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Present But Not Punctual: The Discipline Visibility Gap In An Islamic Hospital In West Sumatra

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Abstract

Hospitals commonly monitor employee discipline through attendance systems, yet patient safety depends on behaviors that attendance data cannot see. This study examines whether attendance-based monitoring conceals discipline lapses in a hospital, a question that the Indonesian human resource literature, which mostly estimates predictors of discipline, has rarely asked. We applied a single-case convergent mixed-methods design at Rumah Sakit Islam Ibnu Sina Padang, Indonesia. We integrated 14 months of attendance records, 15 discipline lapses documented by the quality and nursing divisions, nine staff interviews, and a survey of 137 employees. No unexcused absence was recorded, yet 11 to 25 of 208 employees (mean 8.0%) were late every month, with no downward trend. All 15 documented lapses concerned clinical safety, handover, documentation, or professional commitment, which attendance data cannot detect. Employees rated punctuality (TCR 68.1%) and leaders' role modeling (68.5%) lowest among five discipline indicators. The study introduces the discipline visibility gap as a new concept and recommends adding procedure-based indicators to hospital discipline monitoring.

Keywords: Work Discipline, Attendance Monitoring, Hospital Human Resources, Patient Safety, Mixed Methods

INTRODUCTION

Work discipline is an employee's awareness and willingness to obey organizational rules and the social norms that apply (Hasibuan, 2019). In most organizations, weak discipline raises costs and lowers productivity. In a hospital, it also endangers patients. A skipped surgical time-out, an unstructured shift handover, or an incomplete medication log is a discipline failure with clinical consequences. A recent meta-analysis found that compliance with the WHO Surgical Safety Checklist was only 73% worldwide, fell to 61% for the time-out phase, and that only 51% of checklists were completed in full (Habtie et al., 2025). Missed nursing care, in turn, has been linked to patient dissatisfaction and higher

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hospital costs (Janatolmakan & Khatony, 2022). In Indonesia's national insurance system, discipline lapses in paperwork carry a direct financial price, because incomplete supporting documents are the most common administrative cause of pending inpatient claims (Maulida & Djunawan, 2022).

Rumah Sakit Islam Ibnu Sina Padang, a private Islamic hospital in West Sumatra with 208 employees across 26 work units, illustrates the problem. Its management has set a target that no employee should be late or absent without notice. Its attendance records for January 2024 to February 2025 show that no employee was absent without notice in any month, which suggests compliance. The same records show that 11 to 25 employees were late every month. Meanwhile, the hospital's quality and nursing divisions documented a range of lapses between June and August 2025 that never appear in attendance data: physicians who gave unstructured handovers and skipped checklist steps, nurses who left emergency drug logs unfilled, and non-medical staff who submitted insurance claim files close to the deadline.

Research on work discipline in Indonesia has mostly asked what predicts discipline. Leadership style, work environment, and job satisfaction are the usual candidates, and leadership has been shown to relate to discipline and performance in public organizations (Sudirman & Baviga, 2026). Much less attention has gone to a prior question: how is discipline observed, and what does the observation system leave out? Research by lecturers of the author's university has examined an electronic performance application for improving discipline and performance (Agusnita & Assyahri, 2024), punctuality and timeliness in public service management (Bila & Assyahri, 2023), and employee performance in a hospital in Bukittinggi (Bila et al., 2023), but not the visibility of discipline lapses. To our knowledge, few studies have set routine attendance data side by side with documented clinical and procedural lapses in the same hospital. Without this comparison, a hospital can report high compliance while the behaviors that matter most for safety remain unmonitored.

This study therefore pursues four objectives: (1) to describe the pattern of attendance-based discipline in the case hospital; (2) to classify documented discipline lapses by domain and determine whether routine attendance data could detect them; (3) to compare these records with employees' self-rated discipline across the five indicators of Hasibuan (2019); and (4) to propose a concept, the discipline visibility gap, that explains why formal compliance and actual discipline can diverge. The novelty of the study lies in treating discipline monitoring itself, rather than its predictors, as the object of analysis in a hospital setting, and in integrating four independent data sources to do so.

