

Cultural Competence and Clinical Decision-Making among Nurses in the Philippines

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Abstract

This study examined the cultural competence and clinical decision-making of registered nurses in the Philippines and determined whether these variables differed according to demographic characteristics or were significantly related. Guided by Madeleine Leininger's Culture Care Diversity and Universality Theory and the Sunrise Enabler, the study employed a descriptive-correlational design. A total of 382 registered nurses from selected public and private hospitals across Luzon, Visayas, and Mindanao participated through voluntary response sampling. Data were collected using an online questionnaire comprising demographic items, the 20-item Nurse Cultural Competence Scale, and the 24-item Nursing Clinical Decision-Making Instrument. Descriptive statistics, analysis of variance, the Kruskal-Wallis H-test, and Pearson or Spearman correlation analyses were applied as appropriate. The respondents demonstrated moderate levels of cultural knowledge, cultural sensitivity, cultural skills, and clinical decision-making, indicating uncertainty and inconsistent application in practice. Cultural competence varied according to selected demographic factors, particularly age, religion, and ethnicity, while gender generally showed no significant influence. Clinical decision-making was largely consistent across age, gender, and religion, although data collection differed according to ethnicity and years of nursing experience. Cultural competence and clinical decision-making had a negligible and statistically insignificant overall relationship ($r = -0.097$, $p = 0.059$), suggesting that they function as distinct but complementary nursing capabilities. The study concluded that cultural competence primarily strengthens communication, respect, trust, and patient engagement, whereas clinical decision-making remains guided by evidence-based procedures and institutional standards. Continuous scenario-based training, simulation, reflective practice, mentorship, culturally congruent policies, and curriculum integration were recommended. The study supports SDG 3—Good Health and Well-Being, SDG 4—Quality Education, and SDG 10—Reduced Inequalities. Its sustainability impact lies in strengthening equitable patient care, continuing nursing education, culturally responsive institutions, and inclusive healthcare systems.

Keywords: Clinical Decision-Making, Cultural Competence, Culturally Congruent Care, Filipino Nurses, Nursing Education, Patient-Centered Care, Sustainable Healthcare, Transcultural Nursing

1. Introduction

The Philippines has a culturally diverse healthcare environment shaped by its traditions, geography, history, ethnic communities, languages, religions, family structures, and contemporary practices (Rondilla et al., 2021; Seposo, 2019; Soriano, et al., 2019). This diversity creates complex challenges for nurses because cultural beliefs and practices influence patients' perceptions of illness, communication, treatment preferences, health behaviors, and outcomes (Barral et al., 2023). Rubio (2019) identified traditional healing practices, religious beliefs, communication styles, and family dynamics as important cultural considerations that vary across Philippine regions and socio-economic groups. Cultural competence has consequently become essential to equitable and high-quality healthcare (Swihart et al., 2023). It enables nurses to understand patients' cultural perspectives, develop respectful relationships, conduct appropriate assessments, formulate individualized care plans, and address barriers to treatment. Cultural competence may also strengthen clinical judgments by encouraging nurses to consider patients' beliefs, values, and circumstances when making care decisions (Sampiano et al., 2019). However, Philippine studies have largely examined cultural competence levels or their relationships with caring behaviors and other nursing concepts rather than their specific connection with clinical decision-making (Barral et al., 2023; Cruz et al., 2016; Manlangit et al., 2022; Moratillo, 2021; Soriano, et al., 2019). The present study addressed this gap by examining cultural competence, clinical decision-making, demographic influences, and the relationship between these variables among Filipino staff nurses.

Cultural competence refers to the capacity to understand, appreciate, and interact effectively with individuals from different cultural backgrounds. Davis (2020) described it as a continually evolving journey toward competence in diverse cultural situations and contexts. Rather than being limited to awareness of cultural differences, it encompasses the knowledge,

attitudes, sensitivity, and practical skills required to provide respectful and responsive care. It is therefore an essential professional requirement in culturally diverse healthcare systems such as the Philippines (Barral et al., 2023). The concept developed from transcultural nursing and was initially associated with addressing health disparities among minority populations. It has since become a fundamental component of care for all patients (Swihart et al., 2023). Educational institutions have responded by incorporating cultural competence into nursing curricula and offering focused training programs (Antón-Solanas et al., 2021; Kaihlanen et al., 2019). Healthcare organizations have likewise introduced policies, guidelines, and professional development initiatives, recognizing that culturally responsive care requires both individual competence and institutional support. The Philippine context presents distinctive considerations. Its cultural landscape reflects indigenous, Spanish, American, and other historical influences and includes numerous ethnic groups, more than a hundred dialects, and geographically dispersed communities (Cabrera, 2022). Indigenous healing systems and folk medicine also preserve culturally rooted health beliefs and practices (Rondilla et al., 2021). These conditions require nurses to reconcile standardized clinical care with patients' religious, linguistic, familial, and traditional preferences. Internationally, culturally congruent practice has received explicit professional recognition. The American Nurses Association incorporated a Standard of Culturally Congruent Practice into its nursing scope and standards, providing a framework for nurses to serve as culturally competent practitioners, leaders, and role models (Marion et al., 2016). In the Philippines, Board of Nursing Resolution No. 220, series of 2004, recognizes nurses' responsibility to understand the cultural, social, spiritual, physiological, psychological, and ecological dimensions of illness. Nevertheless, cultural preferences may still be overlooked in communication, task delegation, invasive procedures, and gender-sensitive care. These practical concerns establish the need for a more systematic examination of cultural competence and its role in nursing decisions.

