



# Cultural Adaptation, Workplace Environment, and Support Systems among Filipino Nurses at Darlington Memorial Hospital, United Kingdom

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## Abstract

Internationally educated nurses are essential to the United Kingdom workforce, but migration requires adjustment to new professional expectations, communication practices, social environments, and support structures. This study described cultural adaptation, workplace environment, and support systems among Filipino nurses at Darlington Memorial Hospital (DMH), United Kingdom, and examined their relationships with selected demographic and employment characteristics. A descriptive cross-sectional survey was conducted among 26 Filipino nurses who had worked at DMH for at least six months. A self-developed, expert-validated questionnaire assessed cultural adaptation, workplace environment, and support systems using a four-point Likert scale. Descriptive statistics and Pearson correlation coefficients were used. Most participants were aged 31-40 years (69.24%), female (76.92%), married (53.85%), and had worked at DMH for 1-3 years (50.00%). Workplace environment had the highest domain mean (3.29, Strongly Agree), followed by support systems (3.11, Agree) and cultural adaptation (3.08, Agree). Understanding local healthcare practices and adapting nursing practice to cultural contexts was highly rated (3.46). Regular contact with family and friends was the strongest support item (3.85), whereas community participation (2.42) and housing support (2.46) were the lowest. Age was significantly correlated with all three domains; civil status with cultural adaptation and support systems; and length of service with cultural adaptation and workplace environment. Department was unrelated to the three domains. Filipino nurses reported generally positive workplace experiences, but community integration and practical settlement support remained weaker. Structured mentorship, culturally responsive orientation, psychosocial support, and practical relocation assistance may strengthen adaptation.

**Keywords:** Cultural Adaptation; Filipino Nurses; Internationally Educated Nurses; Migrant Nurses; Social Support; United Kingdom; Workplace Environment.

## Introduction

International nurse migration has become a structural feature of contemporary health systems. High-income countries increasingly rely on nurses educated abroad to address workforce shortages, expand service capacity, and maintain continuity of care [1], [2]. The United Kingdom is one of the major destination countries for internationally educated nurses, and the National Health Service (NHS) has developed recruitment and registration pathways that enable qualified nurses trained outside the UK to enter the workforce [3]. At the same time, international recruitment does not end when a nurse obtains registration or begins employment. The transition involves professional, organizational, linguistic,

cultural, and personal adjustment, all of which can influence nurses' well-being, retention, and ability to function confidently in unfamiliar clinical settings [4]-[6].

The Philippines has a long history of nurse migration and remains an important source country for the international nursing workforce [7]. Migration is shaped by both professional aspirations and broader economic and family considerations. For many Filipino nurses, employment abroad can provide better compensation, career opportunities, and long-term financial security for their families. However, movement into a different healthcare system also requires nurses to learn new organizational norms, local clinical protocols, communication styles, documentation systems, and expectations concerning professional autonomy and teamwork. Evidence on migrant nurses consistently shows that transition is multidimensional: clinical competence may coexist with uncertainty about local workplace culture, language nuances, social belonging, or institutional processes [8], [9].

Cultural adaptation is one central dimension of this transition. Migrant nurses must function in settings where patients and colleagues may have different norms regarding communication, privacy, decision-making, hierarchy, and interpersonal interaction. Adaptation therefore involves more than learning technical procedures. It also requires navigating everyday routines, social expectations, informal communication, and culturally specific ways of interacting in and outside the workplace. Studies of culturally and linguistically diverse nurses have shown that successful integration is supported by orientation, cultural learning, language confidence, mentorship, and repeated exposure to the host environment [10], [11]. Conversely, culture shock, social isolation, language-related misunderstandings, and unfamiliar workplace norms may prolong adjustment and contribute to stress [12], [13].

