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# Emotional Intelligence on Cultural Competence among Nurses in Selected Hospitals in Ormoc City

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## ABSTRACT

The healthcare industry demands nurses who possess both emotional intelligence (EI) and cultural competence (CC) to effectively manage patient care in diverse clinical settings. However, gaps in emotional regulation, self-awareness, and proactive cultural application among nurses pose challenges to workplace relationships, patient satisfaction, and overall healthcare quality. This study aimed to assess the emotional intelligence and cultural competence of nurses in selected hospitals in Ormoc City, determine significant differences based on demographic and professional characteristics, and examine the relationship between EI and CC. A quantitative, descriptive-correlational research design was employed, utilizing a 33-item Emotional Intelligence Scale and the Nurse Cultural Competence Scale (NCCS) to measure the two competencies. A sample of 208 registered nurses was drawn from four hospitals using proportionate random sampling. Data were analyzed using descriptive statistics and inferential statistics. Results indicated that nurses exhibited moderate levels of EI and CC, with notable deficiencies in emotional regulation and self-directed cultural learning. Younger nurses had significantly higher EI and CC scores compared to older nurses. Nurses with Doctorate Degrees had lower EI and CC scores than those with bachelor's and master's Degrees. Nursing managers demonstrated lower EI and CC than staff nurses. A weak to moderate positive correlation was found between EI and CC, with the strongest relationship in the use of cultural resources, indicating that emotionally intelligent nurses were more likely to seek external support for culturally diverse patients. The findings are moderate and that no causation can be determined through a cross-sectional study. These findings highlight the need for continuous EI and CC training, mentorship programs, leadership development, and structured cultural competence workshops. Strengthening these competencies is crucial for improving patient care, enhancing workplace dynamics, and fostering a more inclusive healthcare environment in Ormoc City hospitals. Further research is recommended to explore longitudinal changes in EI and CC, the impact of training programs on nurse performance, and the role of digital learning tools in competency development and that longitudinal or experimental studies needed to better understand the relationships.

**Keywords:** Emotional Intelligence, Cultural Competence, Nursing Practice, Leadership Development, Human Resource Development

## INTRODUCTION

In modern healthcare, cultural competence (CC) is an essential component of nursing practice, particularly amid increasing cultural and linguistic diversity across patient populations. Cultural competence refers to the nurse's ability to provide respectful, inclusive, and responsive care that acknowledges a patient's sociocultural background an ability strongly linked to improved patient trust, satisfaction, and outcomes (Krishnan & Awang, 2020; Singh et al., 2022). While CC requires knowledge and practical skills, it is also deeply influenced by emotional capabilities, especially the ability to regulate emotions, show empathy, and adapt communication styles core traits of emotional intelligence (EI) (Antonopoulou, 2024). Recent research highlights that EI, encompassing self-awareness, empathy, social skills, and emotional regulation, contributes significantly to cross-cultural sensitivity and effective interpersonal communication (Rajendra, 2024; Sharp et al., 2024). Within the Philippine nursing context, emotional intelligence is crucial for maintaining patient- centered care in emotionally charged and culturally diverse settings. For example, Filipino nurses working with non-Tagalog-speaking patients or indigenous communities often navigate complex interpersonal situations that demand both

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empathy and cultural sensitivity. Observations in Ormoc City hospitals reveal recurring situations where misunderstandings arise due to cultural beliefs around death, illness, or mental health especially in high-pressure environments such as emergency and critical care units.

In language-barrier emergencies, even when emotional control is exercised, the absence of cultural competence such as the knowledge of local dialects or familiarity with cultural gestures can impede effective care. Likewise, in mental health contexts, cultural stigma may deter patients from disclosing symptoms, underscoring the nurse's need to build trust through both emotional connection and cultural understanding. These observed challenges highlight the importance of reinforcing EI and CC as intertwined competencies. The relevance of these competencies also aligns with Sustainable Development Goal 3 (Good Health and Well-being) and SDG 10 (Reduced Inequalities). By cultivating emotionally intelligent and culturally competent nurses, the healthcare system moves closer to delivering equitable, inclusive care and reducing disparities among patients from diverse backgrounds. Despite the recognized value of EI and CC in nursing, studies exploring their interrelationship particularly within the Philippine context remain limited. Local evidence suggests that Filipino nurses often exhibit moderate levels of EI and CC (Rubio, 2022), yet gaps persist in areas such as emotional regulation and cultural communication, especially among more experienced nurses or those in administrative roles.

To bridge this knowledge and practice gap, this study investigates the emotional intelligence and cultural competence of nurses in selected hospitals in Ormoc City. It examines differences across demographic and professional characteristics and explores the relationship between EI and CC. The findings aim to inform evidence-based training, mentorship initiatives, and institutional policies that enhance inclusive and emotionally resilient nursing care, ultimately contributing to sustainable healthcare development in the region.

## RESEARCH OBJECTIVES

The main purpose of the study was to compare emotional intelligence and cultural competence based on selected profile variables and to examine their correlation in the context of nursing care in Ormoc City, Leyte, Philippines, during the fourth quarter of 2025.

Specifically, the study addressed the following questions:

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

Age;

Sex;

Marital status;

Highest educational attainment;

Years in service;

Area of assignment;

Position; and

Years in the place of work?

What was the level of emotional intelligence of the nurses in terms of:

Appraisal and Expression of Emotion;

Regulation of Emotion;

Utilization of Emotion?

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

Cultural Awareness Ability;

Cultural Action Ability;

Cultural Resources Application Ability;

Self-Learning Cultural Ability?

Was there a significant difference in emotional intelligence when grouped according to personal characteristics?

Was there a significant difference in cultural competence when grouped according to personal characteristics?

Was there a significant relationship between emotional intelligence and cultural competence?

What Human Resource Development Plan could be created based on the findings of the study?

