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Organizational Resilience in Critical Contexts: A Qualitative Study with Workers at a Public Hospital in Peru

Uvaldo Cuno-Chunga[1]*, Edwin Hernan Asis[2], Bilmir Aguilar Cahuana[1], Jaime Cuno Chunga[3], Kenny Harley Quino Bengolea[1]

[1]Department of Environmental Management, Faculty of Business Sciences, Universidad Cesar Vallejo, Lima, Los Olivos, Peru, [2]Department of Business Administration, Faculty of Business, Universidad Tecnológica del Perú, Lima, Peru, [3]Department of Management, Faculty of Management, Unidad de Gestión Educativa Local Chincheros, Apurimac, Peru. *Corresponding Author's Email: vaniwirawan0@gmail.com, ccunocu@ucvvirtual.edu.pe

Abstract

This study examines organizational resilience in critical contexts, focusing on healthcare workers at a public hospital in Abancay, Peru. Anchored in the Sustainable Development Goal (SDG) 12: Responsible Production and Consumption, it highlights the need for sustainable and resilient operational models in public institutions. Using a qualitative case study approach, the research incorporated semi-structured interviews and thematic analysis to explore staff responses to crisis situations. Findings indicate that healthcare workers relied on rational and empathetic coping mechanisms, including emotional self-regulation, clear communication, teamwork, and a shared sense of mission, enabling the hospital to maintain functionality despite external pressures. Organizational resilience emerged as a collective outcome of individual adaptability, leadership support, and strong institutional culture. The study emphasizes that resilience in healthcare is not only reactive but can be cultivated through organizational planning and emotional infrastructure. Recommended measures include continuous training, psychological support systems, and staff recognition programs to strengthen resilience capacity. Additionally, innovation in organizational processes, such as the integration of new technologies and adaptive workflows, proved crucial for maintaining service quality. The results expand understanding of resilience in public health systems, particularly in resource-constrained environments, and provide practical guidance for policy and administrative reforms. By combining adaptability, emotional management, and innovation, healthcare organizations can strengthen their capacity to withstand and recover from crises, ensuring long-term sustainability. These insights have significant implications for hospital management and policy, offering strategies that can be adapted to similar healthcare settings worldwide to enhance preparedness and operational continuity during future crises.

Keywords: Healthcare, Hospital, Innovation, Management, Resilience.

Introduction

Organizational resilience has become an important concept in recent years as institutions face increasingly frequent and unpredictable crises. Resilience, understood as the ability of an organization to anticipate, withstand, adapt to, and recover from adverse events, is considered vital for ensuring continuity and sustainability (1). Although widely studied at a global level, resilience in healthcare settings is particularly crucial, since health systems operate under constant pressure from emergencies, resource constraints, and shifting social demands. The COVID-19 pandemic clearly demonstrated that many systems lacked the capacity to respond effectively, while those with stronger resilience mechanisms recovered more rapidly and maintained essential services (2). International agencies have stressed the urgency of building resilience in health systems. The Food and Agriculture Organization (FAO) highlighted that vulnerable populations fall deeper into poverty when resilience is absent, while the Inter-American Development Bank (IDB) underscored the growing risks that climate change poses to hospital infrastructure and operations. Global initiatives, such as the "Resilient Hospital" projects in Andean countries, have shown that hospitals must strengthen their capacity to withstand crises and climate impacts in order to protect communities. These experiences provide valuable lessons; however, they also reveal a gap in understanding how resilience operates in specific national contexts such as Peru. Peru's healthcare

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system has long faced resource limitations, workforce shortages, and structural inequalities, which became more visible during the COVID-19 crisis (3). Despite notable progress in expanding healthcare coverage over the last two decades, the system remains highly fragmented, divided among the Ministry of Health, EsSalud (social security), the armed forces, and the private sector (4). This fragmentation complicates coordination, especially during crises. Regional disparities further exacerbate these problems. While Lima and other coastal cities concentrate more advanced infrastructure, rural areas such as the Apurímac region, where Abancay is located, struggle with fewer resources, fewer specialists, and logistical barriers in reaching services (5). These structural inequalities often determine who has access to timely and effective care during emergencies, leaving rural populations disproportionately vulnerable.

