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QUALITATIVE STUDIES

Implementing a hybrid team–primary nursing model to enhance role clarity and care coordination in the hospital: A qualitative evaluation

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Abstract
Strengthening role clarity and care coordination among healthcare professionals is essential to address fragmented workflows and inconsistent continuity of care. Such a lack of systemic cohesion often results in operational gaps that compromise patient safety and clinical efficacy. These challenges manifested as overlapping nursing roles, documentation inconsistencies, and deficient interdisciplinary communication within the shift-based care system. In response, the hospital implemented a hybrid team–primary nursing model as a pilot organizational intervention to enhance coordination. However, a formal evaluation of this program has yet to be conducted to drive continuous hospital service improvements, particularly at the RS PKU Muhammadiyah Wonosobo, Indonesia. Therefore, the study aimed to explore healthcare professionals' experiences and perceptions regarding the implementation of the hybrid model, including its perceived benefits, challenges, and impact on nursing practice. A descriptive qualitative design was utilized to explore staff experiences rather than measure the intervention's effectiveness. This choice was appropriate given that the model had already been implemented before data collection. Data were collected at the RS PKU Muhammadiyah Wonosobo, Indonesia, from May until July 2025. Data were obtained through in-depth interviews, observations, and document reviews involving 18 participants from various multidisciplinary roles. Thematic analysis was conducted following Braun and Clarke's six steps, supported by triangulation and member checking to ensure methodological trustworthiness. The finding documented five themes as follows clearer role division and coordination, enhanced patient familiarity and continuity of care, improved interprofessional collaboration, balanced workload and strengthened supervision, and early adaptation challenges. The hybrid team–primary model remains feasible and relevant for enhancing coordination, accountability, and communication. Future studies should consider mixed-method or quantitative designs to evaluate the model's effectiveness.

Keywords: Care coordination, hybrid team–primary, nursing model, qualitative study, role clarity

Introduction

Global healthcare systems are facing unprecedented pressure driven by escalating patient complexity, workforce shortages, and intensified mandates for clinical quality and safety (Filip et al., 2022; Page et al., 2024). As the largest constituent of the hospital workforce, nurses are positioned at the epicenter of these challenges, navigating ambiguous role boundaries, fragmented delegation, and conflicting priorities (Verhoeven et al., 2024; Bruin et al., 2025). A growing body of literature underscores how inadequate role clarity and coordination failures jeopardize care continuity, undermining nurses' professional identity and career satisfaction (Ditlopo et al., 2024; Al Moteri et al., 2024). Such conditions promote environments where nurses struggle to reconcile individual accountability with teamwork, particularly within high-volume inpatient units (Wong et al., 2025). Evidence from diverse healthcare settings indicates that fragmented professional roles and task-oriented workflows are associated with delayed clinical responses, omitted nursing interventions, and compromised collaboration (Baek et al., 2023; Putra & Sandhi, 2021). From nurses' perspectives, such systems often result in reduced familiarity with patients, repetitive communication with physicians, and increased workload (Miller et al., 2025). These experiences highlight that the structural organization of nursing care models shapes how nurses perceive responsibility, continuity, and collaboration in daily practice (Kraaij et al., 2024).

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Within the Indonesian healthcare context, nursing experiences regarding role responsibility, continuity of care, and interprofessional collaboration are influenced by systemic organizational patterns that prioritize task-based and shift-oriented structures over relationship-centered models (Wardhani & Hariyati, 2023). A study reported that scheduling and workforce management during the pandemic highlighted significant managerial complexity, role negotiation, and logistical challenges (Sugianto et al., 2022). Strengthening professional role boundaries and care coordination is now a primary objective for healthcare services worldwide (Hu et al., 2025; Braam et al., 2023). In Indonesia, challenges related to professional role boundaries and care coordination have been reported across various hospital settings. Several studies indicate that unclear delineation between nurses' independent professional roles and delegated medical tasks leads to role overlap, fragmented accountability, and inconsistent care coordination (Trisyani & Windsor, 2019; Yetty et al., 2021). To address these needs, several care delivery frameworks, such as Primary Nursing, Team Nursing, alongside emerging hybrid models, have been implemented to improve accountability and patient-centered care continuity (Ferua et al., 2016; Gonçalves et al., 2023; Beckett et al., 2021). Hybrid models are viewed as pragmatic solutions because they integrate individual responsibility with collective support, particularly in settings facing staffing variability and high patient turnover (Fernandez et al., 2012).

