ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue VI June 2025

Diversity and Inclusion Practices on The Self- Efficacy of Nursing Clinical Instructors in Cebu City

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DOI: https://doi.org/10.51244/IJRSI.2025.120600145

Received: 09 June 2025; Accepted: 20 June 2025; Published: 17 July 2025

ABSTRACT

The integration of diversity and inclusion (D&I) practices in nursing education is essential in fostering equitable and empowering learning environments. While D&I and self-efficacy are recognized as key components of effective teaching, there remains limited evidence on how these two constructs relate in the context of nursing academe, particularly among clinical instructors in the Philippines. This study assessed the profile, level of D&I practices, and self-efficacy of nursing clinical instructors in Cebu City, as well as the relationship among these variables. A descriptive-correlational research design was employed, utilizing a validated survey tool administered to clinical instructors from various academic institutions. Statistical analyses included frequency distribution, mean scores, chi-square tests, and Pearson r to determine associations among variables. Findings revealed that instructors experienced a very high level of D&I practices and demonstrated strong self-efficacy across instructional, disciplinary, and organizational domains. A significant relationship was observed between diversity and inclusion and self-efficacy, suggesting that inclusive environments enhance faculty confidence. However, challenges were identified in areas such as accessibility, inclusive training, and mentorship opportunities. The study affirms the relevance of Social Identity Theory and Self-Efficacy Theory in the academic nursing context, highlighting the role of inclusive institutional culture in shaping instructor performance and engagement.

Keywords: diversity, inclusion, self-efficacy, nursing education, clinical instructors, nursing management, academic leadership

INTRODUCTION

The nursing field is experiencing a notable shift, influenced by changing healthcare demands and an increasing focus on diversity and inclusion. With healthcare settings becoming more varied, it is crucial for nursing educators to prepare themselves with the skills and knowledge required to promote inclusive practices. Diversity and inclusion are increasingly recognized as essential pillars in nursing education and practice, shaping how future nurses are trained to provide culturally competent and patient-centered care (Jeffreys, 2016).

In the realm of nursing education, clinical instructors play a critical role in translating theoretical knowledge into practical skills, ensuring that nursing students gain the competencies necessary for effective clinical practice. They not only guide students' acquisition of technical competencies but also model culturally competent and inclusive care, especially in culturally diverse environments like Cebu City. However, their ability to perform these roles effectively—and their self-efficacy as educators—can be significantly influenced by the diversity and inclusion practices in their own institutions (National League for Nursing [NLN], 2019).

Diversity in nursing education refers to the presence of differences in ethnicity, gender, socioeconomic background, age, religious beliefs, abilities, and cultural heritage among students, faculty, and patients (American Association of Colleges of Nursing [AACN], 2021). Inclusion, on the other hand, refers to the active creation of an environment where all members—regardless of their differences—feel valued, respected, and empowered to contribute meaningfully (Mor Barak, 2017). In Cebu City's nursing schools, where students and faculty come from diverse cultural and linguistic backgrounds, and where international exchange programs

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and inter-regional enrollment are increasing, the importance of institutionalized diversity and inclusion practices cannot be overstated (Salavea & Salangsang, 2020).

The practice of diversity and inclusion within nursing schools directly impacts clinical instructors' ability to manage diversity in clinical placements. Schools that actively promote diversity and inclusion through clear policies, training programs, mentoring initiatives, and culturally sensitive curricula equip clinical instructors with the skills and confidence to manage multicultural clinical groups effectively (Whitford & Emerson, 2019). Conversely, schools that lack structured diversity and inclusion programs leave clinical instructors to navigate diversity-related challenges independently, often resulting in uncertainty, stress, and diminished self-efficacy (Tschannen-Moran & Hoy, 2001).

From a nursing management perspective, the school's commitment to diversity and inclusion is not merely a symbolic gesture but a core responsibility of academic leadership. Nursing school administrators and faculty managers are responsible for embedding diversity and inclusion into institutional policies, hiring practices, professional development programs, and performance evaluations (AACN, 2021). Schools with strong diversity cultures actively support clinical instructors by providing cultural competence workshops, inclusive teaching resources, and opportunities for peer collaboration—all of which enhance teaching self-efficacy (Clark et al., 2020). When diversity and inclusion are institutionalized, clinical instructors are more likely to feel empowered, confident, and prepared to address the diverse learning needs of their students.

This institutional context is particularly important when considering self-efficacy theory (Bandura, 1997), which posits that self-efficacy is strengthened when individuals experience mastery, observe successful role models, receive positive feedback, and work within environments that reduce unnecessary stress. For clinical instructors, their perceptions of efficacy are shaped not only by individual teaching experiences but also by the supportiveness of the institutional climate. In inclusive schools that prioritize faculty diversity and cultural competence, clinical instructors gain both the practical tools and the institutional affirmation needed to excel in diverse classrooms and clinical placements (Huber, 2018).

As diversity continues to increase in our communities, nurse educators are responsible for creating a climate in the sea of learning that prepare future nurses who respect, value, understand, care for, and meet the unique needs of individuals and families with diverse backgrounds. Through a conducive learning climate, nurse educators have an opportunity to intentionally support and develop a diverse and inclusive nursing workforce. The uniqueness of every nurse adds to the total body of nursing expertise. Each nurse has a different background, different experiences, different cultural views, and can use those attributes in various patient care and classroom settings (Frazer et al., 2021).

In contrast, nursing schools that do not actively promote diversity and inclusion may unintentionally create exclusive, biased, or unsupportive environments. Clinical instructors in such institutions may feel ill-prepared to handle cultural tensions, student misunderstandings, or conflicts arising from cultural differences—leading to lower self-efficacy, teaching stress, and reduced teaching performance. These negative experiences ultimately impact student learning outcomes and contribute to faculty dissatisfaction and attrition.

Despite these realities, local evidence on how the diversity and inclusion practices of nursing schools in Cebu City affect clinical instructors' self-efficacy remains limited. By examining these relationships, this study aims to generate practical, evidence-based insights that nursing administrators and faculty managers can use to strengthen institutional diversity initiatives, improve faculty development programs, and build inclusive and empowering work environments for nursing educators. Ultimately, this aligns with the broader nursing management goal of cultivating a resilient, culturally competent, and self-efficacious faculty workforce, capable of preparing future nurses to excel in diverse healthcare settings.

This study focuses on addressing Sustainable Development Goals (SDGs) number 4: Quality Education, emphasizing the importance of providing accessible and equitable quality education and promoting lifelong learning opportunities for all individuals. This is closely tied to the importance of inclusive and culturally aware nursing education for a diverse student population. Additionally, it concerns SDG number 5: Gender Equality, which aims to achieve gender equality and empower all women and girls. Furthermore, it addresses

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SDG number 8: Decent Work and Economic Growth, which is linked to the concepts of diversity and inclusion, essential for enhancing the self-efficacy of clinical educators. This goal advocates for fairness and equitable opportunities within the workplace, creating an environment where everyone, regardless of their background, can thrive. It also relates to SDG number 10: Reduce Inequalities, which aims to diminish disparities at both national and international levels. This involves tackling inequalities related to race, ethnicity, gender, disability, and other factors. Additionally, it addresses goal number 16: Peace, Justice, and Strong Institutions, highlighting the need for a just and peaceful society to foster an inclusive educational and work environment. A lack of peace can lead to instability, fear, and discrimination, hindering a clinical instructor's ability to focus on their responsibilities and create a supportive and safe setting for students. To ensure equitable treatment and opportunities for all, a strong legal framework and accessibility to justice are paramount. This relates to issues concerning bias, harassment, and discrimination, which can adversely affect both students and clinical educators. Establishing policies and procedures that promote diversity and inclusion requires a strong and effective organization, encompassing the healthcare, education, and broader societal sectors (Carlsen et al,.2022).

Nursing schools aim for inclusivity, but they encounter major obstacles in achieving real diversity and inclusion. These obstacles show up in several important areas: first, there is often a lack of representation among faculty and staff, which can lead to biases in teaching and mentorship; second, students from marginalized groups are often underrepresented, highlighting broader societal inequalities in access to education; third, the curriculum might not fully meet the unique health needs and cultural viewpoints of diverse communities; and finally, the learning environment may not always be welcoming or supportive for students from various backgrounds. To tackle these issues, nursing schools need to take a comprehensive approach. This includes focused efforts to recruit and keep diverse students, developing a curriculum that is culturally aware, and creating an inclusive atmosphere on campus. In the end, achieving real diversity and inclusion in nursing education is essential for building a healthcare workforce that can effectively meet the varied needs of all patients (Frazer et al,.2021).

Nursing school face significant challenges in achieving equitable diversity and inclusion. Underrepresentation of faculty and students from marginalized racial and ethnic groups, LGBTQ+ individuals, and individuals with disabilities is well-documented. This lack of representation can lead to culturally insensitive curricula. The limited diversity among nursing faculty greatly affects how well diversity and inclusion programs work in nursing schools. When faculty members from underrepresented groups are few, the curriculum may not fully meet the health needs and cultural views of various patient populations. Additionally, having a similar faculty group can make the learning environment feel unwelcoming or unhelpful for students from diverse backgrounds, which can hurt their academic success and career growth. This lack of varied viewpoints among faculty also reduces mentorship chances for students from marginalized communities, keeping unfair practices in place. Thus, it is essential to actively recruit and keep nursing faculty from different backgrounds to create a truly inclusive and fair learning environment. This helps prepare future nurses to provide effective care for a wide range of patients.

The researcher is a clinical instructor and experience that other instructors report that even if a nursing school promotes inclusivity within the campus, the same emphasis on diversity is not always present in the clinical area, such as hospitals or community health centers. This misalignment leaves instructors to bridge the cultural gap alone, with minimal institutional support. When the school's culture of inclusion is weak or inconsistent, instructors feel less confident addressing these gaps, further eroding self-efficacy.

This study holds practical value to nursing management because it highlights how diversity and inclusion practices in nursing schools affect the self-efficacy or confidence of clinical instructors in teaching diverse students. For nursing managers, understanding this connection helps them create better policies and faculty development programs that promote inclusive teaching and cultural competence.

Theoretical Framework

This study is anchored on two theories, the Social identity theory by Tajfel & Turner (1979) and the Self-Efficacy Theory by Bandura (1977) as cited in Gallagher (2012) for self-efficacy variable.

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The Social Identity Theory was originally developed to explain the phenomena involved when individuals use group memberships to define themselves and others (Tajfel & Turner, 1979). Social identity theory explains that individuals have social identities (identifying themselves in terms of groups) in addition to defining themselves in terms of purely individual characteristics (Ashforth & Mael, 1989; Hornsey & Jetten, 2004). Individuals want their social identities to be viewed positively in order to maximize self-esteem, which often leads to in-group favoritism (viewing their own group as superior to other groups) (Tajfel & Turner, 1986).

Through self-categorization (an elaboration of social identity theory), individuals define themselves in terms of a particular group as a function of that group's fit and accessibility in a given context (Turner, 1987). Self-categorization thus positions context as a central tenet of the social identity theory perspective (Ellemers et al., 2004). Further, as Jenkins (2004) argues, social identity can be viewed as an ongoing process in which the situation continuously informs how different group memberships inform social interactions over time.

