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Cultural Adaptation and Support Resources among Filipino Migrant Nurses in a UK Hospital: A Descriptive Cross-Sectional Study

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ABSTRACT

Internationally recruited nurses must adapt not only to new healthcare systems but also to unfamiliar cultural and social environments. This study examined cultural adaptation and support resources among Filipino migrant nurses employed at Darlington Memorial Hospital in the United Kingdom and explored associations with selected demographic and employment characteristics. A descriptive cross-sectional survey was conducted among 26 Filipino nurses recruited through purposive sampling. Participants completed a self-developed, expert-validated questionnaire using a four-point Likert-type scale. The analysis focused on cultural adaptation and support system domains. Descriptive statistics and exploratory Pearson correlation analyses were performed. Participants reported generally favorable cultural adaptation (mean = 3.08). Managing cultural differences in the workplace received the highest rating (mean = 3.35), whereas participation in local community events was lowest (mean = 2.42). Perceived support resources were also favorable overall (mean = 3.11). Maintaining contact with family and friends in the Philippines received the highest rating (mean = 3.85), while access to housing assistance was lowest (mean = 2.46). Cultural adaptation was significantly associated with age ($r = .55$, $p = .003$), civil status ($r = .64$, $p < .001$), and length of service ($r = .44$, $p = .026$). Support resources were associated with age ($r = .40$, $p = .041$) and civil status ($r = .58$, $p = .002$). Findings suggest that workplace cultural adjustment may coexist with limited community integration and continued reliance on transnational family support. Targeted organizational support may facilitate broader adjustment.

Keywords
Cultural Adaptation
Filipino Nurses
International Nurses
Migrant Nurses
Social Support
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Introduction

Internationally educated nurses (IENs) have become an integral component of healthcare workforces in many high-income countries, including the United Kingdom. International recruitment may help health systems address staffing pressures, but recruitment alone does not ensure successful workforce integration or long-term retention. Recent evidence from England indicates that internationally recruited nurses encounter a transition extending beyond registration and clinical placement to include settlement, organizational integration, recognition of previous experience, career development, relationships with managers and colleagues, and adaptation to everyday life in the host country [1], [2]. An integrative review focusing specifically on England similarly identified expectations, challenges, and belongingness as recurring dimensions of IENs' experiences during their early years in the National Health Service (NHS) [3].

The transition of internationally educated nurses is therefore better understood as a multidimensional process involving professional, cultural, and social adjustment. A recent systematic review identified discrepancies between nurses' pre-migration expectations and their experiences after arrival, alongside communication difficulties, cultural differences, recognition of professional competence, discrimination, and organizational support as important determinants of integration [4]. Earlier systematic evidence similarly demonstrated that acculturation and retention are influenced by the interaction between workplace conditions and nurses' wider sociocultural experiences [5]. Consequently, successful adjustment should not be conceptualized solely as an individual's capacity to adapt; it also depends on the social and organizational environment into which the nurse is received.

This distinction is particularly important when considering cultural adaptation. International nurses must interpret unfamiliar communication practices, social expectations, professional norms, and relationships while continuing to deliver safe and effective nursing care. An umbrella review of integration strategies identified three interconnected areas of support: intra-organizational strategies, sociocultural support, and professional development [6]. Similarly, a recent qualitative evidence synthesis identified cultural and language differences, variation in the scope of professional practice, leadership, discrimination, and

interpersonal relationships as major influences on workplace integration [7]. These findings suggest that cultural adjustment is not limited to knowledge of local customs; it intersects with communication, professional identity, workplace belonging, social interaction, and opportunities to participate in the wider host community.

Professional adaptation and broader social integration may nevertheless develop at different rates. A nurse may become proficient in navigating clinical routines and communicating within a hospital while having fewer opportunities to develop social connections outside work. This distinction is consistent with contemporary integration frameworks that separate organizational and professional adaptation from sociocultural integration [4], [6]. Such differentiation is important when evaluating migrant nurses because assessments based exclusively on workplace functioning may overlook difficulties related to settlement, belonging, community participation, or relationships outside the employing institution.

