The Egyptian Journal of Hospital Medicine (October 2014) Vol. 57, Page 384-394

Cognitive Competency of Filipino Nurses Working in Some Hospitals of Taif City, Kingdom of Saudi Arabia

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Abstract:

Background: Nurses give care to diverse client population, which necessitates that, they should be culturally competent. Competence in cross cultural practice is a process requiring experience and continued interest in learning and in sharpening cultural assessment and communication skills.

Objectives: Toinvestigate the cognitive competency of Filipino nurses working in five hospitals at Taif City, Kingdom of Saudi Arabia. The study evaluates strength of self-efficacy perception ofthenurses, on the cognitive constructs and the difference among the strength of self-efficacy perception of the nurses when grouped according to their demographic profiles.

Methods: Transcultural Self-Efficacy Tool (TSET) Kit was used to measure the cognitive competency of three hundred and seven respondent Filipino nurses working in five hospitals of TaifCity.

Results: The strength of self -efficacy perceptions of the nurses within the cognitive constructs shows that the five highest means score dealt with “safety”, “hygiene", “Informed consent", “pain relief and comfort” and “life support and resuscitation” while the five lowest scores dealt with “Health History and Interview”, “Sexuality”, “Birth”, “Pregnancy” and "Diagnostic Test". The differences among the strength of self -efficacy perception of the nurses on the cognitive construct when grouped according to seven demographic profiles shows that only three of the demographics were different in some of the cognitive construct variables. These were work setting, department and preferred position

Implications: The findings of the present study suggest in-service educational training to all nurses on transcultural nursing to enhance their cultural competencies.In addition, Arabic Language training is recommended as one of the requirements for new nurse applicants.

Key words: Cognitive competency, cognitive construct, Filipino,nurses, transcultural self-efficacy.

Introduction:

At present nurses from the Philippines have the reputation of qualified and respected workers with high work ethics, and are in high demand worldwide.[(1)]They are appealing as immigrant workers because they had been trained in English, as the medium of instruction,[(2)]by teachers familiar with American nursing practices.[(3)] This can be attributed to Philippine Education patterned against United States Curriculum wherein, the structure of the nursing training was academically and socially very similar to the programs in the Unites States,[(3)]and the mandate of the Commission on Higher Education (CHED) to all nursing schools to have an accreditation.[(4)] This was intended to ensure that, their standards are in par and beyond the minimum requirements of an international standard. As proof of acceptability and recognition increasing number of foreign students are enrolled in tertiary education,[(2)] and many countries send health science students to the Philippines.[(5)]In addition, Philippine colleges and universities, both private and public, through their own accreditation bodies, now actively seek accreditation and recognize that it is the most effective way to spur their institutions to strive to improve themselves.[(6)]Furthermore, the nursing professional is educated through a combination of competency-based and community-oriented BS Nursing curriculum, grounded in Liberal arts that strengthen the character andvalues of the

DOI: 10.12816/0008472

person as a care giver.[5]As Mandated by CHED,[4] on its Memorandum Order (CMO) No. 14 S, Graduates of Bachelor of Science in nursing program must be able to apply analytical and critical thinking in the nursing practice, and should be competent in the eleven key areas of responsibility, one of which is Safe and Quality Nursing Care.

After few years of working in the Philippines, nurses seek new opportunities by going abroad. Kingdom of Saudi Arabia is one of the countries wherein Filipino nurses seek opportunities. According to the 2007-2011 Statistics of the Philippine Overseas Employment Administration,[7]Saudi Arabia is the top country of destination for new and re-hired Overseas Filipino Workers (OFW) where professional nurses rank in the second position by professional categories.

Nurses tend to migrate due to push and pull factor, economic, job related and socio-political and economic environment.[8]Whatever the reason is, Filipino nurses must be competent enough to render health care services to the culturally diverse population. Competence in cross cultural practice is a process requiring experience and continued interest in learning and in sharpening cultural assessment and communication skills.[9]

The aim of the present study was to determine the self -efficacy of Filipino nurses working in the hospitals of Taif City, Kingdom of Saudi Arabia in cognitive construct as part of their Transcultural Competency by determining differences between the levels of cognitive competency among Filipino nurses with their demographic profile.

