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Clinical Cultural Competence on the Quality of Nursing Care from the Perspectives of Nurses in a Level I Hospital

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ABSTRACT

Cultural competence significantly impacts the quality of care by promoting more effective communication, building trust between providers and patients, and leading to more personalized and effective care. However, studies where quality of nursing care is being predicted by clinical cultural competence from the perspective of nurses are limited. This quantitative research made use of the descriptive, correlational (predictive) research design to assess whether the personal characteristics and clinical cultural competence predicted quality of nursing care from the perspectives of nurses in a Level I hospital in Wao, Lanao del Sur for the second quarter of 2025. Findings revealed that majority were 29 to 59 years old, female, and single. Majority were bachelor's degree holder, regular employees and had served for three years below. Just over half spoke other languages other the English, Cebuano, or the local dialect and all celebrated family traditions. There was a high clinical cultural competence. Specifically, they had very high cross-cultural encounters/situations and self-awareness. They had high levels of knowledge, skills, importance of awareness and had moderate levels of negative cross-cultural encounters/situations. The quality of nursing care was very high. They had a very high quality of task-oriented activities, staff characteristics, pre-condition, physical environment, patient outcomes, and human-oriented activities. Other language spoken other than English, Tagalog, and local dialect predicted clinical cultural competence. Employment status predicted quality of nursing care. Comfort of clinical cultural competence predicted quality of nursing care. In order to address the findings of the study, a satisfaction sustenance plan is proposed.

Keywords: Clinical cultural competence; Descriptive, correlational (predictive); Nurses; Quality of nursing care.

INTRODUCTION

The demand for improved cultural competence among nurses has been brought to light as a result of the growing cultural diversity in the healthcare industry. Improving care that is culturally competent can be accomplished through the evaluation of cultural competence and the identification of key influencing factors. This is not only true to developed countries. The Philippines for example, is composed of several regions and each region possesses unique culture and very diverse individuals from ethnic origins, religions, and backgrounds. Deering (2022) mentioned that cultural competency is a vital skill to be developed in the nursing profession; it enables nurses to provide high-quality nursing care to groups with different cultural backgrounds. Also according to Sharifi et al., 2019) cultural competence has been defined as "the dynamic process of acquiring the ability to provide effective, safe, and quality care to the patients through considering their different cultural aspects". Cultural competency is a vital skill for delivering quality nursing care across culturally diverse groups (Deering, 2024).

Healthcare professionals need to understand and respect cultural differences and provide culturally competent care to demonstrate such competence (Cai, 2016 as cited in Osmancevic et al., 2023). Cultural competence has been identified as an important factor in reducing disparities in healthcare and improving patient outcomes (e.g., patient satisfaction) (Kaihlanen et al., 2019). Culturally competent care is sensitive to the cultural implications of this care. It involves the meaningful, culture-based use of health and care knowledge to coordinate the needs of individuals or groups and helps them to acquire good health and well-being or to cope

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with illnesses, disorders, and death (McFarland & Wehbe-Alamah, 2018). Studies have shown that nurses providing culturally competent nursing care have the potential to improve the quality of care (Cai, 2016 as cited in Osmancevic et al., 2023; Kaihlanen et al., 2019), to heighten patient satisfaction, and to challenge racism in healthcare (Antón-Solanas et al., 2021), all of which leads to better health outcomes (e.g., treatment adherence) in patients from a diversity of cultural backgrounds (Ervin et al., 2006 as cited in Osmancevic et al., 2023). Nurses with high levels of cultural competence can establish more effective communication with patients, which, in turn, can help in the development of appropriate treatments (Cai et al., 2021).

Thus, when a nurse is culturally competent this may have an effect as well in providing quality care. Quality care may also be defined as compliance to respecting cultural beliefs and practices of patients. When it comes to quality care, there are many different aspects to consider, all of which are dependent on the performance of the service and the individual's evaluation. It is vital to provide clarity on the concept of quality in order to better assist the acquisition of knowledge and the enhancement of quality in the healthcare industry. In the study of Stavropoulou et al. (2022), four categories were revealed from the data analysis, namely: (a) "Quality care is holistic care", (b) "Good care is an interpersonal issue", (c) "Leadership is crucial", and (d) "Best care is our responsibility". Quality care was defined as holistic care, addressing all patient needs with competency and aiming for the best patient outcomes. It was associated with communication, teamwork, good leadership, and personal commitment. By developing an in-depth and mutual understanding about what quality means, nurse leaders and practitioners may collaborate in finding common paths to support quality interventions and enhance quality nursing care in clinical practice.

As nurses, one of the researchers was able to observe that not much weight has been placed on cultural competence among nurses. Nurses were presumed to be culturally competence. Through random small interviews with the nurses, most of the nurses expressed that they were not given an opportunity to undergo trainings and seminars about cultural competence. They take care of diverse patients and they are presumed to know the cultural beliefs and practices of every patient. On issues relating to quality of nursing care, patients are very good source of information about the quality of care, however, from the perspectives of the one providing the care, there had been no study that has been conducted. There had been a few complaints about satisfaction on the quality of care provided by the nurses among patients and these were not really documented. This might just be too one-sided and it is high time to look at the side of the coin, where perceptions of the nurses on the quality of nursing care is determined. Establishing these data serves as the knowledge gap of the study. Not only that, how this quality of nursing care in influenced by clinical cultural competence is the major gap in the study. The main objective of the study is assessing if the personal characteristics of the nurses has influence over clinical cultural competence and clinical cultural competence having an influence on quality of nursing care. This also serves as the methodological gap of the study. The researcher aims to address these gaps through the development of a quality of nursing care enhancement plan which may be influenced by clinical cultural competence which is in turn influenced by personal characteristics. This output will be beneficial not only to the nursing practice but this will have a benefit to the clients or patients. The patients will be able to achieve good health and well-being, which is very much aligned with the third sustainable developmental goal.

RESEARCH OBJECTIVES

The main purpose of the study was to assess whether the personal characteristics and clinical cultural competence predicted quality of nursing care from the perspectives of nurses in a Level I hospital in Wao, Lanao del Sur for the second quarter of 2025.

Specifically, the study answered the following queries:

What were the personal characteristics of the nurses in terms of:

- age;
- sex;

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- marital status;
- highest educational attainment;
- employment status;
- years of service;
- other language spoken other than English, Tagalog, and local dialect; and
- celebrates family traditions?

What was the clinical cultural competence of the nurses in terms of:

- knowledge,
- skills,
- comfort in terms of:

cross-cultural encounters/situations and negative cross-cultural encounters/situations; and awareness in terms of:

- importance awareness
- self-awareness?

What was the quality nursing care as perceived by the nurses in terms of**:**

- task-oriented activities;
- staff characteristics;
- pre-condition;
- physical environment;
- patient outcomes; and
- human-oriented activities?

Which personal characteristics predicted clinical cultural competence from the perspectives of nurses?

Which personal characteristics predicted quality of nursing care from the perspectives of nurses?

Which dimension of clinical cultural competence predicted quality of nursing care from the perspectives of nurses?

What quality of nursing care sustenance plan was proposed based on the findings of the study?

Statement of Null Hypotheses

Ho1: The personal characteristics predicted clinical cultural competence from the perspectives of nurses.

Ho2: The personal characteristics predicted quality of nursing care from the perspectives of nurses.

Ho3: The dimensions of clinical cultural competence predicted quality of nursing care from the perspectives of nurses.