The workplace environment is equally important. Internationally educated nurses enter institutions with established clinical governance systems, reporting structures, team cultures, and expectations regarding communication and accountability. A supportive environment can facilitate role clarity, professional development, psychological safety, and confidence in patient care. Structured orientation and access to mentors or experienced colleagues are particularly important during the early phase of transition. Review evidence suggests that programs combining organizational induction, preceptorship or mentorship, peer support, and opportunities for professional development can improve the integration of internationally educated nurses and may contribute to retention [9], [10]. In contrast, unclear expectations, inadequate support, or experiences of exclusion can intensify stress and contribute to dissatisfaction or intentions to leave [14], [15].

Support systems extend beyond formal organizational structures. Migrant nurses often rely simultaneously on family relationships in the country of origin, friendships with co-workers and co-nationals, local community networks, and institutional services. Digital communication allows migrants to maintain frequent contact with family and friends across national borders, but transnational connection does not necessarily replace the need for local social integration. Practical issues such as housing, immigration processes, family employment, access to counseling, and participation in community activities may shape whether nurses feel settled in the host country. Social support is

therefore relevant not only to emotional well-being but also to the practical process of remaining in and adapting to a new environment [9], [13].

Although the literature documents common challenges among internationally educated nurses, experiences are context-dependent. They vary according to the receiving institution, department, length of service, personal circumstances, and available formal and informal support. Institution-level evidence can therefore identify specific strengths and gaps that may not be visible in national or international studies. Darlington Memorial Hospital (DMH) employs Filipino nurses across medical and surgical services, providing a relevant setting for examining how internationally educated nurses perceive their adaptation and support within a UK hospital environment.

The source study used the term "lived experiences" to refer to nurses' survey-reported perceptions. Because the present investigation employed a quantitative descriptive survey rather than a phenomenological design, this article uses the more methodologically precise terms experiences, perceptions, or reported adaptation. The study aimed to: (1) describe the demographic and employment characteristics of Filipino nurses working in the medical and surgical departments of DMH; (2) assess their cultural adaptation, workplace environment, and support systems; and (3) examine the relationships between these domains and age, sex, civil status, length of service, and department. The findings were intended to inform practical measures for supporting internationally educated Filipino nurses during professional and social adjustment in the UK.

## Methods

### A. Study design and setting

A descriptive cross-sectional survey design was used. The study was conducted among Filipino nurses working in the medical and surgical departments of Darlington Memorial Hospital in the United Kingdom. The design was selected to describe participants' demographic characteristics and their self-reported experiences in three domains: cultural adaptation, workplace environment, and support systems. The study did not seek to establish causal relationships.

### B. Participants and sampling

The study included 26 Filipino nurses employed at DMH. Purposive sampling was used because participation was restricted to nurses meeting predefined eligibility criteria. Participants were eligible if they were Filipino nurses employed full-time at DMH, were actively working in a medical or surgical unit, had completed at least six months of service at the hospital, and were willing to provide informed consent. Nurses employed part-time, those with less than six months of service, and those who did not consent were excluded.

The six-month minimum was intended to ensure that respondents had sufficient exposure to the hospital and the UK work environment to evaluate their experiences. The sample was small and institution-specific; consequently, the findings should be interpreted as descriptive evidence from this group rather than as estimates that can be generalized to all Filipino nurses in the United Kingdom.

**C. Instrument**

Data were collected using a self-developed questionnaire. The instrument contained two main components. The first collected demographic and employment information, including age, sex, civil status, length of service at DMH, and area or department. The second assessed three domains relevant to migrant nurses' adjustment: cultural adaptation, workplace environment, and support systems.

Cultural adaptation items addressed familiarity with UK customs and traditions, language proficiency, comfort initiating conversations with local people, local friendships, participation in community activities, adjustment to daily routines, management of cultural differences at work, homesickness or culture shock, perceived acceptance by local people, and integration while maintaining cultural identity. Workplace environment items assessed communication with colleagues and supervisors, participation in meetings, professional development, understanding of local healthcare practices and protocols, belonging within the healthcare team, workplace safety and comfort, access to resources, supportive leadership, role clarity, and reporting or communication structures. Support-system items included access to formal support, mentorship, help from fellow Filipino nurses, local peer groups, mental-health or self-care resources, communication with family and friends in the Philippines, connection with colleagues, participation in expatriate groups, housing assistance, and performance feedback or development opportunities.