Materials and Methods

The present investigation is a descriptive – evaluative study conducted in five hospitals of the Saudi Ministry of Health located in Taif, Makkah Region, Kingdom of Saudi Arabia. Nurses were recruited for the study from King Abdulaziz Specialist Hospital, King Faisal Hospital, Children's Hospital, Chest Hospital and Mental Health Hospital. A total of three hundred and seven respondent nurses were included using the simple random sampling fishbowl technique. The nurses were selected, regardless of their position as a staff nurse, assistant head nurse, head nurse, nurse educators, nurse administrator/supervisor and assistant nursing director.

The research questionnaire was prepared based on the Cultural Competence Education Resource (CCER) toolkit.[10] The following research instruments were used according to CCER:

1. Demographic Data Sheet for Nurses (DDSN), to gather demographic information from nurses including educational level.
2. Transcultural Self-Efficacy Tool (TSET), to evaluate confidence for performing general transcultural nursing skills among diverse client populations.

Specifically the following has been investigated:

1. How are the profiles of the nurse respondents be described in terms of:
    a. Age;
    b. Gender;
    c. Employment Status;
    d. Work Setting;
    e. Department;
    f. Current Work Position;
    g. Preferred Nursing Position in the future;
    h. Prior Degree Completed;
    i. Prior Transcultural Competency Training;
    j. Prior Seminars Attended; and
    k. Ethnicity?
2. What is the strength of self-efficacy perceptions of the nurses within the:
    a. Cognitive construct
3. Is there a significant difference among the strength of self-efficacy perception of the nurses on the cognitive construct when grouped according to:
    a. Age;
    b. Gender;
    c. Work Setting;
    d. Department;
    e. Current Work Position;
    f. Preferred Nursing Position in the Future; and
    g. Ethnicity?

The present study was approved by the Biomedical Research Ethics Committee of the affiliated University, and permission of the targeted hospitals. Consent for participation was obtained from respondents after they were informed about the aims, methods, anticipated benefits and potential hazards of the research. It has been confirmed to them that each have the right to terminate his/her participation at any time and that confidentiality is always maintained for their responses.

The obtained data were analysed using Analysis of Variance (ANOVA) for comparisons between the various groups according to specific factors. This test was used to determine the differences among the strength of self-efficacy perceptions of the nurses on the cognitive competency when grouped according to age, gender, work setting, department, current work position, preferred nursing position in the future and ethnicity. Differences between means were considered as significant at the level of $P < 0.05$.

Results and Discussion

The demographic characteristics of the nurses who participated in this study are presented in Table 1. The number of respondents is 307 nurses, of them 167 were from King Abdulaziz Specialist Hospital, 41 were from King Faisal Hospital, 53 were from the Children's Hospital, 24 were from the Chest Hospital and 22 were from the Mental Health Hospital. The nurses were predominantly females with a percentage of 97.1%. The highest percentage of the nurses belongs to the age group of 25-29 years, which comprised 30.6%. Moreover, almost half of the respondents were of the Moro descent, representing 43% of the entire group. All of the respondents were graduates with a Bachelor of Science in Nursing, and the majority of them were working as staff nurses (84.4%). All the nurses were full-time nurses and were mostly assigned in the acute care department (79.8%), whereas only about 18.9% of the respondents were working in the chronic care work setting, and most of them belong to the medical-surgical, obstetrics and gynecology, and intensive care units (20.8%, 11.4% and 19.2% respectively). A large number of them are eyeing to become nursing directors and assistant nursing directors in the future, with a percentage distribution of 42.3% and 24.8%, respectively. However, all nurses have had no formal transcultural competency training and seminars attended.This is in line with the study of Smith, [3]who describedthe learning experiences of new Filipino nurse immigrants to the United States Healthcaresystem, as informal and incidental added to the learning mix as they grew in familiarity with their surroundings and clinical confidence.