Another central challenge is the mental health and well-being of healthcare workers. Long working hours, low pay, and limited professional support create conditions of chronic stress that undermine resilience. During the pandemic, Peruvian doctors, nurses, and support staff faced not only an increased workload but also heightened exposure to infection and limited protective equipment (6). This resulted in high rates of burnout and emotional exhaustion. In many cases, frontline workers had to rely on their own coping strategies to remain functional, highlighting the individual dimension of resilience that complements organizational factors. The importance of emotional intelligence in this context is evident. Research shows that workers with greater ability to regulate their emotions cope better with stress, maintain teamwork, and sustain quality care even under pressure (7).

Peruvian studies have started to shed light on these dynamics, though evidence remains limited. It was found that workplace climate and job satisfaction among emergency nurses in Lima were strongly associated with perceptions of fairness, supervision, and working conditions (8). It was reported that exposure to workplace violence in Chiclayo hospitals was negatively correlated with nurses' emotional intelligence, suggesting that hostile environments not only harm staff but also erode organizational resilience (9). These findings illustrate the complex interaction between institutional structures and individual emotional resources. A resilient hospital environment is therefore not merely one that has adequate beds, medicines, or staff, but one that fosters positive relationships, supportive leadership, and emotional well-being. At the same time, innovation plays a vital role in strengthening resilience. Hospitals that encourage process innovation, such as reorganizing workflows, introducing digital health tools, or developing new patient management protocols, can adapt more quickly to external shocks (10). In Peru, some hospitals improvised new triage systems, adapted telemedicine, and reorganized patient flows during the pandemic (11). While many of these changes were reactive, they provided lessons on the importance of flexibility and creativity. For hospitals in resource-constrained regions such as Abancay, innovation is not a luxury but a necessity to cope with systemic limitations. The theoretical basis for resilience research combines organizational and systems perspectives. Organizational Resilience Theory emphasizes preparedness, rapid response, and adaptability as key to recovery from crises (12), while Resilient Systems Theory defines resilience as the ability to absorb shocks while maintaining essential functions (13). These frameworks stress that resilience is both a process and an outcome: it requires continuous adaptation, but it is ultimately assessed by the ability to sustain performance in adverse conditions. In Peru, ministerial policies also provide a legal foundation. Ministerial Resolution No. 626-2015 focused on ensuring safe, high-quality healthcare and promoting positive organizational climate, while Ministerial Resolution No. 1357-2018 emphasized work–life balance and occupational safety. More recently, Resolution CD59.R12 of the Pan American Health Organization offered a post-COVID strategy to strengthen resilience through integrated care, equity, and sustainable workforce development. These frameworks underline that resilience is not an optional quality but an essential condition for health systems to function in the face of shocks. Within hospitals, resilience can be observed through three interrelated dimensions. Adaptability to organizational change refers to the ability to adjust to internal and external shifts without losing operational continuity (14). Emotional management emphasizes the role of

supportive teams and shared control of stress to foster trust and well-being (15). Organizational process innovation involves implementing new ideas and processes that improve efficiency, reduce costs, and maintain services despite resource limitations (16). These dimensions reinforce each other: adaptability provides flexibility, emotional management sustains the workforce, and innovation ensures relevance. For healthcare workers in Abancay, where material resources are limited, these non-material capacities become even more critical (17).

Despite the importance of these elements, there is still little research on organizational resilience in Peruvian hospitals, especially those located outside major metropolitan centers. Abancay, in the Apurímac region, is of particular interest due to its geographical challenges, resource constraints, and exposure to both health and climate-related crises. Understanding how hospital workers in this context adapt to organizational changes, manage emotions, and innovate in their practices can provide insights into strategies that strengthen resilience in other similar contexts across the country (18). Such evidence is crucial for informing both hospital management and national health policy, particularly at a time when resilience has become a priority for global health governance.