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REVIEW OF RELATED LITERATURE AND STUDIES

Clinical Cultural Competence. The nurses' cultural competence level was moderate to high. Providing culturally competent healthcare services for culturally diverse patients is essential for all healthcare professionals, and especially for nurses who spend the most time with patients. Effective interventions, such as educational training, need to be implemented in order to deliver culturally competent care and potentially reduce disparities in healthcare and improve patient outcomes (Osmancevic et al., 2023). Cultural competence (Ahn, 2017 as cited in Červený et al, 2021) in nursing care is essential for providing quality care for patients from different cultural backgrounds. It is a specific concept related to transcultural nursing and contains a wealth of skills and knowledge regarding cultural values, health beliefs, religion, and human philosophy. It is a concept linked to culturally specific nursing care (Leininger & McFarland, 2002 as cited in Červený et al, 2021). Cultural competence in nursing has been defined as a set of knowledge, skills, and attitudes applied in the clinical practice of nursing in an intercultural context (Cerezo et al., 2014 as cited in Červený et al., 2022; Paric et al., 2021).

Perceptions about the training were divided into three main categories: general utility of the training, personal utility of the training, and utility of the training for patients. General utility pertains to the general approach that the training provided on cross-cultural care, the possibility to initiate an open discussion, and the opportunity to improve current practices. Personal utility pertains to the opportunity to become aware of one's own cultural features, to change one's way of thinking, to obtain a new perspective on one's own communication practices and to receive justification for carrying out particular workable practices. Utility for patients pertains to fostering better awareness and acknowledgement of patients' differing cultural features and an increased respect in healthcare delivery. Additionally, the quality of the training was highlighted, and suggestions for improvement were offered (Kaihlanen et al., 2019).

The overall cultural competence nursing care of mean score was at a moderate level of competency. The language barriers, lack of organizational support, cultural difference, and health care provider-related factors were the main identified themes in qualitative results. The overall cultural competence was at a moderate level, among four subscales cultural sensitivity was the highest. The language barrier and lack of training were the major barriers to culturally competent nursing care (Berie et al., 2021). Results revealed five themes: (a) cultural knowledge, (b) self-awareness, (c) barriers to cultural competency, (d) educational process, and (e) current culturally competent practices. All five themes aligned with the constructs of Campinha-Bacote's cultural competence model. The findings of this study may promote positive social change by identifying strategies for cultural competency improvement at the bedside and in nurses' delivery of care (Cox, 2022).

'Unprepared when encountering different cultures' was the core theme for describing and guiding the process of examining the nurses' experiences with a cultural competence. 'Awareness of value differences' was identified as the antecedent condition. The nurses revealed that they have had difficulty implementing their nursing work and seeking resources that represented situations in which interactive behavioral characteristics appeared to improve their cultural competencies. The nurses managing different cultural situations ultimately learned to tolerate the different cultures and to give patients culturally appropriate care, which thereby enhanced the care quality (Lin et al., 2019).

The themes included: (1) relevance of culture for nursing; (2) culture in the healthcare service; (3) qualities of the healthcare professionals; (4) challenges to culturally competent care; (5) becoming a culturally competent nurse. Conclusions: There are challenges to the delivery of culturally congruent care, namely language and communication difficulties, prejudices and stereotyping in the health service, a tendency for ethnocentrism, a lack of education and training in cultural competence and a lack of support from the health service to facilitate new ways of acting (Antón-Solanas et al., 2022). According to Patov (2024), self-assessment bias is a cognitive bias where individuals inaccurately evaluate their own abilities, often leading to overconfidence or underconfidence.

Personal characteristics of nurses. The study sample was made up of 231 nurses, and majority were women. The average age of the sample was 31.7, and the ages ranged from 22 to 53. Most of the people who were admitted were taking care of family members. The average amount of work experience was 8 years, and the

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range was from 0.5 to 30 years (Ahmad et al., 2023). In the study of Yu et al. (2021), participants' demographic and nurse-related characteristics reveal that the mean age of the participants was 26.95 ± 3.82 years, and most participants were female and held bachelor's degrees. Their nurse work experience averaged 3.88 ± 3.64 years, with the largest portion having less than 2 years of experience. In the study of Havaei et al. (2022), most participants were female and worked in the acute care sector, compared with community and long-term care sectors, and urban settings, compared with suburban and rural areas. On average, participants were 40 years old and had 12 years of nursing experience.

Quality of Nursing Care. According to World Health Organization (WHO) (2025), quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It is based on evidence-based professional knowledge and is critical for achieving universal health coverage. As countries commit to achieving Health for All, it is imperative to carefully consider the quality of care and health services. Quality health care can be defined in many ways but there is growing acknowledgement that quality health services should be: (a) effective – providing evidence-based healthcare services to those who need them; (b) safe – avoiding harm to people for whom the care is intended; and (c) people-centred – providing care that responds to individual preferences, needs and values.

To realize the benefits of quality health care, health services must be: (a) timely – reducing waiting times and sometimes harmful delays; (b) equitable – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status; (c) integrated – providing care that makes available the full range of health services throughout the life course; and (d) efficient – maximizing the benefit of available resources and avoiding waste (WHO, 2025).

The study of Alhussin et al. (2024) revealed that the highest level of satisfaction was observed in the coordination of care after discharge, specifically nurses' efforts to cater to patients' needs after they left the hospital. The lowest satisfaction level was related to privacy, with provisions for patients' privacy by nurses scoring 3.9. Overall, patients expressed general satisfaction with the inpatient nursing care they received, and their perceived needs and care expectations from nurses significantly influenced their satisfaction levels.

The mean total score of patients' satisfaction with nursing care quality (NCQ) was high satisfaction (Al-Hammouri et al.. 2024). The study finding revealed that the perceived quality of nursing care indicated poor perception (Most et al., 2023). In the study of Nyelisani et al. (2023), three themes emerged: professional nurses' descriptions, meanings, and expectations of quality nursing care. The findings highlight that quality nursing care means meeting patients' needs through advocacy, empathy, fulfilment of patients' needs, good interpersonal relationships and teamwork. Challenges experienced included the lack of resources and staff shortage. In the study of Yesuf and Abdu (2023), most patients had a positive perception of the quality of nursing care. Being elderly and feeling towards hospital costs have a negative influence whereas having paid for the treatment has a positive influence on the patients' perception of nursing care. Hence. the need increases with age, and healthcare providers should pay great attention while providing care for elderly patients.

Significant differences were found between Saudi provinces regarding the overall quality of nursing care. The study revealed mean significant variations between patient satisfaction with nursing care and sociodemographic factors, including age, education level, marital status, employment status, urban vs. suburban residence, length of hospitalization, and accompaniment by a family member (Akharbi et al., 2023). In terms of clinical context, attributes such as effectiveness, efficiency, patient safety, best patient outcomes, and effective, continuous interaction and communication between the patient and the nursing staff, seem to be the common denominators that contribute significantly to a high quality of nursing care (Kol et al., 2018 as cited in Stavropoulou et al., 2022). Ryan et al. (2017) as cited in Stavropoulou et al. (2022), who conducted focus group sessions to identify nurses' perceptions of quality nursing care, concluded that characteristics such as clinical competency, collaborative relationships, autonomy, supportive management, appropriate staffing, and control of nursing practice were closely related to quality of care in clinical settings. Furthermore, holistic, individualized, and family-centered care was associated with excellence in nursing practice. As contemporary healthcare systems focus on the patient for achieving a high quality of services, factors such as personalized care, nurses' responsiveness to patient requests, an effective patient –nurse ratio, adequate information, and

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accessibility were valued as important dimensions of quality care and patient satisfaction (Fatima et al., 2018 as cited in Stavropoulou et al., 2022; Bachnick et al., 2018 as cited in Stavropoulou et al., 2022) .

In the study of Yusefi et al. (2022), from the patients' perspective, the mean and standard deviation of the quality of nursing services was moderate. Among the quality dimensions, all services quality: psychosocial, physical, and communication were placed at the moderate level. A significant association was found between patients' age and nursing service quality. The perceived nursing service quality was subject to sex and place of residence. In the study of Weldetsadik et al. (2019), four of the five variables had mean score less than 2.5, suggesting the nursing environment and management was unfavorable to assure quality care. All nursing care performances were low. The highest score was in nurse carryout orders and lowest in nurse-physician collaboration. The quality of nursing care is substandard. Favorable environment and nurse physician relationship must be established to provide quality care.