In Indonesia, many private hospitals continue to rely on shift-based delegation, leading to fragmented nursing assignments and limited familiarity between nurses and patients (Maemunah et al., 2021). A study also highlighted that inconsistent delegation patterns contribute to lowered continuity of care and nurse satisfaction (Sugianto et al., 2022). Similar organizational challenges were identified within the Hafshah 3 Ward at PKU Muhammadiyah Wonosobo, where role overlaps, documentation inconsistencies, and deficient interdisciplinary coordination were observed. To mitigate these issues, the hospital operationalized the hybrid team–primary nursing model as a pilot care framework several months before this study. The hybrid model represents an integration of team nursing and primary Nursing frameworks—a configuration that remains under-explored or even limited in the literature. This implementation was designed to solidify continuity of care and retain the inherent flexibility of team-based nursing. A study reported that hospitals adopt mixed or hybrid approaches to overcome limitations inherent in single-model systems such as pure primary nursing or task-oriented team nursing (Geltmeyer et al., 2025). Since the model was introduced as a pilot initiative, its early implementation phase required reflection to inform decisions regarding sustainability and broader adoption among healthcare professionals in the hospital. Transitions from task-oriented systems to hybrid role-based models often demand role renegotiation at the frontline level, particularly concerning accountability, patient ownership, and interprofessional communication. Previous study suggest that such transitions may generate uncertainty, role strain, and variation in practice, especially when staff are adapting to new expectations within existing workload pressures (Ditlopo et al., 2024). However, a significant gap persists in our understanding of these experiential factors, especially within Indonesian healthcare environments and other low-middle-income countries that face unique challenges.

Despite global emphasis on hybrid models, empirical evidence about their implementation in Indonesian hospital contexts remains limited. Previous research primarily examined primary or team nursing separately, with few studies evaluating experiences and perceptions related to hybrid models (Geltmeyer et al., 2025; Parreira et al., 2021; Nugrahini et al., 2024). Though various nursing care models exist, hybrid models are relevant in units experiencing both documentation inconsistency and fragmented delegation, as the model balances individual accountability with team-based support. Evaluation of this model's implementation is critical, yet it remains under-researched within hospital settings. Though various nursing models are available, no single existing model addresses the challenges of fragmented accountability and uneven workload distribution. In our specific hospital context, previous pure team-based approaches resulted in limited patient continuity; conversely, full primary nursing was considered difficult to sustain given staffing variability and workload intensity. Consequently, a hybrid model was selected as an appropriate solution, as it combines individual accountability with support mechanisms. Furthermore, these experiential and contextual dimensions cannot be captured through quantitative indicators. This justifies the use of a qualitative research design to explore the implementation process from the perspectives of those directly involved.

Method

A descriptive qualitative design was utilized to investigate healthcare professionals' experiences following the implementation of the hybrid team–primary nursing model. Before this study began, the model was launched as a pilot initiative in the Hafshah 3 Ward in January 2025, serving as a cornerstone of the hospital's internal nursing service improvement program. This initial phase was designed to evaluate feasibility, delineate role distribution, and identify emergent operational challenges within the inpatient environment. Following three months of implementation and adaptation, hospital management prioritized an early evaluation to facilitate evidence-based refinements and inform

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strategic decisions regarding a potential scale-up to other units. The qualitative research approach's most significant strength is its ability to offer a rich and detailed examination and representation of healthcare (Renjith et al., 2021). The selection of this research design was particularly appropriate as the model was already established before the study's inception. Thus, the inquiry focused on capturing the professional experience rather than quantifying intervention efficacy or mandating procedural revisions. Furthermore, the inquiry prioritized understanding how the model was interpreted, operationalized, and adapted by staff within the daily clinical practice. Utilizing a descriptive qualitative design facilitated a granular exploration of professional perceptions, role recalibrations, and communicative dynamics, as well as the contextual exigencies emerging from the model's integration within the hospital environment. The study was conducted at RS PKU Muhammadiyah Wonosobo, Indonesia, with data collection taking place from May to July 2025. The hospital was selected as the study site because the principal investigator is employed there and intended to evaluate the model's implementation to optimize healthcare services and minimize errors in clinical practice.