Cultural competence is a transcultural nursing concept encompassing knowledge and skills related to cultural values, health beliefs, religion, and human philosophy. Červený et al. (2022) explained that these competencies enable nurses to respond appropriately to culturally diverse patients. Villagran (2022) emphasized that culturally competent care moves beyond stereotypes by developing authentic relationships founded on mutual respect and an understanding of patients as holistic individuals within their sociocultural environments. Cultural competence is not a fixed achievement. Hashish et al. (2020) described it as a lifelong process developed through practice, reflection, experience, and intentional exposure to different cultures. Cicolini et al. (2015) similarly found that competence develops dynamically, with professional experience generally strengthening nurses' cultural capabilities. Education must therefore combine cultural and religious knowledge with practical preparation for cross-cultural communication, assessment, and care. Swihart et al. (2023) supported a holistic approach that recognizes the influence of culture and religion on health beliefs and practices. Antón-Solanas et al. (2021) recommended integrating cultural diversity, health disparities, communication styles, and culturally appropriate interventions into nursing curricula. Professional values such as respect, empathy, and sensitivity provide an ethical foundation for culturally responsive nursing (Poorchangizi et al., 2019). Simulations, case analyses, and role-playing exercises allow nurses to apply these values and practice communication and decision-making in controlled situations. Ilarde et al. (2023) observed that simulation enables participants to manage cross-cultural encounters, receive feedback, and improve their clinical responses. Mentorship and peer learning further allow nurses to exchange experiences and obtain guidance from experienced practitioners (Kaihlanen et al., 2019). Nurses who participated in cultural competence training reported greater awareness and confidence when caring for diverse patients, demonstrating the practical value of sustained education and mentorship. Kaihlanen et al. (2019) found that these interventions can empower nurses to provide more equitable and effective care.

Research on demographic influences on cultural competence remains mixed. Age, experience, gender, marital status, and education may affect competence, but training, cultural exposure, personality, and practical experience appear more influential (Majda et al., 2021; Zeleke et al., 2024; Manlangit et al., 2023; Yusri & Afrida, 2022). Cultural competence is best developed through integrated education, simulations, case-based learning, transcultural experiences, continuing professional development, and supportive institutional policies (Kim et al., 2019; Antón-Solanas et al., 2021; Getha-Taylor et al., 2020). Openness, self-reflection, active listening, and patient collaboration further promote trust, autonomy, treatment participation, and improved outcomes (Stubbe, 2020; Cox, 2022). Although Filipino nurses are often considered culturally sensitive, evidence from Philippine clinical and mental healthcare settings remains limited (Albougami et al., 2019; Rubio, 2019). Cultural competence may strengthen clinical decision-making by helping nurses align care with patients' beliefs, preferences, communication needs, and family expectations (Manlangit et al., 2022). Experience, education, clinical exposure, self-efficacy, and cultural encounters also improve analytical and intuitive judgment (Farčić et al., 2020; Abu Arra et al., 2023; Kaya & Bakir, 2024). Overall, the literature supports educational and institutional strategies that jointly develop cultural competence and clinical decision-making.

Locally, Philippine healthcare serves communities characterized by linguistic, religious, ethnic, geographic, and socio-economic diversity. The country's archipelagic structure and numerous cultural groups create variation in communication patterns, traditional practices, health beliefs, and access to services (Cabrera, 2022). Folk medicine remains part of the cultural heritage of many communities and may influence how patients understand illness and treatment (Rondilla et al.,

2021). At the national level, professional nursing standards recognize the need to consider patients' cultural, social, spiritual, psychological, physiological, and ecological circumstances. Nevertheless, the comparatively limited emphasis on formal cultural competence standards, training, and implementation creates the possibility that patient preferences will be disregarded during communication, procedures, task delegation, and care planning. Globally, culturally congruent nursing has become an established professional expectation, as reflected in international standards designed to prepare nurses as culturally competent clinicians and leaders (Marion et al., 2016). Filipino nurses participate extensively in this international workforce and are generally viewed as culturally responsive practitioners (Albougami et al., 2019). Their education encourages cultural respect and patient advocacy, consistent with the observations of Argyriadis et al. (2022). However, Rubio (2019) noted that international evidence concerning Filipino nurses may not adequately represent their practice within Philippine institutions. This distinction reinforces the importance of nationally grounded research.