Social identity theory also posits that individuals view themselves in terms of a group prototype, which is an ideal representation of what a group member is, as a means of reducing uncertainty (Hogg & Terry, 2000; Hogg & Mullin, 1999). Overall, social identity theory defines two primary motivations involved as individuals define themselves in terms of groups: uncertainty reduction and increasing self-esteem (Tajfel & Turner,1979 as cited in Randel,2025)

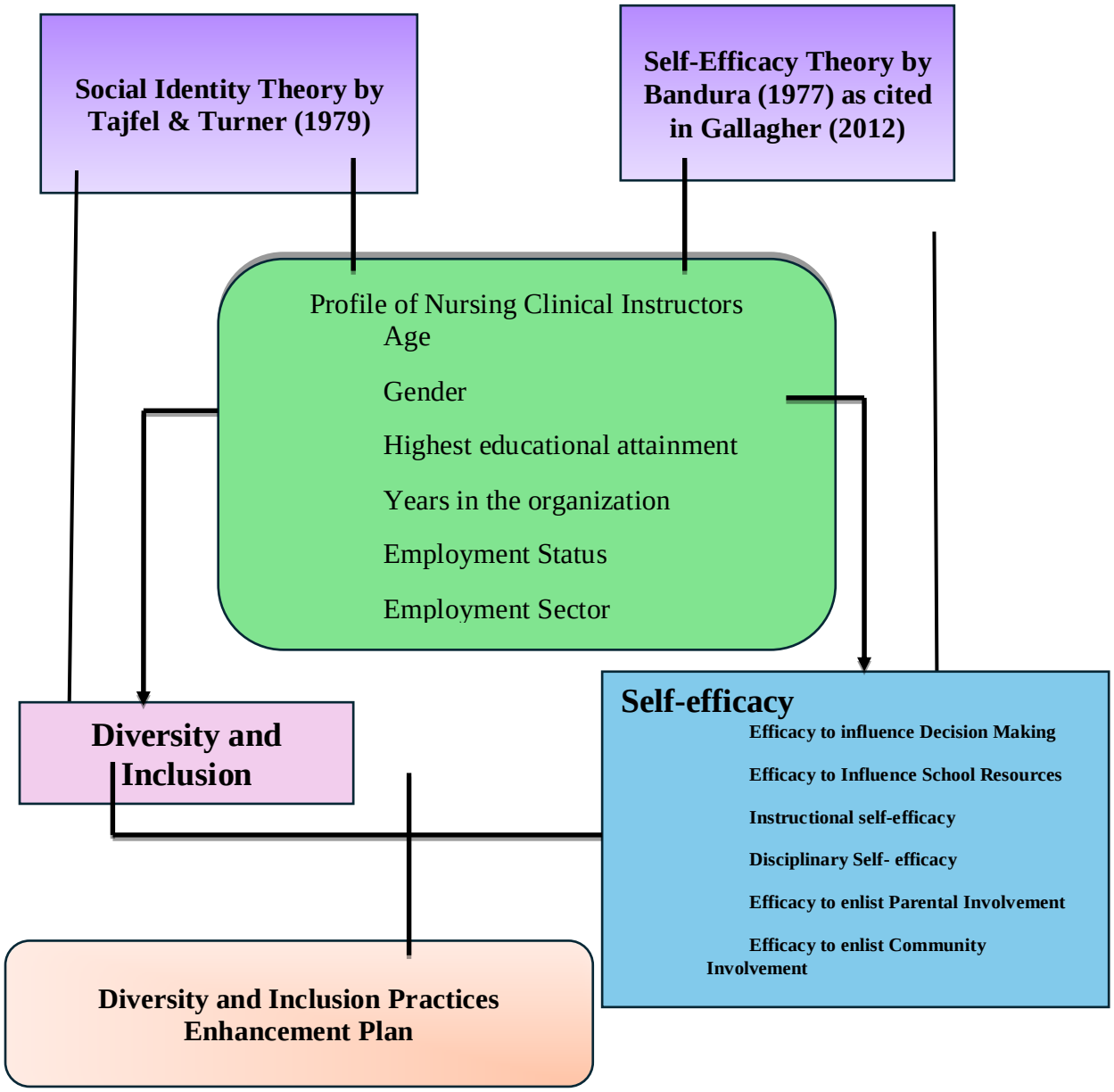

Figure 1 Schematic diagram of the study utilizing the Social Identity theory by Tajfel & Turner (1979) and the Self-Efficacy Theory by Bandura (1977) as cited in Gallagher (2012).

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The theory of Tajfel & Turner seeks to explain the cognitive processes and social conditions underlying intergroup behaviors, especially those related to prejudice, bias, and discrimination and developed to explain how individuals create and define their place in society. According to the theory, three psychological processes are central in that regard: Social Categorization, Social Comparison, and Social Identification.

As applied in the study the Social Identity Theory can be used to analyze how group dynamics influence nursing education, particularly in clinical instruction. In the assumptions of Social Categorization nursing instructors and students may unconsciously categorize themselves based on institutional affiliations, years of experience, ethnicity, or gender. With the Influence of Social Identification on Teaching and Learning Nursing clinical instructors who strongly identify with their group (e.g., senior nurses, faculty members of prestigious universities) may develop a sense of exclusivity.

The Self-efficacy Theory by Bandura (1977) as cited in Gallagher (2012) emphasizes the importance of the individual and the individual's perceptions of his/her personal capabilities as key determinants of successful outcomes. The conceptualization of this construct stemmed from Bandura's concept of outcome judgement, which refers to an individual's expectation of a positive outcome triggering behavior (Bandura, 1982 as cited in Marikyan & Papagiannidis, 2022). This construct derived from the self-efficacy concept, which refers to a situation-specific belief about how well someone can execute actions for the prospective task (Davis, 1989 as cited in Marikyan & Papagiannidis, 2022; Bandura, 1982 as cited in Marikyan & Papagiannidis, 2022).

It was suggested that self-efficacy had a predictive role in decision-making about technology use (Hill et al., 1987 as cited in Marikyan & Papagiannidis, 2022). Also, perceived ease of use shared a similarity with the complexity factor theorized in the innovation diffusion literature as a barrier to innovation adoption. It was defined as the degree to which individuals find the innovation difficult to understand and use (Mahajan, 2010 as cited in Marikyan & Papagiannidis, 2022). The validity and reliability of the constructs were assessed by testing the Diversity and inclusion and the self-efficacy on the Clinical instructors, also the theory was further validated, by confirming significant relationship between the profile of the two variables.

Albert Bandura's Self-Efficacy Theory is part of his broader Social Cognitive Theory, which emphasizes how people learn and develop through observation, experience, and social interaction. According to Bandura (1977), self-efficacy is influenced by four major sources: Mastery Experiences – Direct experiences of success or failure that shape an individual's confidence in performing tasks. For clinical instructors, successful teaching experiences strengthen their belief in their teaching efficacy (Usher & Pajares, 2008). Vicarious Experiences – Observing others, such as senior instructors, can influence self-efficacy. When novice clinical instructors witness effective teaching strategies, they are more likely to believe in their own ability to teach effectively (Schunk & DiBenedetto, 2021). Verbal Persuasion – Encouragement and feedback from peers, administrators, or students can enhance an instructor's sense of effectiveness (Tschannen-Moran & Hoy, 2001). Positive reinforcement can help clinical instructors develop confidence in their teaching abilities. Physiological and Emotional States – Stress, anxiety, and burnout can impact self-efficacy negatively, while motivation and well-being can enhance it. Clinical instructors with high levels of stress may feel less competent in their teaching roles (Bandura, 1997).

The Importance of Efficacy for Clinical Instructors plays a vital role in the professional development of nursing and healthcare students. Their efficacy impacts: Student Learning Outcomes – Instructors with high self-efficacy are more likely to use engaging teaching strategies, provide constructive feedback, and create supportive learning environments (Klassen & Tze, 2014). With Instructional Adaptability, those with strong teaching efficacy are better at adapting to new teaching methods, integrating technology, and addressing diverse student needs (Tschannen-Moran & Hoy, 2001). Professional Development and Job Satisfaction the Higher self-efficacy is linked to job satisfaction and lower burnout rates among educators, including clinical instructors (Chan, 2008).

As applied in the study, Bandura's (1977) Self-Efficacy Theory provides a framework for studying clinical instructors' teaching efficacy. By examining mastery experiences, vicarious learning, verbal persuasion, and physiological/emotional factors, the researcher can gain deeper insights into what strengthens or weakens self-efficacy among clinical educators.

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The diagram shows that the study variable of diversity and inclusion is anchored on the Social Identity theory by Taifel & Turner (1979) while the variable of efficacy is anchored on the Self-Efficacy Theory by Bandura (1977). The study initially starts with determining the profile of the nurses according to age, gender, highest educational attainment, and years in the organization. This will be followed by the descriptive determination of the diversity and inclusion and efficacy of the nurses. Significant relationship among the profile, diversity and inclusion and efficacy of the nurses will then be assessed. As an output of the study, a diversity and inclusion enhancement plan of nurses will be created.

Statement of Purpose

The main purpose of the study was to assess the relationship of profile, diversity and inclusion Practices and self- efficacy among Nursing Clinical Instructors in Cebu City for the 2nd quarter for the year 2025.

This study answered the following questions:

What was the profile of the nursing clinical instructors in terms of:

- age;
- gender;
- highest educational attainment;
- years in the organization;
- employment status;

What was the level of diversity and inclusion Practices among nursing clinical instructors?

What was the level of self- efficacy among nursing clinical instructors in terms of:

- efficacy to influence decision making;
- efficacy to influence school resources;
- instructional efficacy;
- disciplinary efficacy;
- efficacy to enlist parental involvement;
- efficacy to enlist community involvement; and
- efficacy to create positive school climate;

Was there a significant relationship between?

- profile and level of diversity and inclusion;
- profile and level of self- efficacy;
- level of diversity and inclusion and level of self -efficacy?

What were the challenges in the implication of diversity and inclusion practices?

What diversity and inclusion Practices enhancement plan was proposed based on the findings of the study?

Statement of Null Hypotheses

Ho1: There was no significant relationship between profile and level of diversity and inclusion practices among the nursing clinical instructors.

Ho2: There was no significant relationship between profile and level of self-efficacy among nursing clinical instructors.

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Ho3: There was no significant relationship between level of diversity and inclusion practices and level of self-efficacy among clinical instructors.

Significance of the Study

The following group of individuals will be benefitted from the conduct of this study:

Clinical Instructors. The findings of the study can serve as a baseline information which can serve as a basis in assessing the Diversity and Inclusion on self-efficacy. They may provide hands-on training and mentorship in clinical settings, bridging the gap between theoretical knowledge and practical application in healthcare education.

Nursing School administrator. They will promote a culture of inclusivity and respect within the college. This can involve implementing policies and procedures that address bias and discrimination, providing training on diversity and inclusion for faculty and staff, and creating opportunities for students and faculty in interact and learn for each other.

Nursing Students. Their Perspectives and experience provide valuable insights into the importance of creating a welcoming and supportive learning environment.by embracing diversity and promoting inclusion.

Policymaker. They can create rules or guidelines that acknowledge the need for a diverse faculty in healthcare education to support a varied student body. Their goal is to foster a learning environment that is welcoming and accessible for every student.

Commission on Higher Education (CHED), which oversees quality assurance and faculty qualification standards in higher education institutions. The results may inform CHED's efforts to strengthen faculty development policies, particularly in support of inclusive education, faculty empowerment, and alignment with the Philippine Qualifications Framework. Insights from this study may guide future policy issuances or revisions related to the standardization of D&I training and institutional practices across nursing schools.

Researcher. The knowledge or information gained in this work will be a great contribution to the researcher which he can greatly use in the practice of her profession. Also, this work serves as a means of improving the research skills of the researcher.

Future Researchers. The study's findings can serve as a foundation for future research, guiding researchers to explore related topics or conduct follow-up studies to build upon the initial findings.

Definition of Terms

The following terms are defined operationally in order to gain better understanding on how they are used in the study, to wit:

Diversity and inclusion Practices. Interconnected concepts that are crucial for creating equitable and thriving workplace and societies. Encompasses a wide range of strategies and initiatives aimed at creating workplaces where individuals from all backgrounds feel valued, respected, and have equal opportunities.

Diversity and inclusion enhancement plan. This refers to the output of the study addressing the descriptive finding on Diversity and Inclusion on the Self-efficacy as well as interrelationship of the variables of personal characteristics.

Profile. This refers to the defining characteristics of the Clinical Instructors in terms of age, gender, highest educational attainment and years in the organization.

Age. This refers to the length of time that the Clinical Instructors has lived or has existed expressed in years.

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Gender. This refers to either of the two main categories (male and female) or non-binary, an umbrella term for gender identities that fall outside the traditional male/female binary which is the Clinical Instructors are divided.

Highest Educational Attainment. This refers to the highest level of education that the Clinical Instructors has successfully completed whether college level, college graduate, master's level, with master's degree, doctorate level, or doctoral level.

Years in the organization. This refers to the number of years that the Clinical Instructors is working as a Faculty in Colleges of Nursing.

Employment status. This refers to the current work situation and relationship with your employer.

Level of self- efficacy.

efficacy to influence decision making. Refer to the belief in the effectiveness of a chosen action or decision. It's having about having confidence that the chosen course of action will lead to the desired outcome.

efficacy to influence school resources. Refers to a teacher's belief in their ability to successfully advocate for and obtain resources for their students and their school.

instructional efficacy. Refers to a teacher's belief in their ability to effectively teach and positively impact student learning.

disciplinary efficacy. Refers to a teacher's belief in their ability to effectively manage student behavior and create a positive and productive learning environment.

efficacy to enlist parental involvement. Refers to a Treacher's belief in their ability to successfully engage parents in their child's education.

efficacy to enlist community involvement. Refers to a Teacher's belief in their ability to successfully engage community member in supporting their students and school.

efficacy to create positive school climate. Refers to a teacher's belief in their ability to contribute to a positive and supportive learning environment for all student.