Support resources are another central component of international nurses' adjustment. These resources may be formal, such as orientation, mentorship, counseling, or organizational assistance, or informal, including relationships with colleagues, friends, other migrant nurses, and family members. A 2024 systematic review focusing specifically on Asian internationally educated nurses found that workplace social support, induction programs, career opportunities, and the ability to maintain family relationships were among the factors relevant to retention in host countries [8]. Recent research involving Filipino internationally qualified nurses also found that social support was positively related to favorable professional outcomes, while the practice environment was linked to acculturation and psychological adjustment [9]. Together, these findings emphasize that adaptation occurs within networks of both professional and personal resources rather than through individual resilience alone.

For Filipino migrant nurses, family relationships warrant particular attention. Migration is often embedded within family obligations, aspirations, and transnational relationships rather than being an exclusively individual professional decision. Recent research examining Filipino migrant and returnee nurses illustrates how migration trajectories remain closely connected to family structures, expectations, financial responsibilities, and decisions concerning continued migration or return [11]. These connections can persist even when nurses establish careers abroad, suggesting that support in the country of origin and support in the host country may coexist rather than replace one another.

Filipino-specific evidence from the United Kingdom remains comparatively limited. A recent qualitative investigation of Filipino nurses in the UK during the COVID-19 pandemic documented substantial psychological and systemic pressures together with culturally

situated coping responses [10]. However, this work occurred within the exceptional circumstances of the pandemic. More broadly, reviews of IENs working in England continue to identify a need for research addressing cultural, pastoral, social, and training needs during nurses' transition into both the workplace and life in the host country [2], [3].

Another limitation of the existing literature is the tendency to combine different dimensions of adjustment into a general concept of integration. Cultural adjustment, community participation, informal social support, formal organizational support, and practical settlement resources may not develop uniformly. Identifying their relative strengths and limitations can provide more actionable evidence than a single global assessment of migrant experience. Recent reviews of support interventions consequently emphasize that effective programs should be multidimensional rather than relying on one-off orientation or expecting internationally educated nurses to manage adaptation independently [12].

Against this background, the present study examined two related dimensions of adjustment among Filipino migrant nurses working at Darlington Memorial Hospital in the United Kingdom: cultural adaptation and perceived support resources. Specifically, the study aimed to (1) describe participants' perceived cultural adaptation; (2) examine the formal, informal, local, and transnational resources available to support them; and (3) explore whether cultural adaptation and support resources were associated with selected demographic and employment characteristics, including age, sex, civil status, length of service, and clinical department.

Methods

A. Study Design and Setting

A descriptive cross-sectional survey design was used to examine cultural adaptation and perceived support resources among Filipino nurses employed at Darlington Memorial Hospital in the United Kingdom. The study formed part of a broader survey examining adaptation, workplace environment, and support among Filipino nurses working in the hospital's medical and surgical departments.

B. Participants and Sampling

Participants were Filipino nurses employed at Darlington Memorial Hospital. Purposive sampling was used to recruit nurses who met the study eligibility criteria. To be included, participants were required to: (1) be Filipino nurses currently employed full-time at Darlington Memorial Hospital; (2) have been actively working in their respective unit or department for at least six months at the time of data collection; and (3) provide informed consent to participate. Nurses employed part-time, those who had worked in their current department for less than six months, and those who did not consent to participate were excluded. A total of 26 Filipino nurses participated in the study.

C. Survey Instrument

Data were collected using a self-developed questionnaire designed to assess the adjustment and support experiences of Filipino migrant nurses. The broader questionnaire contained three domains: cultural adaptation, workplace environment, and support system. The present article focused only on the cultural adaptation and support system domains. Items were rated using a four-point Likert-type scale ranging from 1 (strongly disagree) to 4 (strongly agree). In the original scoring framework, mean values of 3.25–4.00 were interpreted as *strongly agree*, 2.50–3.24 as *agree*, 1.75–2.49 as *disagree*, and 1.00–1.74 as *strongly disagree*. Mean scores are retained in the present analysis to facilitate comparison across items.

