and strategically oriented. Informants from nursing, medical, and administrative units consistently affirmed that the training aims to form a professional and empathetic work attitude, improve patient satisfaction through emotional and psychological comfort, and build a positive and collaborative organizational culture. Using Kirkpatrick's (1959) four-level evaluation framework as an analytical lens, the findings indicate positive outcomes at Level 1 (Reaction) and Level 2 (Learning), with Level 3 (Behavior) partially achieved and Level 4 (Results) showing preliminary improvements in patient satisfaction scores related to non-medical service dimensions, including reductions in patient complaints concerning staff conduct and increased scores in courtesy and communication clarity.

The training curriculum is structured around core interpersonal and service communication competencies. Key topics include effective verbal and non-verbal communication with patients, empathy expression and active listening, service ethics

and professional deportment, stress and emotional management under difficult patient interactions, and case studies drawn from substandard service incidents and their resolutions. The materials are dynamic and adjusted to emerging service challenges, though they tend to remain conceptually oriented rather than practice-driven. Informants noted that the absence of structured simulations and role-playing scenarios reduces the effectiveness of material internalization, as learners benefit more from experiential rather than didactic instruction.

In terms of delivery methodology, current training is dominated by conventional lecture-based approaches (*ceramah*), supplemented with limited use of group discussions, case studies, and occasional role-play simulations. The findings reveal that the program is in a transitional phase between traditional and more participatory approaches. Most informants expressed a clear preference for interactive methodologies, particularly scenario-based simulations and small group discussions which are perceived as more effective in cultivating attitudinal and behavioral change. The predominance of the lecture method is partly attributed to efficiency constraints within the hospital's tight operational schedule, though its limitations in addressing the affective dimensions of hospitality, such as empathy internalization and emotional responsiveness, are well acknowledged by participants.

Regarding participant targeting, the hospital adopts an inclusive strategy that formally covers medical personnel (physicians, nurses, midwives), administrative staff, security officers, nutritionists, and auxiliary workers. This broad scope reflects an institutional awareness that patient experience is shaped by every service touchpoint within the hospital environment, not solely by clinical interactions. However, the data indicates disparate actual participation rates across units: frontline clinical and administrative units tend to have higher engagement, while peripheral support units particularly housekeeping report limited or no involvement in formal hospitality training programs, an inequity that undermines the goal of embedding a uniform service culture organization-wide.

Training facilitators are primarily sourced internally from management and the *Diklat* unit. Internal trainers demonstrate a strong contextual understanding of the hospital's operational workflows and organizational culture, enabling them to anchor content to real-world service scenarios. Nevertheless, two limitations of internal facilitation emerge from the findings: a tendency toward conventional, one-directional delivery styles that limit active participant engagement, and informal group dynamics between trainers and trainees who are often colleagues, which can diminish the seriousness of the learning environment. There is a recognized institutional need to supplement internal facilitation with external hospitality specialists capable of introducing fresh pedagogical approaches and industry benchmarks.

Each training session is conducted within a 3–5 hour timeframe, typically from morning to midday to accommodate clinical service schedules, with a minimum frequency of once per year. This duration is considered adequate for introductory content delivery but is viewed as insufficient for complex materials requiring practical reinforcement. The annual-only frequency presents a significant continuity challenge, as extended intervals between sessions increase the likelihood of value erosion and behavioral regression. Informants suggested a differentiated approach: longer and more comprehensive training for newly recruited employees, and shorter but more frequent refresher formats for experienced staff, ensuring continuous reinforcement of hospitality values within the institutional culture.

3.2. Discussion

The findings of this study illuminate both the strengths and structural limitations in the implementation of hospitality training at RSUD Dr. R. Goeteng Taroenadibrata Purbalingga. The training program reflects a deliberate strategic orientation toward service differentiation and humanistic care. Drawing on Sedarmayanti's (2014) concept of distinctive competence, the training functions as an internal capability development mechanism that enables the hospital to differentiate itself through the quality of interpersonal service rather than physical infrastructure alone. This alignment is consistent with Berry and Bendapudi's (2007) application of hospitality principles to healthcare settings, wherein patient-centered service is not a peripheral concern but a core competitive asset. The inclusive targeting strategy that encompasses medical, paramedical, administrative, and support staff further demonstrates an organizational understanding that hospitality is a collective institutional responsibility rather than a role-specific function.

However, a gap between strategic intent and operational execution becomes evident when examining actual participation rates. Crick and Spencer (2011) argue that hospitals achieving comprehensive integration of hospitality values across service functions generate not only higher patient satisfaction but also sustainable competitive advantages. The consistent exclusion of housekeeping and ancillary units from formal training participation undermines this aspiration. For training to serve as a genuine competitive differentiator, its coverage must be both systematically planned and rigorously monitored, ensuring that every service touchpoint within the hospital environment reflects the same standard of humanistic care.

Applying Kirkpatrick's (1959) four-level evaluation framework provides a structured lens through which to assess the overall effectiveness of the training initiative. At Level 1 (Reaction), participants generally respond positively to the training content, perceiving it as relevant to their daily service responsibilities. At Level 2 (Learning), the training has succeeded in conveying key conceptual frameworks including effective communication, patient rights, empathetic listening, and interpersonal ethics. However, the predominantly lecture-based delivery limits the depth of cognitive and affective internalization. As Noe (2017) emphasizes, adult learners in professional settings benefit most from active and experiential learning methodologies, and the current over-reliance on didactic instruction constrains the development of tacit knowledge and experiential competency, both of which are critical for genuine hospitality practice.