Surgical hospital patients evaluated the level of the quality of nursing care as high; this was especially true with reference to the environment and staff characteristics, but not to collaboration with family members. Most of the patients had received sufficient knowledge preoperatively and they were familiar with the proceeding of their care and treatment after discharge; in particular, they had received bio-physiological knowledge, consisting of knowledge of the disease, symptoms and the physiological elements of care. The positive correlation between the perceived quality of surgical nursing care and received knowledge was strong, suggesting a positive relationship between patient education and improvement of the quality of nursing care (Gröndahl et al., 2019).

Personal Characteristics and Clinical Cultural Competence. The nurses' age, educational level, cultural diversity training and self-perceived cultural competence significantly influenced the level of cultural competence (Osmancevic et al., 2023). Among critical care nurses, the mean scores for cultural competence was moderate. There was a significant correlation between cultural competence and age, marital status, academic degree, work experiences, empathy, and job conflict. Academic degree and empathy were significant explanatory variables that predict cultural competence (Soleimani et al., 2023).

In the study of et al. (2023), male gender, higher years in practice, local language ability, rehabilitation professionals relative to nursing, high culturally competent practice, higher training opportunities, and higher organisational competence were significant predictors of higher personal competence. In the study of An et al. (2022), cultural competence was significantly positively correlated with cultural intelligence and global competence, and significantly negatively correlated with ethnocentrism. The factors that significantly affected cultural competence were cultural intelligence and global competence. Specifically, factors such as being a female nurse, having a diploma level of education, having 11–20 years of work experience, a 1:15 nurse-to-patient ratio, experience with caring for culturally and ethnically diverse patients, comprehensive hospital level, and attending cultural training were predictors of the mean score for cultural competence (Zeleke et al., 2024).

Personal Characteristics and Quality of Nursing Care. In a higher-income levels, higher education levels, having health insurance, being admitted to private hospitals, being admitted to critical care units, being in a single room, excellent perceived health status and willingness to recommend the hospital to family and friends were significant predictors of patients' satisfaction with NCQ. In the study of Bahari et al. (2024), a significant correlation was found between patient trust in nurses and the overall quality of nursing care as well as its dimensions.

The hierarchical multiple regression showed that QNC scores was predicted with a high variance explained. The strongest predictive contribution was from nursing competencies. Over one third of the participants gave positive scores for the overall QNC, and their perception was moderately positive (Ahmad et al., 2023). Approximately over half of NICU nurses perceived good quality of care. NICU work experience of less than 2 years and 2 to 4 years were associated with increased odds of good nursing quality of care (NQoC) in all regression models. Perceived adequacy of nurse staffing level was significantly associated with increased odds of good NQoC. In the study of Havaei et al. (2022), nurses' reports of healthier workplaces, particularly

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workload management, psychological protection, physical safety and engagement, were associated with higher ratings of quality and safe patient care.

Clinical Cultural Competence and Quality of Nursing Care. The results in the study of Barral et al. (2023), it was found that there is a significant difference in the cultural competency of nurses and the quality of care given to the patients. The study indicates that nurses' cultural competence tends to affect patient outcomes and that the hospital needs training programs for nurses to increase their awareness of their behaviors and their influence on healthcare outcomes. Analysis showed a strong association between cultural competency and quality of care. A positive relationship exists among those with high levels of cultural competency and the type of care being received among diverse populations (Skipworth, 2021). A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of racial and ethnic health disparities. Examples of strategies to move the health care system towards these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to patient care (Health Policy Institute, 2025).

RESEARCH METHODOLOGY

Design. This quantitative research made use of the descriptive, correlational (predictive) research design. In application to the study, the descriptive design was used in determining the personal characteristics, clinical cultural competence, and the quality of nursing care. The correlational (predictive) design was used to assess whether the personal characteristics predict clinical cultural competence and quality of nursing care as well as whether the dimensions of clinical cultural competence predicted quality of nursing care.

Environment. The research locale was the nursing department of X Hospital. It is located in Wao Lanao del Sur, a remote area of autonomous region in Muslim Mindanao, a second municipality in the province of Lanao del sur, Philippines. The institution offered services like minor surgeries, normal/uncomplicated deliveries, Newborn Screening, Family Planning dispensing/counselling, basic laboratory examinations, X-rays, consultations and admissions. It is a 100-bed capacity hospital.

Respondents. Respondents of the study were the 40 staff nurses of the hospital.

Sampling Design. There was no sampling as all of the nurse were invited to participate should they qualify based on the inclusion and exclusion criteria. With this, a complete enumeration was utilized.

Inclusion and Exclusion Criteria. Included in the study were staff nurses who had been employed in the hospital for at least three months already for them to be able to assess clinical cultural competence and quality of nursing care and they should be engaged in the actual patient care. They should have a valid and current license to practice nursing. They had to be of legal age regardless of sex, marital status, educational qualification, religion, and socio-economic status. They should be willing to participate and willing to give voluntary consent. Excluded from the study were nurses who were already holding administrative functions, such as nurse supervisors and the chief nurse. Also, those who had submitted their resignations and intention to retire were excluded as they may possibly be giving biased responses.

Instruments. The study made use of a three-part instrument. Part one of the instrument pertained to the personal characteristics of the nurses. Part two of the instrument pertained to Revised Clinical Cultural Competence Questionnaire-PRE (CCCQ-PRE-R) pre-test and post-test instrument by Mareno et al. (2013). The instrument will be answered using a 5-point Likert scale from not at all (0) to very (4), with an additional option of does not apply. The first four subscales address awareness (8 questions), knowledge (10 questions), skills (15 questions), and comfort in patient/family encounters (16 questions). Part three of the instrument was the Quality Nursing Care Scale (QNCS) as developed by Liu et al. (2021). It is a 48-item questionnaire with seven dimensions: task-oriented activities (14 items), staff characteristics (8 items), pre-condition (7 items), physical environment (6 items), patient outcomes (6 items), and human-oriented activities (7 items). It is scored using a five-point Likert scale where 5 indicating "strongly agree" and 1 indicating "strongly disagree."

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Data Gathering Procedures. The work began with submitting three research titles for a title defense. Once a title was approved, a research adviser was chosen. Initial step included sending of transmittal letters to the Dean of the College of Allied Health Sciences and the Medical Center Chief to be allowed to conduct the study. The study was submitted for a design hearing. Following this, the work was submitted to the ethics committees of the university and of the hospital for ethical approval. Following the issuance of notice to proceed, the recruitment began. Recruitment was done through a face-to-face intercept as the researcher was also working in the hospital. Distribution of questionnaires happened either before the shift of the nurses, during breaktimes or after their shifts. The recruitment process was guided by the inclusion and exclusion criteria. Once the questionnaire was given, they were asked to answer it in a private place where they had privacy and concentration on answering the questionnaire. The researcher waited for the questionnaire to be returned and were checked for completeness prior to allowing the respondent to leave. Should the questionnaire be incompletely filled-out, it was returned to the respondent for completion. This whole process was repeatedly done until all nurses were recruited. All answered questionnaires were tallied and collated using the excel format. This was handed to a statistician for appropriate statistical treatments. Data were presented in tables together with the interpretations, analysis, implications as well as the supporting literature and studies. The paper was presented for a final defense. Following the final defense, all answered questionnaires were shredded and all raw soft copies of data were permanently deleted.