Each item was rated on a four-point Likert-type scale from 1 (Strongly Disagree) to 4 (Strongly Agree). Mean scores were interpreted using the ranges specified in the source study: 3.25-4.00 = Strongly Agree, 2.50-3.24 = Agree, 1.75-2.49 = Disagree, and 1.00-1.74 = Strongly Disagree.

The questionnaire underwent face and content validation by experts in research and nursing and was pilot-tested with five nurses working abroad. Internal consistency was assessed using Cronbach's alpha [insert alpha coefficient].

**D. Data collection and ethical considerations**

The survey was distributed electronically, including through Google Forms and participants' personal email addresses, and respondents were given approximately one week to complete it. Data collection was conducted from [insert start date] to [insert end date]. Procedures were implemented to protect anonymity and confidentiality. Ethical clearance was obtained from Darlington Memorial Hospital [insert approval/reference number, if applicable], and all participants provided informed consent. Data were stored electronically with restricted access, with oversight referenced to the Ethics Review Board of the University of Saint Anthony.

**E. Statistical analysis**

Frequency and percentage distributions were used to describe participant characteristics. Means were calculated to summarize item and domain responses. Pearson's correlation coefficient ( $r$ ) was used to examine relationships between coded profile variables and the three experience domains. Statistical significance was assessed at  $\alpha = .05$ . Because several profile variables were categorical or ordinal and the sample size was small, the association analyses were interpreted cautiously.

## Results

### A. Participant characteristics

All 26 participants were Filipino nurses employed in the medical or surgical services of DMH. Most were aged 31-40 years ( $n = 18$ , 69.24%). Four participants (15.38%) were aged 41-50 years, while two (7.69%) were aged 21-30 years and two (7.69%) were older than 50 years. The sample was predominantly female ( $n = 20$ , 76.92%), and slightly more than half were married ( $n = 14$ , 53.85%).

Half of the respondents had worked at DMH for 1-3 years ( $n = 13$ , 50.00%), and another eight (30.77%) had 4-6 years of service. Only one respondent (3.85%) had 7-9 years of service, while four (15.38%) had worked at the hospital for at least 10 years. Fifteen participants (57.69%) worked in surgical departments and 11 (42.31%) in medical departments. Thus, the sample largely represented female nurses in early to mid-career migration stages, with many still within their first six years at the institution.

**Table 1.** Participant characteristics (N = 26)

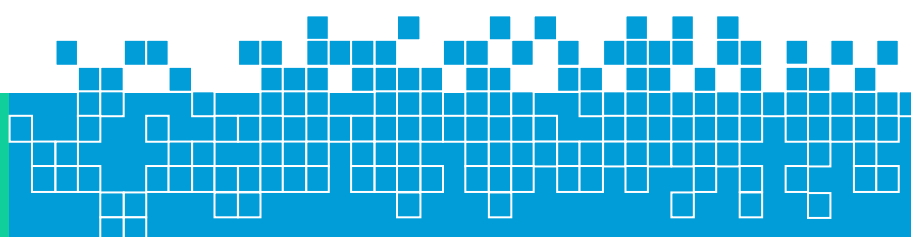
| Characteristic    | Category    | N  | %     |
|-------------------|-------------|----|-------|
| Age               | 21-30 years | 2  | 7.69  |
|                   | 31-40 years | 18 | 69.24 |
|                   | 41-50 years | 4  | 15.38 |
|                   | >50 years   | 2  | 7.69  |
| Sex               | Female      | 20 | 76.92 |
|                   | Male        | 6  | 23.08 |
| Civil status      | Married     | 14 | 53.85 |
|                   | Single      | 12 | 46.15 |
| Length of service | 1-3 years   | 13 | 50.00 |
|                   | 4-6 years   | 8  | 30.77 |
|                   | 7-9 years   | 1  | 3.85  |
|                   | >=10 years  | 4  | 15.38 |
| Area/department   | Surgical    | 15 | 57.69 |
|                   | Medical     | 11 | 42.31 |

Note. Percentages are based on N = 26.