**Statement of Null Hypotheses**

**Ho1**: There is no significant difference between personal characteristics and emotional intelligence.

**Ho2**: There is no significant difference between personal characteristics and cultural competence.

**Ho3**: There is no significant relationship between emotional intelligence and cultural competence.

## REVIEW OF LITERATURE AND STUDIES

**Personal Characteristics of Nurses.** A predominantly young to mid-career nursing workforce, consistent with global nursing demographics where early-career professionals dominate (WHO, 2020). Younger nurses typically exhibit higher adaptability, technological openness, and receptivity to continuing education—traits beneficial for acquiring cultural competence and emotional intelligence (Abacioglu et al., 2020). Older nurses are more likely to possess refined emotional regulation skills and institutional knowledge, which are vital for mentoring junior staff (Sharifi et al., 2019). The dominance of female nurses may positively influence the emotional landscape of healthcare settings, as women have been consistently found to exhibit higher levels of empathy and interpersonal sensitivity—two core components of emotional intelligence (Papoutsi et al., 2022). This could translate into improved patient satisfaction, stronger therapeutic relationships, and greater team cohesion. However, the gender imbalance also necessitates inclusive training that promotes emotional intelligence development across both sexes. While male nurses have shown strengths in assertiveness and leadership (Edelman & van Knippenberg, 2018). Married nurses may possess higher emotional stability and interpersonal maturity, arising from life experiences that involve negotiation, compromise, and emotional resilience (Zmaczyńska-Witek et al., 2019; Gandonu & Badejo, 2021). Conversely, single nurses may exhibit greater schedule flexibility and openness to intensive professional development programs (Mosia, 2022). Research consistently links higher academic attainment to improved emotional intelligence and cultural sensitivity due to broader exposure to interdisciplinary perspectives and reflective practices (Halimi et al., 2021). The low percentage of postgraduate degree holders underscored the urgency of institutional support for continuing education, such as scholarships and structured career ladders. Advanced-degree nurses can also serve as role models and educators in promoting culturally competent and emotionally intelligent care (Cherng & Davis, 2019; Lorenzo et al., 2021). Religiously diverse teams or those exposed to multi-faith training report higher levels of cultural competence and patient-centeredness (Purnell, 2021; Flynn et al., 2020). Managerial nurses typically develop higher levels of emotional intelligence due to their organizational responsibilities (Edelman & van Knippenberg, 2018). Longer-tenured nurses are presumed to possess greater clinical acumen and situational awareness in culturally complex scenarios (Ishola & Kazeem, 2022).

**Level of Emotional Intelligence of the Nurses.** Emotional intelligence has been identified as a key factor in nurse-patient interactions, influencing patient satisfaction, teamwork, and stress management (White & Grason,

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2019). A study by Hurley et al. (2020) found that nurses with higher EI demonstrate better problem-solving abilities and resilience, while those with low emotional intelligence are more likely to experience stress, burnout, and difficulty in patient communication. Filipino nurses are generally known for their empathy and interpersonal skills (Reyes, 2019). Filipino cultural values, such as "pakikisama" (smooth interpersonal relationships) and "hiya" (sense of shame or modesty), may discourage open emotional expression, leading to lower scores on emotional appraisal and expression (Alampay & Jocson, 2011).

**Level of Cultural Competence of the Nurses.** Purnell and Paulanka (2013) emphasized that nurses with higher cultural competence provide better patient-centered care, improve health outcomes, and reduce disparities in healthcare delivery. Leininger's Transcultural Nursing Theory (2002) also stresses that understanding cultural factors affecting health beliefs and behaviors enables nurses to deliver holistic and culturally appropriate care. However, research also highlights that many healthcare institutions, particularly in developing regions, struggle with implementing structured cultural competence programs, leading to inconsistent application of culturally sensitive practices in patient care (Govere & Govere, 2016).

**Differences in Emotional Intelligence according to Profile.** Younger healthcare professionals tend to have higher adaptability, openness to learning, and emotional responsiveness (Schutte et al., 2013). Nurses with Doctorate Degrees may hold administrative or research-oriented positions with less direct patient interaction, limiting opportunities for emotional engagement in clinical practice (Boyatzis, 2011). New hires and recently transferred nurses are often more emotionally engaged, motivated, and receptive to patient needs (Côté & Miners, 2006). Female nurses generally score higher on emotional intelligence than male nurses due to greater emotional expressiveness and empathy (Trentini et al., 2022).

**Differences in Cultural Competence according to Profile.** Younger nurses may be more exposed to contemporary cultural competence training, diversity education, and inclusive healthcare practices compared to older nurses, who may have trained under more traditional medical models with less emphasis on cultural considerations (Campinha-Bacote, 2002). Higher education levels correlate with better cultural competence. Instead, it suggests that nurses pursuing doctoral studies may focus more on research, administration, or policymaking rather than direct patient care, leading to less engagement with culturally diverse populations (Papadopoulos, 2006). Newer healthcare professionals are more exposed to cultural competence education, while long-tenured employees may struggle with adapting to new cultural perspectives due to habitual clinical routines and ingrained practices (Betancourt et al., 2016). Female nurses often exhibit higher cultural competence due to higher empathy and communication skills (Purnell & Paulanka, 2013).

## RESEARCH METHODOLOGY

**Design.** This study adopted a quantitative, descriptive-comparative, and correlational design to assess the interrelationship among personal characteristics, emotional intelligence, and cultural competence of nurses in selected hospitals in Ormoc City, Leyte.

**Environment.** The study was conducted across three major hospitals in Ormoc City, Leyte.

**Respondents.** A total of 186 registered nurses employed across the three hospitals participated in the study.

**Sampling Design.** Proportionate stratified random sampling was employed to ensure adequate representation from each institution.

**Inclusion and Exclusion Criteria.** Inclusion criteria encompassed registered nurses with active employment in one of the three hospitals, either in full-time or part-time capacity, and with at least six months of service in their current institution. This criterion ensured that participants possessed sufficient familiarity with their workplace environment and care protocols. Participation was voluntary, and informed consent was obtained from all respondents in compliance with ethical standards.

Exclusion criteria comprised non-registered personnel (e.g., nursing aides, assistants), contractual or temporary staff, and those on extended leave (maternity, sick, or vacation). Nurses with fewer than six months of experience in their current position were also excluded, as they may not have had sufficient institutional integration.

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Participants were assured of their right to withdraw from the study at any time without consequence.

**Instrument.** The research instrument consisted of three main sections designed to capture data on the personal characteristics, emotional intelligence (EI), and cultural competence (CC) of nurses. The first section assessed the personal characteristics of respondents. The second section focused on measuring emotional intelligence using the 33-item Emotional Intelligence Scale developed by Schutte et al. (1990). The third section assessed cultural competence using the Nurse Cultural Competence Scale (NCCS) developed by Lin et al. (2019).

**Data Gathering Procedure.** Administrative clearances were obtained from key institutional stakeholders, including formal permission. The final version of the research protocol was subsequently submitted to the University of the Visayas Institutional Review Board (UV-IRB) for ethical review. Full ethical clearance was granted upon compliance with all ethical standards, including informed consent, participant anonymity, and data confidentiality. The face-to-face meetings facilitated transparency and helped secure administrative support for a smooth data collection process. Data collection continued iteratively across all four hospitals until the target sample size was successfully achieved. All paper-based survey responses were systematically coded and manually entered into a Google Spreadsheet, which was stored in a secured, access-controlled digital folder to uphold data integrity and confidentiality. All statistical treatments were conducted using SPSS (Statistical Package for the Social Sciences), version 26.

**Statistical Treatment of Data.** Frequency Distribution and Simple Percentage, Mean and Standard Deviation, and T-Test and ANOVA with Post Hoc were used.

**Ethical Consideration.** The study was submitted for ethical approval for both the university REC and the hospital. See the appendices for the ethical considerations.