Statistical Treatment of Data. The following descriptive and inferential statistics were used to treat the data: (a) Frequency Distribution and Simple Percentage were used to determine the personal characteristics of the nurses. Mean score and Standard Deviation were used to determine the clinical cultural competence and quality of nursing care among nurses. Linear Regression was used to assess whether the personal characteristics and clinical cultural competence predicts quality of nursing care.

Ethical Considerations. The study complied with the requirement of seeking ethical approval. This work was submitted to the ethics committee of the university as well as the hospital for assessment of ethical soundness. The study did not proceed with data gathering unless a notice to proceed was issued from the said committees.

Presentation, Analysis, And Interpretation of Data

Table 1 Personal Characteristics of the Nurses

Personal characteristics	*f*	*%*
Age		
18 to 28 years old (Generation Z)	14	35.00
29 to 59 years old (Generation Y)	16	65.00
64Sex		
Male	14	35.00
Female	26	65.00

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Marital Status		
Single	24	60.00
Married	16	40.00
Highest Educational Attainment		
Bachelor's Degree	34	85.00
With Master's units	5	12.50
Master's Degree Holder	1	2.50
Employment Status		
Regular	28	70.00
Contractual	3	7.50
Job Order	9	22.50
Years of service		
3 years below	27	67.50
4 to 6 years	4	10.00
7 to 9 years	3	7.50
10 years and above	6	15.00
Other language spoken		
No	19	47.50

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Yes	21	52.50
Celebrates family traditions		
No	0	0.00
Yes	40	100.00

Note: *n=40.*

Majority of the respondents were 29 to 59 years old while over one third were 18 to 28 years old. Majority of the nurses were females while over one third were males. Majority of the nurses were singles and almost half were married. Majority of the nurses were bachelor's degree holder with few having master's units and a single respondents is a master's degree holder. Majority of the respondents were regular while almost a quarter were job order and very few were contractuals. Majority of the respondents had served the organization for three years below while few had served for ten years or more. Few also served four to six years and very few had served for seven to nine years. Just over half of the respondents spoke other languages other the English, Cebuano, or the local dialect while almost half do not. All of the respondents celebrate family traditions.

The findings clearly depicts that nurses working in healthcare institutions are already so diverse composed of nurses coming from different age groups, sex, and other demographic profiles. Similarly, in the study of Ahmad et al, (2023), majority of the nruses were women. The average age of the sample was 31.7, and the ages ranged from 22 to 53. The average amount of work experience was 8 years, and the range was from 0.5 to 30 years (Ahmad et al., 2023). Also, in the study of Yu et al. (2021), participants' demographic and nurse-related characteristics reveal that the mean age of the participants was 26.95 ± 3.82 years, and most participants were female and held bachelor's degrees. Their nurse work experience averaged 3.88 ± 3.64 years, with the largest portion having less than 2 years of experience. Lasltly, in the study of Havaei et al. (2022), most participants were female and worked in the acute care sector, compared with community and long-term care sectors, and urban settings, compared with suburban and rural areas. On average, participants were 40 years old and had 12 years of nursing experience.

Table 2 Cultural Competence of the Nurses

Dimensions	Mean score	SD	Interpretation
Knowledge	2.98	0.751	High
Skills	3.19	0.725	High
Comfort			
Cross-cultural encounters/situations	3.33	0.543	Very High

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Negative cross-cultural encounters/situations	2.27	1.401	Moderate
Factor mean	2.80	0.879	High
Awareness			
Importance awareness	3.10	0.805	High
Self-awareness	3.53	0.640	Very High
Factor mean	3.31	0.609	Very High
Grand mean	3.07	0.629	High

Note: *n=40.*

Legend: A score of 0.00 – 0.80 is very low (none), 0.81 – 1.60 is low (little), 1.61 – 2.40 is moderate (sometimes), 2.41 – 3.20 is high (much), and 3.21 – 4.00 is very high (a lot).

Overall, the nurses had a high clinical cultural competence. This implies that a high level of clinical cultural competence for nurses is demonstrated by the capacity to serve patients from a variety of cultural backgrounds with care that is safe, effective, and of high quality, while also respecting the patients' individual values and beliefs. Rather than merely being aware of and accepting of cultural differences, it requires incorporating cultural considerations into patient care and relationships.

Cultural competence (Ahn, 2017 as cited in Červený et al, 2021) in nursing care is essential for providing quality care for patients from different cultural backgrounds. It is a specific concept related to transcultural nursing and contains a wealth of skills and knowledge regarding cultural values, health beliefs, religion, and human philosophy. It is a concept linked to culturally specific nursing care (Leininger & McFarland, 2002 as cited in Červený et al, 2021). Cultural competence in nursing has been defined as a set of knowledge, skills, and attitudes applied in the clinical practice of nursing in an intercultural context (Cerezo et al., 2014 as cited in Červený et al., 2022; Paric et al., 2021).

Supporting the findings, the nurses' cultural competence level was moderate to high. Providing culturally competent healthcare services for culturally diverse patients is essential for all healthcare professionals, and especially for nurses who spend the most time with patients. Effective interventions, such as educational training, need to be implemented in order to deliver culturally competent care and potentially reduce disparities in healthcare and improve patient outcomes (Osmancevic et al., 2023). However, this finding could be a result of the respondents being biased. This finding is a consequence of a self-rating survey, where respondents rate themselves high as it pertains to an assessment of themselves. No one would rate himself to be incompetent. According to Patov (2024), self-assessment bias is a cognitive bias where individuals inaccurately evaluate their own abilities, often leading to overconfidence or underconfidence.

In terms of knowledge on clinical cultural competence, the nurse had a high knowledge. This means that know a lot about hospital policy on the subject of cultural diversity. Additionally, they know much about the demographics of diverse ethnic groups within the hospital, sociocultural characteristics of diverse ethnic groups, health risks experienced by diverse ethnic groups, health disparities experienced by diverse ethnic groups, and sociocultural issues in treatment/care in their department. Moreover, they know a lot about

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ethnopharmacology, different healing traditions, historical and contemporary impact of racism, bias, prejudice and discrimination in health care experienced by various population groups in your county, and the national/regional policies dealing with cultural diversity in health care. This implies that nurses have knowledge about many cultures, including their ideas, values, and health practices, along with other cultural information.

In terms of skills, nurses have high skills in clinical cultural competence. They believed that they have much skills in eliciting information about use of folk remedies and/or other alternative healing modalities, in eliciting information about use of folk healers and/or other alternative practitioners, working with medical interpreters, dealing with cross-cultural conflicts relating to diagnosis or treatment, with cross-cultural adherence/compliance problems, and with cross-cultural adherence/compliance problems. However, they believed that they have a lot of skills in terms of greeting patients in a culturally sensitive manner, eliciting the patient's perspective about health and illness, performing a culturally sensitive physical examination, prescribing/negotiating a culturally sensitive treatment plan, and providing culturally sensitive patient education and counseling. Lastly, they believed that they have a lot of skills in providing culturally sensitive clinical preventive services, providing culturally sensitive care for dying patients, assessing health literacy, and apologizing for cross-cultural misunderstandings or errors

In terms of comfort on clinical cultural competence, nurses had a high comfort. As for the cross-cultural encounters/situations they had a very high comfort. They believed that they have a lot of comfort in caring for patients from culturally diverse backgrounds, caring for patients with limited english proficiency, and caring for a patient who insists on using or seeking folk healers or alternative therapies. They also had a lot of comfort in identifying beliefs that are not expressed by a patient or caregiver but might interfere with the treatment regimen and in being attentive to nonverbal cues or the use of culturally specific gestures that might have different meanings in different cultures. Additionally, they believed that they had a lot of comfort in interpreting different cultural expressions of pain, distress, and suffering, working with health care professionals from culturally diverse backgrounds, dealing with large groups of family members accompanying and visiting patients, dealing with patients having culturally different eating habits, and supporting patients' need to practice their religion the awareness of individuals on their own ethnic identity, ethnic stereotypes, biases, and prejudices. However, they believed that they had much comfort in advising a patient to change behaviors or practices related to cultural beliefs that impair one's health, speaking in an indirect rather than a direct way to a patient about his/her illness if this is more culturally appropriate, and breaking "bad news" to a patient's family first rather than to the patient if this is more culturally appropriate.