REVIEW OF LITERATURE AND STUDIES

This Chapter explore the different literature and studies pertaining to the diversity and inclusion practices and self-efficacy of nurses. It delves into implication of diversity and inclusion practices significantly impact nurses' self-efficacy, fostering a more supportive and equitable healthcare environment.

Diversity and Inclusion Practices of nurses

Diversity and inclusion in the nursing profession are critical to ensuring equitable healthcare delivery and fostering an environment that respects and values diverse backgrounds. Recent studies emphasize the importance of a diverse nursing workforce in improving patient outcomes and reducing health disparities. According to Smith et al. (2022), diversity among nurses enhances cultural competence, leading to more effective communication and understanding between healthcare providers and patients from varied backgrounds. The study suggests that culturally competent care can significantly improve patient satisfaction and adherence to medical advice.

Despite the recognized benefits, several barriers hinder diversity and inclusion in nursing. Johnson and Lee (2023) identify systemic issues such as recruitment biases and lack of support for minority nursing students as significant challenges. These barriers contribute to the underrepresentation of minority groups in nursing, which, in turn, affects the quality of care provided to diverse patient populations.

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Efforts to enhance diversity and inclusion within the nursing profession have been documented in recent literature. An article by Gonzalez et al. (2024) outlines successful strategies such as mentorship programs, diversity training, and inclusive policy reforms. These initiatives aim to create a supportive environment for nurses from diverse backgrounds and promote equitable opportunities for career advancement. Several case studies highlight best practices in promoting diversity and inclusion in nursing. For instance, the work by Patel and Kim (2025) showcases a hospital's initiative to implement a comprehensive diversity and inclusion framework. This framework includes regular diversity audits, inclusive hiring practices, and continuous education on cultural competence, resulting in a more inclusive workplace and improved patient care.

Anti-diversity, equity, inclusion, and belonging (DEIB) sentiment has been on the rise over the past couple of years. Unfortunately, this negativism, referred to as the "anti-woke" movement by some states, has sustained and expanded these feelings. With the escalation of global migration, it is imperative that nurse leaders build awareness of the importance of diversity, equity, inclusion, and belonging in their workplaces if they are to maintain a workforce that mirrors the communities they serve. A supportive and inclusive workplace culture can improve team engagement if robust training initiatives that address unconscious bias are ongoing, and changes to policies that address underrepresented groups are addressed (King et al.,2024).

The need for institutions to provide students, especially those from MMC, safe spaces that value, support, and foster belongingness was highlighted by the events of 2020. A student-led DEI, or access and engagement, advisory group for students in higher education is a great way to establish a community for students who are at high risk for additional isolation, stress, and program incompletion while being an initiative that fosters health equity research and diversification of the research workforce. The group developed and worked towards their mission to "strengthen diversity, equity, inclusion, and justice in nursing science and research through scholarship, community-building and advocacy" (Yoder et al.,2025).

Black women academic nurse leaders in the united states yet found many of the same themes seen in studies of Black leaders and other leaders of color in nursing and other academic fields. Through the participants' unique perceptions as Black women academic nurse leaders, they revealed how because the structure, organization, and leadership positions in academic nursing are predominantly White, improving inclusivity in academic nursing leadership is critical to how Black women academic nurse leaders perceive their role and are able to perform as leaders. Higher education leadership involved with nursing programs should implement an anti-racist pedagogy and associated faculty training to improve campus culture and to address racial microaggressions at all levels of nursing education. Nursing education also needs to improve the nursing academic climate by hiring, training, and mentoring academic nurse faculty and administrators from historically racially marginalized groups (Heduru-Anderson et al,.2022).

Working on changing the nursing academic climate to value DEI and engage in inclusive teaching is a long and relentless journey that needs momentum (Charania & Patel 2022). The promotion of diversity, equity, and inclusion in health care is a vital topic with a new sense of urgency. Now more than ever, health care organization understand the strategic importance of working towards a culture rich in DEI, given the effects a lack of DEI has on the work environment, patient outcomes, and organizational performance, Diversity promotes better communication within the staff as well as with patients. It is with this better communication and teamwork that patient outcomes improve. Health care organizations are the key to influencing change and creating a culture of DEI. Making a DEI culture is accomplished through recruitment, retention, and professional development of underrepresented health care providers. Through these actions, incivility, lateral violence, and harassment (Marrison et al.,2021).

"It is important to acknowledge that there are some dichotomies between the reality and rhetoric of equal opportunities, the forms of practitioner and the academic knowledge in the field, scholarly approaches to equal opportunities across disciplines of social sciences and humanities, as well as their use of concepts and methods in order to uncover inequalities, and offer strategies for change towards equality of opportunity, valuing of diversity or pursuit of social inclusion" (Wolbring & Nyugen 2023).

Although many organizations are discussing the importance of DEIB initiatives, segments of communities are still marginalized, health care disparities persist, and despite the good intentions of its participants, the

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workforce or health care systems do not always reflect or advocate for the community they serve (King et al.,2024).

Global migration demands that DEIB be viewed through a lens dependent on varying cultural contexts. In a health care system, at all levels, cultural sensitivity matters. Employees must feel that they belong on the team, especially in health care, as outcomes depend on the full team, not 1 person. As companies more and more continue to create a global footprint, they also must highlight their DEIB priority from the pipeline to the bedside to the boardroom (Stamp,2024).

The concepts of Diversity, Equity, Inclusion, and Belonging (DEIB) are at the forefront of current thought among interprofessional health care leaders including nurses. This report focused on fundamental reform in healthcare and first mentioned the word "equity" on a national level. In 2003, the Institute of Medicine released Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. This report outlined the lower quality of healthcare received by racial and ethnic minorities, rooted in historic and contemporary inequities. This report suggested increasing the proportion of underrepresented racial and ethnic minorities among health professions and increasing cross-cultural education to providers as a means to deliver equitable care (Stamps &Foley, 2023).

According to the American association of Colleges of nursing ,that Students and faculty to critically reexamine the role of the nurse educator in shaping the ability of the future nurse to uphold the ideals of diversity, equity, and inclusion (DEI) and provide to diverse populations, while taking intersectionality and identity of the individual into account. Intersectionality can be defined as recognizing the interconnected nature of many social categories and the overlapping systems of oppression and discrimination (Cox et al.,2023).

Self-Efficacy of nurses

Self-efficacy, a concept originating from Bandura's Social Cognitive Theory, refers to an individual's belief in their capability to execute behaviors necessary to produce specific performance attainments. In the context of nursing, self-efficacy is crucial as it influences nurses' confidence in performing clinical tasks, managing patient care, and adapting to the demands of the healthcare environment. The concept of self-efficacy, rooted in Bandura's Social Cognitive Theory, emphasizes the importance of personal beliefs in performance and motivation (Bandura, 1997). In nursing, self-efficacy affects clinical decision-making, patient care quality, and overall job satisfaction (Cohen et al., 2023).

The nurses' communication competence and self-efficacy were at a moderate level. Considering the correlation and predictive role of SI and its dimensions, it is recommended to promote problem-solving skills, improve self-awareness, and pay attention to moral standards to nurture communication competence and self-efficacy among nurses (Mebralian et al,.2023).

Recent studies indicate that nurses with higher educational qualifications report greater self-efficacy. For instance, Wong et al. (2023) found that nurses with a Bachelor of Science in Nursing (BSN) demonstrated higher self-efficacy levels compared to those with an associate degree. This suggests that advanced education may equip nurses with better skills and knowledge, thus enhancing their confidence.

Experience is another critical factor. A study by Lee et al. (2024) revealed that nurses with more years of clinical experience exhibited higher self-efficacy. This experience allows for the development of competencies and coping strategies, which are essential in high-pressure environments.

The work environment significantly impacts nurses' self-efficacy. Supportive leadership and collaborative team dynamics have been linked to increased self-efficacy among nurses (Smith & Taylor, 2022). Conversely, high-stress environments and inadequate staffing can diminish self-efficacy, leading to burnout and job dissatisfaction.

Self-efficacy influences not only individual performance but also patient outcomes. Nurses with high self-efficacy are more likely to engage in proactive patient education and advocacy, leading to improved patient

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satisfaction and health outcomes (Johnson et al., 2025). Furthermore, enhancing self-efficacy can reduce turnover rates, as confident nurses are less likely to leave the profession (Miller et al., 2023).

Implementing mentorship programs can provide support and guidance to novice nurses, helping to build their confidence and self-efficacy (Garcia et al., 2023). Experienced nurses can offer practical advice, share experiences, and provide emotional support.

Ongoing professional development and training are essential for enhancing self-efficacy. Programs that focus on skill-building and knowledge enhancement can empower nurses, leading to increased confidence in their abilities (Harris & Lee, 2024). Creating a culture of positive reinforcement within healthcare settings can bolster self-efficacy. Recognizing achievements, no matter how small, can help nurses build confidence and encourage them to take on more challenging tasks (Roberts et al., 2022).

Diversity and Inclusion Practices on Self-Efficacy

Self-efficacy is foundational to understanding how individuals perceive their capabilities within diverse environments. Bandura (1997) posited that self-efficacy influences motivation, emotional regulation, and resilience. Recent studies have expanded this framework, emphasizing the role of social contexts, including diversity and inclusion, in shaping self-efficacy beliefs.

Diversity refers to the presence of differences within a given setting, including race, gender, age, sexual orientation, and more. Inclusion, however, goes beyond mere representation; it involves creating an environment where all individuals feel valued and integrated. Research indicates that inclusive practices can significantly affect employee engagement and performance (Shore et al., 2021).

Recent empirical studies have shown a positive correlation between inclusive practices and self-efficacy among employees. For instance, a study by Gonzalez et al. (2023) found that organizations that actively promote diversity and implement inclusive policies report higher self-efficacy levels among their employees. The authors suggested that when individuals feel accepted and valued, their confidence in their abilities increases, leading to better performance outcomes.

Research by Lee and Kim (2024) highlighted that exposure to diverse perspectives can enhance self-efficacy. Their findings indicated that individuals who engage with colleagues from varied backgrounds are more likely to adopt a growth mindset, thereby improving their self-efficacy. This exposure challenges existing biases and encourages individuals to develop new skills and competencies. Psychological safety, a concept closely linked to D&I, has been identified as a crucial factor in fostering self-efficacy. According to a study by Chen et al. (2025), environments that promote psychological safety enable individuals to take risks and express themselves without fear of negative consequences. This safety net not only enhances self-efficacy but also encourages innovative thinking and collaboration among diverse teams.

Despite the positive relationship between D&I and self-efficacy, challenges remain. Not all diversity initiatives lead to successful inclusion. A study by Patel and Zhang (2022) pointed out that superficial D&I efforts can result in backlash, leading to decreased self-efficacy among marginalized groups. It is crucial for organizations to implement genuine and sustained D&I strategies that promote true inclusion and equity.

Profile on the Diversity and Inclusion Practices

The profile of nurses—encompassing education, experience, and demographic factors—significantly influences their engagement with diversity and inclusion initiatives. A study by Thompson et al. (2023) indicates that nurses with higher levels of education and training in cultural competence are more likely to advocate for inclusive practices within their teams. Additionally, the research highlights the importance of leadership roles in promoting diversity and inclusion, suggesting that leaders who prioritize these values contribute to a more inclusive workplace culture.

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Ongoing professional development and training in diversity and inclusion are essential for enhancing nurses' competencies. Baker and Wong (2022) argue that targeted training programs can equip nurses with the skills needed to navigate complex cultural dynamics in patient care. Their findings underscore the need for nursing curricula to incorporate diversity and inclusion training to prepare future nurses for the realities of a diverse healthcare environment. Recent studies have highlighted the increasing diversity among the nursing workforce. According to a report by the American Nurses Association (ANA, 2021), the racial and ethnic composition of registered nurses in the United States has gradually evolved, with a notable increase in the number of Hispanic and Asian nurses. This shift reflects broader societal changes and the growing importance of cultural competence in healthcare delivery.

A study by Smith et al. (2022) analyzed the demographic trends in nursing education, revealing that nursing programs are attracting a more diverse student body. The authors emphasized that educational institutions must continue to foster an inclusive environment to support students from various backgrounds. This trend is crucial for addressing health disparities and enhancing the quality of care provided to diverse populations. Diversity in the nursing workforce has significant implications for patient care. Research conducted by Lee and Chen (2023) found that diverse nursing teams are associated with improved patient satisfaction and outcomes. The authors argue that nurses from varied backgrounds bring unique perspectives that can enhance communication and understanding between healthcare providers and patients.