### B. Cultural adaptation

The overall mean for cultural adaptation was 3.08, interpreted as Agree. This indicates that participants generally viewed themselves as having adapted to the local cultural environment, although adaptation was not uniformly strong across all areas. The highest-rated cultural adaptation item was the ability to manage or cope with cultural differences in the work environment ( $M = 3.35$ , Strongly Agree). Language proficiency was also rated highly ( $M = 3.27$ , Strongly Agree), while maintaining cultural identity while being integrated into the local community received a mean of 3.23 (Agree).

The weakest area was participation in local community events or activities ( $M = 2.42$ , Disagree), the lowest mean among the cultural adaptation items. The remaining indicators, including familiarity with local customs, comfort initiating conversations, daily-routine adjustment, feeling accepted and respected, and the duration of homesickness or culture shock, were generally in the Agree range. The pattern suggests that participants felt more confident navigating cultural differences relevant to work and communication than engaging in broader community life outside the hospital.



**C. Workplace environment**

The workplace environment received the highest domain score ( $M = 3.29$ , Strongly Agree). The strongest item was understanding local healthcare practices and protocols and adapting nursing practices to fit cultural contexts ( $M = 3.46$ , Strongly Agree). Participants also reported high engagement in professional development opportunities ( $M = 3.38$ ), good access to resources and tools needed for job performance ( $M = 3.38$ ), and a sense of belonging and acceptance within the healthcare team ( $M = 3.35$ ).

Comfort discussing work-related issues with colleagues and supervisors, perceptions of safety and comfort in the workplace, and clarity of job roles all had means of 3.31. The lowest workplace item was ease of participating in team meetings or departmental activities ( $M = 3.12$ , Agree). Supportive leadership and management practices and clarity in reporting structures also had comparatively lower, though still positive, means of 3.15. Overall, the results indicate that participants perceived the hospital as a generally supportive and understandable professional environment, with somewhat more room for improvement in participation, management support, and communication structures.

**D. Support systems**

The support-system domain had an overall mean of 3.11 (Agree). The most highly rated item across this domain was regular communication with family and friends in the Philippines through phone calls, video calls, email, or messaging applications ( $M = 3.85$ , Strongly Agree). Connection with colleagues in the workplace, including friendships, mentorship, or peer-support relationships, was also strong ( $M = 3.42$ , Strongly Agree). Seeking help from fellow Filipino nurses was rated positively ( $M = 3.31$ , Strongly Agree).

By contrast, access to housing options or assistance in finding accommodation was the lowest-rated support item ( $M = 2.46$ , Disagree). Participation in local groups that provided a safe space to share experiences and emotions ( $M = 2.69$ ) and participation in expatriate groups or clubs ( $M = 2.81$ ) were also relatively low. Access to mental-health resources and self-care programs was rated 2.92, within the Agree range but below most formal and interpersonal workplace supports. These findings indicate a support pattern anchored strongly in transnational family relationships and workplace peers, while local community integration and practical settlement support were comparatively weaker.

Across the three domains, workplace environment ranked first ( $M = 3.29$ ), support systems second ( $M = 3.11$ ), and cultural adaptation third ( $M = 3.08$ ). The grand mean was 3.16, interpreted as Agree.

**Table 2.** Summary of cultural adaptation, workplace environment, and support-system scores

| Domain                | Domain score          | Highest-rated item                                                                | Lowest-rated item                                                  |
|-----------------------|-----------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------|
| Cultural adaptation   | 3.08 (Agree)          | Cope with cultural differences in work environment (3.35)                         | Participation in local community events/activities (2.42)          |
| Workplace environment | 3.29 (Strongly Agree) | Understand local healthcare practices/protocols and adapt nursing practice (3.46) | Participate easily in team meetings/departmental activities (3.12) |
| Support system        | 3.11 (Agree)          | Regularly communicate with family/friends in the Philippines (3.85)               | Access to housing options or assistance (2.46)                     |
| Overall               | 3.16 (Agree)          | -                                                                                 | -                                                                  |

Note. Scale: 3.25-4.00 = Strongly Agree; 2.50-3.24 = Agree; 1.75-2.49 = Disagree; 1.00-1.74 = Strongly Disagree.