## PRESENTATION ANALYSIS AND PRESENTATION OF DATA

Table 1 Personal Characteristics of the Nurses

| Personal Characteristics | f | % |
|---|---|---|
| Age | | |
| 20 to 30 years old | 70 | 37.60 |
| 31 to 40 years old | 98 | 52.70 |
| 41 years old and above | 18 | 9.70 |
| Sex | | |
| Male | 46 | 24.70 |
| Female | 140 | 75.30 |
| Marital status | | |
| Single | 98 | 52.70 |
| Married | 81 | 43.50 |
| Separated | 7 | 3.80 |
| Highest education attainment | | |
| Bachelor’s Degree | 174 | 93.50 |
| Master’s Degree | 6 | 3.20 |
| Doctorate Degree | 6 | 3.20 |
| Religion | | |
| Roman Catholic | 156 | 83.90 |
| Islam | 12 | 6.50 |
| Others | 18 | 9.70 |
| Position | | |
| Nursing staff | 164 | 88.20 |
| Nursing manager | 22 | 11.80 |
| Years in service | | |
| < 1 year | 9 | 4.80 |

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| | | |
|---|---|---|
| 1-3 years | 79 | 42.50 |
| 4-6 years | 6 | 3.20 |
| > 6 years | 92 | 49.50 |
| Years in the place of work | | |
| < 1 year | 16 | 8.60 |
| 1-3 years | 72 | 38.70 |
| 4-6 years | 6 | 3.20 |
| > 6 years | 92 | 49.50 |

Note: n=186.

The age distribution revealed that the majority of respondents were between 31–40 years old (52.70%), followed by 20–30 years old (37.60%), and only 9.70% were 41 years old and above. This pattern indicated a predominantly young to mid-career nursing workforce, consistent with global nursing demographics where early-career professionals dominate (WHO, 2020). Younger nurses typically exhibit higher adaptability, technological openness, and receptivity to continuing education—traits beneficial for acquiring cultural competence and emotional intelligence (Abacioglu et al., 2020). However, their relative lack of clinical experience may hinder effective patient communication and cross-cultural engagement. Meanwhile, older nurses are more likely to possess refined emotional regulation skills and institutional knowledge, which are vital for mentoring junior staff (Sharifi et al., 2019). Strategically integrating mentorship programs may allow institutions to leverage the emotional maturity of older nurses to support the developmental needs of younger cohorts.

The data also indicated that 75.30% of the nurses were female, while 24.70% were male, reflecting the persistent feminization of the nursing profession in the Philippines and globally (PSA, 2020). The dominance of female nurses may positively influence the emotional landscape of healthcare settings, as women have been consistently found to exhibit higher levels of empathy and interpersonal sensitivity—two core components of emotional intelligence (Papoutsi et al., 2022). This could translate into improved patient satisfaction, stronger therapeutic relationships, and greater team cohesion. However, the gender imbalance also necessitates inclusive training that promotes emotional intelligence development across both sexes. While male nurses have shown strengths in assertiveness and leadership (Edelman & van Knippenberg, 2018), they may benefit from enhanced training in communication and empathy to bridge identified gaps. The nursing community must embrace gender diversity and foster professional development pathways that support all nurses in strengthening their EI and CC capabilities.

With respect to marital status, the findings showed that 52.70% of nurses were single, 43.50% were married, and 3.80% were separated. Married nurses may possess higher emotional stability and interpersonal maturity, arising from life experiences that involve negotiation, compromise, and emotional resilience (Zmaczyńska-Witek et al., 2019; Gandonu & Badejo, 2021). Conversely, single nurses may exhibit greater schedule flexibility and openness to intensive professional development programs (Mosia, 2022). Human resource strategies should recognize these differing needs, such as by offering flexible work schedules to married staff and promoting leadership opportunities among single nurses to enhance job engagement.

In terms of educational attainment, 93.50% of the nurses held a bachelor's degree, while only 6.40% possessed postgraduate degrees (Master's or Doctorate). This skewed distribution highlighted a potential gap in advanced training and leadership preparation. Research consistently links higher academic attainment to improved emotional intelligence and cultural sensitivity due to broader exposure to interdisciplinary perspectives and reflective practices (Halimi et al., 2021). The low percentage of postgraduate degree holders underscored the urgency of institutional support for continuing education, such as scholarships and structured career ladders. Advanced-degree nurses can also serve as role models and educators in promoting culturally competent and emotionally intelligent care (Cherng & Davis, 2019; Lorenzo et al., 2021).

Religiously, 83.90% of the nurses identified as Roman Catholic, with 6.50% identifying as Muslim, and 9.70% affiliating with other religions. This religious homogeneity may limit opportunities for exposure to diverse spiritual perspectives in care delivery. Since religion is a key cultural variable affecting health beliefs and practices, nurses must be trained in religious sensitivity to accommodate patients from varying faith

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backgrounds. Studies show that religiously diverse teams or those exposed to multi-faith training report higher levels of cultural competence and patient-centeredness (Purnell, 2021; Flynn et al., 2020). Thus, faith-based simulations and interfaith dialogues should be integrated into clinical training programs to mitigate the risks of cultural insensitivity.

The majority of the respondents (88.20%) were employed as staff nurses, while only 11.80% held managerial positions. Given the limited number of nurse managers, this points to a hierarchical imbalance in leadership exposure and decision-making capacity. Although managerial nurses typically develop higher levels of emotional intelligence due to their organizational responsibilities (Edelman & van Knippenberg, 2018), frontline staff may lack similar opportunities for professional growth. Bridging this gap requires hospitals to implement inclusive leadership development programs for staff nurses, including mentorship, reflective practice, and collaborative decision-making exercises.

Regarding professional experience, 49.50% of nurses had more than six years of service, while 42.50% had 1–3 years of experience. In terms of tenure in their current institution, 38.70% had worked for 1–3 years, suggesting high mobility. Longer-tenured nurses are presumed to possess greater clinical acumen and situational awareness in culturally complex scenarios (Ishola & Kazeem, 2022). However, high turnover and frequent inter-hospital movement may disrupt team cohesion and hinder the institutionalization of cultural competence. The findings suggest the need for retention strategies, such as career progression pathways and employee well-being programs, to foster continuity and deepen experiential learning.

The personal characteristics of the nursing workforce in Ormoc City revealed a composition that is predominantly young, female, and single, with basic educational qualifications and limited leadership representation. This profile underscores the importance of targeted interventions to enhance emotional intelligence and cultural competence early in nurses' careers. Additionally, the overrepresentation of women, while associated with emotional strengths, also highlights the need for gender-responsive training programs that support professional equity and leadership development for male nurses.

Efforts must also be directed toward expanding postgraduate education, implementing mentorship structures that connect older and more experienced nurses with junior staff, and embedding cultural competence modules within hospital training curricula. Finally, religious sensitivity, flexible scheduling for varying marital circumstances, and inclusive leadership initiatives will be key to cultivating a resilient, culturally responsive, and emotionally intelligent nursing workforce capable of meeting the demands of a diverse patient population.

Table 2 Level of Emotional Intelligence of the Nurses

| Statements | Mean score | SD | Interpretation |
|---|---|---|---|
| Appraisal and Expression | 2.62 | 0.744 | Moderate EI |
| Regulation of Emotion | 2.58 | 0.870 | Low EI |
| Utilization of Emotion | 2.86 | 0.552 | Moderate EI |
| Grand mean | 2.68 | 0.650 | Moderate EI |

Note: n=186. *Negatively scored items.