The target population comprised 253 healthcare professionals within the research setting. However, the final sample was selectively determined based on specific inclusion and exclusion criteria established by the researchers. Purposive sampling was employed to recruit participants who were directly involved in the implementation of the model. Additionally, specific inclusion and exclusion criteria were applied to the selection of study participants. The inclusion criteria were male and female, healthcare professionals involved in the model implementation for more than 3 months, able to articulate experiences, and willing to participate. The exclusion criteria were staff on probation, rotating <1 month, or unavailable during data collection. A multidisciplinary sampling strategy was utilized, acknowledging that the model necessitates interdependent roles across both clinical and managerial hierarchies. Consequently, the study engaged a diverse cohort, including staff nurses, team leaders, physicians, the head nurse, the unit manager, and members of the nursing committee. This multi-perspective approach facilitated a comprehensive exploration of how the model was interpreted and operationalized across various functional roles, particularly regarding role clarity, coordination mechanisms, and interprofessional dynamics. Participants were recruited sequentially based on clinical relevance and availability, with recruitment persisting until thematic saturation was achieved. Finally, saturation was reached after 18 interviews. This sample provided sufficient depth and variation to robustly address the study's primary objectives.

Data were collected through semi-structured and in-depth interviews. The interview guide was developed in alignment with the study's objectives and a comprehensive review of relevant literature on the topic. The interview guide covered five main domains, including experiences with role division and accountability under the hybrid model, communication and coordination with physicians and other professionals, supervision mechanisms and workload distribution, perceived benefits and challenges of the model, and expectations regarding sustainability and future implementation. The interview guide was structured into three distinct sections, personalized to accommodate the different professional roles involved: nurses, physicians, and nursing team leaders **(Table 1)**. Individual interviews lasted approximately 30–60 minutes and were scheduled outside peak hours or during agreed-upon intervals—including break periods—to minimize disruption. Interviews with nurses and ward managers took place in the ward meeting room, while consultations with physicians occurred in their respective outpatient clinic offices, subject to availability and prior appointment. All sessions were held in private settings to ensure confidentiality and were audio-recorded following participants' informed consent. To complement the interviews, non-participant observations were conducted, focusing on handovers, ward rounds, and interprofessional coordination processes. Furthermore, document reviews of nursing assignment schedules and selected clinical formats were performed to contextualize the interview findings and facilitate data triangulation.

All interviews were transcribed verbatim and analyzed using thematic analysis, following Braun and Clarke's six-phase framework (Braun & Clark, 2024). First, the researchers conducted repeated readings of the transcripts to achieve familiarity with the data, while recording initial impressions and reflective notes. Second, meaningful segments of text related to role clarity, care coordination, workload, supervision, and interprofessional interaction were coded. Coding was conducted inductively, allowing codes to emerge from participants' narratives rather than being predetermined. In the third phase, codes with conceptual similarity were clustered and compared across participants to identify preliminary themes. These candidate themes were then reviewed and refined through iterative comparison with the original transcripts to ensure internal coherence and clear distinction between themes. In the fifth phase, themes were defined, named, and linked to the study objectives, resulting in five themes that captured shared patterns of experience across professional groups. The final phase involved integrating the themes into a coherent narrative supported by representative quotations. NVivo software version 15 was used to assist in organizing data and verifying coding consistency; however, all analytic decisions were made by the researchers to maintain closeness to the data. An audit trail documenting coding development, theme refinement, and analytic decisions is provided to enhance transparency.

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To uphold methodological rigor, this study adhered to Lincoln and Guba's evaluative framework encompassing credibility, transferability, dependability, and confirmability (Lincoln & Guba,1986; Ahmed, 2024). The researchers ensured credibility by utilizing a multi-faceted approach. Data triangulation involved gathering insights from various professional roles, which facilitated the cross-validation of key findings. To achieve prolonged engagement, repeated visits were conducted over a one-month period, during which interprofessional processes were observed. Member checking was subsequently used with a representative subset of six participants to verify that the interpretive findings were consistent with their experiences. Transferability was supported by providing thick descriptions of the research context, including ward characteristics, staffing structure, patient flow, and the organizational background. Detailed contextual information enables readers to assess the relevance and applicability of the findings to other inpatient settings with similar organizational conditions. Dependability was ensured by maintaining a comprehensive audit trail documenting all stages of the research process, including interview guide development, data collection procedures, coding decisions, theme refinement, and analytical memos. The analytic process was iterative, with themes continuously reviewed and refined as new data emerged during the data collection process in the hospital. Confirmability was addressed through reflexive journaling and peer debriefing. The researchers maintained reflexive notes throughout data collection and analysis to record assumptions, positionality, and emerging insights. Regular peer debriefing sessions with academic supervisors were conducted to examine coding decisions and theme interpretations and ensure the findings were grounded in participants' accounts rather than researcher bias.