The study was anchored in Madeleine Leininger's Culture Care Diversity and Universality Theory, also known as Culture Care Theory. The theory positions culture and care as central to nursing and provides a foundation for examining the beliefs, patterns, and practices that affect the health and well-being of individuals, families, and cultural groups (McFarland & Wehbe-Alamah, 2019). Leininger's Sunrise Enabler presents cultural care as the product of interconnected influences. It begins with an individual's worldview and encompasses environmental context, language, and ethnohistory. These interact with technological; religious, spiritual, and philosophical; kinship and social; cultural value and lifeway; biological; political and legal; economic; and educational factors. The framework guides nurses in assessing cultural phenomena and making culturally relevant care decisions (Salinda et al., 2021). Its structure and culture-care relationships are further detailed by McFarland and Wehbe-Alamah (2019, p. 4). The framework distinguishes generic or folk care, professional care systems, and nursing care. By comparing these systems, nurses can identify both cultural similarities and differences. Care decisions may then involve cultural preservation or maintenance, accommodation or negotiation, and repatterning or restructuring. These approaches are intended to produce culturally congruent care across health, illness, disability, dying, and death. The framework is broad enough to examine healthcare systems while remaining culturally specific to individual patients and communities (McFarland & Wehbe-Alamah, 2019). In the study's conceptual relationship, cultural competence served as the independent variable and clinical decision-making as the dependent variable. Age, gender, religion, ethnicity, and years of experience as a registered nurse were treated as modifying demographic variables.

Although cultural competence is associated with trust, individualized care, and broader consideration of patient circumstances (Sampiano et al., 2019), Philippine research has concentrated mainly on cultural competence among students and professionals or its relationship with caring behaviors and related nursing concepts (Barral et al., 2023; Cruz et al., 2016; Manlangit et al., 2022; Moratillo, 2021; Soriano, et al., 2019). Research directly examining its relationship with clinical decision-making among nurses working in Philippine hospitals remained limited. This gap is important because nursing knowledge and theory must be continually developed and revised in response to contemporary healthcare conditions and technological change (O'Connor et al., 2023). Deering (2024) identified cultural competence as essential to quality care among diverse populations, while previous evidence connected it with decision-making processes (Louw, 2016; Manlangit et al., 2022). Nevertheless, the extent to which cultural competence relates to nurses' data collection, data processing, action planning, implementation, and evaluation in the Philippine context required further investigation. The study therefore assessed nurses' self-perceived cultural knowledge, cultural sensitivity, and cultural skills; examined their clinical decision-making in data collection, data processing, planning action, and implementation and evaluation; determined whether these variables differed according to age, gender, religion, ethnicity, and years of experience; and tested the relationship between cultural competence and clinical decision-making. Its findings were also intended to guide culturally responsive in-service training and institutional improvement.

The study aligns most directly with SDG 3 – Good Health and Well-Being because culturally competent nursing can improve communication, trust, patient participation, individualized planning, treatment adherence, and the overall quality and equity of care. Cultural considerations may also strengthen clinical judgments by ensuring that healthcare decisions account for patient beliefs and preferences (Sampiano et al., 2019). The emphasis on respectful nurse-patient relationships further supports safe and responsive healthcare delivery, as described by Deering (2024). It also supports SDG 4 – Quality Education through its emphasis on culturally responsive nursing curricula, experiential learning, mentorship, simulations, and continuing professional development (Antón-Solanas et al., 2021; Kaihlanen et al., 2019). Phanphairoj (2021) specifically emphasized curriculum design, cultural exposure, faculty preparation, and practical learning as mechanisms for developing cultural competence. The research is relevant to SDG 10 – Reduced Inequalities because equitable healthcare requires nursing care that does not disadvantage patients because of ethnicity, religion, language, geographic origin, or socio-economic circumstances. Cultural congruence promotes respect for patient beliefs, autonomy, and participation, thereby reducing the risk that cultural differences will become barriers to appropriate care. Schim and Doorenbos (2010) linked culturally aligned care with patient autonomy, while accessible communication and shared decision-making can improve informed participation (Tolentino Diaz et al., 2023).

The study contributes to public health sustainability by supporting nursing practices that strengthen trust, treatment participation, and continuity of care among culturally diverse patients. Patient collaboration and accessible care can promote better experiences and outcomes across clinical settings, consistent with the principles discussed by Peate (2024). Its contribution to educational sustainability lies in providing evidence that may inform nursing curricula, simulation activities, mentorship, orientation, and continuing education. Sustained cultural learning is necessary because competence evolves through education, reflection, and clinical experience rather than through one-time instruction. Kim et al. (2019) supported educational programs that integrate theoretical and experiential preparation. The study also advances socio-cultural and community sustainability by recognizing cultural values, religious beliefs, languages, family relationships, and traditional practices as relevant dimensions of healthcare. Respecting these dimensions helps preserve patient dignity and cultural identity while allowing care to remain clinically appropriate. Stubbe (2020) emphasized self-reflection, listening, and partnership as foundations for working effectively across cultural differences. For institutional and governance sustainability, the research can assist nurse managers and healthcare organizations in developing policies, protocols, training programs, and support structures for culturally responsive practice. Getha-Taylor et al. (2020) identified knowledge, skills, attitudes, and behaviors as interconnected dimensions requiring sustained institutional attention, while Alshmemri et al. (2021) emphasized professional support and organizational guidelines. Finally, the study has implications for workforce and socio-economic sustainability. Inclusive healthcare environments may strengthen teamwork, professional engagement, job satisfaction, and staff retention, as reported by Rodriguez (2020) and Osmancevic et al. (2023). Improved adherence, fewer misunderstandings, reduced complications, and more efficient care may also lower avoidable healthcare costs, according to Rubio (2019). Collectively, these contributions position cultural competence as a multidisciplinary element of sustainable, equitable, patient-centered, and institutionally supported nursing practice.