The objective of this study was to analyze the organizational resilience of workers at a hospital in Abancay, Peru. Specifically, it sought to explore how hospital workers cope with and adapt to organizational changes in their work environment; to understand the emotional management strategies they implement during crises, and to identify innovative practices in organizational processes that contribute to resilience.

Methodology

Research Type and Philosophical Approach

This study was designed as basic research, also known as pure or fundamental research, with the goal of expanding theoretical understanding of organizational resilience within healthcare institutions. The purpose was not immediate application but rather the development of new conceptual knowledge in a critical organizational context.

The study adopted a qualitative paradigm, grounded in interpretivism. This perspective emphasizes the subjective interpretation of experience, focusing on how individuals understand their social realities in natural work environments particularly within the dynamics of organizational behavior under pressure.

Design: Case Study and Exploratory Level

The research employed a case study design, suitable for exploring complex social phenomena within a real-life bounded system in this case, a public hospital in Abancay, Peru. Case studies offer the depth and contextual richness needed to understand the multidimensional nature of resilience in action.

Exploratory in nature, the study sought to generate new insights in a domain with limited empirical literature, particularly in the Latin American healthcare context. A cross-sectional time frame was used, gathering data at one point to assess prevailing perceptions and behavioral patterns within the institution.

Organizational resilience was the central construct, operationalized through three subcategories:

- Capacity to adapt to organizational change
- Emotional management in the workplace
- Innovation in organizational processes

Each subcategory included three evaluative criteria. These criteria were explored through two open-ended questions each, built into a semi-structured interview guide. This design enabled nuanced exploration of individual and collective responses to organizational challenges.

Study Population and Sampling

The study population consisted of contracted employees at the hospital. Inclusion criteria required participants to be actively employed at the time of data collection, while staffs on leave due to vacation, illness, or other reasons were excluded. A total of 10 participants were recruited using non-probability convenience sampling. This sample size was appropriate for the exploratory case study design, which prioritizes depth of insight and contextual understanding over numerical representativeness. In qualitative research, sample adequacy is not determined by statistical representativeness but by the depth and richness of the data collected. The guiding principle is thematic saturation, the point at which additional interviews no longer generate new information. Prior methodological studies indicate

that saturation in relatively homogeneous populations is commonly achieved with 9–12 interviews. In this study, saturation was reached by the eighth interview, with the final two confirming consistency of themes. Thus, a sample of 10 participants was sufficient to capture diverse perspectives while ensuring methodological rigor and feasibility within the scope of the case study.

Data Collection Instruments

Data were gathered using semi-structured interviews. An interview guide was designed to ensure coverage of key themes while retaining flexibility to pursue relevant threads introduced by participants. This allowed for deeper probing and more authentic responses.

The guide was validated by three subject experts to ensure thematic alignment and clarity. Its structure encouraged participants to articulate their lived experiences, offering insights into both individual coping mechanisms and institutional dynamics.

Validity and Reliability

The research instrument was aligned with the study's conceptual framework to ensure validity. Reliability was reinforced through consistent application of the interview protocol and by reaching thematic saturation where additional interviews produced little new data demonstrating internal consistency in responses.

Ensuring Scientific Rigor

Scientific rigor in the study was maintained through several key principles:

- Credibility: Findings were presented transparently, with participant quotes supporting the interpretations.
- Auditability: The research process was well-documented, enabling replication and traceability.
- Impartiality: The data and analysis were evaluated based on their scientific merit, independent of researcher identity or affiliation.
- Transferability: The contextual detail in the findings enables applicability to similar healthcare settings experiencing organizational strain.