Table 2 illustrates the strength of self-efficacy perceptions of the participant nurses within the cognitive constructs. Among the 25 cognitive scales dealt with in this study, the highest are safety, followed by hygiene, then informed consent, then pain relief and comfort followed by life support and resuscitation, with the means scores of 8.55, 8.48, 8.43, 8.34 and 8.28, respectively. On the other hand, the five lowest mean scores are health history and interview, sexuality, birth, pregnancy, diagnostic test with a mean score of 7.61, 7.81, 7.82, 7.86 and 7.92, respectively. However, the total mean score is 7.77, which denotes that the nurses are knowledgeable about ways cultural factors may influence the nursing care. This is in accord with a previous study,[11] which reported that,although non-Muslim nurses, who worked at Obstetrical Ward in Saudi Arabia, always include cultural aspects in their plan of care; however, they had limited knowledge about Saudi Arabian culture.

It can be noted that nurse's perception of their cognitive skills are the results of their education and training, how a nurse should care for the patient, wherein, provision of safety is the highest. This is evident that nurses are knowledgeable about the patient rights.Most patients' bills of rights are concerned with informed consent, confidentiality, privacy, autonomy, safety, respect, treatment choice, refusal of treatment and participating in the treatment plan.[12] The patient has a right to expect that those who are providing care are knowledgeable and competent and will provide safe care. On the other hand, nurses are

competent too in the provision of hygiene as well as pain relief and comfort. Assisting patients to maintain personal hygiene is a fundamental aspect of nursing care.[13] However, cultural awareness and personal preferences should be taken into consideration, and the nurse should acknowledge the patient preference before giving any aspect of hygiene, and should not impose his or her own standards of cleanliness on the patient.[13] According to Kolcaba's comfort theory,[14] which presents the essence of nursing, provision of care and comfort are the initial interventions a nurse does for a sick person. Filipino Nurses know that these are basic needs of the patient and they are doing this since their internship days, however, caring for a patient in multi-cultural setting, impose on them some inhibition, because of the differences in the customs and traditions. More so, with those scale with the lowest mean, like the health history and interview, they don't feel the confidence because of the language barrier. This is in accord with the previous study,[15] on expatriate non- Muslim nurses experiences of working in cardiac intensive care unit in Saudi Arabia, which reported that the language barrier influenced nursing care because the participants felt that they were unable to communicate effectively with patients. In addition, nurses are perceived as helpers, not as healthcare professionals, and their suggestions and advice are not taken seriously,[16]and shyness and reluctance of the patient when it comes to sexuality, birth and pregnancy. Some Arabs are reluctant to disclose detailed information about themselves and their families to strangers. They tend to give as little information as possible and may not give enough for a proper diagnosis. Being conservative, they may be embarrassed by questions about their sexual relationships and other personal questions. Women are shy to talk about their private lives and may feel more comfortable with women doctors.[16] Culturally competent assessment skills are essential to facilitate communication, to demonstrate respect for cultural diversity, and to ask culturally sensitive questions about beliefs and practices that need to be considered in the delivery of health care. The more knowledge a nurse has about a specific culture, the more accurate and complete the cultural assessment will be.[17] This means that Nurses still lack the competency in these skills, most probably because of their little knowledge of the Saudi culture.Furthermore with the diagnostic test, they are not used to do this because it is beyond the scope of the nursing practice.[18]

Differences were observed among the strength of self-efficacy perception of the respondent nurses, on the cognitive construct when grouped according to age, gender, work setting, department, current work position, preferred nursing position in the future and ethnicity (Table 3). The cognitive scale is divided into 25 subscales. Each of these subscales was tested for variations in seven demographic profiles. Of these characteristics, three were found to be different in some of the cognitive constructs, namely; work setting, department, and preferred position in the future. The level of confidence of the respondents regarding the health history, and interview were found to be different on the work setting and department profiles ($P \leq 0.01$). Moreover, there were differences in the following cognitive competencies when grouped according to work setting, namely; health history and interview, informed consent, health promotion, health restoration, patient teaching, anxiety and stress reduction, diagnostic tests, birth, growth and development, aging, dying and death, grieving and loss, life support and resuscitation, sexuality and rest and sleep. Therefore, it could be illustrated that, the nurses' knowledge on health history and interview varies from one work setting to another, as well as between different departments. It means that each nurse has an individual approach towards the determination of the patient's health history. A previous study found that nurses seek to combine the philosophical learning they gained during their earlier nursing careers and history taking for some nurses may focus on identifying the underlying biomedical problem, (interpretation of laboratory results, signs and symptoms of illness), while other nurses may have a different focus like social and psychological factors that may require aesthetic and personal knowledge, as nurses listen to and interpret patients' stories of their illness and experiences, they are able to

identify what matters to them.[19]However, differences were observed in the procedural measures and conduct of understanding in the level of knowledge of each of the nurses in the medical-surgical ward in an acute work setting. This can be attributed to their foundational knowledge regarding health history and interview, which may be deemed related to the school where they study,[20] locality, age and Clinical Instructor's (CIs) influence.[3] One expectation espoused by nursing programs is that CIs act as a knowledge transfer bridge for students between classroom theory and practice care situations.[21]