The study sought to answer the question: does attendance-based monitoring in a hospital conceal discipline lapses? The results are expected to inform hospital managers,

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quality committees, and human resource units on what a discipline monitoring system should include, and to add a hospital-based perspective to the human resource literature.

THEORETICAL REVIEW

Hasibuan (2019) defines discipline as awareness and willingness to comply with rules and norms, and operationalizes it through five indicators: goals and ability, the leader as a model, punctuality, fairness, and responsibility in carrying out tasks. Mangkunegara (2013) similarly separates discipline into compliance with rules and willingness to carry out instructions. Both views imply that discipline has a visible side (being present and on time) and a less visible side (carrying out tasks to standard even when no one is checking). Only the first side can be read from a time clock. Leaders are also expected to motivate employees to manage their time with discipline (Rijal & Muhlis, 2025), and an IJBQR study found that workload and work stress lower employee performance (Laia & Ermalina, 2026), which suggests that conditions beyond individual will also shape workplace behavior.

In clinical settings, the less visible side of discipline takes the form of protocol adherence. Surgical safety checklist compliance is suboptimal and often incomplete worldwide, and the barriers identified include high workload, lack of ownership of the checklist, weak audit systems, and resistance to change, while management support and regular monitoring with feedback improve compliance (Habtie et al., 2025). Structured handover tools such as SBAR have been studied for their effect on patient safety (Müller et al., 2018), and a recent review reports that structured training supports adherence to such tools (Rasiya & Raheem, 2025). On the administrative side, incomplete supporting documents are the leading cause of pending claims in Indonesian hospitals (Maulida & Djunawan, 2022). The consequences of lapses in care can reach patients, nurses, and the organization (Janatolmakan & Khatony, 2022).

What this literature shares is that each lapse is detected through a dedicated audit, not through attendance monitoring. Yet in hospital human resource management, discipline is often tracked through attendance and punctuality. The two worlds rarely meet in a single analysis.

This study defines the discipline visibility gap as the share of discipline domains, or of documented discipline lapses, that routine monitoring indicators cannot detect. A hospital has a large gap when its main discipline indicator (for example, unexcused absence) is satisfied while lapses accumulate elsewhere. Three analytical expectations follow from this definition. First, attendance indicators should show high formal compliance. Second, documented lapses should concentrate in domains outside attendance. Third, employees'

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perceptions should show weakness in the behaviors that connect the two, namely punctuality in work activities and leaders' role modeling. The study tests these expectations descriptively in one case.

METHOD

Research Design

The study used a single-case, convergent mixed-methods design (Yin, 2018; Creswell & Plano Clark, 2018), in which documentary records, interviews, and a cross-sectional survey were collected independently and integrated at the interpretation stage. The focus was discipline monitoring in one hospital. The three analytical expectations were tested descriptively, and no inferential model was estimated on the survey.

Setting and Study Population

The case was Rumah Sakit Islam Ibnu Sina Padang, Jalan Gajah Mada, Padang Utara, Padang City, West Sumatra, a private hospital under the Yayasan Rumah Sakit Islam Sumatera Barat. It was selected because its management sets zero tolerance for lateness and unexcused absence, which makes attendance the declared discipline benchmark. The population comprised all 208 employees across 26 work units, including specialist and general physicians, nurses, midwives, pharmacy, laboratory, and administrative and support staff.

Sampling Technique Procedure

For the survey, the sample size was determined with Slovin's formula at a 5% margin of error (Sugiyono, 2019), which gave 137 respondents, drawn by cluster random sampling with work units as clusters and proportional allocation. The attendance records covered the whole workforce for 14 months, and the lapse registers covered all lapses recorded by the quality and nursing divisions in the study window. Interviews were held with one employee from each of nine units (casemix, nutrition, laboratory, pharmacy, inpatient nursing, general administration, cashier, sterilization and laundry, and medical technician).

Instruments

Four instruments were used:

The attendance record was the monthly recapitulation of employees recorded as late, on leave, and absent without notice, from January 2024 to February 2025 (14 months). The

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lapse register consisted of lists of physician and nurse discipline lapses documented by the hospital's quality division and nursing division between June and August 2025, plus one administrative case reported by the casemix unit. Interview was a conversation with each informant about conditions and behavior in the informant's unit, held on 9 to 13 March 2025.