Furthermore, a systematic review by Johnson et al. (2024) explored the relationship between nurse diversity and health equity. The findings indicated that diverse nursing teams are more effective in addressing the needs of underrepresented populations, thereby reducing health disparities. This literature underscores the importance of promoting diversity not only for the sake of representation but also for improving healthcare delivery.

Despite the positive trends in nurse diversity, several challenges remain. A study by Thompson and Garcia (2025) identified systemic barriers that hinder the recruitment and retention of diverse nursing professionals. These barriers include financial constraints, lack of mentorship, and implicit biases within healthcare organizations. The authors advocate for targeted interventions that address these challenges and promote a more inclusive nursing workforce. Additionally, the COVID-19 pandemic has exacerbated existing disparities in the nursing profession. Research by Patel et al. (2022) highlighted that minority nurses faced disproportionate risks during the pandemic, impacting their mental health and job satisfaction. This situation calls for a reevaluation of support systems for diverse nurses, ensuring their well-being and professional growth.

Profile on Self Efficacy

The self-efficacy of nurses plays a crucial role in their professional performance and patient care outcomes. Understanding how various demographic and professional profiles influence self-efficacy can provide insights into enhancing nursing practices and education. Several studies have highlighted the impact of demographic factors on nurses' self-efficacy. For instance, a study by Afolabi et al. (2022) found that younger nurses reported lower self-efficacy levels compared to their older counterparts. This finding suggests that age may correlate with experience and confidence in clinical settings. Furthermore, the research indicated that educational qualifications significantly affect self-efficacy, with nurses holding advanced degrees exhibiting higher self-efficacy levels (Baker & Lee, 2023).

Experience is another critical factor influencing self-efficacy. According to a study by Chen et al. (2024), nurses with more than five years of experience demonstrated higher self-efficacy in managing complex patient care scenarios. The study emphasized that practical experience contributes to the development of skills and confidence, leading to improved patient outcomes. Conversely, novice nurses often face challenges that may hinder their self-efficacy, as highlighted by Smith and Johnson (2021), who noted that new graduates frequently experience anxiety and self-doubt in their first year of practice.

The area of specialization also affects self-efficacy among nurses. Research by Patel et al. (2025) indicated that nurses working in high-acuity settings, such as intensive care units, reported higher self-efficacy levels than those in less demanding environments. This may be attributed to the rigorous training and continuous

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professional development required in specialized fields, which enhance nurses' competencies and self-confidence.

The relationship between nurses' profiles and self-efficacy has significant implications for nursing practice and education. Understanding these dynamics can inform targeted interventions to boost self-efficacy among nurses. For instance, mentorship programs that pair less experienced nurses with seasoned professionals can help bridge the confidence gap (Nguyen et al., 2023). Additionally, incorporating self-efficacy training in nursing curricula may empower future nurses to build resilience and confidence in their skills.

Transcultural nursing, as defined by Madeleine Leininger, is a humanistic and scientific area of formal study and practice in nursing that focuses on differences and similarities among cultures concerning human care, health, and illness based on the people's cultural values, beliefs, and practices. This field aims to provide culturally congruent nursing care, which is sensitive and adapted to the cultural needs of patients (Leininger, 2002).

A diverse healthcare workforce is essential for effective transcultural nursing. Jones et al. (2024) highlight that diversity among healthcare professionals can enhance communication and reduce health disparities. Their study suggests that healthcare institutions should focus on recruiting and retaining staff from varied cultural backgrounds to better serve diverse patient populations. Despite advancements, challenges remain in implementing transcultural nursing practices. According to Garcia and Thompson (2023), common barriers include language differences, lack of cultural knowledge, and resistance to change among healthcare providers. They recommend ongoing education and training to overcome these obstacles.

Synthesis

Research shows that nurses who see similarities between themselves and their teachers, coworkers, and leaders feel more confident and empowered in their jobs. This feeling of belonging helps build a stronger belief in their own abilities. Studies reveal that nurses trained in cultural competency are better prepared to offer care that respects different cultures. This training improves their confidence in talking to patients from various backgrounds, which leads to better results and satisfaction for patients. Additionally, studies indicate that learning environments that respect and value students' differences help raise self-confidence for both students and teachers. However, research also points out ongoing challenges to diversity and inclusion in nursing, such as hidden biases, discrimination, and the lack of representation in leadership roles. These issues can harm the confidence of nurses from underrepresented groups. Research suggests that programs aimed at increasing diversity and inclusion, like cultural competency training, mentorship opportunities, and fair hiring practices, can greatly enhance self-confidence and help create a more equal nursing workforce.

Diversity and inclusion are more than just nice ideas; they are crucial for effective nursing practice. A nurse's confidence, or self-efficacy, plays a key role in delivering high-quality, culturally aware care. It is important to create inclusive and fair learning spaces to help nurses from various backgrounds build their self-efficacy. We must tackle the systemic obstacles to diversity and inclusion in nursing to develop a fairer and more effective healthcare system. Additionally, ongoing research is necessary to better understand how diversity, inclusion, and self-efficacy are connected in nursing. This research should guide the creation and execution of evidence-based strategies and policies that enhance diversity, inclusion, and self-efficacy among nurses. Working together, researchers, educators, policymakers, and nursing organizations can drive meaningful and lasting change. This discussion highlights the strong link between diversity, inclusion, and self-efficacy in nursing. By encouraging inclusive environments, enhancing cultural understanding, and addressing systemic challenges, we can empower nurses to achieve their maximum potential and build a fairer and more effective healthcare system for everyone.

RESEARCH METHODOLOGY

This chapter presented the research design used, the local of the study, the respondents along with the sampling design and inclusion and exclusion criteria, the instrument used, the data gathering procedures, the statistical treatment of data, and the ethical considerations observed in the conduct of the study.

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Design

This quantitative research made use of the descriptive, correlational design. A descriptive, correlational research is a type of research design that attempts to explain the relationship between two or more variables without making any claims about cause and effect. It includes collecting and analyzing data on at least two variables to see if there was a link between them. In descriptive correlational research, researchers collected data to explain the variables of interest and figure out how they relate. The main goal was to give a full account of the variables and how they are related without changing them or assuming that one thing causes another. In descriptive correlational research, researchers did not change any variables or try to find cause-and-effect connections. Instead, they observed and measured the variables of interest and then look at the patterns and relationships that emerge from the data (Bhat, 2024).

In application to the study, the descriptive design was used in determining the profile, diversity and inclusion and self-efficacy of the nurses. The correlational design was used to assess the relationship of the profile, diversity and inclusion and self-efficacy among nurses.

Environment

The study was conducted in Cebu City, a lively center of cultural diversity that features a blend of different ethnic groups, languages, and religions. This colorful mix offers a special chance to see how clinical instructors work with a varied student body. However, this diversity can also create difficulties, like problems with communication, misunderstandings due to cultural differences, and varying views on healthcare practices. These factors add layers of complexity to the study, making it important to understand the specific cultural details of Cebu City. Additionally, Cebu experiences economic differences, with some communities facing limited access to resources and opportunities. These challenges can affect students' experiences, their backgrounds, and how they interact with their instructors.

This research will include five nursing schools in Cebu City. The nursing schools chosen for this study have been offering a Bachelor of Science in Nursing (BSN) program for the past 20 years. Cebu City has many nursing schools and colleges that use different teaching styles and methods for nursing education. This study examines the backgrounds and experiences of clinical instructors at these nursing schools, focusing on their cultural backgrounds and experiences with diversity. The aim is to assess how their profiles, practices regarding diversity and inclusion, and confidence in their abilities are connected.

Respondents

The respondents of the study were the 220 clinical instructors in Cebu City. The study covered 5 nursing schools with the following: Nursing school (a) 13 clinical instructors, Nursing school (b) 23 clinical instructors, nursing school (c) 25 clinical instructors, nursing school (d) 74 clinical instructors, and nursing school (e) 85 clinical instructors. The five nursing schools represented by the nursing clinical instructors, who took part in the study, have been operating in the nursing education industry for nearly 20 years.

Sampling Design. No sampling was used in the study as a complete enumeration will be used. By complete enumeration, all qualified respondents, based on the inclusion and exclusion criteria were invited to participate.

Inclusion Criteria. The study included only registered nurses, nursing clinical instructors working in colleges and university in Cebu City. This criterion ensured that the participants had the necessary qualifications and experience relevant to the research topic.

Exclusion Criteria. Excluded from the study were clinical instructors who are not actively teaching during the study period, individuals who do not hold a nursing qualification. The study excluded those who had submitted their resignations and retirement intentions were also excluded.

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Instrument

The primary research instrument used in the study was a four-part instrument. Part one of the instrument dealt with the personal characteristics of the clinical instructor in terms of the age, gender, higher educational attainment, and year of practice in clinical supervision, and employment status. Part two of the instrument was a standardized questionnaire called the Diversity and inclusion staff survey by Diversity Council Australia (2018). This was used to assess and measure employee diversity and inclusion experiences within participating organization. The survey aimed to gather the diversity amongst the staff in the organization that can program towards an inclusive workplace. It was a 34-item questionnaire answered using five-point Likert scale where 1 was Strongly Disagree, 2 was Disagree, 3 was Neither agree nor disagree, 4 was Agree, and 5 was Strongly Agree.

Parametric scores and interpretation were as follow: A score of 4.21-5.00: very high; 3.41-4.20: high; 2.61-3.40: moderate; 1.81-2.60: low; and 1.0-1.80: very low.

Part three of the instrument was standardized questionnaire called Banduras instrument Teachers Self-efficacy scale. This questionnaire was designed to help us gain understanding of the kinds of things that create difficulties for teachers in their school activities. There were seven dimensions, to include, Efficacy to influence decision making, Efficacy to influence school resources, Instructional self-efficacy, Disciplinary self -efficacy, Efficacy to enlist parental involvement, Efficacy to enlist community involvement, and Efficacy to create a positive school climate. It had 30-item questionnaire answered using five-point Likert scale where 1 - Nothing; 2 - Very little; 3 - Some Influence; 4 - Quite Bit; and 5 - A Great Deal. Parametric scores and interpretations: A score of 4.21 - 5.00: very high; 3.41 – 4.20: high; 2.61 – 3.40: fair; 1.81 – 2.60: low; and 1.00 – 1.80: very low.

Part four of the instrument was a researchers made checklists questionnaire, called challenges in diversity and inclusion practices checklists. This checklist offered a way to take a closer look at the challenges and opportunities related to diversity and inclusion among nursing clinical instructors. Its strength comes from looking at all parts of the learning environment, including recruitment, curriculum, assessment, and support. By carefully examining each point, institutions can find their strengths and weaknesses in terms of diversity and inclusion. A "Yes" answer doesn't mean everything is perfect; ongoing improvement is essential.it has 28-item checklist of challenges on diversity and inclusion practices, Cronbach's Alpha Reliability Analysis will be used to assess how well the items within a test measures the same underlying construct. The Cronbach's alpha of reliability where $a \geq 0.9$: Excellent; $0.9 > a \geq 0.8$: Good; $0.8 > a \geq 0.7$: Acceptable; $0.7 > a \geq 0.6$: Questionable; $0.6 > a \geq 0.5$: Poor; and $0.5 > a$: Acceptable.

Data Gathering Procedures

The following procedures were observed in the conduct of the study:

Pre-Data Gathering. The study began with the submission of three research titles for an approval of a single title. Once a title was approved, an Adviser was assigned. While crafting the paper, permission letter was submitted to the Dean of the College of Allied Health Sciences, Graduate Studies. The study was then submitted for a design hearing under a panel of experts. Following the incorporation of the suggestions and recommendations, the study was submitted to the institutional review board of the university for ethical approval.

Actual Data Gathering. Once the notice to proceed was issued, this signaled the start of the recruitment process. Recruitment was guided by the sampling design and the inclusion and exclusion criteria. All recruited participants were informed regarding the objective of the study to ensure complete transparency. Individual dissemination of survey questions was conducted, with each session on casting between 5-10 minutes. This was done until the sample size was achieved

Post-data Gathering. After completing the sample size, all the data were collated and tallied using excel. The data were treated with the appropriate statistical treatment and presented in tables. The tables were

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accompanied by their respective interpretations, implications, and supporting literature and studies. At the end of the data analysis, all answered questionnaires were shredded and all raw data were deleted permanently.

Statistical Treatment of Data

The following Descriptive and inferential statistics were used in the study:

Frequency Distribution and Simple Percentage. This was used to present the data on the profile of the nursing clinical instructors.