2. Material and methods

2.1 Research Design

A descriptive-correlational design was used to describe the respondents' demographic characteristics and self-assessed cultural competence and clinical decision-making. It also examined differences in these variables according to demographic characteristics and determined their relationship. Descriptive-correlational research describes the characteristics of a population and assesses relationships between variables without establishing causality (Wilson et al., 2021). A similar design was used by Manlangit et al. (2022) to examine cultural competence and decision-making among nurse leaders, although the study focused on general rather than clinical decision-making. Other Philippine studies investigated cultural competence in relation to caring behaviors, spiritual competence, instrument validation, nursing education, and mental healthcare (Soriano et al. (2019); Soriano (2021); Moratillo (2021); Cruz (2016); Rubio (2019)). However, these studies did not directly examine its relationship with clinical decision-making. Geographic recruitment and clear demographic classification were used to strengthen the representativeness of the findings.

2.2 Locale of the Study

The study involved selected public and private hospitals across Luzon, Visayas, and Mindanao. Including the three major island groups provided broader geographic representation of Filipino nurses. Recruitment was also conducted through participating hospitals and nursing social network groups and associations, including Philippine Registered Nurses, Registered Nurse in the Philippines, Nurses of the Philippines, and Registered Filipino Nurses.

2.3 Respondents of the Study

The population consisted of registered Filipino nurses employed in public or private hospitals. According to the Professional Regulation Commission (2023), nearly one million nurses were registered in the Philippines, although only 53.55 percent, or 509,297, were professionally active. Eligible respondents were registered nurses currently employed in Philippine hospitals who voluntarily provided informed consent. Nursing students, nursing assistants, volunteer nurses, and trainees were excluded. A total of 382 nurses completed the survey.

2.4 Sample and Sampling Procedure

The initial required sample of 377 was determined using the Raosoft Sample Size Calculator (© 2024), based on a population of 20,000, a 95 percent confidence level, and a 5 percent margin of error. The final sample was increased to 382 to compensate for possible incomplete responses. Voluntary response sampling was used because the respondents were geographically dispersed and participation depended on accessibility, time, and willingness to join the study (Doebel & Frank, 2023). This method was also suitable for gathering sufficient data to examine patterns and relationships among the variables (Makwana et al., 2023). The possibility of self-selection bias was considered when interpreting the results.

2.5 Research Instrument

Data were collected through a 44-item self-administered online questionnaire, completed in approximately 15–20 minutes. It included demographic questions on age, gender, religion, ethnicity, and years of nursing experience. Cultural competence was measured using the 20-item Nurse Cultural Competence Scale by Perng and Watson (2012), covering cultural knowledge, sensitivity, and skills. Responses used a five-point scale, with higher scores indicating greater competence. The original and Filipino versions demonstrated excellent reliability, with Cronbach's alpha values of 0.96 and 0.986, respectively (Soriano, 2021). Clinical decision-making was assessed using the 24-item Nursing Clinical Decision-Making Instrument by Lauri and Salantera (2002). It measured data collection, data processing, planning, implementation, and evaluation. Responses used a five-point scale, with odd-numbered items reverse-scored. Scores indicated intuitive, flexible, or analytical decision-making. The instrument showed good reliability, with a Cronbach's alpha of 0.863 (Björk & Hamilton, 2011), and reflected nurses' use of analytical and intuitive approaches across clinical settings (Kosicka et al., 2019).

2.6 Data Gathering Procedure

Approval was obtained from the Philippine Christian University Ethics Review Board, followed by permission from participating hospitals, nursing service departments, and administrators of nursing organizations and social media groups. Letters explaining the study's objectives, procedures, significance, and participant protections were distributed to the concerned institutions and administrators. Electronic posters containing QR codes and survey links were circulated through email, direct messages, hospital bulletin boards, and nursing social media pages. The links directed respondents to the informed consent form and questionnaire in Google Forms, while responses were recorded through Google Sheets. Participants were instructed to read each item carefully, answer honestly, remain objective, and omit questions that were unclear or inapplicable. They were informed of how the data would be used and were assured that their privacy and confidentiality would be protected. After collection, the data were analyzed and interpreted, and the findings were used to formulate conclusions and recommendations.

2.7 Data Analysis Techniques

Frequencies, percentages, means, and standard deviations were used to describe the respondents' demographic characteristics. Weighted means were used to determine their self-assessed levels of cultural competence and clinical decision-making. One-way Analysis of Variance was used to test differences in cultural competence and clinical decision-making according to demographic characteristics. When the assumptions for parametric analysis were not satisfied, the Kruskal-Wallis H-test was applied. The Pearson Product-Moment Correlation Coefficient was used to examine the relationship between cultural competence and clinical decision-making. Spearman's Rank Correlation Coefficient was used when the data did not meet normality assumptions. Correlation coefficients were interpreted from negligible to very high relationships following Ahammad (n.d.) as cited by Jaadi (2019). IBM SPSS Statistics for Windows, Version 25, was used for normality testing, while Minitab 18 was used for comparative and post hoc analyses.