Ethical clearance was granted by the Universitas Muhammadiyah Yogyakarta Ethics Committee (Approval No. 432/D.2-III/PPs-UMY/III/2025), with institutional permission provided by RS PKU Muhammadiyah Wonosobo, Indonesia. All participants provided written informed consent before engaging in the study. Data privacy was maintained by utilizing pseudonyms in all documentation and reports to ensure the protection of participant identities.

Table 1. Domains and interview guidelines.

Domains	Questions
Nurses (N)	
Experience with model change	How do you perceive the changes in the work system since the implementation of this nursing model?
Patient familiarity	Do you feel more familiar with and responsible for the patients under your care?
Team communication	Has communication within the nursing team or across shifts improved?
Physician collaboration	How is communication with physicians during ward rounds or clinical procedures now?
Workload and fatigue	Do you feel your workload and fatigue level have changed since implementation?
Barriers &recommendations	What challenges did you experience, and what improvements do you suggest?
Physicians (P)	
Care changes	How do you perceive nursing service after the implementation of this model?
Clinical communication	Are nurses now able to communicate patient conditions clearly during ward rounds?
Clinical efficiency	Does this model support your decision-making and medical workflow?
Barriers and continuation	Do you see any obstacles, and should this model be continued?
Head nurses (HN)	
Managerial workflow	Does the model improve coordination and efficiency in nursing management?
Quality and safety	Have you noticed improvement in quality indicators or patient safety?
Staffing workload	Do you observe changes in workload distribution or nurse fatigue levels?
Challenges and improvement	What key challenges emerged, and how should the model be improved?

Results

The study involved 18 participants representing multiple professional roles in the hospital **(Table 2)**. The diversity of professional backgrounds facilitated the capture of perspectives on role clarity, coordination mechanisms, and interprofessional dynamics within the model. These varied experiences enabled an exploration of how the framework influenced care architecture, role distribution, nurse–patient relationships, and collaborative practice. Though space constraints preclude the inclusion of every verbatim quotation in the primary text, all participants' insights were instrumental in the inductive development of codes and themes. Representative excerpts were strategically selected to

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illustrate thematic findings, supported by a thematic matrix and extended excerpts that substantiate the attainment of data saturation. To ensure transparency in how themes were derived, the finding presents representative quotes categorized by professional groups **(Table 3)**. This structure highlights how the perspectives of participants align or differ regarding the model. The professional grouping also demonstrates that the data supporting each theme were not dominated by a single cadre but distributed across roles, enhancing the depth and credibility of the interpretation. The themes were then compared with participant groups and supporting evidence to ensure analytical rigor and reduce interpretive bias. The table presents a thematic matrix showing how each theme was supported by multiple participant groups, demonstrating data saturation across roles rather than reliance on isolated responses **(Table 4)**.

The following section elaborates upon the five identified themes, substantiated by contextual participant excerpts. The quotations presented alongside the themes below are illustrative excerpts; a more comprehensive set of participant quotes is provided in the preceding tables. The first theme was optimization of role division and coordination. Participants described clearer delegation of responsibilities and improved workflow organization under the new care model. The shift from task-based routines to patient focused assignment allowed nurses to understand their roles with greater clarity and reduced dependency on shift leaders. Many participants described the system as more structured and fairer, reflecting enhanced accountability and distributed decision-making.

"*Now responsibilities are clearer and no longer accumulate on one person"* (AN-04).

The second theme was enhanced patient familiarity and continuity of care. The continuity of care emerged as a strong theme with participants reporting increased familiarity with patient conditions and histories. For instance, this included more consistent communication during handovers and improved traceability of treatment plans. Physicians also noted smoother ward rounds due to nurses' deeper patient knowledge.