As for the negative cross-cultural encounters/situations, this was rated as moderate. Respondents believed that they sometimes work with a colleague who makes derogatory remarks about patients from a particular ethnic group, treating a patient who makes derogatory comments about their ethnic background, and dealing with patients who make derogatory comments about other patients' ethnic background. This implies that nurses are acquiring the ability to connect with patients who come from a variety of backgrounds, including language skills, while also developing good communication and interpersonal skills.

In terms of awareness on clinical cultural competence, respondents had a very high awareness. As for the importance awareness, the respondents had a high importance awareness. They believed that they had much awareness on the degree of importance individuals felt sociocultural issues were in their interactions with patients, the degree of importance individuals felt sociocultural issues were in their interactions with patient relative/family, the degree of importance individuals felt sociocultural issues were in their interactions with other visitors, the degree of importance individuals felt sociocultural issues were in their interactions with colleagues form your own profession, and the degree of importance individuals felt sociocultural issues were in their interactions with other staff. As for self-awareness, the respondents had a very high level of self-awareness about clinical cultural competence. They believed that they had a lot of self-awareness in terms of their own ethnic or cultural identity, on their own ethnic or cultural stereotypes, and on their own biases and prejudices. This implies that nurses have the acknowledgment and appreciation of the cultural diversity of patients, as well as the comprehension of the ways in which patients' cultural beliefs and practices influence their health.

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Contrary to the findings, the overall cultural competence nursing care of mean score was at a moderate level of competency. The language barriers, lack of organizational support, cultural difference, and health care provider-related factors were the main identified themes in qualitative results. The overall cultural competence was at a moderate level, among four subscales cultural sensitivity was the highest. The language barrier and lack of training were the major barriers to culturally competent nursing care (Berie et al., 2021).

Results revealed five themes: (a) cultural knowledge, (b) self-awareness, (c) barriers to cultural competency, (d) educational process, and (e) current culturally competent practices. All five themes aligned with the constructs of Campinha-Bacote's cultural competence model. The findings of this study may promote positive social change by identifying strategies for cultural competency improvement at the bedside and in nurses' delivery of care (Cox, 2022). For the purpose of providing patients with treatment that is of the highest possible quality, most effective, and ethical, nurses should have clinical cultural competence. This involves having a grasp of and respect for the many cultural values, beliefs, and traditions that exist. This, in turn, allows for the development of trust, the improvement of communication, the enhancement of patient adherence to treatment programs, and eventually results in improved health outcomes.

Table 3 Quality of Nursing Care as Perceived by the Nurses

Dimensions	Mean score	SD	Interpretation
Task-oriented Activities	4.57	0.428	Very high quality
Staff Characteristics	4.59	0.496	Very high quality
Pre-condition	4.37	0.597	Very high quality
Physical Environment	4.34	0.553	Very high quality
Patient Outcomes	4.42	0.549	Very high quality
Human-oriented Activities	4.44	0.538	Very high quality
Grand mean	4.45	0.464	Very high quality

Note: *n=40.*

Legend: A score of 1.00 – 1.80 is very low quality (strongly disagree), 1.81 – 2.60 is low quality (disagree), 2.61 – 3.40 is fair quality (neither agree nor disagree), 3.41 – 4.20 is high quality (agree), and 4.21 – 5.00 is very high quality (strongly agree).

Overall, the quality of nursing care was very high. To provide nursing care that is of very high quality, it is necessary to provide care that is not only safe and effective but also timely, patient-centered, and efficient, while also being equitable. As part of this, nurses are expected to possess good communication and critical thinking abilities, as well as the ability to demonstrate competence, expertise, and compassion. In order to provide high-quality care, it is essential to pay attention to the requirements of the patients, to make certain that

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they are safe and healthy, and to advocate for their best interests. Supporting the finding, from the perspective of patients, the mean total score of patients' satisfaction with nursing care quality (NCQ) indicated a high satisfaction (Al-Hammouri et al., 2024). However, contrary to the findings, the study finding revealed that the perceived quality of nursing care indicated poor perception. There was statistically significant different between quality nursing care with gender, duration of hospital stays, ward service type, and history of previous hospitalization (Most et al., 2023). Having said that, this finding might be the result of the respondents having a biassed perspective. The results of a self-rating survey, in which respondents gave themselves high ratings in relation to an evaluation of themselves, led to the discovery of this conclusion. There is no one who would consider themselves to be not giving quality care. According to Patov (2024), self-assessment bias is a cognitive bias where individuals inaccurately evaluate their own abilities, often leading to overconfidence or underconfidence.

Task-oriented activities were rated to be of very high quality. Respondents strongly agreed that they were able to clearly explained to the patients about their questions related to medical expense, they provided guidance to do self-care for patients, they provided the information to patient with effective communication, and they provided sufficient information related to nursing care to patients' relatives. Additionally, they strongly agreed that they performed the standardized nursing service to patient according to their situation, they informed their patients before providing any nursing intervention, they performed the good basic nursing care to patients, they performed nursing duties in a professional manner, and provided sufficient information to their patients about their care or treatment with clear word. Moreover, they strongly agreed that they immediately responded to patient and family's problems, they provided individualized care for patients, provided medication and treatment at the correct time, provided effective health education to patients, and although they were busy, they provided nurse service on time.

Staff characteristics was rated as having a very high quality. They strongly agree that they carefully followed hospital rules and regulations, they were very cautious in performing nursing duties, were polite and pleasant to treat patients, and they smiled to patients when providing nursing service. Moreover, they strongly agreed that they closely observed the patient condition, focusing on the dynamic change of the disease, they patiently listen to their patients, when they want to talk about their problems, they worked well with their team, and they patiently and repeatedly explain patients doubt.

Pre-condition was rated to be having a very high quality, Respondents strongly agreed that they mastered the clinical technical operations to meet the needs of nursing care, are up-to-date with theoretical knowledge to meet the needs of nursing care, mastered operating process of basic nursing care and special nursing care, managed drugs well, participated in the ward quality management, their professional experience was helpful for their nursing job, and they intended to help patients whenever the help is needed. The physical environment was rated as having a very high quality. They strongly agree that the nurses provided the hygienic room to the patients, provided a comfortable environment for patient to rest in, kept patient room has the good ventilation, provided safe environment to patients for their treatment, and provided the quiet ward environment for patients staying in the hospital and immediately disposed patients' reflection environment problems.

In terms of the quality of patient outcomes, this was rated as very high quality. Respondents strongly agreed that they ensured to provide safety service to patient, avoid patient physical damage, never get complains from the patients and their relatives, avoid patient chemical damage, avoid patient biological damage, and ensured that the provided service would meet patient's satisfaction criteria. In terms of the quality of human-oriented activities, this was also rated as very high quality. They strongly agreed that they helped their patients to relive their worry about illness, helped patients build confidence to overcome the disease, ensured to provide services that would meet patient individual needs, and provided humanity services to patients based on their characteristics. Additionally, they strongly agreed that they helped their patients to relieve their fear about treatment and procedure, analyzed the patient psychological feelings to provide care, and protected patient's privacy when provide nursing service.