2.8 Ethical Considerations

Participation was voluntary, and respondents could withdraw at any time without penalty. Informed consent was obtained before access to the questionnaire. Names and hospital affiliations were optional, and findings were reported without personal identifiers. Electronic files were stored in password-protected systems, while printed records were kept in secure storage. Access was limited to authorized research and institutional personnel. Research records and respondent data were retained for five years for verification and academic reference, after which electronic files were securely deleted and physical documents were shredded. Recruitment through multiple hospitals and nursing groups was intended to obtain broader participation, although voluntary response sampling remained subject to self-selection bias. The researcher declared no financial, personal, or professional conflict of interest. Inclusive language was used, and respondents' cultural identities, beliefs, values, languages, and backgrounds were respected throughout the study.

3. Results and Discussion

3.1 Demographic Profile of the Respondents

3.1.1 Age

Most respondents were 30–39 years old, representing 65.6% of the sample, followed by those aged 20–29 years at 25.6% and 40–49 years at 9.0%. The respondents had a mean age of 32.83 years with a standard deviation of 5.63, indicating that the nursing workforce was concentrated in the early- to middle-career age range. This pattern was consistent with Philippine nursing studies reporting a concentration of nurses in their late twenties and thirties. Feliciano et al. (2019) reported a mean age of 31.64 years, while Tan and Conde (2021) found substantial representation in the 26–30 and 31–35 age groups. Although this concentration supports workforce continuity, generational diversity remains important because it facilitates the exchange of skills and experience but may also require strategies for managing differences in professional perspectives and communication (Manlangit et al. (2022)).

3.1.2 Gender

Female nurses comprised 59.7% of the respondents, while males accounted for 40.3%. Although women remained the majority, the proportion of male respondents indicated increasing gender diversity in Philippine nursing. The distribution reflected nursing's continuing sociocultural association with femininity (Rubio, 2019; Salinda et al., 2024). Nevertheless, effective nursing practice was not dependent on gender. Differences in professional opportunities may instead arise from institutional conditions, self-perception, and persistent occupational stereotypes (Masibo et al., 2024).

3.1.3 Religion

Christian respondents represented 95.0% of the sample, with Roman Catholics forming the largest group at 69.9%. Iglesia ni Cristo accounted for 7.1%, Seventh-Day Adventists and other Christian groups each represented 6.5%, and the Philippine Independent Church accounted for 5.0%. Muslim respondents comprised the remaining 5.0%. The predominance of Roman Catholicism reflected its historical and continuing influence on Philippine society (Anthony, 2016; Statista, 2024). The presence of several Christian denominations and Islam nevertheless demonstrated religious diversity, particularly the representation of Muslim communities associated with Mindanao (PSA, 2023; Pinas Culture, 2023).

3.1.4 Ethnicity and Geographic Origin

Most respondents originated from Luzon at 65.70%, followed by Mindanao at 20.94% and the Visayas at 13.35%. Tagalog nurses formed the largest ethnic group at 36.6%, followed by Ilocano at 16.0%, Bisaya/Binisaya at 10.5%, Cebuano at 9.2%, Bicolano at 6.3%, Waray and Maguindanao at 4.5% each, Hiligaynon/Ilonggo at 4.2%, and Maranao at 3.9%. Other ethnicities, including Kapampangan, Pangasinense, and Chavacano, represented 4.5%. The predominance of Tagalog respondents was consistent with national demographic patterns (Philippine Statistics Authority [PSA], 2023), while the presence of Ilocano, Bisaya, Cebuano, and other ethnolinguistic groups reflected the country's regional diversity (Caña, 2023). The smaller ethnic categories further demonstrated the multicultural composition of the nursing workforce (PSA, 2023). Such diversity is clinically relevant because cultural competence improves trust, communication, and care outcomes across ethnolinguistic communities (Moratillo, 2021). However, nurses may remain inadequately prepared for culturally diverse practice, supporting the need for transcultural education and community immersion (Calaranan et al., 2024).

3.1.5 Years of Nursing Experience

Most respondents had substantial clinical experience. Nurses with more than five years of practice constituted 65.4%, while 19.1% had four to five years, 10.7% had two to three years, and 4.7% had one year or less. Overall, 84.5% had at least four years of nursing experience. This experienced workforce provides opportunities for peer learning and culturally individualized care because experienced nurses may integrate patient preferences and contextual information more effectively (Salinda et al., 2024; Ozdemir, 2019). However, the small proportion of novice and advanced-beginner nurses also highlights the importance of structured mentorship to support progression through the developmental stages described by Ozdemir (2019).

3.2 Cultural Competence

3.2.1 Cultural Knowledge

The respondents obtained an overall cultural knowledge mean of 3.34, interpreted as "Not Sure" and indicating moderate competence. Familiarity with health- and illness-related cultural knowledge received the highest mean of 3.43. The lowest scores concerned explaining the relationship between culture and health beliefs at 3.30 and providing examples of cross-cultural communication skills at 3.29. The results indicated that nurses possessed foundational theoretical knowledge but remained uncertain about applying it in clinical encounters. Barral et al. (2023) similarly reported moderate cultural awareness, knowledge, and skills among nurses in Southern Philippines. Comparable research found low-to-adequate competence, particularly in practical knowledge application (Cai et al., 2021; Červený et al., 2020; Urbanavičė et al., 2025). Limited training, theoretical preparation, and language differences may contribute to this uncertainty (Golsäter et al., 2022; Lin & Hsu, 2020; Vandecasteele et al., 2024). Zhao (2021) emphasized that intercultural communication is necessary for trust and therapeutic relationships. Cai et al. (2021) observed that understanding concepts does not automatically ensure their clinical application, while Lin and Hsu (2020) found that structured training improves confidence. Communication barriers identified by Golsäter et al. (2022) and the training needs emphasized by Vandecasteele et al. (2024) support greater experiential and communication-focused instruction.