Results

Semantic Analysis and Word Cloud Findings

The word cloud generated by Atlas.ti revealed the most frequently used terms within the analyzed discourses, allowing us to visualize the concepts with the greatest semantic weight in understanding organizational resilience at the Abancay hospital in Peru (19).

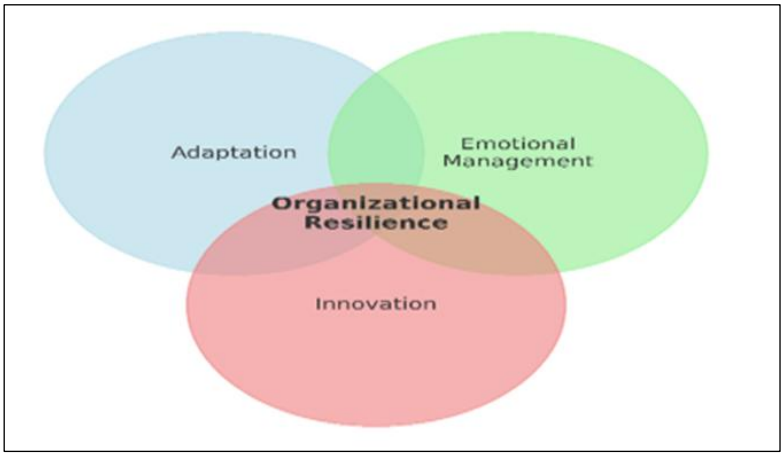

Figure 1: Dimensions of Organizational Resilience

As shown in Figure 1, organizational resilience was conceptualized through three interconnected dimensions that structured both the interview guide and the thematic analysis.

In Figure 1, the three dimensions include: capacity to adapt to organizational change, emotional management in the workplace, and innovation in organizational processes. These interconnected dimensions formed the analytical framework that guided data collection and thematic analysis.

Semantic Analysis of Organizational Resilience

The semantic analysis conducted using Atlas.ti revealed the most frequently occurring terms

across participant discourses, enabling the identification of concepts with the highest semantic weight in understanding organizational resilience within the Abancay hospital in Peru (20). The most prominent words included: "communication," "team," "work," "change," "decisions," "patients," "stress," "management," and "support." These terms represented dominant thematic cores. Among them, communication emerged as the most central concept, reflecting the importance staff placed on the transparent and effective flow of information crucial not only for operational coordination but also for emotional stability and collective decision-making in times of uncertainty (21). This emphasis was supported by associated terms such as meetings, open information, effective, and good, which suggested that communication was perceived as a strategic organizational glue rather than a mere formality.

The concept of team also held significant weight, underscoring the belief that collective action was key to navigating institutional transformations. Terms like work, labor, collaboration, and personal pointed to a resilience built on relational dynamics, dialogue, and mutual support.

Recurrent terms such as change, decisions, uncertainty, management, and adapting highlighted the volatile environment staff faced requiring continuous flexibility, calm leadership, and shared decision-making. This turbulence was further echoed in emotional vocabulary such as calm, well-being, health, and emotional, emphasizing that caring for emotional health was central to organizational functioning (22).

Additionally, terms associated with innovation and technology such as digital, tools, and system emerged, indicating that technical adaptability and continuous learning were also key factors (23). Simultaneously, the presence of words like patients, care, hospital, and health reaffirmed the ethical motivation of staff to prioritize patient-centered service amid institutional shifts.

In relation to the general objective, the semantic analysis demonstrated that organizational resilience functioned as a unifying concept linking adaptive, emotional, and transformative behaviors of hospital personnel in response to adversity. Notably, the ability to adapt to internal changes stood out as a collective strength, enabling staff to adopt new protocols, digital tools, restructured workflows, and collaborative work dynamics. This adaptability fostered not only individual flexibility but also enhanced overall organizational performance.

The coding map (Figure 2) illustrates how participant responses were categorized into resilience dimensions. First-level codes (e.g., teamwork, flexibility, emotional support) were clustered under adaptation, emotional management, and innovation, highlighting the central role of emotional management in organizational resilience (24).