**E. Relationships between participant profile and experience domains**

Age was significantly and positively correlated with cultural adaptation ( $r = .55, p = .003$ ), workplace environment ( $r = .52, p = .007$ ), and support systems ( $r = .40, p = .041$ ). These coefficients indicate moderate positive associations in the original analysis, with older age categories tending to be associated with higher domain scores.

Sex was not significantly related to cultural adaptation ( $r = .16, p = .430$ ), workplace environment ( $r = .06, p = .078$ ), or support systems ( $r = .23, p = .265$ ). Civil status was significantly associated with cultural adaptation ( $r = .64, p < .001$ ) and support systems ( $r = .58, p = .002$ ), but not workplace environment ( $r = .29, p = .152$ ).

Length of service was significantly associated with cultural adaptation ( $r = .44, p = .026$ ) and workplace environment ( $r = .51, p = .007$ ), but not support systems ( $r = .24, p = .245$ ). Area or department was not significantly associated with cultural adaptation ( $r = .19, p = .365$ ), workplace environment ( $r = .11, p = .590$ ), or support systems ( $r = .27, p = .190$ ). The pattern suggests that age, civil status, and length of service may be more relevant to the reported adaptation of this sample than assignment to medical versus surgical services.

**Table 3.** Correlations between participant profile variables and experience domains

| Profile variable  | Cultural adaptation $r$ ( $p$ ) | Workplace environment $r$ ( $p$ ) | Support system $r$ ( $p$ ) |
|-------------------|---------------------------------|-----------------------------------|----------------------------|
| Age               | .55 (.003)                      | .52 (.007)                        | .40 (.041)                 |
| Sex               | .16 (.430)                      | .06 (.078)                        | .23 (.265)                 |
| Civil status      | .64 (<.001)                     | .29 (.152)                        | .58 (.002)                 |
| Length of service | .44 (.026)                      | .51 (.007)                        | .24 (.245)                 |
| Area/department   | .19 (.365)                      | .11 (.590)                        | .27 (.190)                 |

Note. Statistical significance was assessed at  $\alpha = .05$ . The p-value of .078 for sex and workplace environment is reproduced from the supplied source table and should be rechecked before submission.

**Discussion**

This study described the experiences of 26 Filipino nurses working in medical and surgical services at Darlington Memorial Hospital using three interrelated domains: cultural adaptation, workplace environment, and support systems. The overall pattern was favorable. Participants rated the workplace environment most positively, while cultural adaptation received the lowest of the three domain means, although it remained in the Agree range. The strongest individual findings concerned understanding local healthcare practices and protocols, maintaining communication with family and friends in the Philippines, and coping with cultural differences in the workplace. The weakest areas were participation in local community activities and access to housing support. The association analysis further suggested that age was related to all three domains, civil status to cultural adaptation and support systems, and length of service to cultural adaptation and workplace environment; department was not associated with any domain. Recent systematic syntheses similarly characterize internationally educated nurses' transition as a multidimensional process shaped by communication, organizational support, discrimination, and social belonging [16], [17].

**A. Cultural adaptation: professional confidence but limited community integration**

The cultural adaptation findings show an important distinction between adaptation within work and integration into the wider community. Participants strongly endorsed their ability to cope with cultural differences at work and reported relatively high language proficiency. These results are consistent with literature indicating that internationally educated nurses often develop functional strategies for navigating culturally diverse clinical environments, particularly when they have repeated exposure to local teams, patients, and institutional routines. Integration models emphasize that familiarity with host-country norms grows through orientation, social learning, feedback, and participation in everyday workplace activities [10], [11]. An umbrella review further identified cultural difference, communication beyond language fluency, differing nursing cultures, and ethnic identity as recurring challenges, while Filipino nurses entering practice in England have described language and competency requirements as central elements of transition [18], [19].