3.2.2 Cultural Sensitivity

Cultural sensitivity had an overall mean of 3.34, also interpreted as "Not Sure." The respondents were most confident that they actively tried to understand the beliefs of different cultural groups, with a mean of 3.40. They were less certain about discussing differences between patients' health beliefs or behaviors and professional nursing knowledge, which obtained a mean of 3.28. The result indicated general openness toward cultural diversity but inconsistent application during direct patient discussions. Foronda et al. (2018) found that healthcare professionals often valued cultural competence while remaining uncertain about its practical implementation. Workload and staffing conditions may further limit meaningful patient interaction. Alibudbud (2023) identified understaffing and heavy workloads as barriers to quality engagement, while Kwame and Petrucka (2021) associated staffing shortages with reduced therapeutic communication. The attitudinal

readiness discussed by Foronda et al. (2018) therefore requires experiential learning, institutional support, and adequate time for culturally sensitive dialogue.

3.2.3 Cultural Skills

The overall mean for cultural skills was 3.40, indicating moderate competence. The highest-rated ability was guiding colleagues in displaying appropriate behaviors when caring for culturally diverse patients, with a mean of 3.49. Guiding colleagues about cultural similarities and differences, establishing culturally appropriate goals, and meeting culturally diverse patient needs each obtained a mean of 3.45. The lowest score was for teaching colleagues communication skills for culturally diverse patients at 3.21. The respondents appeared more confident in discussing general cultural practices with colleagues than in directly communicating complex cultural information to patients. Cultural competence is strengthened through exposure to diverse communities, formal diversity training, and cross-cultural clinical experiences (Johnston et al. (2023)). Without sustained practical experience, cultural skills may remain developmental. Language differences, stereotyping, and limited cultural awareness may also reduce confidence in communicating and explaining how culture influences health beliefs (Vandecasteele et al. (2024)).

3.3 Clinical Decision-Making

3.3.1 Data Collection

Data collection obtained an overall mean of 2.96, interpreted as “Not Rarely or Not Often.” The respondents were most confident in distinguishing relevant from irrelevant patient information, with a mean of 3.37. They were least consistent in confirming initial impressions through supporting symptoms, with a mean of 2.61, and reviewing as much advance information as possible from patient records, with a mean of 2.74. The findings showed functional assessment skills but inconsistent systematic verification. Comprehensive decision-making requires the collection and integration of multiple information sources (Clemett and Raleigh (2021)). Experienced nurses may use pattern recognition to identify relevant cues efficiently (Marshall and Finlayson (2022)), but early impressions require validation to minimize cognitive bias. Camilleri (2025) observed that nurses in fast-paced environments often rely on experience rather than structured hypothesis testing. Information-literacy instruction can improve data retrieval and utilization (Farokhzadian et al. (2020)), while evidence-based and simulation-based education can strengthen clinical judgment, as demonstrated by Ghodsi Astan et al. (2022) and Görücü et al. (2024).

3.3.2 Data Processing

The respondents obtained an overall data-processing mean of 2.99. Comparing patient information with personal nursing experience received the highest mean of 3.54, followed by forming an overall picture of the patient’s condition at 3.51. Comparing information with research evidence received the lowest mean of 2.45, while objectively defining nursing problems from observed symptoms and complaints obtained 2.53. The results indicated that respondents relied more on experiential knowledge than research evidence. Nurses commonly move between intuitive and analytical reasoning in dynamic settings (Banks (2023)), and experience can support rapid interpretation of patient situations (Camilleri (2025)). However, limited time, access to research, and appraisal skills may constrain evidence use (Abdalhafith et al. (2025)). Structured reflection can improve data integrity and reduce cognitive bias, thereby strengthening the objective validation of nursing problems (Mutlak et al. (2025)).

3.3.3 Planning Action

Planning action had an overall mean of 2.95. Documenting general directions for patient care obtained the highest mean of 3.35, followed by anticipating the effects of nursing interventions at 3.33. The lowest score concerned preparing nursing plans according to the formal stages of clinical decision-making, with a mean of 2.60. Planning was therefore practiced at a moderate level but was not always based on formal nursing frameworks. In fast-paced settings, nurses may prioritize experience-based decisions over structured planning procedures (Dumez and L’Espérance (2024)). Documentation may be reinforced by institutional requirements and electronic record systems (Jedwab et al. (2022)), whereas formal care-planning stages may be less consistently applied. Lavoie (2025) identified similar gaps between nursing theory and clinical practice. Evidence-based planning requires measurable goals and alignment with clinical standards, as emphasized by Hysong et al. (2022).