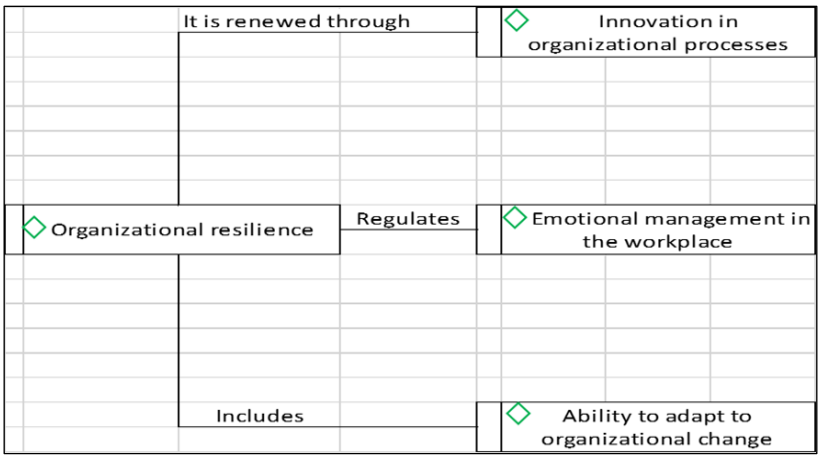

Figure 2: Interview Coding Map Illustrating How Participant Responses were Categorized into Resilience Dimensions

Adaptation to Organizational Change

This theme aligned with the first specific objective and represented a central component of how hospital staff responded to institutional transformations. Adaptation was not optional; it was a necessity. As stated in Interview 6: "Many changes, and the issue was adapting," adaptation became the starting point for resilient responses.

Technological transitions were integral to this process. Interview 4 described the "implementation of a new patient management system and technologies like telemedicine," which required rapid staff training and operational adjustments (25). These changes illustrated the need for digital fluency alongside procedural agility.

Adaptation also relied on personal skills and resources such as emotional self-regulation, teamwork, and learning. Interview 5 highlighted "controlling emotions, staying calm, reducing anxiety, communicating fluidly, staying informed, and learning from past experiences" all reinforcing both individual and group resilience (26).

Importantly, adaptation involved collaborative decision-making, as Interview 4 explained: "In times of change, maintaining an open and flexible attitude is essential. Constant feedback and a willingness to learn from mistakes also play a key role in the process." This quote showed that decision-making was participatory and dynamic.

A positive attitude toward change emerged as a reinforcing factor. Interview 2 stated: "Being willing to learn every day is important," indicating an active mindset toward continuous adaptation (27).

Furthermore, interpersonal adaptation was key in a hospital setting, where collaboration is constant. Interview 5 noted: "I had to understand my colleagues' temperaments and adapt to work as a team for the good of the patients." This required relational awareness in addition to technical competence. Finally, an open attitude toward structural and procedural change enabled smoother transitions. As Interview 2 reflected: "The changes I experienced included new procedures, policies, and technology (28). To adapt, it was important to be flexible and willing to learn." This openness formed the foundation of long-term organizational adaptability.

Emotional Management in the Workplace

Addressing the second specific objective, this subcategory explored how emotional regulation served as a transversal skill, enabling staff to maintain clarity, collaboration, and operational continuity during crises.

One major strategy was rational stress management. Interview 4 emphasized: "Managing stress is crucial to maintaining mental clarity and making effective decisions." Interview 9 added: "I organize tasks, prioritize, and maintain a positive attitude to avoid spreading stress." These practices were supported by autonomous emotional regulation, such as deep breathing (Interview 3), coordination (Interview 6), and tolerance (29). Personal emotional strategies reinforced collective well-being.