The lowest cultural adaptation score concerned participation in local community events. This finding suggests that professional adjustment can advance more rapidly than social integration outside work. Nurses may become competent in local clinical practices without developing equally strong ties to the surrounding community. Several factors could explain this pattern in the present sample. Half of the participants had worked at DMH for only one to three years, and early migration often requires substantial time for learning the job, managing shift work, arranging housing and finances, and maintaining obligations to family members in the country of origin. These demands can limit opportunities for local community participation even when individuals function successfully at work. Research on cross-cultural adjustment similarly describes social integration as a gradual process shaped by time, social opportunity, language confidence, and the availability of supportive networks [9], [13]. For Filipino nurses in the UK, migration and adjustment are also intertwined with family obligations and perceived security, while broader evidence emphasizes resilience, social capital, and community engagement as resources for adaptation [20]-[22].

The results also suggest that cultural adaptation should not be treated as a simple transition from "not adapted" to "adapted." A nurse may simultaneously demonstrate high professional cultural competence, maintain a strong Filipino cultural identity, communicate effectively in English, and still experience limited participation in community life. For hospital managers and migrant-nurse support programs, this means that orientation should extend beyond technical induction. Information about local services, community organizations, social activities, transportation, housing, and culturally diverse networks may help nurses build a stronger sense of belonging outside the hospital. Such support may be particularly relevant for recruits who are clinically competent but have not yet developed local social networks.

**B. A relatively positive workplace environment**

The workplace environment was the strongest domain in this study. Participants most strongly endorsed understanding local healthcare practices and protocols and adapting nursing practices to the cultural context. High ratings were also observed for professional development, access to work resources, team belonging, and role clarity. These findings are important because migration into a new

health system can expose nurses to unfamiliar documentation, scope-of-practice expectations, communication patterns, escalation procedures, and governance requirements. A workplace that enables nurses to understand these expectations reduces ambiguity and can support safe clinical practice. UK-focused analysis also cautions that overseas nurses may encounter structural and racialized barriers alongside communication and professional adjustment demands [23].

The findings broadly align with evidence that structured integration and organizational support facilitate internationally educated nurses' transition into host-country health systems. Kamau et al. [10] identified orientation, mentorship, education, supportive leadership, and collegial relationships as recurring components of successful integration strategies. Pressley et al. [9] similarly emphasized organizational and social factors that support acculturation and retention. The relatively high DMH ratings for access to resources and professional development may therefore represent meaningful institutional strengths. Similar review evidence links the quality of orientation and organizational support with transition outcomes, while studies of mentorship and preceptorship stress the need for trained and adequately supported supervisors [24]-[26].

Nevertheless, several workplace items were less strongly endorsed. Participation in team meetings or departmental activities had the lowest workplace mean, while supportive leadership and clarity of reporting structures were also below the domain average. These are not negative results in absolute terms, because all remained in the Agree range, but they point to areas where internationally educated nurses may still experience hesitation or uncertainty. Team meetings often require rapid conversational exchanges, confidence with local terminology, and familiarity with informal organizational norms. Nurses who are competent in direct patient care may need additional time before feeling equally comfortable contributing to multidisciplinary or departmental discussions. Cross-country qualitative evidence likewise shows that communication challenges can persist beyond basic language proficiency and can affect participation in complex clinical interactions [27].

This distinction matters for integration. A nurse who understands clinical protocols but is less active in meetings may have fewer opportunities to influence team decisions, clarify concerns, or develop leadership visibility. Managers can address this by creating psychologically safe meeting practices, explicitly inviting contributions from newly recruited international nurses, providing clear communication channels, and pairing new staff with mentors who can explain both formal and informal workplace expectations. Such measures are consistent with literature documenting the role of supportive professional relationships in internationally educated nurses' transition and retention [11], [14]. Systematic evidence on international nursing graduates similarly identifies role uncertainty and the need for explicit guidance and structured transition support [28].