From the perspective of patients, in the study of Yesuf and Abdu (2023), most patients had a positive perception of the quality of nursing care. In terms of clinical context, attributes such as effectiveness, efficiency, patient safety, best patient outcomes, and effective, continuous interaction and communication

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between the patient and the nursing staff, seem to be the common denominators that contribute significantly to a high quality of nursing care (Kol et al., 2018 as cited in Stavropoulou et al., 2022). Ryan et al. (2017) as cited in Stavropoulou et al. (2022), who conducted focus group sessions to identify nurses' perceptions of quality nursing care, concluded that characteristics such as clinical competency, collaborative relationships, autonomy, supportive management, appropriate staffing, and control of nursing practice were closely related to quality of care in clinical settings. Furthermore, holistic, individualized, and family-centered care was associated with excellence in nursing practice. As contemporary healthcare systems focus on the patient for achieving a high quality of services, factors such as personalized care, nurses' responsiveness to patient requests, an effective patient –nurse ratio, adequate information, and accessibility were valued as important dimensions of quality care and patient satisfaction (Fatima et al., 2018 as cited in Stavropoulou et al., 2022; Bachnick et al., 2018 as cited in Stavropoulou et al., 2022).

Contrary the findings, in the study of Yusefi et al. (2022), from the patients' perspective, the mean and standard deviation of the quality of nursing services was moderate. Among the quality dimensions, all services quality: psychosocial, physical, and communication were placed at the moderate level. A significant association was found between patients' age and nursing service quality. The perceived nursing service quality was subject to sex and place of residence. It is essential to provide nursing care of a high quality in order to achieve better outcomes for patients, higher levels of patient satisfaction, and overall enhanced functioning of the healthcare system. It helps to improve patient safety, ensure that patients receive timely care, and limit the number of medical errors that occur, which ultimately results in favorable patient experiences and outcomes.

Table 4 Personal Characteristics Predicting Clinical Cultural Competence

Variables	B	Std error	Beta	t	*p* value	Decision	Interpretation
(Constant)	2.942	.800		3.677	.001		
Age	.234	.228	.196	1.029	.311	Failed to reject Ho	Not significant
Sex	-.294	.215	-.226	-1.372	.180	Failed to reject Ho	Not significant
Marital status	.199	.231	.157	.862	.395	Failed to reject Ho	Not significant
Highest educational attainment	.518	.286	.368	1.810	.080	Failed to reject Ho	Not significant

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Employment status	-.045	.119	-.061	-.381	.706	Failed to reject Ho	Not significant
Years of service	-.195	.118	-.353	-1.662	.106	Failed to reject Ho	Not significant
Other language spoken other than English, Tagalog, and local dialect	-.435	.198	-.350	-2.193	.036	Reject Ho	Significant
Celebrates family traditions*	--	--	--	--	--	--	--

Legend: Significant if *p* value is ≤ .05. * One group only. If R-squared value < 0.3 is None or Very weak effect size, if R-squared value 0.3 < r < 0.5 is Weak or low effect size, if R-squared value 0.5 < r < 0.7 is Moderate effect size, and if R-squared value r > 0.7 is Strong effect size.

The table shows that the *p* value for other language spoken other than English, Tagalog, and local dialect was lesser than the significant value of .05. This value was interpreted as significant leading to the decision of rejecting the null hypothesis. Thus, other language spoken other than English, Tagalog, and local dialect predicted clinical cultural competence. Looking at the table, the t value for other language spoken other than English, Tagalog, and local dialect was negative which indicates that the influence of other language spoken other than English, Tagalog, and local dialect towards clinical cultural competence was negative. A negative prediction means that as the person speaks English, Tagalog, and local dialect only, the clinical cultural competence increases. For every one unit decrease in other language spoken other than English, Tagalog, and local dialect, the clinical cultural competence increases by 2.193 units.

Contradictory to the findings, knowing several languages best prepares the nurse to deal with different language-speaking patients. The more language the nurse learns, the wider the coverage of the patients that the nurse can handle. However, the area is not widely visited by foreign nationals who do not speak English. English is a universal language and almost everybody in the world speaks English. Thus, it is only English that may be required to be known to the nurses for them to be considered culturally competence in terms of the language. Contrary to the findings, among critical care nurses, the mean scores for cultural competence was moderate. There was a significant correlation between cultural competence and age, marital status, academic degree, work experiences, empathy, and job conflict. Academic degree and empathy were significant explanatory variables that predict cultural competence (Soleimani et al., 2023).

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Also, in the study of et al. (2023), male gender, higher years in practice, local language ability, rehabilitation professionals relative to nursing, high culturally competent practice, higher training opportunities, and higher organisational competence were significant predictors of higher personal competence. In the study of An et al. (2022), cultural competence was significantly positively correlated with cultural intelligence and global competence, and significantly negatively correlated with ethnocentrism. The factors that significantly affected cultural competence were cultural intelligence and global competence.

Additionally, factors such as being a female nurse, having a diploma level of education, having 11–20 years of work experience, a 1:15 nurse-to-patient ratio, experience with caring for culturally and ethnically diverse patients, comprehensive hospital level, and attending cultural training were predictors of the mean score for cultural competence (Zeleke et al., 2024).

The model summary revealed the following values: R = .541, R Square = .293, Adjusted R Square = .138, Std. Error of Estimate = .58368, F = 1.893, Sig. = .104. Therefore, the regression model created is as follows:

Clinical Cultural Competence = 2.942 – 2.193 (other language spoken other than English, Tagalog, and local dialect)

The equation reads that clinical cultural competence is the difference of the constant value of 2.942 minus 2.193 of other language spoken other than English, Tagalog, and local dialect. Based on the model summary, the r squared value was .293 which indicates that the total variation in the clinical cultural competence can be explained by the independent variable of other language spoken other than English, Tagalog, and local dialect. In this case, 29.30 percent can be explained which is very weak. This means that the variable of other language spoken other than English, Tagalog, and local dialect predicting clinical cultural competence had no effect. Thus, the regression model was also very weak. Based on the significant value of .104, the regression model predicts the dependent variable insignificantly. The value was equal to .104, and indicates that, overall, the regression model statistically insignificantly predicts the outcome variable (i.e., it is a good fit for the data).

However, the *p* values for age, sex, marital status, highest educational attainment, employment status, years of service, and celebrates family traditions were greater than the significant value of .05 which were interpreted as not significant which further means that they did not predict clinical cultural competence. Therefore, clinical cultural competence is not influenced by age, sex, marital status, highest educational attainment, employment status, years of service, and celebrates family traditions. There can still be a high level of clinical cultural competence no matter what age, sex, marital status, highest educational attainment, employment status, years of service, and celebrates family traditions.

Table 5 Personal Characteristics Predicting Quality Nursing Care

Variables	B	Std error	Beta	T	*p* value	Decision	Interpretation
(Constant)	5.576	.530		10.529	.000		
Age	.297	.151	.336	1.968	.058	Failed to reject Ho	Not significant
Sex	-.055	.142	-.057	-.385	.703	Failed to reject Ho	Not significant
Marital status	-.300	.153	-.320	-1.964	.058	Failed to reject Ho	Not significant

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Highest educational attainment	.069	.189	.067	.365	.717	Failed to reject Ho	Not significant
Employment status	-.342	.079	-.623	-4.351	.000	Reject Ho	Significant
Years of service	-.124	.078	-.302	-1.588	.122	Failed to reject Ho	Not significant
Other language spoken other than English, Tagalog, and local dialect	.093	.131	.102	.710	.483	Failed to reject Ho	Not significant
Celebrates family traditions	--	--	--	--	--	--	--

Legend: Significant if *p* value is $\leq$ .05. If R-squared value < 0.3 is None or Very weak effect size, if R-squared value 0.3 < r < 0.5 is Weak or low effect size, if R-squared value 0.5 < r < 0.7 is Moderate effect size, and if R-squared value r > 0.7 is Strong effect size.

The table shows that the *p* value for employment status was below the significant value of .05. This value was interpreted as significant leading to the decision of rejecting the null hypothesis. Thus, employment status predicted quality of nursing care.