In emotionally charged environments, empathic crisis responses also played a role. Interview 5 described a conciliatory gesture: "I apologized, hugged her, and helped her with her work to restore harmony." Interview 4 added: "Staying calm during a crisis is essential to being effective." These responses were reinforced by emotional communication and mediation. Interview 6 described communication as "100% effective," and Interview 5 stressed the importance of "fluid and respectful" dialogue. In Interview 3, "the coordinator brings together those involved to resolve conflicts," demonstrating a formal mechanism for conflict resolution (30). Overall, emotional management contributed significantly to the team's resilience and their ability to continue performing effectively in demanding circumstances.

Innovation in Organizational Processes

The third specific objective focused on how innovation served as a key pillar of institutional resilience. Innovation manifested in both planned and emergent forms and was closely tied to technology, teamwork, and adaptability.

A primary example was the adoption of clinical technologies. Interview 6 noted: "Technology plays an important role in improving the efficiency, accuracy, and quality of care, such as electronic medical records." Crisis-driven innovation was also observed (31). During the COVID-19 pandemic, Interview 5 described using diaper bibs to prevent pressure ulcers, reflecting spontaneous, context-specific creativity. Innovation further materialized through organizational implementation. Interview 2 mentioned: "We have recently been coordinating," suggesting that ideas were moving from discussion to action, initiating structural change.

Technology extended to advanced tools such as artificial intelligence. Interview 6 referenced "AI training," which improved clinical and administrative processes. Importantly, these innovations were user-centered. Interview 6

mentioned "humanized treatment," affirming that the ultimate goal was to improve patient experience not just modernize systems (32).

Innovation was enabled through institutional support. Interview 1 stressed the need for guidance, visibility of pilot projects, and leadership backing: "Hospitals should provide support in terms of time and management commitment."

Finally, collaborative practices supported innovation. Interview 2 highlighted the role of "open communication, shared goals, appreciation, and regular meetings," promoting continuous learning and change. Interview 6 affirmed that professionals were "proactive to change," emphasizing that innovation depends not only on strategy, but on organizational culture.

Discussion

Organizational Resilience as a Strategic Mechanism

This study demonstrated that resilience in the hospital context functions as more than a temporary coping strategy; it operates as a strategic organizational mechanism sustained by individual, collective, and institutional resources. This interpretation aligns with prior literature, which stresses that resilience is both a process and an outcome, embedded in the daily practices and culture of organizations (33). By examining the lived experiences of healthcare workers in Abancay, the study adds evidence to theories that resilience strengthens institutional continuity by integrating adaptive capacities with emotional and structural support.

These findings resonate with the proposal that organizations employ capitalization, realignment, and reorientation to remain viable under stress (34). In the case of Abancay Hospital, realignment was evident in how staff adjusted workflows and adopted new protocols during crises, while capitalization referred to leveraging existing knowledge and teamwork to sustain service delivery. Reorientation appeared in the development of innovative practices that enhanced long-term adaptability. The study confirms that resilience is not an isolated response but an evolving organizational capacity with strategic value.

Adaptation to Change

The first specific objective emphasized how healthcare workers adapt to institutional changes. Unlike studies that treat adaptation as a passive adjustment, the Abancay case shows that adaptation was proactive and collaborative. Workers demonstrated flexibility, openness to change, and participatory decision-making elements widely recognized in resilience literature as central to organizational survival in uncertain contexts (35).

Comparative studies suggest that adaptability depends heavily on human capital, particularly on the willingness of employees to engage in learning and problem-solving. In Abancay, this manifested as staff members taking ownership of new processes, supporting colleagues, and engaging constructively with change. Such behaviours contrast with accounts of resistance to organizational transformation in healthcare institutions elsewhere (36). Instead, the hospital's staff reflected a culture that views adaptation as a shared responsibility. This proactive orientation reinforces the argument that resilience is built not only on systems and policies but on the attitudes and actions of frontline professionals.