#### **C. Support systems: strong transnational ties, weaker practical settlement support**

The support-system results show that participants relied heavily on relationships that crossed national borders. Regular contact with family and friends in the Philippines received the highest item mean in the support domain and one of the highest scores in the study. This is understandable in the context of Filipino labor migration, where family ties often remain central to emotional support and decision-making after relocation. Digital communication allows migrant nurses to sustain frequent

interaction with family members despite geographic separation. Such relationships can provide reassurance, continuity of identity, and a space to discuss difficult experiences.

Workplace peer relationships were also positively rated. Participants reported connection with colleagues and willingness to seek help from fellow Filipino nurses. Peer support can be particularly valuable because co-national or experienced migrant colleagues may understand both the professional requirements of the host system and the cultural transition experienced by newly arrived nurses. Mentorship models that formally connect recently recruited nurses with experienced colleagues could build on this existing strength. Integration reviews have repeatedly identified mentorship and peer support as useful strategies for reducing uncertainty and strengthening belonging [9], [10].

In contrast, access to housing assistance was rated negatively and was the lowest support-system item. Housing is not merely an administrative issue; it directly affects commuting, financial security, family settlement, and overall stability. For internationally recruited staff who arrive without detailed knowledge of local rental markets, limited housing assistance can increase the burden of adjustment. The relatively low ratings for expatriate groups, local support groups, and mental-health or self-care resources also suggest that formal and community-based supports were less central than family and workplace relationships.

These results indicate that hospitals and recruitment partners may need to conceptualize support more broadly. Clinical orientation alone does not resolve the practical challenges of international relocation. A comprehensive program could include pre-arrival information, temporary accommodation guidance, housing referral resources, clear information on employment and immigration processes, access to counseling, and introductions to local community or professional networks. International evidence indicates that challenges faced by migrant nurses span both work and non-work domains, and unresolved settlement difficulties can interact with occupational stress [12], [13], [15]. A recent UK scoping review similarly identified workplace adaptation, discrimination, social integration, and coping and support as recurring dimensions of internationally educated nurses' experiences [29].

#### **D. Demographic and employment correlates**

Age was positively associated with all three domains in the original analysis. One possible interpretation is that older nurses may bring more accumulated professional and life experience, enabling them to contextualize unfamiliar situations, regulate stress, and draw on established coping strategies. Age may also overlap with unmeasured factors such as prior international experience, seniority, family resources, or professional confidence. Because the study used a small cross-sectional sample, age should not be treated as a causal determinant of adaptation. Rather, the finding suggests that younger nurses may warrant particular attention during transition, especially when they are simultaneously adapting to a new healthcare system and living environment.

Civil status was associated with cultural adaptation and support systems but not workplace environment. This pattern is plausible because marital status may shape social responsibilities, family communication, living arrangements, and the structure of emotional support more directly than it shapes day-to-day clinical processes. Married nurses may maintain different family obligations and transnational support patterns from single nurses, while single nurses may have different opportunities

or needs for local social engagement. However, the study included only married and single participants and did not measure family co-residence, dependents, or whether spouses lived in the UK. The observed correlations therefore should be interpreted as preliminary rather than as evidence that one civil-status group adapts better than another.

Length of service was positively associated with cultural adaptation and workplace environment, but not support systems. This is consistent with the idea that repeated exposure to organizational routines, communication practices, colleagues, and local cultural norms can increase familiarity over time. Longer-serving nurses have more opportunities to learn how the institution functions and to build confidence within the team. By contrast, support systems may depend less on tenure and more on personal relationships, family circumstances, housing, and access to services. The absence of an association between department and any domain suggests that the broad challenges and supports experienced by these nurses were not specific to medical versus surgical assignment in this sample.

These correlations need methodological caution. The sample was only 26 participants, several predictors were categorical or ordinal, and the original analysis relied on Pearson correlation coefficients. Small samples can produce unstable coefficients, and coding choices for categorical variables can affect the magnitude and direction of associations. The findings are therefore best treated as exploratory signals that can guide future research rather than as definitive evidence of demographic effects.