Work Discipline Questionnaire measured discipline with 18 closed items on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree), built on the five indicators of Hasibuan (2019): goals and ability (4 items), leader as a model (4), punctuality (4), fairness (3), and responsibility (3). It contains positive and negative statements, and negative statements were reverse-scored, so that a higher score always indicates more disciplined behavior. Sample items include "I try to be on time at every activity or meeting" and "I finish tasks on time according to targets".

Data Collection

Attendance and quality records were obtained from the hospital's personnel administration, quality division, and nursing division. Interviews were conducted in March 2025, and the questionnaire was administered in November 2025 to the 137 selected employees, all of whom were included in the analysis. Participation was voluntary, respondents' answers were treated as confidential, and interviewees were identified by work unit only.

Data Analysis

Attendance data were summarized with means, standard deviations, a 95% confidence interval, and the share of the 208 employees recorded as late. Trend was tested with Spearman's rank correlation and a linear regression of monthly lateness on a month index. The lapse registers were coded deductively into domains derived from the literature (clinical safety protocols, handover and coordination, documentation and administrative compliance, and professional commitment). For each lapse, the author asked whether routine attendance data (arrival time, absence, or leave) could detect it. Interviews were analyzed thematically and are reported through paraphrase. Survey data were analyzed descriptively, through item means, indicator means, the respondent achievement level (TCR = mean ÷ 5 × 100%), and percentage distributions. Credibility was supported by triangulating the four sources, by explicit coding rules that can be replicated, and by reporting survey results at the item and indicator level. The four sources were compared in a joint display (Table 6).

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RESULTS

Table 1: Participants' Demographic Information

Variable	Categories	Frequency	%
Gender	Female	82	59.85
	Male	55	40.15
Age	< 25 years	25	18.25
	25–30 years	63	45.98
	31–35 years	25	18.25
	36–40 years	15	10.95
	> 40 years	9	6.57
Education	Senior high school	50	36.50
	Diploma (D3)	24	17.52
	Bachelor/D4	36	26.28
	Professional	26	18.98
	Master	1	0.72
Length of service	1–5 years	28	20.44
	6–10 years	53	38.69
	11–15 years	35	25.55
	16–20 years	12	8.76
	> 20 years	9	6.56
Total		**137**	**100.0**

Table 1 presents the demographic profile of the 137 survey respondents. Descriptive statistics revealed that most respondents were female (59.85%), the largest age group was 25–30 years (45.98%), the largest education group was senior high school or equivalent (36.50%), and the largest group by length of service had worked for 6–10 years (38.69%).

Attendance records: formal compliance with persistent lateness

Table 2: Monthly attendance records, January 2024–February 2025 (N = 208 employees)

Month	Employees late	% of 208	Employees on leave	Absent without notice
Jan 2024	13	6.3	9	0
Feb 2024	25	12.0	6	0
Mar 2024	11	5.3	7	0
Apr 2024	17	8.2	4	0

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Month	Employees late	% of 208	Employees on leave	Absent without notice
May 2024	18	8.7	6	0
Jun 2024	22	10.6	5	0
Jul 2024	14	6.7	3	0
Aug 2024	12	5.8	3	0
Sep 2024	16	7.7	4	0
Oct 2024	19	9.1	3	0
Nov 2024	17	8.2	5	0
Dec 2024	14	6.7	6	0
Jan 2025	16	7.7	13	0
Feb 2025	18	8.7	9	0
Mean (SD)	**16.6 (3.8)**	**8.0**	**5.9 (2.8)**	**0**

Source: hospital personnel administration records.

Table 2 shows that no employee was recorded as absent without notice in any of the 14 months, so the declared benchmark of zero unexcused absence was met. The lateness target of zero, however, was never met. Between 11 and 25 employees were late each month (mean = 16.6, SD = 3.8, 95% CI [14.4, 18.8]), which equals 8.0% of the workforce on average and ranged from 5.3% to 12.0%. Figure 1 shows that lateness did not decline over time. The fitted slope was −0.05 employees per month (p = .86; Spearman's ρ = .07, p = .81), which indicates a stable level and not a passing episode.