Looking at the table, the t value for employment status was negative which indicates that the influence of employment status towards quality of nursing care was negative. A negative prediction means that as the employment status becomes job order, the quality of nursing care increases. For every one unit decrease in employment status, the quality of nursing care increases by 4.351 units. Job orders do not have job security, for them to be renewed they have to be performing well and as a consequence of performing well, they have to gain clinical cultural competence as well for them to serve well their patients. Thus, being a job order exerts more effort to become competent in order for them to be renewed with their contracts and therefore strive to have a high quality of nursing care. Contrary to the findings, in the study of higher-income levels, higher education levels, having health insurance, being admitted to private hospitals, being admitted to critical care

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units, being in a single room, excellent perceived health status and willingness to recommend the hospital to family and friends were significant predictors of patients' satisfaction with NCQ. In the study of Bahari et al. (2024), a significant correlation was found between patient trust in nurses and the overall quality of nursing care as well as its dimensions. Additionally, the hierarchical multiple regression showed that QNC scores was predicted with a high variance explained. The strongest predictive contribution was from nursing competencies. Over one third of the participants gave positive scores for the overall QNC, and their perception was moderately positive (Ahmad et al., 2023).

Moreover, approximately over half of NICU nurses perceived good quality of care. NICU work experience of less than 2 years and 2 to 4 years were associated with increased odds of good nursing quality of care (NQoC) in all regression models. Perceived adequacy of nurse staffing level was significantly associated with increased odds of good NQoC. In the study of Havaei et al. (2022), nurses' reports of healthier workplaces, particularly workload management, psychological protection, physical safety and engagement, were associated with higher ratings of quality and safe patient care.

The model summary revealed the following values: R = .658, R Square = .433, Adjusted R Square = .308, Std. Error of Estimate = .38625, F = 3.485, Sig. = .007. Therefore, the regression model created is as follows:

Quality of Nursing Care = 5.576 – 4.351 (employment status)

The equation reads that quality of nursing care is the difference of the constant value of 5.576 minus 4.351 of employment status.

Based on the model summary, the r squared value was .433 which indicates that the total variation in the quality of nursing care can be explained by the independent variable of employment status. In this case, 43.30 percent can be explained which is weak or low effect. This means that the variable of employment status predicting quality of nursing care had a low effect. Thus, the regression model was also weak. Based on the significant value of .007, the regression model predicts the dependent variable significantly. The value was equal to .007, and indicates that, overall, the regression model statistically significantly predicts the outcome variable (i.e., it is a good fit for the data).

However, the *p* values for age, sex, marital status, highest educational attainment, years of service, other language spoken other than English, Tagalog, and local dialect, and celebrates family traditions were greater than the significant value of .05 which were interpreted as not significant which further means that they did not predict quality of nursing care. Therefore, quality of nursing care is not influenced by age, sex, marital status, highest educational attainment, years of service, other language spoken other than English, Tagalog, and local dialect, and celebrates family traditions. There can still be a high level of quality of nursing care no matter what age, sex, marital status, highest educational attainment, years of service, other language spoken other than English, Tagalog, and local dialect, and celebrates family traditions.

Table 6 Dimensions of Clinical Cultural Competence predicting Quality of Nursing Care

Variables	B	Std error	Beta	T	*p* value	Decision	Interpretation
(Constant)	3.965	.360		11.007	.000		
Knowledge	.072	.113	.117	.640	.526	Failed to reject Ho	Not significant
Skills	.167	.132	.261	1.267	.214	Failed to reject Ho	Not significant

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Comfort	-.443	.103	-.838	-4.283	.000	Reject Ho	Significant
Awareness	.295	.171	.387	1.725	.093	Failed to reject Ho	Not significant

Legend: Significant if *p* value is ≤ .05. If R-squared value < 0.3 is None or Very weak effect size, if R-squared value 0.3 < r < 0.5 is Weak or low effect size, if R-squared value 0.5 < r < 0.7 is Moderate effect size, and if R-squared value r > 0.7 is Strong effect size.

The table shows that the *p* value for comfort was below the significant value of .05. This value was interpreted as significant leading to the decision of rejecting the null hypothesis. Thus, comfort predicted quality of nursing care. Looking at the table, the t value for comfort was negative which indicates that the influence of comfort towards quality of nursing care was negative. A negative prediction means that as the comfort of clinical cultural competence decreases, the quality of nursing care increases. For every one unit decrease in comfort of clinical cultural competence, the quality of nursing care increases by 4.283 units. Contradicting the findings, the promotion of patient satisfaction, adherence to treatment, and improved health outcomes are all positively impacted by comfort of clinical cultural competence, which has a substantial impact on the quality of nursing care. The ability to develop trust, improve communication, and provide care that is more tailored and effective can be achieved by nurses who demonstrate an understanding of and respect for the cultural values and beliefs of their patients. This results in improved outcomes for patients and a more robust relationship between the nurse and the patient. Supporting the finding, the results in the study of Barral et al. (2023) indicated that nurses' cultural competence tends to affect patient outcomes and that the hospital needs training programs for nurses to increase their awareness of their behaviors and their influence on healthcare outcomes.

Analysis showed a strong association between cultural competency and quality of care. A positive relationship exists among those with high levels of cultural competency and the type of care being received among diverse populations. Understanding the impacts of cultural barriers, and their implications on individuals practicing and receiving medical care is a key starting point to addressing this issue. The skill of cultural competence can greatly impact the overall quality of care and patient experience. Knowing that this awareness can benefit both the patient and provider, it would be beneficial for society to understand the relationship between healthcare professionals and cultural competence (Skipworth, 2021). A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of racial and ethnic health disparities. Examples of strategies to move the health care system towards these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to patient care (Health Policy Institute, 2025).

The model summary revealed the following values: R = .593, R Square = .352, Adjusted R Square = .278, Std. Error of Estimate = .39463, F = 4.756, Sig. = .004. Therefore, the regression model created is as follows:

Quality of Nursing Care = 3.965 – 4.283 (comfort)

The equation reads that quality of nursing care is the difference of the constant value of 3.965 minus 4.283 of comfort of clinical cultural care. Based on the model summary, the r squared value was .352 which indicates that the total variation in the quality of nursing care can be explained by the independent variable of comfort. In this case, 35.20 percent can be explained which is weak or low effect. This means that the variable of comfort predicting quality of nursing care had a low effect. Thus, the regression model was also weak. Based on the significant value of .004, the regression model predicts the dependent variable significantly. The value was equal to .004, and indicates that, overall, the regression model statistically significantly predicts the outcome variable (i.e., it is a good fit for the data).

However, the *p* values for knowledge, skills, and awareness were greater than the significant value of .05 which were interpreted as not significant which further means that they did not predict quality of nursing care. Therefore, quality of nursing care is not influenced by knowledge, skills, and awareness of clinical cultural

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competence. There can still be a high level of quality of nursing care despite the low levels of knowledge, skills, and awareness on clinical cultural competence.

CONCLUSION AND RECOMMENDATIONS

Conclusion. In conclusion, quality of nursing care is influenced comfort of clinical cultural competence. The lower the comfort of clinical cultural competence, the higher the quality of nursing care. Further, other language spoken other than English, Tagalog, and local dialect influences clinical cultural competence. As the person speaks English, Tagalog, and local dialect only, the clinical cultural competence increases. Furthermore, employment status influences quality of nursing care. As the employment status becomes job order, the quality of nursing care increases. The high level of clinical cultural competence is reflective of the Model of Cultural Competence in Health Care Delivery relating knowledge, skills, comfort and awareness. Also, the very high quality of nursing care is an affirmation of the Quality of Care Assessment Model where staff characteristic and physical environment, task-oriented activities, human-oriented activities, and precondition were reflective of structure, process, and outcomes. In order to address the findings of the study, a satisfaction sustenance plan is proposed.