#### **E. Implications for nursing management and international recruitment**

The study identifies a practical pattern that can inform local workforce support. First, the strong workplace scores suggest that DMH can build on existing strengths in clinical orientation, professional development, and access to resources. Second, the lower community-participation and housing-support scores indicate that adaptation programs should not end at the ward or departmental level. International nurses require support as employees and as migrants establishing daily life in a new country.

A staged support model may be appropriate. Before or immediately after arrival, nurses could receive structured orientation on the NHS and local hospital systems, communication expectations, patient-safety processes, employment rights, local transportation, accommodation, and community services. During the first year, formal mentorship could pair newly recruited Filipino nurses with experienced nurses who understand both DMH systems and the adjustment challenges of international recruitment. Peer-support meetings could provide a structured space to discuss communication difficulties, role expectations, stress, and practical concerns without stigma. Managers could also encourage participation in professional development and departmental discussions so that international nurses move from basic role adaptation toward fuller professional inclusion. A 2026 systematic review of workplace support strategies likewise emphasizes tailored orientation, communication support, mentorship, and organizational approaches for internationally educated nurses' transition [30].

Psychosocial and settlement support should be visible and easy to access. Counseling and mental-health resources may exist but remain underused if staff are uncertain about confidentiality, eligibility,

or how to access them. Similarly, community and expatriate groups are useful only when nurses know they exist and can participate around shift schedules. Hospitals do not necessarily need to provide housing directly, but they can maintain vetted housing information, connect recruits with reliable local resources, and coordinate temporary accommodation or relocation guidance where feasible.

#### **F. Strengths and limitations**

The study provides institution-specific evidence from Filipino nurses working directly within medical and surgical services in a UK hospital. It examines professional, cultural, and social dimensions together rather than treating transition solely as a clinical competency issue. The item-level results also identify specific areas of strength and weakness that can be translated into practical support measures.

Several limitations substantially constrain interpretation. The sample was small ( $n = 26$ ), selected purposively, and drawn from a single hospital. The results therefore cannot be generalized to all Filipino nurses in the NHS or the wider UK. Self-reported responses may be influenced by social desirability, particularly when questions concern the employer, supervisors, or professional competence. The questionnaire was self-developed; although the source manuscript reports expert validation and pilot testing, the numerical reliability coefficient was not provided. The study is cross-sectional, so temporal or causal relationships cannot be inferred. The use of Pearson correlation for categorical and ordinal profile variables also warrants caution. Finally, complete reporting of instrument reliability, the data-collection period, and ethical approval details is important for reproducibility and should accompany the final journal submission.

Future studies should recruit larger multi-site samples and use validated measures of acculturation, workplace integration, psychological well-being, and organizational support. Qualitative interviews could also complement survey findings by exploring why community participation and housing support are relatively weak and how nurses experience mentorship, leadership, and belonging over time. Longitudinal designs would be especially useful for examining how adaptation changes from arrival through the first several years of UK employment.

### **Conclusion**

Filipino nurses working in the medical and surgical services of Darlington Memorial Hospital reported generally positive experiences across cultural adaptation, workplace environment, and support systems. The workplace environment emerged as the strongest domain, particularly participants' understanding of local healthcare practices and ability to adapt nursing practice to the UK context. Support was strongly anchored in family relationships and workplace peers. In contrast, local community participation and housing assistance were comparatively weak, suggesting that professional adaptation may progress more quickly than broader social and practical settlement.

Age, civil status, and length of service showed significant relationships with selected domains in the original analysis, while department did not. Given the small sample and exploratory analytic approach, these findings should be interpreted cautiously. For practice, the results support a broader model of international nurse integration that combines clinical orientation with mentorship, peer support, visible psychosocial services, opportunities for participation in team activities, and practical settlement

assistance. Such measures may help internationally educated Filipino nurses move beyond initial workplace adjustment toward sustained professional inclusion and social integration.

### Conflict of Interest

There is no conflict of interest among the authors.

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