"*Patients now recognize the nurse responsible for them, and coordination during rounds feels faster and more accurate"* (DR-01).

The third theme was strengthened interprofessional collaboration. Participants described improvements in communication between physicians and nursing teams, strengthened decision pathways, and more consistent follow-up on medical orders. The model promoted a culture where collaboration became a shared responsibility rather than an individual task.

"Doctors now trust me during rounding because I understand my patients" (TL-04).

The fourth theme 4 was balanced workload and strengthened supervision. Many participants expressed that the model reduced work overload and increased supervision quality. The clearer role allocation supported task distribution and reduced stress, especially across shifts with high patient volume. Supervisory roles of primary nurses also became more visible and purposeful in this context.

"Workload feels lighter now because everyone knows their responsibility" (TL-03).

The fifth theme was early adaptation challenges. While benefits were acknowledged, participants noted challenges during early implementation, including confusion about responsibilities, hesitation in independent decision making, and the need for coaching and supervision. Despite these barriers, adaptation progressed as familiarity with the model increased.

"At first it was confusing, but over time the responsibilities became clear" (TL-05).

The description above shows that the hybrid team–primary nursing model was perceived to improve care coordination, staff role clarity, continuity of care, and interprofessional communication. Challenges identified were primarily transitional and related to adaptation rather than resistance, suggesting a positive readiness for adoption. These results indicate that while structural changes cause friction, the underlying alignment between the hybrid model and clinical goals improves an authentic agreement and active support.

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Table 2. Characteristics of study participants and rationale for inclusion.

Participants*	Role	Experiences (years)	Rationale for inclusion	Relevant exposure to the model
AN-01	Associate nurse	5 – 10	Direct care provider	Assigned to patient groups under the hybrid system
AN-02	Associate nurse	<5	Early-career perspective	Participated in daily implementation activities
AN-03	Associate nurse	<5	Direct care provider	Engaged in shift handovers and documentation
AN-04	Associate nurse	<5	Direct care provider	Rotation within a hybrid team
AN-05	Associate nurse	<5	Direct care provider	Involved in nurse–patient assignment
TL-01	Team leader	5 – 10	Coordination role	Oversaw group tasks & assisted the primary nurse
TL-02	Team leader	<5	Shift coordinator	Supported supervision in the new model
TL-03	Team leader	<5	Coordination role	Engaged in doctor–nurse communication
TL-04	Team leader	<5	Shift coordinator	Managed workloads in the pilot ward
PN-01	Primary nurse	>10	Direct responsibility for case continuity	Led patient management under a hybrid model
PN-02	Primary nurse	>10	Continuity provider	Accompanied doctors, evaluated care plans
HW-01	Head of ward	>10	Managerial oversight	Responsible for supervising model implementation
UM-01	Unit manager	>10	Administrative authority	Oversaw staffing and policy adjustments
TL-05	Team leader	5 – 10	Coordination role	Supported hybrid system rollout
TL-06	Team leader	<5	Shift coordinator	Assisted with workload redistribution
DR-01	Doctor	5 – 10	Interprofessional collaborator	Engaged in ward rounds with primary nurses
DR-02	Doctor	<5	Interprofessional collaborator	Provided a perspective on communication quality
NC-01	Nursing committee	>10	Policy & governance role	Involved in standard-setting & evaluation

*AN: Associate nurse; TL: Team leader; PN: Primary nurse; HW: Head of ward; UM: Unit manager; DR: Doctor; NC: Nursing committee.

Discussion

The implementation of the hybrid model within the hospital demonstrated significant improvements in coordination, accountability, and continuity of care. These findings indicate that integrating elements of primary and team nursing facilitates a structured and patient-centered workflow that maintains essential flexibility in task sharing. Before implementation, role overlap and ambiguous responsibilities frequently resulted in operational inefficiencies and heightened staff stress. However, the hybrid model recalibrated the roles of head nurses, team leaders, primary nurses, and associate nurses, establishing more accountability frameworks and facilitating coordination. This transition aligns with

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evidence suggesting that delineated professional roles enhance interdisciplinary teamwork, mitigate task duplication, and improve patient safety (Kaiser & Westers, 2018; Kämmer et al., 2024). In the present study, nurses perceived that structured delegation and clearer supervisory pathways enabled them to perform their clinical functions more effectively and with greater confidence.

Table 3. Representative quotes categorized by professional group.