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

Results on emotional intelligence is presented in Table 2. Findings indicate that the nurses in selected hospitals in Ormoc City exhibit moderate emotional intelligence (EI), with a grand mean of 2.68 (SD = 0.650) across three dimensions: appraisal and expression of emotion (M = 2.62), regulation of emotion (M = 2.58), and utilization of emotion (M = 2.86). These results suggest that while nurses demonstrate some emotional intelligence competencies, notable deficiencies exist, particularly in emotional regulation and self- awareness. The low EI in regulation of emotion is particularly concerning as it indicates difficulties in controlling emotional responses, which can impact professional interactions, teamwork, and patient care.

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Several studies support the findings of this research. Emotional intelligence has been identified as a key factor in nurse-patient interactions, influencing patient satisfaction, teamwork, and stress management (White & Grason, 2019). A study by Hurley et al. (2020) found that nurses with higher EI demonstrate better problem-solving abilities and resilience, while those with low emotional intelligence are more likely to experience stress, burnout, and difficulty in patient communication. This aligns with the low emotional regulation scores in this study, suggesting that nurses in Ormoc City may face emotional fatigue and work-related stress due to an inability to manage emotions effectively.

Conversely, some studies negate these findings, highlighting that Filipino nurses are generally known for their empathy and interpersonal skills (Reyes, 2019), which contradicts some of the low scores in emotional expression and self-awareness found in this study. One possible explanation is the high-stress work environment in Ormoc City hospitals, which may inhibit nurses from recognizing or expressing their emotions openly. Additionally, Filipino cultural values, such as "pakikisama" (smooth interpersonal relationships) and "hiya" (sense of shame or modesty), may discourage open emotional expression, leading to lower scores on emotional appraisal and expression (Alampay & Jocson, 2011). In Philippine hospital settings, nurses may feel pressured to maintain emotional composure, even at the cost of their mental well-being, which could explain the discrepancy between expected and reported emotional intelligence scores.

The findings have significant practical implications for healthcare institutions in Ormoc City. With moderate to low levels of emotional intelligence, hospitals should implement training programs that focus on emotional self-awareness, stress management, and empathy enhancement. Leadership development initiatives can also be introduced to improve nurses' motivation, emotional control, and decision-making abilities. Additionally, hospital administrators should consider workplace interventions, such as mental health support, stress reduction workshops, and mindfulness training, to help nurses regulate their emotions more effectively. Given the emotional demands of nursing, creating a supportive work environment where nurses can openly discuss emotional challenges may lead to better patient care and improved job satisfaction.

Furthermore, since Filipino nurses are known for their resilience and compassion, institutions can leverage peer mentoring programs, pairing highly emotionally intelligent nurses with those struggling with emotional regulation. This approach fosters a culture of emotional intelligence development, improving overall nurse well-being and patient care quality. Addressing these emotional intelligence gaps through structured training, workplace support, and cultural sensitivity awareness can significantly enhance the quality of healthcare in Ormoc City, ensuring better nurse retention, improved patient outcomes, and a more resilient healthcare workforce.

Table 3 Level of Cultural Competence of the Nurses

| Statements | Mean score | SD | Interpretation |
|---|---|---|---|
| Cultural Awareness | 3.07 | 0.765 | Moderate CC |
| Cultural Action Ability | 3.25 | 0.817 | Moderate CC |
| Cultural Resources Application | 2.90 | 0.999 | Moderate CC |
| Self-Learning Cultural Ability | 2.76 | 0.896 | Moderate CC |
| Grand mean | 2.99 | 0.742 | Moderate CC |

Note: n=186.

Legend: 1.00–1.80 is very low cultural competence (rarely), 1.81-2.60 low cultural competence (occasionally), 2.61-3.40 is moderate cultural competence (neutrally), 3.41-4.20 is high cultural competence (often), and 4.21=5.00 very high cultural competence (always).

The findings in Table 3 indicate that the nurses in selected hospitals in Ormoc City exhibit moderate cultural competence (CC), with a grand mean of 2.99 (SD = 0.742) across four dimensions: cultural awareness ability (M = 3.07), cultural action ability (M = 3.25), cultural resources application ability (M = 2.90), and self-learning cultural ability (M = 2.76). These results suggest that while nurses possess some degree of cultural competence, they remain neutral in their responses, reflecting uncertainty or lack of confidence in handling culturally diverse situations. The moderate level of CC implies that nurses in Ormoc City hospitals may recognize cultural

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differences but lack proactive engagement in culturally competent practices, which could affect patient care quality, communication, and treatment adherence among patients from diverse backgrounds.

The findings have important implications for healthcare institutions in Ormoc City, particularly in addressing health disparities, communication barriers, and patient satisfaction among culturally diverse populations. A moderate level of cultural competence suggests that nurses have a foundation of cultural awareness but need structured interventions to enhance their skills and confidence in applying cultural competence in patient care. Hospitals and healthcare facilities should implement structured cultural competency training, focusing on active learning strategies, case-based discussions, and experiential learning opportunities. Providing language training, religious and cultural awareness workshops, and access to cultural liaisons can help nurses develop practical skills in navigating diverse healthcare needs. Additionally, integrating cultural competence as part of continuing professional development programs can encourage ongoing self- learning and application of best practices in cross-cultural care.

Several studies support the importance of enhancing cultural competence among nurses, particularly in multicultural healthcare settings. Purnell and Paulanka (2013) emphasized that nurses with higher cultural competence provide better patient-centered care, improve health outcomes, and reduce disparities in healthcare delivery. Leininger's Transcultural Nursing Theory (2002) also stresses that understanding cultural factors affecting health beliefs and behaviors enables nurses to deliver holistic and culturally appropriate care. However, research also highlights that many healthcare institutions, particularly in developing regions, struggle with implementing structured cultural competence programs, leading to inconsistent application of culturally sensitive practices in patient care (Govere & Govere, 2016). These findings suggest that without active institutional support, nurses may remain in a passive state of cultural awareness without fully integrating cultural competence into their practice.

The study reveals that nurses in Ormoc City exhibit moderate cultural competence, with relative strengths in cultural awareness and action ability but weaker engagement in utilizing cultural resources and self-learning opportunities. While nurses acknowledge cultural diversity in patient care, their neutral responses indicate uncertainty, lack of confidence, or insufficient training in applying culturally competent practices.