3.3.4 Implementation and Evaluation

Implementation and evaluation obtained an overall mean of 2.98. Flexibly changing interventions according to patient feedback received the highest mean of 3.47, while anticipating changes from subtle patient cues obtained 3.35. The lowest score concerned following the patient’s existing nursing plan, with a mean of 2.55, followed by using disease-specific treatment information in nursing decisions at 2.58. The findings indicated strong adaptability but less consistent adherence to documented plans and disease-specific guidance. Effective clinical judgment requires continuous implementation, evaluation, and adjustment based on patient outcomes (Dresser et al., 2023). Adaptive surveillance can support patient safety and timely intervention (Menon and Verma (2025)); however, flexibility should remain balanced with formal care

plans and evidence-based protocols. Protocol availability alone does not ensure adherence, and implementation may require education, leadership support, audit, and feedback (Fontaine et al., 2024).

3.4 Cultural Competence According to Demographic Characteristics

3.4.1 Age and Gender

Age produced a significant difference only in cultural skills, with a reported p-value of 0.050. Nurses aged 40–49 obtained the highest mean rank of 233.2. Cultural knowledge and sensitivity did not significantly differ by age. No significant gender differences were found in cultural skills, knowledge, or sensitivity. The age-related difference in practical skills suggested that repeated clinical exposure may strengthen the application of cultural competence, while knowledge and attitudes may depend more on formal learning (Kaihlanen et al. (2019)). Direct patient interaction can develop behavioral cultural skills more effectively than theory alone (Li et al. (2025)), while experience in diverse settings may improve skills without necessarily changing knowledge or attitudes (Young & Guo, 2020). Structured education may also standardize competence across age groups (Dinglasan et al., 2026). Gender appeared less influential than education, experience, and training, consistent with findings that professional preparation predicts competence more strongly than gender (Urbanavičė et al., 2025). Similar conclusions were reported by studies emphasizing exposure and culturally relevant education (Zelege et al., 2024) and equivalent training opportunities (Osmancevic et al., 2023).

3.4.2 Religion and Ethnicity

Religious affiliation produced significant differences in cultural skills, knowledge, and sensitivity, with p-values of 0.000, 0.009, and 0.018, respectively. Respondents from Seventh-Day Adventist and other less represented religious groups generally obtained higher scores. Ethnicity also produced significant differences in cultural skills, knowledge, and sensitivity, with p-values of 0.003, 0.000, and 0.032. Hiligaynon/Ilonggo and Tagalog respondents generally obtained higher mean ranks, while lower ranks were observed among some other ethnic groups. Religious and ethnic identities may shape empathy, worldview, communication, and openness to cultural difference. Strong spiritual engagement has been associated with compassion and respect for patient values (Dillard et al., 2021), while experiences of identity difference or marginalization may promote cultural humility (Hughes et al., 2020). Religious traditions emphasizing service may also support culturally responsive practice (Poudel et al., 2025). Multicultural experiences can enhance intercultural communication among health professionals (Rost et al., 2023), and exposure to diverse groups may strengthen cultural knowledge and sensitivity (Kaihlanen et al., 2022). Nurses working in multicultural environments similarly demonstrate higher intercultural competence (Antón-Solanas et al., 2022).

3.4.3 Years of Experience

The manuscript interpreted years of experience as having no significant effect on cultural skills, knowledge, or sensitivity. Although nurses with six months to one year of experience obtained relatively high mean ranks, the discussion concluded that professional longevity alone did not determine competence. The reported cultural-sensitivity p-value was 0.012, despite its classification in the manuscript as not significant. The result suggested that experience without deliberate cultural learning may not consistently improve competence. Theodosopoulos et al. (2025) found that longer experience could be associated with lower self-efficacy when cultural learning was not intentionally reinforced. Individual preparation, prior training, and cultural background may be more influential than organizational support alone, although institutional readiness remains necessary to sustain culturally responsive practice (Schenk et al., 2022). Structured educational interventions can improve competence regardless of baseline experience (Kaihlanen et al., 2022).

3.5 Clinical Decision-Making According to Demographic Characteristics

3.5.1 Age, Gender, and Religion

No significant differences in data collection, data processing, planning action, or implementation and evaluation were found according to age, gender, or religious affiliation. Median scores across these demographic groups were generally similar. The findings indicated that clinical decision-making was shaped more by professional education and clinical preparation than personal demographic characteristics. Fero and Dokoupilová (2019) emphasized that experience and training are more influential than age. Simulation can improve decision-making across age groups (Görücü et al., 2024), while workplace learning and continuing development may be stronger predictors than demographics (Kaihlanen et al., 2022). Cognitive and critical-thinking preparation also contributes to clinical performance (Zainal et al., 2025). Comparable responsibilities and training may explain the absence of gender differences (Zainal et al., 2025), while staffing, leadership, and continuing education may exert greater effects (Alsadaan et al., 2023). Decision-making is therefore associated more with knowledge and critical thinking than gender (Song & Park, 2025). Religion also did not alter clinical judgment because nursing practice is governed by shared ethical and professional standards. Varkey (2020) explained that universal moral principles are reinforced through professional healthcare codes. Clinical guidelines may minimize the influence of personal values (Saygili & Ozturkoglu, 2020), while structured training promotes equitable decisions across religious backgrounds (Kaihlanen et al., 2022). Accountability and interprofessional collaboration further support objective professional judgments (Bouchez et al., 2024).