Mean Score and Standard Deviation. This was used in determining the diversity and inclusion and self-efficacy of the nursing clinical instructors.

Chi Square. This was used to assess the significant relationship between the profile and diversity and inclusion as well as the profile and the self-efficacy of the nursing clinical instructor

Cramer's V. This was used to find out the strength of the relationship should there be a relationship using the chi square.

Pearson r. This was used in statistical measures that describes the strength and direction of the linear relationship between two variables.

Ethical Consideration

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

PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

This chapter is the presentation of collated and treated data as answers to the research problems of the study. The data are presented in tables along with the interpretations, implications, and supporting literature and studies.

Profile of the Nursing Clinical Instructors

Table 1 is the presentation of the data on the profile of the nursing clinical instructors in terms of age, gender, highest educational attainment, years in the organization, and employment status.

Table 1 Profile of the Nursing Clinical Instructors

Personal Characteristics	*f*	*%*
Age		
Below 25 years old	12	5.50
26 to 35 years old	87	39.50
36 to 45 years old	87	39.60
46 to 55 years old	26	11.80
56 years old and above	8	3.60
Gender		

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Male	66	30.00
Female	121	55.00
Non-Binary	33	15.00
Highest Educational Attainment		
Bachelor's Degree	24	10.90
Master's Level	59	26.80
Master's Degree	105	47.70
Doctorate Level	16	7.30
Doctorate Degree	16	7.30
Years in the Organization		
3 years and below	107	48.60
4 to 6 years	80	36.40
7 to 9 years	23	10.50
10 years and above	10	4.50
Employment Status		
Full-time	188	85.50
Part-time	32	14.50

Note: *n=220.*

The demographic data of nursing clinical instructors in Cebu City show that most are in their 30s to early 40s. This age group reflects a workforce that is still energetic, up to date with current nursing practices, and capable of adjusting to the evolving needs of students. This stage also represents the productive years of early to middle adulthood, a period often characterized by high levels of motivation, career growth, and goal-directed performance. Individuals in this life stage typically have developed professional maturity while still retaining the drive and adaptability that benefit dynamic work environments. However, this also means they may still be balancing personal, academic, and professional responsibilities, which could lead to work related stress if support systems are lacking. Kim et al. (2021) point out that younger faculty members often find it difficult to manage teaching and clinical tasks at the same time, especially in the early years of their career. A successful workplace must embrace the varied perspectives and experiences of the 30s-to 40s-years-old age group. This group offers leadership potential, proven abilities, and a healthy mix of young vitality and life experience. Their input improves team dynamics, encouraging creativity and a more welcoming workplace. Investing in this group ensures a sustainable future for the organization.

There are more females in the group, which is consistent with the common pattern in nursing, but it's also worth noting that there are many male and non-binary instructors. This increasing diversity in gender reflects a more inclusive work environment. A teaching group that represents a variety of gender identities can create a more open and respectful atmosphere for both students and patients. As Zamanzadeh et al. (2019) highlighted, having diverse educators contributes to a more supportive and understanding learning space. A workforce of

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nursing clinical instructors with a greater proportion of women and meaningful inclusion of non-binary people is not just a question of demographics; it is an essential part of promoting diversity and inclusion. Students are exposed to a greater variety of viewpoints, experiences, and leadership styles thanks to this diverse composition, which enhances the learning environment and eventually results in a more effective and compassionate nursing profession.

In terms of educational attainment, almost half of the nursing clinical instructors have already completed their master's degrees, while many others are still working toward it. This indicates that most instructors meet the minimum academic qualifications for teaching, as required by the Commission on Higher Education (CHED, 2017), which mandates at least a master's degree for faculty in higher education institutions. The strong presence of graduate level credentials among faculty members helps strengthen nursing education and enhances students' exposure to evidence-based instruction and research-driven practice. In the academic setting, pursuing higher degrees such as a doctorate is not only encouraged but also strategically important for advancing faculty careers, assuming leadership roles, and contributing to the long-term development of nursing programs. However, the data reveal that only a small proportion have reached the doctorate level. This may suggest that instructors face barriers to further education, such as time limitations, workload demands, or financial constraints. Manzano and Abao (2021) emphasized that obtaining a doctoral degree empowers educators to influence curriculum, conduct impactful research, and elevate the overall quality and competitiveness of academic programs.

Nearly half of the respondents have been in the organization for only three years or less. While this shows that new instructors are being hired and integrated into the academic system, it may also suggest issues with turnover or difficulty in retaining faculty members long-term. New hires bring fresh ideas and enthusiasm, but too many new faculty at once can affect continuity and stability in teaching. Abuhammad (2020) emphasized that without proper guidance and mentorship, new instructors may feel overwhelmed by academic responsibilities and less connected to their institutions.

The majority of instructors are full-time, which is beneficial for consistency in teaching, mentoring, and active participation in curriculum development and institutional planning. Full time faculty are generally more accessible to students and are more involved in academic initiatives, ensuring alignment with the school's mission and educational goals. However, a small yet notable portion of the faculty are part time. In the past, part time employment was not commonly accepted in the academe, particularly in nursing education, due to concerns about limited availability and reduced engagement in institutional affairs. However, the current shortage of qualified clinical instructors has led many institutions including those in Cebu City to accommodate part time faculty. Many of these part-time instructors are active hospital nurses or are concurrently teaching in other universities, bringing with them valuable clinical expertise and real-time industry experience. While their dual roles offer practical insights for students, their limited time on campus may affect continuity in student support and involvement in academic planning. Villanueva and Gallo (2020) stressed the importance of having committed full time instructors to ensure the delivery of high-quality nursing education, but in the current context, part-time faculty have become a necessary and strategic complement to meet academic demands and maintain adequate faculty-student ratios.

In general, the profile of the nursing clinical instructors points to a promising and competent workforce. Their age, gender diversity, academic background, and employment status show that they are well-positioned to contribute meaningfully to nursing education. At the same time, the findings highlight the importance of providing ongoing support to newer faculty, encouraging academic growth, and promoting long-term engagement within the institution. These elements are all key in ensuring the continuity and quality of clinical instruction for future nurses.

Level of Diversity and Inclusion Practices among Nursing Clinical Instructors

Table 2 is the presentation of the data on the level of diversity and inclusion Practices among nursing clinical instructors.

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Table 2 Level of Diversity and Inclusion Practices among Nursing Clinical Instructors

Statements	Mean score	SD	Interpretation
Employees from diverse backgrounds are encouraged to apply for higher position	4.54	.784	Very High
In my organization, I feel like I can be successful as my authentic self	4.76	.479	Very High
In my organization, I feel like I belong because I am recognized for my accomplishments, feeling that contribute in team meetings are valued and comfortable with being myself at work	4.78	.469	Very High
I can voice a contrary opinion without fear of negative consequences	4.41	.673	Very High
When I speak up at work, my opinion is valued	4.63	.588	Very High
My organization enables me to balance my work and personal life	4.79	.470	Very High
There is a career development path for all employees in this organization	4.63	.712	Very High
If I have concern about harassment or discrimination, I know where and how to report that concern	4.83	.515	Very High
The organization's policies and procedures discourage discrimination	4.83	.485	Very High
. I believe this organization will take appropriate action in response to incidents of discrimination	4.83	.421	Very High
. Whitin the organization, everyone has access to equal opportunities regardless of their differences.	4.84	.435	Very High
. My supervisors demonstrate commitment and support for diversity	4.05	.729	High
. My supervisors Manges diversity matters appropriately	4.25	.552	Very High
. The organization handles diversity matters appropriately	4.05	.657	High
. The organization has done a good job providing training programs that promote understanding of diversity	4.09	.445	High
. I see strong leadership support for the organization's	4.10	.473	High

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value of diversity and inclusion			
. Our organization is committed to diversity and inclusion	4.03	.472	High
. People from all cultures and backgrounds are respected and valued	4.41	.594	Very High
. I feel included and respected within the organization	4.28	.541	Very High
. I'm comfortable talking about my background, cultural and life experiences within the organization	4.64	.481	Very High
. Employees of diverse backgrounds interact well within our organization	4.12	.432	High
. Management demonstrates a commitment to meeting the needs of employees who need flexible work practices because of caring responsibilities	4.16	.465	High
. Management demonstrates a commitment to meeting the needs of employees with disabilities	4.41	.546	Very High
. The organization provides an environment for an open expression of ideas, opinions and beliefs	4.47	.544	Very High
Grand mean	4.46	.197	Very High

Note: *n=220*.

Legend: A score of 4.21-5.00 is very high (strongly agree); 3.41-4.20 is high (agree); 2.61-3.40 is moderate (neither agree nor disagree); 1.81-2.60 is low (disagree); and 1.0-1.80 is very low (strongly disagree).

The findings show that nursing clinical instructors in Cebu City very high level of diversity and inclusion (D&I) practices are being implemented effectively in their organizations. The overall result reflects a very high level of support for D&I, suggesting that the institutions where they work are promoting fairness, equal opportunity, and respect for all backgrounds. This positive environment is crucial, especially in health education, where inclusiveness influences how instructors relate not only to each other but also to students and the communities they serve.

Instructors feel comfortable being their authentic selves at work and believe they belong in their organization. These are powerful indicators of psychological safety and trust in the workplace. When educators feel they can be themselves without fear of being judged or excluded, they are more likely to engage meaningfully in teaching, mentoring, and collaboration. In clinical settings, this comfort is often seen when instructors openly share their experiences or teach from a culturally responsive perspective. According to Shore et al. (2018), the sense of belonging and authenticity are key components of inclusion that lead to greater job satisfaction and commitment.

Another notable area is the belief that everyone has access to equal opportunities regardless of differences, and that policies discourage discrimination. These responses suggest that instructors see their institutions as just and fair. In practice, this may be reflected in fair hiring and promotion systems, as well as transparent handling of grievances. Many instructors report that colleagues are promoted based on merit rather than favoritism, and that concerns about discrimination if any arise are addressed swiftly. This perception helps maintain trust

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within the academic and clinical workforce. Supporting this, Roberson (2019) emphasized that when employees trust their organizations to act against discrimination, they are more likely to be loyal and productive.

The highest-rated items involve clarity on how to report discrimination and confidence that actions will be taken. This points to the presence of strong institutional systems to handle harassment or misconduct. These systems provide a safety net for instructors, allowing them to focus on their teaching without fear of being mistreated due to their gender, background, or beliefs. Real-world experience in Cebu City institutions suggests that schools are becoming more responsive to issues involving gender sensitivity and cultural awareness topics that were once overlooked but are now part of faculty orientations and HR trainings.

However, while most indicators are very high, some items particularly those involving visible leadership support and training programs scored slightly lower, though still high. Instructors agree, rather than strongly agree, that management provides enough training and visibly demonstrates commitment to diversity. This may reflect gaps in formal D&I education or occasional inconsistencies in how leaders handle diversity-related concerns. Some instructors have noted that while they feel respected, structured diversity programs or workshops are not held regularly. Kim and Holley (2020) argued that without ongoing training, diversity efforts risk becoming symbolic rather than transformative. This suggests that lived experiences of inclusion may be more dependent on interpersonal dynamics than on formal institutional efforts.

Another area that scored slightly lower is the perception of diversity management by supervisors and leadership. Although instructors agree that supervisors manage diversity appropriately, it appears that there may be room for more visible involvement or clearer messaging from the top. In some settings, instructors shared that while they feel respected, discussions on inclusion are not always explicitly encouraged during department meetings or policy reviews. Literature by Thomas et al. (2021) emphasized that leadership visibility and involvement are essential for sustaining a culture of inclusion.

Despite these small variations, instructors strongly agree that their opinions are valued, they can voice concerns without fear, and their backgrounds are respected. These responses reflect an environment of mutual respect and open communication, which are essential in the culturally diverse Philippine context. In real situations, this is often seen when instructors discuss personal stories or local health beliefs during lectures, and their perspectives are welcomed rather than dismissed. This mirrors findings from Oducado and Estoque (2022), who found that inclusive academic environments improve faculty engagement and enrich classroom discussions.

The strong agreement that employees of diverse backgrounds interact well and support flexible work practices, including accommodations for disability and caregiving, shows that inclusivity is not only a value but also part of daily operations. Clinical instructors often work with colleagues from various provinces, cultural groups, and life situations. The ability to adjust work schedules or tasks for those with special needs or family duties demonstrates a culture that is both compassionate and inclusive.