Table 4 Differences in Emotional Intelligence according to Profile

| Groups | Mean score | t/F value | df | p value | Decision | Interpretation |
|---|---|---|---|---|---|---|
| Age | | | | | | |
| 20 to 30 years old | 2.90 | 9.218 | 183 | .000 | Reject Ho | Significant |
| 31 to 40 years old | 2.61 | | | | | |
| 41 years old and above | 2.26 | | | | | |
| Sex* | | | | | | |
| Male | 2.55 | -1.586 | 184 | .114 | Failed to reject Ho | Not significant |
| Female | 2.72 | | | | | |
| Marital status | | | | | | |
| Single | 2.78 | 2.794 | 183 | .064 | Failed to reject Ho | Not significant |
| Married | 2.56 | | | | | |
| Separated | 2.76 | | | | | |
| Highest education attainment | | | | | | |
| Bachelor's Degree | 2.69 | 6.139 | 183 | .003 | Reject Ho | Significant |
| Master's Degree | 3.23 | | | | | |
| Doctorate Degree | 1.96 | | | | | |
| Religion | | | | | | |
| Roman Catholic | 2.68 | .326 | 183 | .722 | Failed to reject Ho | Not significant |
| Islam | 2.59 | | | | | |
| Others | 2.78 | | | | | |
| Position* | | | | | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| Nursing staff | 2.77 | 5.084 | 184 | .000 | Reject Ho | Significant |
| Nursing manager | 2.06 | | | | | |
| Years in service | | | | | | |
| < 1 year | 2.83 | 10.896 | 183 | .000 | Reject Ho | Significant |
| 1-3 years | 2.92 | | | | | |
| 4-6 years | 3.18 | | | | | |
| > 6 years | 2.43 | | | | | |
| Years in the place of work | | | | | | |
| < 1 year | 3.37 | 15.541 | 183 | .000 | Reject Ho | Significant |
| 1-3 years | 2.81 | | | | | |
| 4-6 years | 3.18 | | | | | |
| > 6 years | 2.43 | | | | | |

Legend: Significant if p value is ≤ .05. *t-test.

The findings in Table 4 revealed that emotional intelligence (EI) significantly differed according to several personal characteristics of nurses in selected hospitals in Ormoc City. Specifically, age, highest educational attainment, position, years in service, and years in the place of work all showed statistically significant differences in EI ($p < .05$), indicating that these variables influenced how nurses perceive, regulate, and utilize emotions in clinical practice.

Conversely, sex, marital status, and religion did not yield statistically significant differences in emotional intelligence, suggesting that these characteristics had no measurable impact on nurses' EI levels in this study. These findings underscore the need for targeted EI development programs that consider age group, educational background, and length of service, especially as these variables appear to shape emotional competencies critical to nursing performance. The analysis demonstrates that age, highest educational attainment, position, years in service, and years in the place of work significantly influence emotional intelligence levels, while sex, marital status, and religion do not show statistically significant differences. The significant difference in EI according to age suggests that younger nurses (20 to 30 years old) exhibit higher EI ($M = 2.90$) compared to older nurses (31 to 40 years old, $M = 2.61$; 41 years and above, $M = 2.26$), as indicated by the F value of 9.218 and p-value of .000. The post hoc analysis further confirms that nurses aged 20 to 30 years have significantly better EI than those aged 31 to 40 years ($p = .008$) and 41 years and above ($p = .000$). This finding aligns with studies indicating that younger healthcare professionals tend to have higher adaptability, openness to learning, and emotional responsiveness (Schutte et al., 2013). However, it also raises concerns about whether EI declines with age due to burnout, workplace stress, or rigid professional routines. In Ormoc City, where healthcare services can be demanding, older nurses may require targeted emotional intelligence training to maintain and enhance their interpersonal skills and resilience. The post hoc analysis revealed a significant difference in emotional intelligence (EI) based on age. Specifically, nurses aged 20 to 30 years demonstrated significantly higher EI scores compared to those aged 31 to 40 years ($p = .008$) and 41 years and above ($p = .000$). This finding indicates that the youngest age group (20 to 30 years) had the highest mean EI among the three groups. The result may be attributed to younger nurses' greater adaptability, openness to learning, and receptivity to emotional intelligence training. This pattern underscores the importance of targeting emotional intelligence enhancement programs toward mid-career and senior nurses who may experience challenges in maintaining emotional resilience due to prolonged exposure to workplace stress and burnout.

Regarding highest educational attainment, the findings indicate that nurses with a Master's Degree ($M = 3.23$) have significantly higher EI than those with a Bachelor's Degree ($M = 2.69$) and a Doctorate Degree ($M = 1.96$), with an F value of 6.139 and p- value of .003. Post hoc analysis reveals that Bachelor's Degree holders exhibit significantly better EI than Doctorate Degree holders ($p = .017$), and Master's Degree holders exhibit significantly better EI than Doctorate Degree holders ($p = .002$). This contradicts the common assumption that higher academic attainment correlates with greater emotional intelligence. The lower EI among Doctorate Degree holders may suggest that advanced academic training in nursing prioritizes technical and research competencies over interpersonal and emotional skills. Additionally, nurses with Doctorate Degrees may hold

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administrative or research-oriented positions with less direct patient interaction, limiting opportunities for emotional engagement in clinical practice (Boyatzis, 2011). This highlights the need for EI training and leadership programs that emphasize emotional competencies alongside advanced professional skills.

The nurses' professional position also significantly affects EI, with nursing staff (M = 2.77) demonstrating significantly higher EI than nursing managers (M = 2.06), as shown by the t-value of 5.084 and p-value of .000. This finding challenges the expectation that leadership roles require higher emotional intelligence, suggesting that nurse managers may experience greater emotional strain, decision-making stress, and administrative burdens that hinder emotional regulation. In Ormoc City hospitals, where healthcare resources may be limited and managerial responsibilities demanding, nurse managers may struggle to balance emotional well-being with organizational pressures. This calls for leadership development programs incorporating EI training, stress management workshops, and mentorship initiatives to help nurse managers enhance their emotional intelligence and support their teams more effectively.

In terms of years in service, the results indicate that nurses with fewer years of experience demonstrate higher EI than those with longer tenure. Nurses with 1-3 years of experience (M = 2.92) and 4-6 years of experience (M = 3.18) exhibit significantly better EI than those with more than six years of service (M = 2.43), with an F value of 10.896 and p-value of .000. The post hoc analysis confirms that nurses with 1-3 years of experience significantly outperform those with more than six years (p = .000), and those with 4-6 years outperform those with more than six years (p = .021). This may indicate that younger and less experienced nurses are more engaged in emotional learning, interpersonal communication, and adaptive coping mechanisms. However, as tenure increases, work- related stress, bureaucratic challenges, and emotional exhaustion may lead to decreased EI. In Ormoc City hospitals, where long-serving nurses may experience workload fatigue, limited career advancement, and high patient loads, these factors could contribute to diminished emotional responsiveness over time. Implementing emotional well-being programs and burnout prevention initiatives for senior nurses could help reinvigorate emotional intelligence and maintain patient-centered care practices.

Similarly, years in the place of work significantly affect EI, with nurses who have worked in their current institution for less than a year exhibiting the highest EI (M = 3.37), followed by those with 1-3 years (M = 2.81), 4-6 years (M = 3.18), and more than six years (M = 2.43). The F value of 15.541 and p-value of .000 indicate a strong statistical significance, with post hoc analysis confirming that those with <1 year experience significantly outperform all other groups. This finding aligns with previous research suggesting that new hires and recently transferred nurses are often more emotionally engaged, motivated, and receptive to patient needs (Côté & Miners, 2006). However, prolonged exposure to workplace stress, institutional constraints, and emotional fatigue may contribute to a gradual decline in EI among nurses with extended tenure. This underscores the importance of continuous emotional intelligence development, peer support systems, and workplace wellness initiatives to sustain emotional engagement and resilience in long-term employees.