Group	Code*	Quotes
AN	AN -01	*Now I remember patients better because responsibilities are clear. Previously, everything was scattered and harder to recall.*
	AN-02	*It feels more structured. We focus on our assigned block first before assisting others.*
	AN-03	*Patients now recognize the nurse responsible for them, which improves comfort and trust.*
	AN-04	*Previously, the workload was accumulated on one person. Now responsibilities are distributed.*
	AN-05	*I like this model because responsibilities are clear, so I no longer feel overwhelmed working alone.*
TL	TL-01	*There is significant improvement; we now manage our patients confidently, and task division is clear.*
	TL-02	*At night, we may have over 30 patients, and previously, we handled all of them without a clear division.*
	TL-03	*Workload feels lighter now because everyone knows their responsibility.*
	TL-04	*I am learning decision-making, and doctors now trust me during rounds.*
	TL-05	*At first, it was confusing, but now it's clearer that my role and responsibilities are defined.*
	TL-06	*I feel more capable now because I am trusted to contribute to patient care planning.*
PN	PN-01	*Documentation is easier to verify for accuracy because responsibility is shared.*
	PN-02	*Shift handover is faster now because everyone understands their assigned work.*
HW	HW-01	*Roles are clear, and I observe that SOAP and diagnoses are consistently updated.*
UW	UM-01	*Structurally and operationally, the model is more effective than the previous system.*
DR	DR-01	*Rounds are smoother now because nurses who accompany truly understand the patients' condition.*
	DR-02	*Physician orders are rarely missed now, and coordination is easier.*
NC	NC-01	*This model reinforces scope of practice clarity and supports credentialing processes.*

*AN: Associate nurse; TL: Team leader; PN: Primary nurse; HW: Head of ward; UM: Unit manager; DR: Doctor; NC: Nursing committee.

Similar findings have been reported that hybrid and team-based nursing models were associated with reduced role ambiguity and improved intra-unit coordination, particularly in high-acuity and high-turnover hospitals (Aiken et al., 2017). Furthermore, the leadership role of the head nurse shifted from predominantly technical supervision toward a more managerial and coordination-oriented function (Alsadaan et al., 2023). The transition aligns with existing literature on team-based leadership in inpatient units, which underscores the critical importance of managerial oversight in sustaining coordinated care delivery (Weston et al., 2021; Ystaas et al., 2023). In addition to enhancements in workflow, nurses described a marked shift in their professional identity following implementation of the model. Rather than focusing on task completion, nurses reported a stronger accountability for continuity of care. A study supported that greater role accountability correlates with enhanced professional autonomy and increased self-efficacy among nursing staff (Yuk & Yu, 2023; Uysal & Ekiz, 2025). The introduction of role clarity was not without its challenges, creating a paradox of both empowerment and increased workload. This finding underscores that clarifying roles requires a complementary investment in managerial support and ongoing supervision to prevent role overload. Such insight is relevant for hospital units with heterogeneous nurse competencies seeking to adopt the model effectively.

The findings call attention to primary and associate nurses who reported increased familiarity with patient conditions, greater preparedness, and enhanced confidence when communicating updates to physicians. Being familiar with the workflow equipped nurses to anticipate patient needs and reduced fragmentation across shifts (Trotta et al., 2020). These experiences suggest that the model reorganized care delivery and reshaped nurses' professional identity. Also, nursing assignments based on continuity of care were associated with increased clinical autonomy, professional satisfaction, and

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role legitimacy (Santomassino et al., 2012; Pursio et al., 2024). In this study, nurses' narratives indicate that clearer role boundaries reduced ambiguity and supported more proactive engagement in care planning and interprofessional discussions. From a qualitative perspective, this finding illustrates how structural continuity translates into experiential continuity at the bedside. However, the findings also reveal that role adaptation was not seamless. During the early stages of implementation, several nurses experienced uncertainty regarding decision-making authority and accountability boundaries, particularly when transitioning away from task-based practices. The finding corroborates earlier research that hybrid or transitional care models often generate temporary role strain and require mentoring to support professional adjustment (Bogaert et al., 2013; Rossiter et al., 2024). In this context, ongoing supervision by team leaders and head nurses played a critical role in facilitating adaptation and reinforcing expectations (Fagerdal et al., 2022). The successful implementation of nursing models depends on structural design, leadership engagement, and support mechanisms. From an experiential perspective, the hybrid model functioned as both an organizational framework, enabling accountability and collaboration.