At Level 3 (Behavior), measurable but uneven behavioral change is evident across the organization. Trained staff report improvements in patient greeting conduct, tone of communication, and responsiveness to complaints, yet these changes are not uniformly distributed across units. Kirkpatrick and Kirkpatrick (2006) assert that behavioral transfer from training to the workplace is contingent not only upon the quality of training design but also upon the existence of supportive organizational conditions, including managerial reinforcement and performance feedback mechanisms. The absence of such structural supports within certain units helps explain the observed unevenness in behavioral outcomes. At Level 4 (Results), management informants report preliminary improvements in patient satisfaction scores within non-clinical service dimensions, pointing toward a positive organizational impact. Nevertheless, the absence of a systematic pre- and post-training measurement instrument limits the rigor of outcome attribution, and the operationalization of a

formal evaluation system aligned with return-on-training-investment principles (Phillips, 2003) remains a priority for future institutional development.

The dominance of lecture-based instruction represents a central methodological limitation that warrants particular attention. Contemporary training theory strongly advocates for blended learning approaches that combine conceptual instruction with experiential methods such as role-playing, simulation, and problem-based learning (Kolb, 1984; Mezirow, 1991). In the healthcare hospitality context, simulation-based training is especially valuable because it allows practitioners to rehearse emotionally complex interactions, including managing anxious patients, handling complaints, and delivering sensitive information, in a safe and controlled environment before encountering them in actual clinical practice. The inequity in training participation across organizational units compounds this concern, as a hospitality culture that is inconsistently embedded across service touchpoints creates an uneven patient experience that can undermine institutional trust and reputation. Goldstein and Ford (2002) argue that effective training needs analysis must encompass all roles within a service delivery system to ensure comprehensive competency alignment.

The broader implications for human resource management in healthcare are significant. The training implementation at RSUD demonstrates that public healthcare institutions in Indonesia are increasingly cognizant of the strategic value of hospitality as a quality driver. This reflects a wider trajectory in health services management literature, wherein clinical quality and service experience are progressively integrated into unified patient-centered care paradigms (Luxford, Safran and Delbanco, 2011). Mangkunegara (2013) emphasizes that effective training must be specific, measurable, and aligned with strategic human resource priorities. For hospitality-oriented training to move beyond a ceremonial function and become a genuine instrument of organizational transformation, the hospital must invest in increasing training frequency to a minimum of bi-annual cycles, transitioning toward experiential and simulation-based methodologies, developing internal trainer competencies through structured training-for-trainer programs, selectively engaging external hospitality specialists to diversify facilitation approaches, and establishing a formal evaluation mechanism aligned with the Kirkpatrick framework to systematically track training impact across all levels.

Finally, in the context of Indonesia's transition toward a knowledge and service-intensive economy under Industry 4.0 and 5.0 frameworks (Andriani et al., 2021), healthcare organizations face escalating demands for adaptive and multi-competent human capital. Hospitality training, when strategically designed and consistently implemented, contributes not only to immediate service quality improvements but to the formation of a resilient, patient-centric organizational culture capable of sustaining competitive performance in an evolving healthcare landscape. The present study affirms that the foundations for such a culture are already being laid at RSUD Dr. R. Goeteng Taroenadibrata Purbalingga, while also underscoring that realizing its full potential requires a more systematic, inclusive, and methodologically diversified approach to training design and delivery.

4. CONCLUSION

This study concludes that hospitality service training at RSUD dr. R. Goeteng Taroenadibrata Purbalingga has been implemented in a planned and regular manner as part of the hospital's efforts to improve the quality of non-medical services. The training covers essential topics such as service excellence principles, interpersonal communication,

complaint management, work ethics, and the development of a patient-oriented service culture. The implementation of this program has contributed positively to increasing employees' awareness of the importance of friendly, respectful, and communicative service. In several service units, the training has also encouraged observable behavioral changes, particularly in how staff interact with patients and their families.

Nevertheless, the effectiveness of the training has not yet reached its full potential. Several limitations were identified, including the relatively short duration of the training, the dominance of lecture-based learning methods, unequal participation among employees, especially outsourced staff, and the absence of a comprehensive post-training evaluation system. Although improvements have been observed in certain aspects of service quality, particularly in the dimensions of responsiveness and assurance, these improvements have not been evenly experienced across all hospital units. These findings indicate that improvements in training design, delivery methods, and evaluation mechanisms are necessary to ensure that positive behavioral changes can be sustained over time and consistently reflected in daily service practices.

Based on these findings, it is recommended that the hospital further develop its hospitality training program by incorporating more interactive learning approaches such as simulations, role playing, and case-based discussions. These methods can encourage greater participant engagement and enable employees to internalize service excellence principles more effectively. Equal access to training opportunities should also be ensured for all categories of staff, particularly outsourced personnel who frequently interact with patients and visitors, so that service quality remains consistent throughout the organization. In addition, the evaluation system should be strengthened by adopting a comprehensive framework such as the Kirkpatrick model, which assesses not only participants' reactions and learning outcomes but also behavioral changes in the workplace and their impact on patient satisfaction. Integrating the results of these evaluations into employee performance appraisal systems would further reinforce positive service behaviors through recognition and incentives. Through these improvements, hospitality service training at RSUD dr. R. Goeteng Taroenadibrata Purbalingga is expected to produce more substantial and sustainable contributions to the overall quality of hospital services.

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