Overall, the results paint a picture of a supportive, respectful, and inclusive academic environment where clinical instructors feel safe, valued, and empowered. This inclusive climate enhances their ability to teach effectively and collaborate with others, while also serving as a strong model for the nursing students they mentor. In the field of nursing education, where compassion and equity are central values, such a culture not only supports faculty well-being but also prepares future nurses to practice with respect for all people. One outstanding illustration of a strong commitment to diversity and inclusion is the workforce of nursing clinical instructors in Cebu City. This commitment is not just a policy declaration; rather, it is a deeply ingrained practice that is represented in the makeup of the faculty and the educational strategies used. Nursing students benefit from a dynamic and stimulating learning environment since clinical instructors are highly represented in terms of gender, age, and background.

A more nuanced and thorough understanding of patient care within the particular context of Cebu is fostered by this variety, which goes beyond simple demographics and encompasses a wide range of experiences, perspectives, and cultural backgrounds. The inclusive practices extend beyond representation, encompassing

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equitable opportunities for professional development, mentorship, and leadership roles for all instructors, regardless of their background. This commitment to equity translates into a curriculum that is sensitive to the diverse needs and experiences of patients, promoting culturally competent and holistic nursing care. The resulting educational environment is not only more representative of the population served but also demonstrably more effective in preparing future nurses to provide high-quality, compassionate care to the diverse communities of Cebu City and beyond. The dedication to diversity and inclusion within the clinical instructor ranks serves as a powerful model for other healthcare institutions, highlighting the significant benefits of prioritizing equitable representation and inclusive practices in nursing education. This commitment strengthens the nursing profession as a whole, ensuring a workforce that is both highly skilled and deeply empathetic to the diverse needs of the patients they serve.

Level of Self-efficacy among Nursing Clinical Instructors

Table 3 is the presentation of the data on the level of self- efficacy among nursing clinical instructors in terms of efficacy to influence decision making, efficacy to influence school resources, instructional efficacy, disciplinary efficacy, efficacy to enlist parental involvement, efficacy to enlist community involvement, and efficacy to create positive school climate.

Table 3 Level of Self-efficacy among Nursing Clinical Instructors

Dimensions	Mean Score	SD	Interpretation
Efficacy to Influence Decision Making			
How much can you influence the decisions that are made in the school?	4.10	.652	High
How much can you express your views freely on important school matters?	4.25	.646	Very high
Factor mean	4.17	.492	High
Efficacy to Influence School Resources			
How much can you do to get the instructional material and equipment you need?	4.27	.686	Very high
Factor mean	4.27	.686	Very high
Instructional Self-efficacy			
How much can you do to influence the class sizes in your school?	4.65	.690	Very high
How much can you do to get through to the most difficult student?	4.75	.520	Very high
How much can you do to promote learning when there is lack of support from the home?	4.75	.520	Very high
How much can you do to keep students on task on difficult assignments?	4.75	.520	Very high

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How much can you do to increase students' memory of what they have been taught in previous lessons?	4.75	.520	Very high
How much can you do to motivate students who show low interest in schoolwork?	4.71	.528	Very high
How much can you do to get students to work together?	4.71	.528	Very high
How much can you do to overcome the influence of adverse community condition on students' learning?	4.71	.528	Very high
How much can you do to get children to do their homework?	4.71	.528	Very high
Factor mean	4.72	.396	Very high
Disciplinary Self-efficacy			
How much can you do to get children to follow classroom rules?	5.00	.000	Very high
How much can you do to control disruptive behavior in the classroom?	5.00	.000	Very high
How much can you do to prevent problem behavior on the school grounds?	5.00	.000	Very high
Factor mean	5.00	.000	Very high
Efficacy to Enlist Parental Involvement			
How much can you do to get parents to become involved in school activities?	3.84	.890	High
How much can you assist parents in helping their children do well in school?	4.25	.646	Very high
How much can you do to make parents feel comfortable coming to school?	3.84	.890	High
Factor mean	3.98	.642	High
Efficacy to Enlist Community Involvement			
How much can you do to get community groups involved in working with the school?	4.75	.520	Very high
How much can you do to get churches involved in working with the school?	5.00	.000	Very high
How much can you do to get business involved in working with the school?	4.75	.520	Very high

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How much can you do to get local colleges and universities involved in working with the school?	4.75	.562	Very high
Factor mean	4.81	.298	Very high
Efficacy to Create a positive School Climate			
How much can you do to make the school a safe place?	4.71	.528	Very high
How much can you do to make students enjoy coming to school?	4.71	.528	Very high
How much can you do to get students to trust teachers?	4.71	.528	Very high
How much can you help other teachers with their teaching skills?	4.79	.470	Very high
How much can you do to enhance collaboration between teachers and the administration to make the school run effectively?	4.71	.528	Very high
How much can you do to reduce school dropout?	4.79	.470	Very high
How much can you do to reduce school absenteeism?	4.71	.528	Very high
How much can you do to get students to believe they can do well in schoolwork?	5.00	.000	Very high
Factor mean	4.74	.394	Very high
Grand mean	4.53	.213	Very high

Note: *n=220*.

Legend: A score of 4.21 - 5.00 is very high (a great deal); 3.41 – 4.20 is high (quite a bit); 2.61 – 3.40 is fair (some influence); 1.81 – 2.60 is low (very little); and 1.00 – 1.80 is very low (nothing).

The overall findings show that nursing clinical instructors in Cebu City have very high level of self-efficacy, with the strongest beliefs in their ability to manage student behavior, lead instruction, involve the community, and maintain a positive school climate. This reflects a confident and competent group of educators who feel highly capable in fulfilling their roles not just in teaching but in shaping the broader learning environment. In day-to-day hospital-based teaching, this level of confidence is often evident when clinical instructors take initiative during patient rounds, confidently handle students' questions in fast-paced environments, and act decisively during emergencies all signs of strong self-belief in their professional capacity.

Their disciplinary efficacy is perfect across all indicators, showing that these instructors are fully confident in managing classroom and clinical discipline. This is likely shaped by their direct, daily engagement with nursing students in both academic and clinical settings where order, focus, and safety are critical. In real hospital rotations, clinical instructors are often seen stepping in quickly when protocols are not followed or When patient safety is in danger, they follow practices that show the control they think they have. According to Bandura's theory, such mastery experiences enhance self-efficacy (Bandura, 1997), and this appears to be evident here. Supporting this, Jiang et al. (2022) found that high disciplinary self-efficacy among nurse educators leads to better clinical supervision and fewer student-related incidents.

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Instructional self-efficacy is also very high. Instructors believe strongly in their ability to teach effectively even to disengaged students or those with challenging home or community situations. This is supported by their confidence in motivating learners and adapting lessons despite external barriers. Many clinical instructors report working with students who arrive underprepared or distracted by personal challenges, yet manage to keep them engaged through storytelling, real-life patient cases, or motivational talks. This ability to adjust teaching strategies reinforces the findings. Similarly, a study by Reyes et al. (2020) showed that nursing faculty with high teaching self-efficacy were more likely to use active teaching strategies and student-centered approaches in clinical instruction.

When it comes to accessing school resources, instructors also show strong belief in their ability to secure necessary materials. In practice, this may involve coordinating with hospital staff for training equipment or negotiating for the use of simulation labs. Such confidence in resource acquisition suggests instructors are not passive recipients but active participants in the educational process. This aligns with the findings of Kim and Lim (2021), who noted that nurse educators with high resource-efficacy were more proactive in ensuring learning environments were adequately equipped.

The results also show high confidence in influencing school decisions. Clinical instructors seem to feel that their voices are heard in institutional matters. This may stem from their involvement in curriculum planning, faculty meetings, or program evaluation committees. In many nursing schools, particularly in Cebu, clinical instructors also serve as coordinators, research advisers, or policy reviewer's roles that allow them to share ideas and shape program directions. When educators feel they are part of the decision-making process, they tend to be more committed and aligned with the institution's goals, as supported by Lorenzo et al. (2021).

On the other hand, the only area that didn't reach a "very high" rating is parental involvement. Clinical instructors feel slightly less confident in getting parents to participate in school-related activities. This may reflect the reality that, at the college level, parental engagement is naturally lower, and cultural norms in the Philippines may discourage active parental presence in tertiary education. Instructors often report that most students manage their academic responsibilities independently, with limited parental interference. As such, instructors might feel that engaging parents is beyond their usual scope. Yet, their belief in helping parents support their children's education still remains strong. This matches the findings of Oducado et al. (2021), who noted that while nursing faculty in higher education rarely engage directly with parents, they still influence family-centered learning indirectly through guidance given to students.

In contrast, instructors show very high confidence in involving community sectors, such as churches, businesses, and colleges. This is often reflected in community outreach, health missions, and partnerships for practicum. Many clinical instructors in Cebu regularly organize public health activities in barangays and involve local institutions for collaborative events. These actions suggest that instructors not only see the value of community partnerships but also believe in their ability to establish and sustain them.

Finally, their confidence in promoting a positive school climate is also very high. Instructors believe they contribute to making the school a safe, enjoyable, and motivating place for students. This sense of agency may be linked to their daily interactions with learners, their efforts to build rapport, and their participation in activities that boost morale, such as student-led programs or peer mentoring. The belief that they can reduce absenteeism, support teacher collaboration, and prevent dropouts indicates a deeper commitment beyond teaching it reflects their role as mentors and role models. In practice, this shows up when instructors go the extra mile to check on students' well-being, adjust their schedules to accommodate struggling learners, or offer career advice. According to Santos and Ramel (2020), nursing faculty who actively foster a positive academic environment contribute to lower stress levels and better student retention.

Altogether, the findings reveal a faculty group that is not only knowledgeable but deeply engaged in multiple aspects of student growth, school development, and community partnership. Their high self-efficacy supports their willingness to take on these roles, and their daily actions in hospital and school settings show how these beliefs translate into practice. The nursing clinical instructors in Cebu City exhibit exceptionally high levels of self-efficacy, a characteristic that significantly enhances their teaching effectiveness and contributes to the overall quality of nursing education in the region. This high self-efficacy isn't merely a matter of confidence;

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it's a demonstrable belief in their capabilities to successfully perform their roles as educators, mentors, and role models. This confidence is rooted in a combination of factors, including extensive experience in clinical practice, ongoing professional development, and a supportive institutional environment that values their expertise and contributions. The instructors' strong self-efficacy translates into a number of observable positive outcomes. For example, their proactive development and implementation of innovative teaching strategies, such as simulation-based learning, showcase their belief in their ability to continuously improve student outcomes. They are more likely to set challenging yet achievable goals for their students, providing effective guidance and support throughout the learning process. Their belief in their abilities fosters a positive and encouraging classroom atmosphere, empowering students to overcome challenges and develop their own confidence. Furthermore, instructors with high self-efficacy are more likely to adapt their teaching methods to meet the diverse learning styles and needs of their students, ensuring a more inclusive and effective learning experience. This dedication to continuous improvement and adaptation reflects a proactive approach to professional growth, further strengthening their self-efficacy and enhancing their ability to prepare competent and compassionate nurses for the future. The high levels of self-efficacy among Cebu City's nursing clinical instructors are a significant asset, contributing to the overall excellence of nursing education and the development of a highly skilled and confident nursing workforce. This positive attribute ripples outwards, impacting not only the students under their tutelage but also the wider healthcare community they serve.

Relationship between Profile and the Level of Diversity and Inclusion Practices

Table 4 is the presentation of the data on the significant relationship between profile and level of diversity and inclusion.

Table 4 Relationship between Profile and the Level of Diversity and Inclusion Practices

Personal characteristics vs. Digital Health Literacy	chi value	*p* value	Cramer's V value	Decision	Interpretation
Age	1.424E2	.272	--	Failed to reject Ho	Not significant
Gender	48.793	.113	--	Failed to reject Ho	Not significant
Highest educational attainment	75.585	.492	--	Failed to reject Ho	Not significant
Years in the organization	83.150	.014	.355	Reject Ho	Significant
Employment status	22.735	.249	--	Failed to reject Ho	Not significant

Legend: Significant if *p* value is < .05. Dependent variable: Level of Diversity and Inclusion Practices. Cramer's V values: A value of >0.25 is very strong, >0.15 is strong, >0.10 is moderate, >0.05 is weak, and >0 is no association.

The analysis explored whether the profile of nursing clinical instructors such as age, gender, educational attainment, years in the organization, and employment status has a significant relationship with how they experience diversity and inclusion (D&I) practices in their workplace.