Recommendations. The following recommendations are crafter to address the findings of the study:

Nursing Practice. The first step is to disseminate the study findings to the nursing staff and administrators of the hospital to guide their practice of nursing. Consequently, the quality of nursing care enhancement plan will be recommended for use in the hospital especially the nursing department. Other hospitals may opt to adopt the enhancement plan as they deem it applicable to their organization. The enhancement plan provides several activities that can be adopted in whole or in part allowing hospitals administrators to revisit, review and revise their already established plans.

Nursing Education. The study findings serves as an additional knowledge on clinical cultural competence and quality of nursing care. They may serve as examples when discussing topics on clinical cultural competence and quality of nursing. Consequently, the study can serve as an article that could be made as an example when discussing research methodology, statistics, and ethics in research.

Nursing Policy. The study findings will call for policy making in terms of making cultural competence a major component in providing holistic care to patients. Internal policies relating to making cultural competence as a component of the staff development plan in healthcare institutions may be created to best prepare nurses in caring a diverse clientele.

Nursing Research. To disseminate the findings, the researcher aims to submit the paper for publication in any refereed local or international journal. The researcher also aims to submit the paper for a possible oral or poster presentation in any local or international research congress. Moving forward, the following research titles are also suggested to address the new gaps discovered in the study:

Nurses' clinical cultural competence on quality of nursing care from the perspective of discharged patients;

Clinical cultural competence on quality of nursing care among patients and nurses: A Convergent parallel mixed method;

Validating the findings of the study on prediction where a greater number of respondents will be included.

Quality of Nursing Care Sustenance Plan

Rationale

When it comes to improving patient outcomes, enhancing patient safety, and increasing patient satisfaction, providing nursing care of a high quality is absolutely necessary. Not only does it play a significant part in lowering the expenses of healthcare, but it also contributes to the general improvement of the clinical environment. Care that is of high quality helps to prevent fatalities and illnesses that could have been avoided,

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which ultimately leads to improved health outcomes. The provision of nursing care that is both compassionate and effective can facilitate a more expedient recovery from illness or accident. It is possible for nurses to assist in the prevention of readmissions to the hospital by attending to the needs of patients and offering ongoing assistance. Patient safety is given top priority in high-quality care, and errors that could have been avoided and could have caused injury are avoided. The nurses are frequently the first to recognize any changes in the status of a patient, which enables them to intervene in a timely manner and prevent complications from occurring. In order to ensure that all parties involved in the healthcare process are on the same page, nurses play a crucial role in efficiently communicating with patients and other healthcare providers. Patients who are provided with high-quality medical care are more likely to report being pleased with their overall experience with healthcare. Nurses who exhibit compassion, understanding, and a commitment to the well-being of their patients are able to earn the trust of their patients and the relatives of those patients. The best nurses are those who fight for their patients' needs and preferences, making sure that their patients' opinions are taken into consideration. It is possible for high-quality care to contribute to a reduction in healthcare expenditures by thereby reducing problems and facilitating a faster recovery. It is possible for nurses who are experienced and well-trained to operate more efficiently, so reducing the amount of time patients have to wait and making the most of the resources available. One of the factors that contributes to a more positive and collaborative team environment is the presence of nurses who are skilled and dedicated. Providing care of a high quality encourages accountability among all healthcare providers, making certain that each individual is accountable for the role that they play in the delivery of care. Nurses who exhibit professionalism and a dedication to providing high-quality care are a significant contributor to the creation of a healthy and supportive working environment for all employees. Findings of the study revealed that nurses had a high cultural competence and had a very high quality of nursing care. There is a need to further improve the clinical cultural competence and sustain the quality care and thus, the creation of this quality nursing care sustenance plan.

General Objectives

This quality of nursing care sustenance plan is primarily created to further improve clinical cultural competence and sustain the quality of nursing care of the nurses.

Specific Objectives

Specifically, this quality of nursing care sustenance plan is aimed at achieving the following specific objectives:

To further improve from high to very high clinical cultural competence among nurses; and

To sustain the very high quality of nursing care of the nurses.

Areas of Concern	Specific Objectives	Activities	Persons responsible	Resources	Time frame	Success Indicators
The need to improve high level of clinical cultural	To further improve from high to very high clinical cultural	**Personally initiated activities:** Read or view videos about culture care and	Staff Nurses Nurse Supervisor Chief Nurse HR Director Hospital Administrators	Internet connectivity. Desktop, laptops, tablets or android phones. Instrument to measure	Third quarter of 2025 onwards	Saved articles of videos. Certificates of attendance, participation in the seminars, webinars, and trainings. Minutes of meetings.

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competence.	competence among nurses.	Madeleine Leininger's theory, also known as the Transcultural Nursing Theory or Culture Care Theory. Attend or join webinars or seminars on topics relating to Culture Care. Learn a second, third or fourth language. **Hospital-initiated activities:** Conduct a seminar about Gaining Understanding and Awareness of Culture Care. Conduct a seminar on Madeleine Leininger's theory, also known as the Transcultura		clinical cultural competence. Budget for the seminar (Php 10,000.00 / activity).		Survey result-very high leve lof clinical cultural competence.

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		l Nursing Theory or Culture Care Theory. Conduct a seminar workshop on Active Listening and Effective Communication. Conduct a self-awareness workshop. Conduct periodic meetings with the nursing staff to discuss culture care issues. Re-assess the level of clinical cultural competence of nurses using the same instrument six months following the implementation of this plan.				
The need to sustain the very high quality of	To sustain the very high quality of nursing	**Personally initiated activities:** Read or view videos	Post-partum mothers. Staff Nurses at the OB-Gyne Ward Nurse	Internet connectivity. Desktop, laptops, tablets or android	Third quarter of 2025 onwards	Saved articles of videos. Certificates of attendance, participation in the seminars, webinars, and trainings.

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nursing care.	care of the nurses.	about quality nursing care. Attend or join webinars or seminars on topics relating quality nursing care. **Hospital-initiated activities:** Institute continuous quality improvement activities such as Conduct regular and periodic review of guidelines, protocols, policies, etc. Conduct regular Nursing Audit. Conduct seminars on Inter and Intrapersonal Relationships. Conduct seminar on	Supervisor Chief Nurse HR Director Hospital Administrators	phones. Interview guide Official website and Facebook account. Budget for the seminar (Php 10,000.00 / activity).		Summary reports on the interview. List of continuing professional development activities from the PNA. Installed suggestion box. Running and updated Facebook and official website. Minutes of meetings. Survey result-very high quality of nursing care.

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		ethics and professionalism Involve family in the care Conduct seminar on patient-centered care. Re-orientation on the Rules and regulations of the hospital Conduct seminar or training on Customer service Conduct seminar or training on Collaboration and Teamwork Conduct a seminar on Continuous Quality Improvement and Quality Management System Maintain cleanliness of the hospitals and posting signages on observing cleanliness and keeping				

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		silence Strict compliance on hospital waste management Conduct a seminar on ethical and Legal aspects of Nursing Conduct seminar-workshop on Nurses as an effective communicator and therapeutic communication Conduct training on physical assessment Nurse: Patient-advocates Re-orientation on the patient's bill of rights Conduct a seminar on Data Privacy Act in patient care Conduct a random interview of post-partum mothers on				

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		their feedback about the services provided. Coordinate with Accredited Professional Organization for trainings and continuing professional development activities. Install a suggestion box in the Wards for comments and suggestions. Conduct periodic meetings with the nursing staff to discuss how to improve nursing services. Making sure that portals are also available like |Facebook or the official website where patients can raise concerns. Re-assess the quality of nursing				

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		care using the same instrument six months following the implementation of this plan and periodically, every six months as a continuing quality improvement activity.				

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