Table 4. Thematic matrix of themes and supporting quotes.

Themes	Participants*	Supporting quotes (example)
Optimization of role division and coordination	AN-01, AN-02, AN-04, TL-01, TL-03, TL-05, TL-06, PN-01, HW-01, UM-01, NC-01	*Now it is clearly embedded and not concentrated in one person*. (AN-04)
Enhanced patient familiarity and continuity of care	AN-01, AN-03, AN-05, TL-01, TL-04, TL-06, PN-01, PN-02, DR-01, DR-02, HW-01	*Patients get to know their nurses*. (AN-03)
Strengthened interprofessional collaboration	AN-02, TL-01, TL-04, TL-06, PN-01, PN-02, DR-01, DR-02, NC-01	*The doctor wants to visit me*. (TL-04)
Balanced workload and strengthened supervision	AN-01, AN-05, TL-01, TL-03, TL-05, PN-01, HW-01, UM-01	*The workload is lighter*. (AN-01)
Early adaptation challenges	AN-04, TL-01, TL-05, TL-06, PN-01, HW-01, UM-01, NC-01	*At first, I was confused, but after a while I understood*. (TL-05)

*AN: Associate nurse; TL: Team leader; PN: Primary nurse; HW: Head of ward; UM: Unit manager; DR: Doctor; NC: Nursing committee.

The study also documented that interprofessional collaboration was improved, as reflected in smoother ward rounds and better communication between nurses and physicians. Participants described a shift in how information was exchanged, with nurses providing comprehensive and anticipatory clinical updates rather than fragmented task-based reports. Previous studies emphasize that the higher the level of communication satisfaction among nurses, the more effectively the patient safety culture is applied (Noviyanti et al., 2021). Physicians reported increased confidence in nurses' clinical judgment, documentation accuracy, and continuity of information across shifts. Effective interprofessional collaboration is recognized as a cornerstone of high-quality hospital care as it promotes shared decision-making and mutual respect among healthcare professionals (McLaney et al., 2022). The hybrid model appeared to facilitate these improvements by maintaining involvement in patient care. When nurses retained responsibility for specific patients, communication during ward rounds became more focused, relevant, and effective. These findings are supported with study that explained that structured nurse role allocation improves interprofessional communication quality and reduces missed information during clinical handovers (Gleeson et al., 2023). However, enhanced collaboration was not an immediate result of the transition. During early implementation, several nurses expressed reluctance to engage with physicians, especially while professional boundaries and role expectations remained in flux. To address these barriers, the hospital implemented structured interdisciplinary briefings and clarified role protocols, which provided the necessary framework for more confident nurse-physician engagement. Active engagement from team leaders and head nurses was also identified as a decisive factor in facilitating effective hospital-wide collaboration.

Redistribution of tasks among team members resulted in a more balanced workload across nursing roles. Associate nurses reported less fatigue, and team leaders experienced greater clarity in coordination duties. Similar outcomes were observed in a study that workload equalization increased job satisfaction and reduced burnout (Shin et al., 2018). Transcending mere operational adjustments, the hybrid model catalyzed the transformation of supervisory practices. Head nurses pivoted from traditional task-based monitoring to an anticipatory leadership approach, which

proved instrumental in clinical workflows. Consequently, this transition enabled the early detection of systemic inefficiencies and promoted care quality. Such leadership transformation aligns with evidence emphasizing the critical role of managerial supervision in sustaining quality improvement (Restivo et al., 2022). Participants described feeling more secure in clinical decision-making when supervision was clearly defined and readily accessible. The finding was supported by a prior study that effective supervision enhances professional confidence and reduces role-related stress (Stacey et al., 2022; Gheisari et al., 2024). Participants also reported that shared accountability reduced the sense of individual burden, particularly during high patient census or complex case management. Taken together, these findings indicate that the model functions as a task redistribution mechanism and internal support system that integrates supervision, leadership, and peer collaboration.