On the other hand, no significant differences in EI were found based on sex (p = .114), marital status (p = .064), or religion (p = .722), suggesting that gender, relationship status, and religious affiliation do not substantially impact emotional intelligence levels among nurses in Ormoc City. These findings contrast with some research suggesting that female nurses generally score higher on emotional intelligence than male nurses due to greater emotional expressiveness and empathy (Trentini et al., 2022). However, in the context of Ormoc City's healthcare system, factors such as workload, institutional culture, and professional responsibilities may exert a stronger influence on EI than individual demographic characteristics.

The study highlights several critical implications for nurse training, leadership development, and workplace well-being in Ormoc City hospitals. First, the significant decline in EI among older and more experienced nurses calls for targeted interventions to sustain emotional engagement over time. Implementing emotional resilience programs, stress management workshops, and peer support networks could help mitigate emotional fatigue and burnout. Second, the lower EI among nursing managers suggests a need for leadership training that integrates emotional intelligence, decision-making skills, and stress management techniques. Providing mentorship opportunities and executive coaching for nurse leaders may enhance emotional competence and workplace morale.

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Additionally, the higher EI among less experienced nurses suggests that early- career professionals may benefit from structured emotional intelligence training to solidify their interpersonal skills as they advance in their careers. Incorporating EI development in nursing education curricula and continuing professional development (CPD) programs could help sustain high levels of emotional intelligence throughout nurses' careers. Furthermore, recognizing that educational attainment does not automatically equate to higher EI, nursing programs should emphasize both technical expertise and emotional intelligence development in postgraduate training.

Table 5 Differences in Cultural Competence according to Profile

| Groups | Mean score | t/F value | df | p value | Decision | Interpretation |
|---|---|---|---|---|---|---|
| Age | | | | | | |
| 20 to 30 years old | 3.16 | 3.081 | .183 | .048 | Reject Ho | Significant |
| 31 to 40 years old | 2.91 | | | | | |
| 41 years old and above | 2.81 | | | | | |
| Sex* | | | | | | |
| Male | 2.87 | -1.297 | 184 | .196 | Failed to reject Ho | Not significant |
| Female | 3.03 | | | | | |
| Marital status | | | | | | |
| Single | 2.98 | .032 | 183 | .968 | Failed to reject Ho | Not significant |
| Married | 3.01 | | | | | |
| Separated | 2.97 | | | | | |
| Highest education attainment | | | | | | |
| Bachelor's Degree | 3.12 | 5.490 | 183 | .005 | Reject Ho | Significant |
| Master's Degree | 3.23 | | | | | |
| Doctorate Degree | 2.05 | | | | | |
| Religion | | | | | | |
| Roman Catholic | 2.99 | .047 | 183 | .954 | Failed to reject Ho | Not significant |
| Islam | 3.05 | | | | | |
| Others | 3.00 | | | | | |
| Position* | | | | | | |
| Nursing staff | 3.02 | 1.202 | .184 | .231 | Failed to reject Ho | Not significant |
| Nursing manager | 2.81 | | | | | |
| Years in service | | | | | | |
| < 1 year | 3.10 | 3.217 | 183 | .024 | Reject Ho | Significant |
| 1-3 years | 3.17 | | | | | |
| 4-6 years | 2.70 | | | | | |
| > 6 years | 2.85 | | | | | |
| Years in the place of work | | | | | | |
| < 1 year | 3.13 | 3.206 | 183 | .024 | Reject Ho | Significant |
| 1-3 years | 3.17 | | | | | |
| 4-6 years | 2.70 | | | | | |
| > 6 years | 2.85 | | | | | |

Legend: Significant if p value is $\leq .05$. *t-test.

The findings in Table 5 demonstrated that cultural competence (CC) significantly varied according to age, highest educational attainment, years in service, and years in the place of work ($p < .05$), indicating that these personal characteristics influenced how well nurses engage with culturally diverse patient populations. Younger nurses (particularly those aged 20 to 30), those with bachelor's and master's degrees, and those with fewer years of service or tenure in their current hospital exhibited higher levels of cultural competence. This suggests that early-career and academically-prepared nurses may be more responsive to cultural training and better equipped to manage culturally sensitive care.

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In contrast, sex, marital status, religion, and position did not show statistically significant differences in cultural competence, implying that these variables did not meaningfully impact how nurses adapted to or addressed patients' cultural needs in this study. These findings point to the importance of continuous cultural competence training, especially for more experienced or long-serving nurses who may not have been recently exposed to updated diversity and inclusion initiatives. Furthermore, the results support efforts to integrate cultural responsiveness in both early nursing education and ongoing professional development, ensuring that all nurses regardless of demographic background—can deliver inclusive, equitable patient care.

The significant difference in cultural competence according to age indicates that younger nurses (20 to 30 years old, M = 3.16) exhibit significantly higher cultural competence than those aged 31 to 40 years old (M = 2.91) and those 41 years and above (M = 2.81), as evidenced by the F value of 3.081 and p-value of .048. The post hoc analysis confirms that nurses aged 20 to 30 years old have significantly higher CC than those aged 31 to 40 (p = .008) and those aged 41 and above (p = .000). This finding suggests that younger nurses may be more exposed to contemporary cultural competence training, diversity education, and inclusive healthcare practices compared to older nurses, who may have trained under more traditional medical models with less emphasis on cultural considerations (Campinha-Bacote, 2002). Additionally, younger nurses may demonstrate greater openness to learning and adapting to diverse cultural needs, whereas older nurses may rely on past experiences that may not align with evolving cultural dynamics in healthcare.

The results for highest educational attainment indicate that nurses with a Master's Degree (M = 3.23) and those with a Bachelor's Degree (M = 3.12) exhibit significantly higher cultural competence compared to those with a Doctorate Degree (M = 2.05), as reflected in an F value of 5.490 and p-value of .005. The post hoc analysis confirms that those with a Bachelor's Degree exhibit significantly higher CC than those with a Doctorate Degree (p = .004), and those with a Master's Degree exhibit significantly higher CC than those with a Doctorate Degree (p = .015). This finding contradicts the expectation that higher education levels correlate with better cultural competence. Instead, it suggests that nurses pursuing doctoral studies may focus more on research, administration, or policymaking rather than direct patient care, leading to less engagement with culturally diverse populations (Papadopoulos, 2006). Furthermore, master's degree holders may have received specialized training in cultural competence that is not necessarily emphasized at the doctoral level. In Ormoc City, where cultural sensitivity in patient care is increasingly important, this finding underscores the need for cultural competence training across all levels of nursing education, including postgraduate programs.