Emotional Management as a Core Component

The second specific objective centered on emotional regulation, which emerged as a pivotal element of organizational resilience. Staff applied rational stress-management strategies, demonstrated empathy, and relied on mediation to resolve conflicts. These practices align with research identifying emotional intelligence as a key enabler of resilience in healthcare institutions (37). By maintaining emotional stability and encouraging supportive interactions, the workforce preserved both collaboration and continuity of care during crises.

The results contrast with studies documenting high rates of burnout and emotional exhaustion among healthcare workers during the COVID-19 pandemic (38). Instead of succumbing to overwhelming stress, participants in this study highlighted constructive strategies that buffered emotional decline. Institutional mechanisms, such as formal mediation processes and supportive leadership, reinforced these efforts. This suggests that organizational culture plays a decisive role in either amplifying or alleviating stress. When employees perceive that their emotional well-being is supported, they are more likely to sustain performance under adverse conditions.

The findings also extend theories of emotional intelligence by demonstrating how individual competencies translate into organizational outcomes. Emotional regulation at the personal level promoted a climate of trust and psychological safety at the collective level, which in turn supported resilience across the institution. This confirms arguments that employee well-being is inseparable from organizational functioning (39).

Innovation and Institutional Support

Innovation was the third pillar explored in this study. It emerged in both structured initiatives, such as the adoption of electronic records and artificial intelligence tools, and in spontaneous creative practices developed during crises. These observations reinforce the argument that resilience requires not only flexibility but also the capacity to generate novel solutions under pressure (40). What is noteworthy in the Abancay case is that innovation occurred despite limited resources. This challenges assumptions that innovation is restricted to highly resourced institutions. Instead, the findings illustrate that collaborative culture, supportive leadership, and openness to experimentation can enable innovation even in constrained environments. Prior research emphasizes that resilience is strengthened when organizations combine structural readiness with cultural openness (41). Abancay Hospital exemplified this intersection by promoting an environment where new ideas could be tested and implemented, thereby reinforcing institutional adaptability.

Innovation in this context was also strongly linked to patient-centered care. Rather than pursuing modernization for its own sake, staff emphasized that innovations were designed to improve service quality and patient experiences. This perspective resonates with studies highlighting that resilience in healthcare must be ethically grounded in patient well-being (42). The integration of technology with humanized care demonstrates that resilience is multidimensional, connecting technical, emotional, and ethical dimensions.

Comparative Reflections

Placing the findings in dialogue with existing literature highlights both convergences and divergences. Convergences appear in the confirmation that adaptation, emotional regulation, and innovation are foundational elements of resilience across healthcare contexts (43). Divergences emerge in the relatively positive emotional climate reported in this study, contrasting with widespread accounts of burnout. One possible explanation is the presence of institutional mediation and open communication mechanisms, which helped sustain morale. This supports research showing that internal communication is a critical determinant of resilience, as it builds trust and coordination.

Unlike quantitative models that focus on measuring resilience indicators, this qualitative approach captured how resilience is enacted in daily practice (44). The narratives revealed that resilience is not abstract but lived, shaped by interpersonal relationships, emotional regulation, and practical innovation. This interpretive contribution adds depth to the literature by clarifying how organizational resilience is experienced and sustained in a developing-country healthcare context.

Contribution to Resilience Theory in Healthcare

Beyond aligning with existing frameworks, this study advances resilience theory by illustrating how resilience is enacted in a resource-constrained, non-metropolitan healthcare context. Much of the resilience literature has emerged from high-income countries or large urban hospitals, where structural and financial resources buffer institutions against shocks. In contrast, the Abancay case demonstrates that resilience can also be generated through relational and cultural mechanisms rather than material abundance (45). Three theoretical contributions emerge. First, the findings highlight the primacy of emotional management as an institutional resource. While existing models recognize emotional intelligence as a personal trait, this study shows how collective emotional regulation through mediation, empathy, and supportive communication functions as an organizational capacity that sustains resilience. Second, the results point to innovation as a cultural practice rather than merely a technical adjustment (46). Staff-driven improvisations, such as context-specific solutions during crises, reveal that innovation in constrained environments is embedded in creativity and collaboration, expanding theoretical understandings of resilience beyond formal technological adoption. Third, the study introduces the idea of resilience as a unifying mechanism that links adaptation, emotional