The last theme described the initial challenges that emerged during the transition phase, particularly related to role adjustment and accountability. Several nurses described uncertainty in decision-making authority and hesitation in exercising autonomy. Such adaptation difficulties are reported during transitions process in the hospital. In this study, early confusion was not indicative of resistance but rather reflected the cognitive and professional recalibration. Existing research highlights that workplace adaptation is an integrated, individual-driven process that remains distinct from top-down organizational socialization (Xu et al., 2025). Similar findings have been reported that the implementation new model demands structural change and a shift in professional mindset and accountability norms (Baharum et al., 2023; Peteet et al., 2023). Structured mentoring, ongoing supervision, and regular feedback emerged as critical enabling factors during this adaptation phase. The involvement of team leaders and head nurses proved critical to the successful implementation of transitional care (Nzinga et al., 2021). From an implementation perspective, these findings highlight the importance of viewing adaptation challenges as an expected phase in organizational change rather than a failure of the model itself. The adaptation period in this study required stronger managerial involvement and structured mentoring due to differences in organizational culture and staffing patterns. These distinctions suggest that while hybrid models are relevant, their successful implementation requires contextual adaptation.

The study contributes to the global discourse on nursing care models by providing empirical evidence on the implementation of a hybrid model in the hospital setting. Unlike studies that focus on structural outcomes, the study highlights nurses' experiences, including increased role ownership, patient familiarity, and confidence. The findings suggest that the hybrid nursing model may serve as a practical bridge between task-oriented care and primary nursing. This model provides both structure and flexibility to ensure continuity without overburdening staff. Future implementation in other hospital units should be accompanied by competency-based mentoring, structured monitoring, and sustained managerial support to maintain quality and prevent role regression. This study was conducted within a short implementation window, which may limit the understanding of long-term adaptation, sustainability, and outcomes. In addition, the study focused on healthcare professionals' experiences and did not include patient outcomes or satisfaction measures that restrict evaluation to organizational and staff-level perspectives. Nevertheless, examining the model during its early implementation phase provided valuable insight into feasibility, role adaptation, and operational dynamics within a hospital. As a qualitative exploratory study, the findings are intended to generate contextual understanding rather than causal inference.

Conclusion

The study concludes that implementing the hybrid team–primary nursing care model enhances nursing role clarity, accountability, and collaboration. However, the optimal success of the model is contingent upon structural redesign, leadership engagement, and staff readiness. Hospitals are therefore encouraged to adopt and refine the model by integrating continuous training, supervision, and regular performance evaluations. At the organizational level, managers should formalize hybrid care models within standard operating procedures and performance evaluation systems to ensure long-term sustainability and consistency. Future research should employ quantitative or mixed-method approaches to rigorously examine the model's long-term effects on coordination, workload balance, and patient outcomes.

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AI statements
The manuscript was prepared without the use of generative AI tools. All ideas, analyses, and writing remain the sole work of the human authors.

Author's declaration
All authors have made substantial contributions to the conception, design, data collection, analysis, and interpretation of this research, and approved the final version for publication.

Availability of data and materials
All data and materials supporting the findings of this research are available from the corresponding author on reasonable request.

Competing interests
The authors declare no conflicts of interest related to this research.

Ethical clearance
The research received ethical clearance from the Universitas Muhammadiyah Yogyakarta Ethics Committee under protocol number 432/D.2-III/PPs-UMY/III/2025.

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Publishers and journal's note
Editor-in-Chief noted that this research highlights a significant innovation in nursing by integrating two models to improve hospital care. Although these models are already in use at the primary researcher's institution, their effectiveness remains unevaluated. Assessing this impact is vital, as model implementation can either improve or inadvertently hinder service delivery. Given these complexities, the chosen research design is perfectly suited to address the objectives of this study.

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Authors' insight

Key points

- The study examines the hybrid model as a strategic middle ground, blending the collaborative strengths of team nursing with the individual accountability of primary nursing to solve modern hospital workflow issues.
- The research targets the common systemic failures in healthcare settings that fragmented communication and professional ambiguity.
- The qualitative evaluation prioritizes the lived experience of the staff, providing insights into how new nursing models impact institutional services and professional morale rather than just measuring raw metrics.

Emerging nursing avenues

- How does the hybrid model successfully reconcile the potential conflict between collective team efforts and the strict individual patient responsibility inherent in primary nursing?
- What specific "role clarity" barriers did nurses encounter when transitioning from traditional shift-based models to this hybrid structure?
- Does the qualitative data suggest that improved care coordination is a permanent result of the new model in the hospital?

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