3.5.2 Ethnicity and Years of Experience

Ethnicity significantly influenced data collection, with $H = 25.24$ and $p = 0.003$, but did not significantly affect data processing, planning action, or implementation and evaluation. Years of experience also produced a significant difference only in data collection, with $H = 10.20$ and $p = 0.017$. Nurses with two to five years of experience obtained higher data-collection ranks than those with one year or less. Ethnicity may affect initial assessment through language, communication style, and cultural familiarity. Cultural and linguistic congruence can improve the completeness of patient information and strengthen trust (Kaihlanen et al. (2021)). Nurses from diverse backgrounds may also use cultural knowledge to interpret patient cues during assessment (Antón-Solanas et al. (2022)). However, subsequent clinical stages may become more standardized through professional frameworks (Li et al. (2023)). Experience similarly influenced how nurses gathered information. Novices commonly depend on checklists, whereas experienced nurses use pattern recognition and tacit knowledge (Lasater et al. (2019); Njie-Mokonya (2024)). Structured competency training can reduce differences in later analytical and planning stages (Chen et al. (2022)), while standardized frameworks promote consistency despite variations in situational awareness (Feller et al. (2023)).

3.6 Relationship Between Cultural Competence and Clinical Decision-Making

No significant relationship was found between cultural competence and clinical decision-making. Correlations between the cultural domains and the four decision-making domains ranged from -0.096 to 0.050 and were interpreted as negligible, with all p -values above 0.05 . The overall relationship was also negligible and not statistically significant at $r = -0.097$ and $p = 0.059$. The finding suggested that cultural competence and clinical decision-making functioned as related but distinct professional capabilities. Cultural competence supported communication, respect, trust, and patient engagement, while clinical decisions remained primarily governed by evidence-based procedures and systematic reasoning. Kaihlanen et al. (2021) explained that cultural competence improves mutual understanding and patient assessment but does not replace standardized clinical processes. Agbi et al. (2023) likewise connected cultural competence with trust and satisfaction while emphasizing the role of structured guidelines in maintaining reliable decisions. Sharifi et al. (2019) concluded that cultural competence primarily affects the interpersonal and relational dimensions of care rather than its technical and analytical components.

3.7 Results-Based In-Service Training Programs

The findings informed two cultural competence programs. The program for newly hired nurses was designed for implementation in January and June and included guided self-awareness and bias-reflection exercises, a cultural competence seminar and workshop, and a supervised clinical practicum. These activities aimed to strengthen cultural knowledge, sensitivity, communication, and the practical delivery of culturally congruent care. The program for tenured nurses included an intergenerational cultural competence workshop, peer mentoring, culturally focused case simulations, an annual cultural emphasis activity, and biannual competence evaluations using supervisory and patient feedback. The proposed activities addressed the moderate competence scores, communication difficulties, demographic variations, and need for continuing education identified in the study. They also emphasized reflective learning, respectful cultural representation, measurable evaluation, policy development, and institutional accountability.

4 Conclusion & Recommendations

Staff nurses in the Philippines demonstrated moderate cultural competence and clinical decision-making, reflecting uncertainty and inconsistent application in practice. Cultural competence varied significantly according to age, religion, and ethnicity but not gender or years of experience, whereas clinical decision-making was generally consistent across demographic groups except for differences in data collection based on ethnicity and years of service. No significant relationship was found between cultural competence and clinical decision-making, indicating that cultural competence primarily supported culturally responsive patient interactions, while clinical reasoning remained guided by standardized institutional protocols and evidence-based frameworks. These findings supported the development of cultural competence integration programs for newly hired and tenured nurses to strengthen inclusive, equitable, and patient-centered nursing practice.

Healthcare institutions should provide continuous, scenario-based cultural competence training using simulation, role-playing, reflective practice, mentorship, and supervised clinical application. Nurse managers should establish institutional policies, culturally congruent protocols, mandatory diversity education, and mentorship arrangements, while nurse educators should integrate cultural competence into theoretical courses, case analyses, care planning, and clinical judgment exercises. Future researchers should examine the long-term influence of cultural competence interventions on clinical decision-making, compare nurses across Luzon, Visayas, and Mindanao, investigate specific local cultural contexts, and evaluate the effectiveness of the proposed programs after implementation.

The study was limited by its descriptive-correlational design, which identified relationships but could not establish that cultural competence caused changes in clinical decision-making (Devi et al., 2022). Its reliance on voluntary response

sampling and self-assessment introduced possible self-selection and response biases, limiting the generalizability of the findings to the broader population of registered nurses (Mukti, 2024; Hiratsuka, 2025). Regional classifications were used only for descriptive purposes, and the specific steps of clinical decision-making were not explored. Online data collection may also have excluded nurses with limited internet access, digital resources, or familiarity with electronic platforms.

Compliance with ethical standards

The study complied with the ethical standards of Philippine Christian University and received approval from its Ethics Review Board, together with permission from participating institutions. Participation was voluntary, informed consent was obtained, and respondents could withdraw at any time without penalty. Confidentiality and anonymity were maintained through optional identifying information, restricted data access, secure storage, and proper disposal after the prescribed retention period. The researcher declared no conflict of interest, obtained permission to use the adopted instruments, acknowledged the contributions of the participants, adviser, panel members, and participating institutions, and assumed responsibility for the accuracy, originality, authorship, and copyright compliance of the research.

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