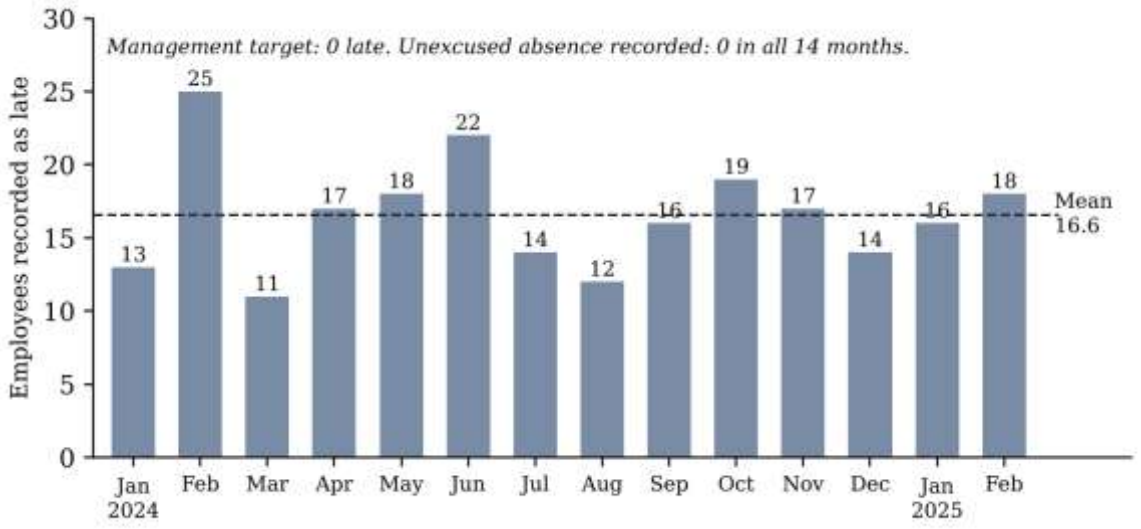


Figure 1. Employees recorded as late per month, January 2024–February 2025

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Documented lapses: what attendance data cannot see

Table 3: Documented discipline lapses by domain (June–August 2025)

Domain	n	Documented lapses (examples)	Detectable from attendance data?
Clinical safety protocols	7	Surgical time-out and sign-out steps skipped; time-out omitted before minor invasive nursing procedures; side-rail and fall-risk tags not applied; vital-sign monitors not calibrated; antibiotic stewardship gaps; clinical guidelines not followed; defensive over-testing	No
Handover and coordination	3	Physician handover not structured (SBAR); emergency department summary delivered late to wards; night-shift nurses leaving before checking supplies	No
Documentation and administrative compliance	3	Emergency drug stock log left incomplete; insurance claim files assembled close to the deadline; referral pathway bypassed	No
Professional commitment	2	Dual-practice schedules reducing hospital follow-up; low participation in quality programs	No
Total	**15**		**0 of 15**

Source: quality division, nursing division, and casemix unit records; coding by the author.

Table 3 reports 15 documented lapses, 8 among physicians, 6 among nurses, and 1 in claim administration. Seven concerned clinical safety protocols, three concerned handover and coordination, three concerned documentation and administrative compliance, and two concerned professional commitment. None of the 15 could have been detected from arrival times, absence records, or leave data. The registers also note consequences, including delayed follow-up of patients, higher nurse workload, and rejected insurance claims.

Interview evidence

Four themes emerged from the interviews. The first is deadline-driven work. A case mix staff member explained that claim files are often assembled near the submission deadline, that supporting documents are missing, and that rejected claims become a loss for the hospital. The second is compliance without commitment. A nutrition unit employee said that work follows the standard operating procedure, but that inspiring direction from superiors is almost absent, and a sterilization and laundry employee said that mistakes are corrected with a verbal reprimand and no coaching to prevent repetition. The third is distance from leaders. A laboratory employee reported that superiors hardly know staff

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members' personal circumstances. The fourth is working conditions that delay tasks, such as a medical technician queuing for shared equipment, a hot pharmacy room with a broken air conditioner, and noise from trolleys and imaging equipment that disturbs nurses' concentration.