The question about the preferred position of the nurses in the future, displayed differences on the level of confidence of the nurses on their knowledge on physical examination, health promotion, illness prevention, health maintenance, health restoration, safety, exercise and activity, pain relief and comfort, diet and nutrition, patient teaching, hygiene, anxiety and stress reduction, diagnostic tests, blood tests, pregnancy, birth, growth and development, and aging. In the same direction of knowledge and information, it can be presumed that the nurses' aspired position in the future that dictates the way they deal with the cognitive competencies. This is in accord with a previous report,[22]that suggested nurse education, experience, and staffing to have strong predictive ability on the professional practice environment, and that practice environment was largely responsible for the perception of the nurse to provide quality care. That the improvement of the nurse knowledge in one aspect varies with the needed information on his/her preferred position in the future.

The differences in the various work settings among the investigated different cognitive constructs may be attributed to differences in foundational knowledge acquisition, experiential practice, personal preferences of learning, environmental influence or beliefs and urgency of needs. According to a previous study,[23] people's self-efficacy beliefs determine their level of motivation, as reflected in how much effort they will exert in an endeavor and how long they will persevere in the face of obstaclesFurthermore, The stronger people's self -beliefs in their capabilities, the more options they consider possible, the greater the interest they show in them, and the better they prepare themselves for different pursuits.[24]In addition, since chronic care, and acute care settings have been previously presented as the two major classification of time related admission of patient, it can be presumed that experiential practice and exposure play a role in the variations in cognitive improvement and reasoning of nurses. Moreover, Childhood experiences and upbringing form the basis on which one's self-esteem is built, but experiences in adulthood and how someone deal with them also affect self-esteem levels.[25] While nurses may achieve a certain degree of competence in some diverse cultures, they cannot be totally competent in all cultures.[17]Cognitive competency is influenced by the level of nurses' knowledge of client's cultural health beliefs and practices, by their intentional reflection on their own attitudes, by their skill in cross-cultural communication.[9] Verbal and non-verbal communication is very essential in the implementation of nursing care, especially in doing health history, however, during applicant's interview, most of the hospital representative spoke entirely in English, while most of the patient speak in Arabic Language, so the need to determine patient cultural beliefs and practices is not being elucidated, which in turn jeopardizes nursing care. Apparently, if clients are unable to communicate in the same language, or, even worse, afraid to interrupt nurses who are always busy, and ask for assistance, care will be compromised.Therefore, the patient focused communication between health professionals and patients is of high importance. This is seen as vital to achieving patient satisfaction, inclusive decision making in caregiving and an efficient health service.[26] In addition,Quality of care for those who are not fluent in an official language is affected through interaction with health professionals who may, because of language barriers, fail to meet ethical standards in providing health care. Language barriers may result in failure to protect patient confidentiality, or to obtain informed consent.[27]The culturally bound beliefs, values, and preferences a person holds influence how a

person interprets healthcare messages, therefore knowing about a patient's language and culture is key for knowing how health literate the person is in a given situation.[28] Therefore, communication barrier is one aspect of cultural incompetence that is reflected in linguistic barriers, geographic inaccessibility, and unawareness of cultural norms.[29]

Conclusion

Filipino Nurses perceived themselves with high self- efficacy in cognitive competencies however, because of lacking formal education or seminars on transcultural nursing they are being affected by the perceived cultural belief and practices of patient with diverse culture, for they know that this will affect the care to be given to them. The demands of life are not constant, so self-esteem levels will fluctuate depending on what is happening in a person's life and how everyone is able to deal with them. Redundancy, bereavement, illness, studying, gaining a qualification, parenthood, poverty, divorce, promotion at work will all have an impact on every individuals' self-esteem levels. It is therefore suggested to the hospital administrators and nursing directors to conduct in service educational training to all nurses on transcultural nursing to address the competencies with low score, and to enhance their cultural competencies, adding to this is the Arabic Language training. It is also recommended to the Saudi Ministry of Health to have the Basic Arabic Language skills as one of the requirement for new nurse applicants.