Among the five profile characteristics, only years in the organization showed a significant relationship with how instructors perceive diversity and inclusion (D&I) practices. This indicates that the length of service within the institution influences how included, supported, and engaged instructors feel regarding diversity-related efforts. Specifically, those who have stayed longer may have had greater opportunities to participate in inclusive initiatives, observe institutional shifts in policy and practice, and form meaningful professional relationships that reinforce a sense of belonging.

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The longer instructors remain in an organization, the deeper their understanding becomes of the institution's culture, values, and diversity dynamics. Through continued exposure and engagement, they develop a more comprehensive perspective on inclusivity not just as a policy but as a lived experience. Furthermore, interacting with different cohorts of students and new colleagues each year enhances cultural sensitivity and openness. This evolving exposure allows instructors to encounter a variety of backgrounds, perspectives, and needs, thereby strengthening their capacity to be inclusive. Over time, inclusivity becomes more internalized, making long-serving faculty not only more aware but also more effective in applying inclusive principles in both instruction and professional relationships.

In actual practice, longer-serving instructors often speak about how the culture of respect, openness, and fairness has evolved within their schools. They may recall earlier years when inclusion efforts were less visible and contrast them with present practices that are now more structured or openly discussed. Newer instructors, on the other hand, might still be adjusting, or may not yet have had the opportunity to fully engage with diversity-focused events or committees. This is consistent with the idea that inclusion is not only a policy matter, but also a process of social integration, as supported by Shore et al. (2018), who noted that inclusion becomes meaningful when individuals feel consistently valued through their daily work experiences.

Interestingly, there was no significant relationship between D&I practices and other profile characteristics such as age, gender, educational attainment, or employment status. This finding reflects a fairly equal experience of inclusion across different personal backgrounds, suggesting that institutions in Cebu City may be doing well in promoting fair treatment regardless of who the instructor is. In many hospitals and nursing schools in the region, both junior and senior faculty regardless of gender or rank are often given the same platforms for expression, access to opportunities, and participation in school programs. For example, both male and female clinical instructors are assigned leadership roles, and instructors with only a master's degree may still be selected as research advisers or committee chairs. This environment promotes equity in practice, not just in writing.

These findings are encouraging, especially in a country like the Philippines where diversity in terms of culture, gender expression, and academic backgrounds is becoming more visible in the nursing profession. According to Oducado and Estoque (2022), faculty members in inclusive institutions tend to experience higher job satisfaction and feel more empowered to contribute meaningfully. The data suggest that in Cebu City, such inclusiveness is being felt regardless of age or gender, which is a positive sign of progress.

However, the significant relationship with organizational tenure implies that inclusion is not automatic. It takes time to feel truly connected, valued, and integrated. This also means that institutions may need to maintain efforts in building inclusive relationships and systems that support both new and long-term instructors. As Thomas et al. (2021) explained, sustainable diversity practices involve not just policies, but day-to-day interactions, relationship-building, and a shared commitment to fairness.

The instructors' perceptions of diversity and inclusion are largely consistent across different backgrounds, which shows that schools are fostering fair environments. But the fact that perceptions strengthen over time reflects the importance of lived experience, long-term engagement, and relational trust within the institution. This highlights the role of community, continuity, and support in shaping an inclusive academic culture that benefits both faculty and students.

Relationship between Profile and the Level of Self-efficacy

Table 5 is the presentation of the data on the significant relationship between profile and level of self- efficacy.

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Table 5 Relationship between Profile and the Level of Self-efficacy

Personal characteristics vs. Digital Health Literacy	chi value	*p* value	Cramer's V value	Decision	Interpretation
Age	4.078E2	.870	--	Failed to reject Ho	Not significant
Gender	1.273E2	.451	--	Failed to reject Ho	Not significant
Highest educational attainment	2.854E2	.073	--	Failed to reject Ho	Not significant
Years in the organization	1.605E2	.935	--	Failed to reject Ho	Not significant
Employment status	47.364	.929	--	Failed to reject Ho	Not significant

Legend: Significant if *p* value is < .05. Dependent variable: Level of Self-efficacy. Cramer's V values: A value of >0.25 is very strong, >0.15 is strong, >0.10 is moderate, >0.05 is weak, and >0 is no association.

The data show that there is no significant relationship between the profile of the nursing clinical instructors such as their age, gender, educational attainment, length of service, or employment status and their level of self-efficacy. This suggests that regardless of background or work history, instructors in Cebu City generally report similarly high levels of self-belief in their ability to teach, manage students, influence learning, and contribute to school and clinical environments.

This result reflects a culture of competence and confidence that seems to be consistent across the faculty, regardless of demographic differences. It shows that self-efficacy among nursing clinical instructors is likely being shaped more by shared professional experiences, workplace support, and the nature of the role itself, rather than by personal characteristics. In everyday practice, instructors whether new or seasoned, male or female, full-time or part-time are all exposed to the same demanding clinical environments where they must guide students, handle patient scenarios, and deliver immediate feedback. These repeated experiences help strengthen professional confidence across the board.

One key observation from clinical instructors in Cebu is that confidence is often built through immersion. Even younger or newer faculty, once assigned to real clinical settings with students, quickly develop the necessary confidence because of the hands-on nature of the role and the support they receive from peers and department heads. This aligns with Bandura's (1997) theory that self-efficacy is largely shaped by mastery experiences and the successful handling of real-world tasks.

The finding that self-efficacy is not dependent on educational attainment is also meaningful. While it is common to assume that those with advanced degrees may feel more confident, in this setting, instructors with bachelor's or master's degrees reported similar levels of self-efficacy. This suggests that in the field of nursing education especially clinical instruction practical experience, mentorship, and institutional culture may matter just as much, if not more, than formal academic achievement when it comes to feeling capable. Reyes et al. (2020) found that clinical teachers' self-efficacy is highly influenced by professional collaboration and exposure to challenging teaching scenarios, not just credentials.

The lack of difference based on years in the organization indicates that even relatively new instructors already feel equipped and empowered to fulfill their roles. In many schools in Cebu, it is common for newly hired instructors to immediately join team-teaching setups, preceptorships, or simulation labs, giving them active roles right away. This early engagement may explain why even those with limited tenure already feel highly confident. As supported by Kim et al. (2021), active integration and involvement from the beginning can help instructors internalize their role and build self-efficacy quickly.

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The absence of a significant relationship with gender also reflects a positive work culture where both male and female instructors, as well as non-binary individuals, feel equally capable and supported. This suggests a teaching environment where respect for ability is more emphasized than gender identity something that faculty in Cebu have noted in informal interviews, where performance and initiative are valued more than personal background.

Overall, the results suggest that self-efficacy among nursing clinical instructors in Cebu is widespread and evenly distributed, shaped more by professional exposure and institutional support than by personal characteristics. This shared confidence supports a strong instructional culture that benefits students, strengthens clinical training, and ensures consistency in the quality of education delivered, regardless of who is leading the instruction.

Relationship between Level of Diversity and Inclusion Practices and Level of Self-efficacy

Table 6 is the presentation of the data on the significant relationship between level of diversity and inclusion and level of self -efficacy.

Table 6 Relationship between Level of Diversity and Inclusion Practices and Level of Self-efficacy

Variables	r value	*p* value	Decision	Interpretation
Level of Diversity and Inclusion Practices vs. Level of Self-efficacy	.155	.021	Reject Ho	Significant

Legend: Significant if *p* value is < .05. Dependent variable: Level of Self-efficacy. 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 analysis shows a significant positive relationship between diversity and inclusion (D&I) practices and the level of self-efficacy among nursing clinical instructors. Although the correlation is weak in statistical strength, the presence of a significant link suggests that instructors who experience higher levels of D&I in their institutions also tend to feel more confident in their professional roles.

This relationship reflects how a supportive and inclusive work environment can reinforce one's belief in their own capabilities. In daily practice, instructors who feel accepted, respected, and valued regardless of background are more likely to express themselves freely, take initiative, and feel secure in managing students and clinical challenges. Many instructors in Cebu have observed that when they are encouraged to bring their unique perspectives to teaching whether from their cultural identity, previous clinical experiences, or teaching style they tend to perform better and feel more effective.

Self-efficacy is not formed in isolation; it grows in environments where people feel empowered. According to Bandura's (1997) social cognitive theory, self-efficacy develops through mastery experiences, social modeling, and positive feedback. In inclusive institutions, instructors are more likely to be given opportunities to lead, speak up in meetings, or contribute to new programs all of which build confidence. This dynamic is supported by recent studies, such as Shore et al. (2018), which highlight how inclusive workplaces foster psychological safety and trust, which are key to improving performance and belief in one's own abilities.

Clinical instructors who feel that their background, identity, or opinions are respected are also more likely to experiment with new teaching strategies, lead community outreach programs, or handle complex student situations with greater assurance. In contrast, instructors who feel marginalized may hesitate to speak up, make suggestions, or assert authority reducing their sense of self-efficacy even if they have the knowledge and skills.

In Cebu-based institutions, instructors who say they feel a strong sense of belonging are often more vocal during faculty discussions and take active roles in student mentoring or hospital coordination. They are also

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more likely to serve as resource speakers or research advisers, further boosting their professional identity. As noted by Roberson (2019), employees who perceive inclusion at work tend to be more engaged and confident in decision-making.

The significance of this relationship, even with a weak r value, suggests that even small improvements in inclusion practices can influence how instructors see themselves professionally. This is particularly relevant in nursing education, where instructors serve as role models. When instructors feel confident, their teaching becomes more intentional, their guidance more consistent, and their presence more influential in both the classroom and clinical area.

The data confirm that an inclusive academic environment contributes positively to clinical instructors' self-efficacy. The sense of being heard, respected, and supported especially in a diverse setting like Cebu has meaningful effects on how capable instructors feel in fulfilling their educational and clinical roles. This highlights the importance of maintaining inclusive systems that not only promote diversity on paper but translate it into everyday positive experiences for faculty.

Challenges on the Implementation of Diversity and Inclusion Practices

Table 7 is the presentation of the data on the challenges in the implementation of diversity and inclusion practices.

Table 7 Challenges on the Implementation of Diversity and Inclusion Practices

Challenges	*f*	%	Rank
Simulated clinical settings and learning materials accessible to student with disabilities are inadequate.	148	67.27	1
There are no ongoing training on recognizing and preventing bias for instructors,	132	60.00	9
Reasonable accommodation provided for student with disabilities is limited.	132	60.00	9
Clinical instructors receive training to provide effective instruction to students with diverse learning needs but under limited opportunities.	132	60.00	9
Assistive technologies and other support services are inadequate.	132	60.00	9
Free mentorship programs to support diverse student and instructors are not available.	132	60.00	9
There is no system for providing emotional and practical support to student facing challenges related to diversity and inclusion.	132	60.00	9
There are ways for students and instructors to report concerns related to diversity and inclusion, but confidentiality may be breached.	132	60.00	9
Assessment methods may not always be fair and equitable for all students, regardless of their backgrounds.	126	57.27	12

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Assessment result are not for potential bias.	126	57.27	12
There is a lack of culturally sensitive evaluation tools used.	105	47.73	17
There is scarcity of professional development which are focused on cultural humility and sensitivity.	80	36.36	21
There are insufficient methods for assessing cultural competency of clinical instructors.	78	35.45	22
Clinical instructors do not receive adequate training in cultural competence and health equity.	69	31.36	27
Resources to help in instructors understand and respond to the needs of diverse student population are inadequate.	69	31.36	27
There are no peer support groups or networks for diverse instructors and students.	53	24.09	28

The table presents several challenges that clinical instructors in Cebu City encounter in implementing diversity and inclusion (D&I) practices within their institutions. The most frequently reported issue is the accessibility of clinical settings and learning materials for students with disabilities, which indicates a growing awareness that physical and educational environments must accommodate all learners. Instructors have observed that while hospitals may have ramps or elevators, actual clinical tools and written materials are not always accessible for example, printed content may lack large-text versions, or some simulation equipment may not be adaptable for learners with mobility issues. This gap limits equitable learning experiences for all students, especially those with special needs.

Another widely recognized challenge relates to the provision of reasonable accommodations and support services, such as assistive technologies and mental health systems, especially for diverse learners and instructors. In practice, some instructors shared that while students with visible disabilities are accommodated, those with less obvious challenges such as learning disabilities, chronic illnesses, or language barriers often go unsupported due to the absence of formal systems. These real-life accounts reflect what Thomas et al. (2021) emphasized: inclusive institutions must go beyond physical access and adopt a broader understanding of equity, including emotional and academic support.