Survey: employees' self-rated discipline

Table 4: Self-rated work discipline by indicator (N = 137)

Indicator (Hasibuan, 2019)	Items	Mean	TCR (%)	Category
Goals and ability	4	3.70	74.0	Fair
Leader as a model	4	3.43	68.5	Fair
Punctuality	4	3.41	68.1	Fair (lowest)
Fairness	3	3.71	74.2	Fair
Responsibility	3	3.74	74.7	Fair (highest)
Overall discipline	**18**	**3.58**	**71.7**	**Fair**

TCR = respondent achievement level (mean ÷ 5 × 100). Categories follow the fair band of 60–80%.

Table 4 shows that overall self-rated discipline was fair (mean = 3.58; TCR = 71.7%). The lowest indicators were punctuality (68.1%) and the leader as a model (68.5%), while responsibility (74.7%), fairness (74.2%), and goals and ability (74.0%) were rated higher. Table 5 presents selected items behind these patterns.

Table 5: Selected discipline items (N = 137)

Item (abbreviated)	Mean	% scoring 4–5	% scoring 1–2
P13. I try to be on time at every activity or meeting	3.09	38.0	24.1
P12. I finish tasks on time according to targets	3.26	48.2	18.2
P11. I always arrive according to schedule	3.47	56.9	13.9
P15.* I experience lateness arriving at work	3.81	73.0	11.7
P6. My leader always arrives on time and is an example	3.64	62.0	13.1
P8. I am motivated to be disciplined by my leader's example	3.31	56.9	27.7
P10.* Leaders give unclear direction on applying discipline	3.36	49.6	24.8
P25.* I am careless in tasks because I rush	3.96	84.7	9.5
P3. I have adequate ability to finish work to hospital standards	4.01	81.0	4.4

**Negative statement, reverse-scored: a score of 4–5 means the respondent rejects the statement.*

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Only 38.0% of respondents scored 4–5 on trying to be on time at activities and meetings (P13), the lowest-rated item, while 24.1% scored 1–2. Arrival on schedule (P11) was rated higher (56.9%) than finishing tasks on time (P12; 48.2%). On the reverse-scored lateness item (P15), 11.7% of respondents admitted to lateness, an order of magnitude similar to the 8.0% monthly rate in the attendance records, although the bases differ. Leaders' modeling was rated modestly: 62.0% agreed that leaders arrive on time, and 56.9% felt motivated by leaders' example. By contrast, self-rated care and ability were high (84.7% on P25 and 81.0% on P3).

Testing the analytical expectations

Table 6: Joint display of findings

Question	Attendance records	Lapse registers and interviews	Survey	Convergence
Is formal compliance achieved?	Zero unexcused absence in 14 months	Not applicable	Arrival on schedule rated 3.47	Partial
Is time discipline achieved?	8.0% late monthly; no downward trend	Claims assembled near deadlines; delays from shared equipment	Punctuality lowest indicator (68.1%)	Yes, weakness confirmed
Where do other lapses occur?	Not visible	15 lapses, all outside attendance domain	Responsibility rated highest (74.7%)	Divergent (perception vs. record)
What links them?	Not visible	Compliance by SOP only; reprimand without coaching; distance from leaders	Leader as model second lowest (68.5%)	Yes, leadership gap

Source: author's integration of Tables 2–5 and interview data.

Table 6 shows that the three analytical expectations were supported in this case. Attendance indicators showed high formal compliance, with zero unexcused absence in all 14 months. All 15 documented lapses concentrated in domains outside attendance. Employees' perceptions were weakest in punctuality and in leaders' role modeling, the behaviors that connect formal compliance to substantive discipline.

DISCUSSION

The central finding is that the hospital's main discipline indicator and its actual discipline problems occupy different places. Unexcused absence was zero in every month, which would satisfy a manager reading attendance reports. Yet lateness persisted at about

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8% of staff with no downward trend, and all 15 documented lapses lay outside what attendance can measure. This is the discipline visibility gap in operation: 0 of 15 lapses detectable, in a hospital that reports full compliance on its declared benchmark. A stable lateness level further suggests that the cause is structural, since a one-off disturbance would be expected to fade.