regulation, and innovation into a dynamic system. This integrative perspective refines resilience theory by moving beyond linear cause–effect models toward a more holistic, interdependent framework (47). By situating resilience within the lived realities of frontline staff, this study contributes to a more contextualized and practice-oriented theory of organizational resilience in healthcare. It suggests that resilience is not only about structural readiness but also about the cultivation of cultural and relational assets that allow organizations to thrive amid persistent uncertainty.

Practical Implications and Future Research

The findings suggest several practical implications. First, strengthening resilience in hospitals requires investment not only in infrastructure but also in staff development, particularly in emotional intelligence and adaptive skills. Training programs that enhance stress management, communication, and conflict resolution could reinforce resilience across healthcare teams. Second, leadership plays a pivotal role in enabling innovation and sustaining morale. Encouraging participatory decision-making and supporting pilot initiatives can create an environment where resilience flourishes. Finally, resilience must be understood as an ethical commitment, ensuring that organizational adaptation and innovation ultimately serve patient well-being.

Future research could build on this study by examining resilience across different hospitals and regions in Peru, allowing for comparative analysis of institutional contexts. Mixed-methods studies may also provide a more comprehensive understanding by combining qualitative insights with quantitative measures of resilience capacity. Longitudinal designs could further explore how resilience evolves over time, particularly in response to recurrent crises.

Conclusion

Organizational resilience manifested itself as a comprehensive process that combined the ability to adapt to change, emotional management, and institutional innovation in the face of adverse situations. This ability to get back on track not only helped address environmental challenges but was also supported by a combination of teamwork, emotional autonomy, and a willingness to change ingredients that, together, improved daily routines, united the group, and gave the organization a more sustainable tone in the face of difficult situations. Faced with new work situations, they moved and adjusted actively, collaboratively, and attentively to what they felt: they combined new technology courses, team decisions, self-control, a positive attitude, and openness to change, which together served as their strategic response to the institutional transformation. They thus demonstrated that the capacity to adapt was woven from both the individual and collective levels, ultimately reflecting the resilience of the entire organization. Furthermore, they managed their emotions with a rational and kind balance: they self-monitored, regulated their calm, maintained clear communication, and, when necessary, resorted to institutional mediation. Thanks to this, they were able to remain stable on a personal level, maintain the work environment, and keep operations running smoothly, which ultimately gave emotional management the status of a practical pillar within the company's resilience. They became pillars of the organization's resilience because they enabled the adoption of technological tools, the creation of collaborative strategies, and rapid responses to urgent challenges. These achievements were born from an institutional climate open to change, a proactive team, and an approach that focuses on both process improvement and user experience, thus cementing an adaptable and sustainable culture in difficult situations.

Abbreviations

AI: Artificial Intelligence, FAO: Food and Agriculture Organization, IDB: Inter-American Development Bank, SDG: Sustainable Development Goal.

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Author Contributions

Uvaldo Cuno-Chunga: Conceptualization, Methodology, Formal Analysis, Writing—Original

Draft, Edwin Hernan Asis: Investigation, Resources, Validation, Bilmir Aguilar Cahuana: Data Curation, Visualization, Jaime Cuno Chunga: Project Administration, Supervision, Kenny Harley Quino Bengolea: Writing—Review and Editing, Validation.

Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this paper.

Declaration of Artificial Intelligence (AI) Assistance

No generative artificial intelligence (AI) or AI-assisted technologies were used in the writing, editing, data analysis, or preparation of this manuscript.

Ethics Approval

The study protocol was reviewed and approved by the Research Ethics Committee of Universidad César Vallejo, Peru (Approval No.: UCV-REC-2024-015, Date: 15 March 2024). Written informed consent was obtained from all participants prior to data collection.

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