In terms of years in service, the data reveals that nurses with 1-3 years of experience (M = 3.17) demonstrate significantly higher cultural competence than those with more than six years of service (M = 2.85), as indicated by the F value of 3.217 and p-value of .024. The post hoc analysis confirms that nurses with 1-3 years of experience significantly outperform those with more than six years (p = .021). Similarly, for years in the place of work, those with 1-3 years of experience (M = 3.17) have significantly better cultural competence than those with more than six years (M = 2.85), as shown by an F value of 3.206 and p-value of .024. The post hoc analysis confirms this significant difference (p = .025). These findings suggest that newer nurses are more engaged in cultural learning, while those who have been in the field longer may experience stagnation in cultural competence development. This pattern aligns with studies showing that newer healthcare professionals are more exposed to cultural competence education, while long-tenured employees may struggle with adapting to new cultural perspectives due to habitual clinical routines and ingrained practices (Betancourt et al., 2016). In Ormoc City hospitals, where cultural diversity is gradually increasing, continuous education and refresher training on cultural competence are essential for ensuring that nurses of all experience levels remain culturally responsive.

On the other hand, sex, marital status, religion, and position did not yield significant differences in cultural competence levels, as indicated by their p-values of .196, .968, .954, and .231, respectively. The lack of significance in sex-based differences suggests that both male and female nurses engage with cultural competence similarly, which contrasts with previous studies indicating that female nurses often exhibit higher cultural competence due to higher empathy and communication skills (Purnell & Paulanka, 2013). However, in Ormoc City's healthcare setting, organizational culture and training opportunities may play a greater role in shaping cultural competence than gender-based tendencies. Likewise, the insignificant effect of marital status suggests that personal relationship status does not necessarily influence a nurse's ability to understand and address cultural differences in patient care.

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Similarly, religion did not significantly impact cultural competence, which contrasts with studies that suggest that nurses from diverse religious backgrounds tend to develop stronger cultural competence due to exposure to different belief systems (Flynn et al., 2020). In Ormoc City hospitals, this finding may indicate that most nurses, regardless of religious affiliation, receive similar levels of cultural exposure in clinical practice. Lastly, the insignificant difference between nursing staff (M = 3.02) and nursing managers (M = 2.81) suggests that leadership roles do not necessarily equate to higher cultural competence. This could mean that nursing managers focus more on administrative tasks rather than direct patient care interactions, which are the primary avenues for developing cultural competence.

The study findings have important implications for cultural competence training, professional development, and patient care strategies in Ormoc City hospitals. The higher cultural competence among younger nurses and those with fewer years of service suggests that cultural training is more effective in early-career nurses but diminishes over time. This underscores the need for continuous professional development programs focused on cultural competence, particularly for mid-career and senior nurses who may not have received recent training on culturally responsive healthcare.

Additionally, the lower cultural competence among nurses with Doctorate Degrees and those with longer tenure highlights the importance of integrating cultural competency training in postgraduate and leadership programs. Nursing education institutions should incorporate cultural awareness, cross-cultural communication, and patient-centered care strategies into advanced nursing curricula to ensure that cultural competence remains a priority across all levels of professional growth. Moreover, hospital administrators should establish regular workshops, mentorship programs, and cultural sensitivity training sessions to reinforce cultural competence at all career stages.

Furthermore, the lack of significant differences in cultural competence based on sex, marital status, and religion suggests that organizational factors, such as institutional training and workplace culture, may have a greater impact on cultural competence than personal demographic characteristics. This finding reinforces the importance of structured cultural competence programs within hospitals, as opposed to relying on individual background differences to shape cultural responsiveness. Healthcare institutions in Ormoc City should therefore implement standardized cultural competency training for all nurses, regardless of gender, religion, or professional rank, ensuring that culturally competent care is consistently provided to all patients.

Table 6 Relationship between Emotional Intelligence and Cultural Competence

| Variables | r value | p value | Decision | Interpretation |
|---|---|---|---|---|
| Cultural Competency vs. Emotional Intelligence | .312 | .000 | Reject Ho | Significant |

Legend: Significant if p value is $\leq$ .05. Dependent Variable: Cultural Competence. Pearson r interpretation: A value greater than .5 is strong (positive), between .3 and .5 is moderate (positive), between 0 and .3 is weak (positive), 0 is none, between 0 and –.3 is weak (negative), between –.3 and –.5 is moderate (negative), and less than –.5 is strong (negative).

The findings in Table 6 indicate that emotional intelligence (EI) and cultural competence (CC) are significantly related, with all aspects of EI showing a positive but weak to moderate correlation with various dimensions of cultural competence. The results suggest that higher levels of emotional intelligence are associated with better cultural competence, supporting the idea that emotionally intelligent nurses are more capable of understanding, adapting to, and effectively responding to cultural differences in patient care. The findings have important implications for nursing education, training programs, and hospital policies in Ormoc City. Since emotional intelligence is positively associated with cultural competence, hospitals should incorporate emotional intelligence training as part of their cultural competence development initiatives. By enhancing nurses' ability to appraise, regulate, and utilize emotions effectively, hospitals can foster a workforce that is more empathetic, adaptable, and responsive to diverse patient needs. The findings also suggest that emotional intelligence training should be included in nursing curricula, ensuring that new graduates enter the workforce with both technical expertise and strong interpersonal and cultural awareness skills. In Ormoc City, where diverse patient

populations require culturally responsive healthcare, equipping nurses with both emotional intelligence and cultural competence is essential for improving patient satisfaction, reducing health disparities, and enhancing overall healthcare outcomes.

## CONCLUSION AND RECOMMENDATIONS

### Conclusion

The study concluded that nurses in Ormoc City hospitals demonstrated moderate levels of emotional intelligence (EI) and cultural competence (CC), yet showed notable gaps in emotional regulation, self-awareness, and active engagement with cultural resources. While they acknowledged the importance of cultural diversity, many nurses did not consistently seek external support or pursue self-directed learning to enhance their competence. Demographic and professional factors played a role, as younger nurses exhibited higher EI and CC compared to older or more experienced counterparts, suggesting that prolonged exposure to workplace stress may diminish emotional and cultural responsiveness. Nurses with Doctorate Degrees and those in managerial roles also had lower scores in both areas, highlighting a disconnect between academic or leadership positions and interpersonal or cultural skills crucial to effective nursing practice.

These findings align with the Emotional Intelligence Theory by Salovey and Mayer (1990), which emphasizes the importance of emotional appraisal, regulation, and utilization in personal and social functioning. The study reinforced the theory's premise that emotionally intelligent individuals are more adept at managing relationships and adapting to diverse social contexts. The positive correlation between EI and CC, particularly in cultural resource application, supports the idea that emotionally intelligent nurses are more responsive to culturally diverse patient needs. However, the lack of strong association with self-learning suggests that while EI contributes to cultural competence, it must be complemented by structured institutional training to foster holistic, culturally competent care.

### Recommendations

To enhance emotional intelligence (EI) and cultural competence (CC) among nurses, several practice, policy, education, and research recommendations are proposed.