Several respondents noted difficulties in ensuring instructors are trained to address diverse learning needs, particularly in adapting instruction for different learning styles and cultural backgrounds. In day-to-day teaching, this can show up when students from rural areas struggle with English-based instruction or when instructors use examples that may not resonate with the student population. The lack of ongoing training in cultural competence and health equity suggests that while diversity is acknowledged, deeper engagement with these topics may still be lacking. This aligns with findings by Kim and Holley (2020), who stressed the importance of regular professional development in diversity awareness, particularly for faculty working in multicultural environments like the Philippines.

Many instructors also indicated that while mechanisms for reporting discrimination or bias exist, policies alone are not enough. There seems to be uncertainty about whether these systems are confidential or effective in resolving concerns. Instructors have shared that while the school may have anti-discrimination policies in place, few people use them, possibly due to fear of backlash or lack of clarity in procedures. These concerns highlight the need for a more transparent and trust-based system for raising issues a concern supported by Shore et al. (2018), who emphasized the role of psychological safety in sustaining inclusion.

The data also point out that diverse representation in faculty recruitment and curriculum development remains limited. Instructors often mentioned that while the student population is quite diverse culturally and socioeconomically this diversity isn't always reflected in the curriculum or faculty lineup. For example,

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clinical case examples used in lectures may not represent rural communities or indigenous health practices, even though many students and patients come from such settings. This gap can leave students feeling disconnected from the content. Roberson (2019) notes that truly inclusive education reflects the identities, experiences, and needs of the community it serves.

Additionally, a substantial portion of instructors shared concerns about the lack of mentorship and peer support structures for both students and faculty from diverse backgrounds. These systems are critical in helping underrepresented individuals navigate academic and clinical challenges. Without such programs, instructors may feel isolated, and students may miss out on valuable guidance. Some instructors shared that newer faculty especially those from outside the region struggle to integrate without structured peer support. Oducado and Estoque (2022) also emphasized that support networks enhance retention and satisfaction for both faculty and students.

Moreover, challenges in creating fair and bias-free assessment methods were reported. While instructors strive to grade fairly, some admit that personal biases conscious or not can influence how student performance is evaluated. The absence of culturally sensitive evaluation tools may contribute to this, as standardized assessments often fail to account for the varied communication styles and values of different student groups. This concern was similarly addressed by Reyes et al. (2020), who argued that assessment tools should be contextualized to promote both academic fairness and inclusivity.

Overall, the data reveal that while diversity and inclusion are clearly valued, there are practical barriers to consistent implementation, especially in areas of accessibility, training, support systems, and representation. The results suggest that inclusion is not just a matter of policy but also of lived experience something shaped by institutional culture, teaching practices, and the availability of concrete support. In the context of Cebu City's nursing schools and clinical settings, these findings reflect the ongoing need to align good intentions with action, ensuring that all instructors and students can thrive in a diverse educational landscape.

DIVERSITY AND INCLUSION PRACTICES ENHANCEMENT PLAN

Rationale

The implementation of diversity and inclusion practices in nursing education is essential to fostering a safe, equitable, and effective learning environment for both instructors and students. While the current study revealed a very high level of perceived D&I practices among nursing clinical instructors in Cebu City, it also identified gaps that need to be addressed to ensure these practices are fully implemented. Specific challenges included underrepresentation of minority groups, limited cultural competence training, and inadequate support systems for diverse learning needs. By enhancing D&I practices, nursing institutions can promote faculty well-being, strengthen inclusivity in teaching, and better prepare future nurses to care for diverse patient populations. The enhancement plan aims to strengthen institutional systems, foster inclusive faculty development, and ensure all instructors feel empowered and valued.

General Objective

To enhance the implementation and sustainability of inclusive, equitable, and culturally responsive practices among nursing clinical instructors in Cebu City.

Specific Objectives

- To increase institutional responsiveness to underrepresentation and support systems for minority groups;
- To strengthen training and professional development focused on diversity, equity, and inclusion;
- To improve accessibility and culturally responsive teaching tools and learning environments;
- To promote faculty empowerment and peer support through inclusive leadership and engagement structures;

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- To implement systematic and bias-aware evaluation methods for both students and instructors.

Areas of Concern	Specific Objectives	Activities	Persons Responsible	Resources Needed	Time Frame	Success Indicators
Underrepresentation and lack of diverse faculty support	To increase institutional responsiveness to underrepresentation and support systems	• Conduct diversity audits of faculty profile • Launch mentorship programs for underrepresented groups • Partner with minority-serving institutions for recruitment	Nursing Dean, HR, Department Chairs	Audit tools, MOUs with institutions, mentorship framework	Q1 2025	Completed audit reports Launched mentorship program Recruitment MOUs
Lack of D&I-focused professional development	To strengthen faculty training on cultural competence, equity, and inclusion	• Organize quarterly webinars/seminars on DEI topics • Facilitate case discussions on culturally diverse scenarios • Require participation in DEI continuing education	Faculty Development office, Nursing Dept	Speaker honoraria, online platforms, training materials	Q1–Q4 2025	Attendance sheets, post-training evaluations, DEI CPD certificates
Accessibility and cultural responsiveness of materials	To improve accessibility and responsiveness of teaching tools and learning environments	• Review and revise syllabi and clinical materials to reflect cultural diversity • Provide assistive technologies for instructors and students • Include	Curriculum Committee, IT Dept, Faculty	Content reviewers, editing team, assistive tools budget	Q2–Q4 2025	Updated syllabi Installed support tools Inclusion minutes documentation

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		disability inclusion in curriculum development meetings				
Limited support systems and peer networks	To promote faculty empowerment and peer support through inclusive structures	• Create peer support groups or affinity circles • Establish D&I committee with faculty representation • Conduct regular listening sessions and feedback surveys	D&I Committee, Department Chairs	Facilitators, committee TOR, feedback tools	Q2–Q4 2025	Formed peer groups Feedback summaries Policy drafts submitted
Unconscious bias and non-standardized evaluations	To implement fair, bias-aware assessment tools	• Conduct training on inclusive assessment and grading practices • Review and standardize evaluation rubrics with cultural sensitivity • Pilot anonymous feedback system from students and peers	Academic Council, Quality Assurance, Faculty Evaluators	Rubric templates, IT support, training resources	Q3–Q4 2025	Revised rubrics Training completion reports Pilot feedback analytics

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ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue VI June 2025

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SUMMARY OF FINDINGS, CONCLUSION, AND RECOMMENDATIONS

This chapter is the presentation of the summary of the findings of the study together with the conclusion and recommendations.

Summary of Findings

Based on the findings of the study, the following revealed:

The study revealed that nursing clinical instructors in Cebu City came from a range of age groups, with most being in their early to mid-career stages. The workforce was predominantly female, though male and non-binary instructors were also represented, reflecting a growing gender diversity in nursing education. Most instructors held a master's degree or were pursuing graduate studies, indicating a strong academic foundation. Many were relatively new to their institutions, with a large number having served for less than four years, and the majority held full-time positions. These findings suggest a young, academically prepared faculty who are actively engaged in clinical teaching.

The level of diversity and inclusion practices was perceived to be very high. Instructors reported feeling respected, included, and valued in their institutions, with policies and workplace culture supporting fairness and equity. They were confident that discrimination was not tolerated and that diverse backgrounds were welcomed. However, there was slightly less agreement in areas such as visible leadership commitment, structured training on diversity, and mentorship opportunities for underrepresented groups, indicating areas that may need more institutional attention.

Nursing clinical instructors also demonstrated very high levels of self-efficacy across all measured areas. They felt particularly confident in managing student behavior, delivering instruction, and fostering a positive learning environment. They also expressed strong beliefs in their ability to engage with community stakeholders and influence institutional decisions. While instructors remained confident in enlisting parental involvement, it was comparatively lower, likely due to the limited interaction between parents and instructors at the college level, which is typical in higher education.

In examining relationships among variables, the study found that years of service had a significant relationship with perceived diversity and inclusion practices suggesting that longer tenure may enhance an instructor's experience of inclusivity. However, no significant relationships were found between other profile characteristics and levels of inclusion or self-efficacy, indicating a generally consistent experience across demographic groups. Importantly, a significant, though weak, positive correlation was observed between diversity and inclusion and self-efficacy. This implies that instructors who feel supported and included in their institutions are more confident in performing their roles. Despite the positive outlook, the study also identified key challenges in D&I implementation, such as limited accessibility for persons with disabilities, lack of culturally inclusive materials, inconsistent training, and insufficient systems for addressing bias highlighting the need for more structured, continuous improvements in fostering inclusive academic environments.

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Conclusion

The findings of the study demonstrate that nursing clinical instructors in Cebu City perceive a very high level of diversity and inclusion practices in their institutions and exhibit a very high degree of self-efficacy in their roles. Regardless of their age, gender, educational attainment, or employment status, instructors consistently expressed strong confidence in managing instruction, engaging students, and contributing to a positive school climate. However, challenges remain in areas such as inclusive curriculum design, support for minority faculty, and accessibility for persons with disabilities. While these issues signal areas for improvement, the overall positive perception of diversity and self-efficacy highlights the strength of institutional efforts to promote inclusive, empowering environments for faculty.

The study affirms both Social Identity Theory and Self-Efficacy Theory. Social Identity Theory, which posits that individuals derive self-worth and a sense of belonging from their group affiliations, is supported by the finding that instructors who feel included and respected in their workplace tend to report higher levels of confidence and engagement. This sense of belonging fosters motivation and strengthens their professional identity as educators. Similarly, Bandura's Self-Efficacy Theory is upheld, as instructors who experience supportive, inclusive environments exhibit higher self-efficacy reflecting Bandura's assertion that positive social experiences and reinforcement contribute to one's belief in their capabilities. .

Recommendations

Based on the findings of the study, the following recommendations are given:

Practice As part of research utilization, a Diversity and Inclusion Practices Enhancement Plan is recommended for integration into the institutional management systems of nursing education programs. This plan should be aligned with the strategic, operational, and faculty development plans of nursing schools to address gaps in cultural competence, inclusive teaching strategies, accessibility, and support systems. Nursing administrators may spearhead the creation of support networks and mentorship structures for instructors from underrepresented backgrounds, and facilitate the adoption of inclusive evaluation practices. This initiative promotes an inclusive academic climate that strengthens the professional identity, satisfaction, and teaching effectiveness of clinical instructors.

Policy. The findings may support the enhancement of institutional policies promoting inclusive faculty development. Nursing school administrators and department heads should review and reinforce policies on recruitment, promotion, and professional development to ensure equity and representation. The development of formal guidelines on inclusive pedagogy, culturally responsive assessments, and bias reporting mechanisms may also be considered. In addition, the institutionalization of routine diversity audits and monitoring tools will help ensure sustained compliance with equity and inclusion goals, in line with national and international standards in higher education.

Education. This study can serve as a useful reference in the instruction of nursing leadership, academic governance, and faculty development courses in the Master of Arts in Nursing major in Nursing Management program. The data offer practical insights on how leadership and organizational culture affect faculty confidence and teaching effectiveness. Furthermore, the study may be integrated into topics related to inclusive education, organizational behavior, and change management in nursing schools. Nursing management students may also benefit from case-based learning activities that simulate real-life diversity management challenges in academic settings.

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Research. To extend the utility of this study, the findings may be disseminated through institutional platforms such as school websites, faculty development forums, or nursing academic conferences. The research may also be submitted for publication in refereed journals focusing on nursing education, faculty development, or diversity studies. Additionally, the study may be presented in local or international congresses focused on higher education, health professions, or inclusive management in the academe.

Suggested future research topics include:

A qualitative inquiry on inclusive leadership and its influence on faculty performance in nursing education institutions; A correlational study on the relationship between cultural competence training and faculty retention in nursing schools; and an evaluative study on the implementation of bias-free assessment tools in clinical nursing education.

ACKNOWLEDGMENTS

The following individuals were a huge help and contribution to the success of this study, and the researcher wants to express his sincere gratitude to them.

To the Research Adviser, Dr. Joan P. Bacarisas for her support, patience, motivation and immense knowledge. Her guidance, standards and directions aided in making these study feasible;

To the thesis panel professor, Dr. Joel B. Serad, Dr. Resty L. Picardo, and Dr. Geronima Emma A. Amores, for their constructive criticisms and corrections needed for the output, insightful comments, suggestions and expertise to help make the study detailed and concise;

To the University of Southern Philippines Foundation- College of Health Sciences, Department of Nursing, to the Dean and the faculty, for the unwavering support and understanding;

To the respondents, for sharing their time, effort and willingness in participating in the research study; and

Lastly, to my family, my mama, my sisters, friends and loved ones for their unending financial, emotional, moral and spiritual support in ensuring the success of my research.

Thank you very much.

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