Acknowledgement

The authors are grateful to all respondent nurses for agreeing to participate in the study.

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Table 1: Distribution of the studied of Filipino Nurses (n= 307) working in Taif City Hospitals according to their demographic Characteristics

Variables	Frequency (N=307)	Percentage
Age		
Under 25	28	9.1
25-29	94	30.6
30-34	42	13.7
35-39	40	13.0
40-44	43	14.0
45-49	12	3.9
50-54	22	7.2
55-59	24	7.8
Over 60	2	0.7
Gender		
Male	9	2.9
Female	298	97.1
Employment Status		
Full Time	307	100
Others	0	0
Work Setting		
Acute Care	245	79.8
Chronic Care	58	18.9
Clinic	4	1.3
	N=307	
Department		
Medical-surgical	64	20.8
Oncology	2	0.7
Psychiatry	26	8.5
Ob-Gyne	35	11.4
Pediatrics	24	7.8
Emergency	33	10.7
Intensive Care Unit	59	19.2
Others	64	20.8
Current Work Position		
Staff nurse	259	84.4
Assistant Head Nurse	13	4.2
Head Nurse	27	8.8
Nurse Educator	4	1.3
Nurse Administrator/Supervisor	3	1.0
Assistant Nursing Director	1	0.3
Preferred Nursing Position in the Future		
Head Nurse	19	6.2
Nurse Educator	7	2.3
Nurse Administrator/Supervisor	51	16.6
Clinical Nurse Specialist	21	6.8

Assistant Nursing Director	76	24.8
Nursing Director	130	42.3
Nurse Entrepreneur	3	1
Prior Degree Completed		
BSN	307	100
Others	0	0
Prior Transcultural Competency Training?		
None	307	100
Yes	0	0
Prior Seminars Attended?		
None	307	100
Yes	0	0
Ethnicity		
Ilocano	49	16
Ibanag	52	16.9
Moro	132	43.0
Chavacano	72	23.5
Bisaya	2	0.7

Table 2: Mean Score Distribution of the Strength of Self-Efficacy Perceptions on the Cognitive Construct of the Filipino Nurses working in Taif City, Kingdom of Saudi Arabia

Cognitive Scale	Mean	SD	Rank
Health history and interview	7.61	1.869	25
Physical examination	7.96	1.680	18
Informed consent	8.43	1.747	3
Health promotion	8.24	1.744	8
Illness prevention	8.15	1.728	12
Health maintenance	8.24	1.686	9
Health restoration	8.11	1.628	14
Safety	8.55	1.682	1
Exercise and activity	8.16	1.772	11
Pain relief and comfort	8.34	1.612	4
Diet and nutrition	8.24	1.645	10
Patient teaching	8.27	1.654	6
Hygiene	8.48	1.742	2
Anxiety and stress reduction	8.01	1.709	15
Diagnostic tests	7.92	1.669	21
Blood tests	8.13	1.629	13
Pregnancy	7.86	1.759	22
Birth	7.82	1.767	23
Growth and development	7.99	1.678	16
Aging	7.95	1.595	19
Dying and death	7.99	1.657	17
Grieving and loss	7.93	1.718	20
Life support and resuscitation	8.28	1.578	5
Sexuality	7.81	1.781	24
Rest and sleep	8.25	1.645	7

Table 3: Comparisons of the Strength of Self-Efficacy on the Cognitive Construct Grouped According to the Demographic Profiles of the Filipino Nurses working in Taif City, Kingdom of Saudi Arabia