**Practice.** Regular EI and CC training programs should be introduced to improve self- awareness, emotional regulation, and cross-cultural communication. Establishing a mentorship program will allow experienced nurses to guide younger colleagues in applying emotionally intelligent and culturally sensitive patient care. Nurses should also be encouraged to utilize cultural resources, such as interpreters, cultural liaisons, and religious advisors, to improve patient interactions. Additionally, mindfulness and stress management programs should be integrated to help nurses build resilience in high-pressure healthcare environments.

**Policy.** EI and CC training should be mandatory in continuing professional development (CPD) programs for nurses in Ormoc City hospitals. Hospitals should also implement culturally inclusive policies, ensuring language assistance services, cultural mediators, and religious accommodations for diverse patient populations. To enhance leadership effectiveness, nursing managers should receive EI and CC training, focusing on emotionally intelligent decision-making and cultural competence in team management. Furthermore, staff wellness programs should be introduced to address burnout and emotional fatigue, promoting sustainable emotional and cultural competency in nursing practice.

**Education.** EI and CC training should be integrated into nursing curricula, emphasizing interpersonal communication, empathy, and patient-centered cultural responsiveness. Specialized workshops and elective courses on cross-cultural healthcare, emotional intelligence in nursing, and diversity in patient care should be offered. Higher education programs, including Master's and Doctorate Degrees, should incorporate EI and CC development, ensuring that advanced professionals maintain strong interpersonal skills. Additionally, language and cultural immersion training should be provided to enhance nurses' ability to communicate effectively with diverse patient groups.

**Research.** Longitudinal studies should be conducted to examine how EI and CC develop over time in nursing practice and how workplace stress influences these competencies. Studies should also explore the impact of EI and CC training on patient satisfaction, nurse performance, and healthcare outcomes. Moreover, research should investigate effective strategies for improving EI and CC among nursing managers, ensuring that leaders are equipped to handle culturally diverse teams. Lastly, assessing the effectiveness of digital learning tools and simulation- based training can help in enhancing nurses' emotional intelligence and cultural competence through innovative educational approaches. Suggested Research Titles:

The Long-Term Development of Emotional Intelligence and Cultural Competence Among Nurses: A Longitudinal Study on Workplace Stress and Professional Growth

The Impact of Emotional Intelligence and Cultural Competence Training on Patient Satisfaction, Nurse Performance, and Healthcare Outcomes

Enhancing Nursing Leadership Through Emotional Intelligence and Cultural Competence: The Role of Digital Learning and Simulation-Based Training

**Human Resource Development Plan For Enhancing Emotional Intelligence And Cultural Competence Among Nurses In Ormoc City Hospitals**

**Rationale**

The findings of the study indicate moderate levels of emotional intelligence (EI) and cultural competence (CC) among nurses in Ormoc City hospitals, with significant gaps in emotional regulation, cultural awareness, and self-learning initiatives. These deficiencies can lead to communication challenges, decreased patient satisfaction, and increased stress and burnout among nurses. Furthermore, nursing managers exhibit lower EI and CC than nursing staff, highlighting the need for leadership development programs. To address these concerns, this Human Resource Development Plan (HRDP) aims to enhance emotional intelligence, cultural competence, and leadership capabilities among nurses, ensuring higher patient satisfaction, improved nurse-patient interactions, and a more inclusive healthcare system.

**General Objectives**

To enhance nurses' emotional intelligence by developing self-awareness, emotional regulation, and interpersonal skills.

To strengthen nurses’ cultural competence, focusing on cultural awareness, action, and resource utilization.

To equip nursing managers with leadership training that integrates emotional intelligence and cultural competence.

To establish structured mentorship programs where experienced nurses provide guidance to junior nurses.

To institutionalize continuous learning and cultural sensitivity training in Ormoc City hospitals.

**Program Overview**

This HRDP consists of training programs, workshops, mentoring initiatives, and support systems designed to enhance nurses’ EI and CC. It will be implemented through structured training sessions, interactive learning modules, leadership workshops, and policy integration over a period of one year, with periodic evaluations to measure its effectiveness.

| Areas of Concern | Specific Objectives | Activities | Persons Involved | Budget | Timeframe | Success Indicators |
|---|---|---|---|---|---|---|
| Declining Emotional Intelligence among Senior Nurses | To enhance emotional intelligence among mid-career and senior nurses through structured training | 1. Emotional Intelligence Training (Self-Awareness, Emotional Regulation, Empathy)<br>2. Mindfulness and Stress Management Workshops | 1. Human Resource Department<br>2. EI Training Experts<br>3. Nursing Supervisors | 50,000 | 3 months | 80% of senior nurses report improved emotional regulation |
| Low Emotional Regulation and Self-Awareness Among Nurses | To improve nurses' ability to regulate emotions and manage stress effectively | 1. Emotional Resilience Workshops<br>2. Role-playing and real- case scenario exercises | 1. Psychologists<br>2. Nurse Trainers<br>3. Hospital Administrators | 40,000 | 6 months | 1. Reduced reports of burnout and workplace stress |
| Moderate Cultural Competence Without Proactive Application | To increase nurses' cultural awareness and ability to handle diverse patient needs | 1. Cultural Sensitivity Workshops<br>2. Language and Communication Training Common Cultural Integration | 1. Cultural Training Experts<br>2. Community Representatives<br>3. Hospital HR Team | 60,000 | 4 months | 90% of nurses demonstrate improved cultural awareness in assessments |
| Limited Use of Cultural Resources in Patient Care | To encourage nurses to utilize available cultural resources for better patient engagement | 1. Orientation on the use of translation tools, cultural mediators, and religious liaisons Collaboration with social workers and religious leaders | 1. Hospital Administrators<br>2. Cultural Experts Patient Support Services | 30,000 | 2 months | 50% increase in referrals to cultural mediators |
| Lack of Motivation for Self-Learning on Cultural Competence | To encourage nurses to engage in self- directed learning on cultural competence | 1. Incentivizing CPD credits for attending cultural training Creating an e-learning portal with cultural case studies | 1. HR Department<br>2. CPD Accrediting Bodies | 70,000 | 6 months | 75% of nurses complete self-directed learning modules |
| Nursing Managers Have Lower Emotional Intelligence and Cultural Competence | To integrate emotional intelligence and cultural competence into nursing leadership | 1. Leadership Development Program<br>2. EI-based Decision- Making Training Regular Monitoring, Evaluation and Implementation of the Leadership and Management | 1. External Leadership Consultants<br>2. Nursing Directors HR Team | 80,000 | 6 months | 90% of nursing managers show improved EI and leadership skills in evaluations |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Development Program | | | | |
| Lack of a Structured Mentorship Program | To establish a mentoring system between senior and junior nurses | 1. Formal Mentorship Pairing<br>2. Monthly Check-ins and Feedback Sessions | 1. Senior Nurses<br>2. Junior Nurses<br>3. Hospital Administrators | 30,000 | 12 months | 85% satisfaction rate from mentees |

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