The pattern of lapses is consistent with the international evidence, but the explanation differs. Studies of surgical checklists report suboptimal compliance and incomplete use worldwide, and they identify weak audit systems and lack of ownership as barriers,, and management support and regular monitoring with feedback as enablers (Habtie et al., 2025). The lapses recorded here, including skipped time-out steps and unstructured handovers, fit that profile. Structured handover and training have been associated with better adherence (Müller et al., 2018; Rasiya & Raheem, 2025), yet the case hospital's monitoring architecture offers no routine way to observe either. In the administrative domain, the claim files assembled near deadlines mirror the incomplete-document problem that dominates pending claims in Indonesian hospitals (Maulida & Djunawan, 2022), and the consequence is financial. The costs of lapses in care for patients and organizations (Janatolmakan & Khatony, 2022) underline why the invisible side of discipline matters.

The survey adds a perception gap. Employees rated their own responsibility and ability highest, yet records show clinical and procedural lapses. These two observations are not necessarily contradictory, since the registers cover specific events while the survey captures self-image, and social desirability may inflate self-ratings. The interpretation is also limited because the lapses cannot be linked to individual respondents. What the integration does support is that employees' weakest self-rated behaviors, punctuality at activities and leaders' role modeling, are exactly the behaviors that connect formal compliance to substantive discipline. This agrees with Hasibuan (2019), who treats leaders as models whose own conduct shapes subordinates' discipline, and with a study published in the International Journal of Business and Quality Research that recommends leaders provide exemplary behavior and open two-way communication to strengthen discipline (Sudirman & Baviga, 2026). The interviews point to the same pattern: compliance by procedure alone, reprimand without coaching, and leaders who are distant from staff. Work at another Islamic hospital in West Sumatra has likewise been linked to staff professionalism and motivation (Delita et al., 2024), which is consistent with an arrangement that depends on individual commitment more than on monitoring.

The study makes three contributions. Conceptually, it introduces the discipline visibility gap, which shifts attention from predictors of discipline to the observation system

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itself. Empirically, it integrates attendance records, lapse registers, interviews, and a survey in one hospital, which is a combination rarely reported in the discipline literature. Practically, it suggests that hospitals complement attendance monitoring with procedure-based indicators, for example the rate of complete surgical checklists, structured-handover audits, completeness of emergency drug logs, and the lead time of claim submission before the deadline, and that unit heads make their own punctuality and compliance visible. Because the indicators come from processes that hospitals already audit, adding them to a single discipline dashboard may be feasible without new data collection. Digital attendance tools can help, as an electronic performance application has been used to improve discipline and performance in public organizations (Agusnita & Assyahri, 2024), but the present results caution that such tools observe only one domain of discipline.

CONCLUSION

The study set out to examine whether attendance-based monitoring conceals discipline lapses in a hospital. In the case hospital, attendance records showed formal compliance (zero unexcused absence in 14 months) but persistent lateness (mean 8.0% of employees monthly, no downward trend). All 15 documented lapses fell in clinical safety, handover, documentation, and professional commitment, and none was detectable from attendance data. Employees rated punctuality and leaders' role modeling lowest among the five discipline indicators. These results support the proposed discipline visibility gap: a hospital can meet its declared discipline benchmark while the behaviors most relevant to patient safety remain unmonitored.

Recommendations

The study put forth the following recommendations:

First, hospital management should add procedure-based discipline indicators to its monitoring system, such as the rate of complete surgical checklists, structured-handover audits, completeness of emergency drug logs, and the lead time of claim submission before the deadline, and report them on the same dashboard as attendance.

Second, unit heads should make their own punctuality and compliance visible and replace reprimand-only correction with brief coaching, since leaders' role modeling and punctuality were the weakest self-rated indicators. Third, attendance data should be read together with periodic audits and staff interviews, so that a favorable attendance record is not mistaken for overall discipline.

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Limitations and suggestions for further study

The study has limitations. It is a single case in one private hospital, so the findings cannot be statistically generalized. The lapses were coded by one author, and a second coder would strengthen reliability. Attendance records (14 months), lapse registers (three months), interviews (March 2025), and the survey (November 2025) cover different periods, and lapses cannot be linked to individual employees. The survey is self-reported and was analyzed descriptively, and the interviews were brief and role-anonymized. Future studies should replicate the approach in several hospitals, add direct observation or audit data for clinical protocols, link discipline indicators to leadership measures, and test whether introducing procedure-based indicators narrows the gap.

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