Demographic Profile	**Age**		**Gender**		**Work Setting**		**Department**		**Current Work Position**		**Preferred Position**		**Ethnicity**	
Cognitive Scale	**F**	**Sig.**	**F**	**Sig.**	**F**	**Sig.**	**F**	**Sig.**	**F**	**Sig.**	**F**	**Sig.**	**F**	**Sig.**
Health history and interview	0.45	0.89	0.65	0.42	8.12	**0.00****	2.72	**0.01***	0.99	0.43	1.45	0.19	0.79	0.53
Physical examination	0.55	0.82	0.28	0.59	2.72	0.07	2.03	0.05	0.85	0.51	2.74	**0.01***	1.14	0.34
Informed consent	0.71	0.68	1.31	0.25	4.07	**0.02***	1.19	0.31	1.36	0.24	2.03	0.06	1.20	0.31
Health promotion	1.00	0.44	0.38	0.54	3.87	**0.02***	1.26	0.27	1.63	0.15	3.98	**0.00****	1.29	0.27
Illness prevention	1.15	0.33	0.01	0.90	3.09	0.05	1.50	0.17	1.63	0.15	3.00	**0.01***	0.76	0.55
Health maintenance	0.75	0.65	0.05	0.82	2.89	0.06	1.12	0.35	1.75	0.12	3.41	**0.00****	0.72	0.58
Health restoration	0.78	0.62	0.04	0.84	3.70	**0.03***	1.37	0.22	1.53	0.18	3.02	**0.01***	0.94	0.44
Safety	1.13	0.34	0.04	0.85	1.35	0.26	1.59	0.14	1.40	0.23	3.39	**0.00****	1.44	0.22
Exercise and activity	0.83	0.57	0.09	0.76	2.25	0.11	1.64	0.12	1.49	0.19	3.46	**0.00****	1.66	0.16
Pain relief and comfort	1.07	0.38	0.04	0.85	2.86	0.06	1.00	0.43	1.77	0.12	3.97	**0.00****	0.86	0.49
Diet and nutrition	0.55	0.82	0.35	0.56	2.64	0.07	0.87	0.53	1.78	0.12	2.46	**0.02***	1.17	0.32
Patient teaching	0.78	0.62	0.27	0.60	3.92	**0.02***	1.37	0.22	1.43	0.21	3.01	**0.01***	2.09	0.08
Hygiene	1.05	0.40	0.02	0.89	1.47	0.23	1.22	0.29	1.43	0.21	2.26	**0.04***	1.34	0.26
Anxiety and stress reduction	1.17	0.31	0.96	0.33	3.19	**0.04***	1.84	0.08	0.96	0.44	2.81	**0.01***	1.74	0.14
Diagnostic tests	1.77	0.08	0.07	0.79	4.70	**0.01***	2.64	**0.01***	0.90	0.48	2.36	**0.03***	1.02	0.40
Blood tests	0.95	0.48	0.44	0.51	2.54	0.08	1.33	0.24	1.05	0.39	2.75	**0.01***	0.60	0.66
Pregnancy	1.15	0.33	0.39	0.53	2.87	0.06	1.72	0.10	1.62	0.16	2.60	**0.02***	1.04	0.39
Birth	0.86	0.55	0.78	0.38	4.01	**0.02***	1.39	0.21	1.34	0.25	2.26	**0.04***	0.62	0.65
Growth and development	0.90	0.52	0.18	0.67	4.81	**0.01***	1.96	0.06	1.91	0.09	2.20	**0.04***	1.24	0.29
Aging	1.09	0.37	0.89	0.35	3.82	**0.02***	2.36	**0.02***	2.03	0.07	2.32	**0.03***	1.14	0.34
Dying and death	0.77	0.63	0.19	0.67	6.32	**0.00****	4.85	**0.00****	1.79	0.11	2.05	0.06	1.89	0.11
Grieving and loss	0.63	0.75	0.26	0.61	8.35	**0.00****	3.54	**0.00****	1.80	0.11	1.32	0.25	2.19	0.07
Life support and resuscitation	0.83	0.57	0.01	0.92	7.31	**0.00****	3.21	**0.00****	1.37	0.24	1.79	0.10	0.98	0.42
Sexuality	0.48	0.87	1.17	0.28	5.51	**0.00****	2.36	**0.02***	0.93	0.46	1.11	0.35	1.47	0.21
Rest and sleep	0.49	0.86	0.95	0.33	6.98	**0.00****	3.06	**0.00****	1.60	0.16	1.56	0.16	1.74	0.14

**F value is significant at the 0.01 level
* F value is significant at the 0.05 level