The cultural adaptation domain consisted of 10 items assessing familiarity with local customs, language proficiency, communication with local residents, local social connections, participation in community activities, adjustment to everyday routines, management of cultural differences, experiences of homesickness or culture shock, acceptance by local residents, and integration while retaining cultural identity.

The support system domain contained 10 items addressing access to formal organizational services, mentorship, assistance from fellow Filipino nurses, local support groups, mental health resources, communication with family and friends in the Philippines, relationships with workplace colleagues, expatriate groups, housing assistance, and performance feedback.

D. Instrument Validation

The questionnaire underwent face and content validation involving experts from academic and nursing backgrounds. Feedback concerning the relevance and appropriateness of the survey items was incorporated into the instrument before administration. A pilot study involving five nurses working abroad was also undertaken to assess internal consistency using Cronbach's alpha. The original document does not report the numerical reliability coefficient. The coefficient for each subscale should therefore be retrieved from the original dataset or pilot analysis and reported before journal submission:

E. Data Collection

Electronic and printed versions of the questionnaire were prepared. Survey forms were distributed to eligible participants through available institutional and personal communication channels, including email. Participants were provided with instructions for completing the questionnaire and were given approximately one week to respond. Participation was voluntary. Procedures were implemented to protect anonymity and confidentiality throughout data collection and handling.

F. Statistical Analysis

Participant characteristics were summarized using frequencies and percentages. Mean scores were calculated for individual cultural adaptation and support items and for the two

overall domains. Exploratory bivariate associations between participant characteristics and domain scores were examined using Pearson correlation coefficients in the original analysis. Statistical significance was evaluated at an alpha level of .05. Because several profile variables were categorical or ordinal and the sample was small, these correlation results should be interpreted as exploratory. The numerical coding of age, civil status, length of service, sex, and department should be confirmed against the original dataset before publication, and an alternative non-parametric or group-comparison analysis may be considered during final statistical verification.

Results

A. Participant Characteristics

The study included 26 Filipino nurses. Most participants were aged 31–40 years (69.24%), while 15.38% were aged 41–50 years. Participants aged 21–30 years and those older than 50 years each represented 7.69% of the sample. Most participants were female (76.92%), and slightly more than half were married (53.85%). Half of the nurses had worked at Darlington Memorial Hospital for one to three years. Approximately 30.77% had four to six years of service, whereas 15.38% had worked for 10 years or longer. Fifteen participants (57.69%) worked in surgical areas and 11 (42.31%) in medical areas.

Table 1. Characteristics of Participants (N = 26)

Characteristic	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
Clinical area		
Surgical	15	57.69
Medical	11	42.31

B. Cultural Adaptation

The overall cultural adaptation mean was 3.08, corresponding to *agree* within the original scoring framework. The highest-rated item was the participants' perceived ability to manage or cope with cultural differences in the work environment (M = 3.35). High language proficiency was also rated relatively favorably (M = 3.27), followed by participants' perception

that they could integrate into the local community while maintaining their cultural identity (M = 3.23). The lowest-rated cultural adaptation item was participation in local community events or activities (M = 2.42). This was the only item within the domain that fell within the original *disagree* range. Having local friends or acquaintances was also comparatively lower (M = 3.00) than most other cultural adaptation indicators.

Table 2. Cultural Adaptation among Filipino Migrant Nurses

Cultural adaptation indicator	Mean	Original interpretation
Familiar with local customs and traditions in the UK	3.08	Agree
High proficiency in the local language	3.27	Strongly Agree
Comfortable initiating conversations with local residents	3.08	Agree
Has local friends or acquaintances	3.00	Agree
Participates in local community events or activities	2.42	Disagree
Has adapted daily routines to local practices	3.08	Agree
Can manage or cope with cultural differences in the work environment	3.35	Strongly Agree
Experienced homesickness/culture shock only for a short period	3.12	Agree
Feels accepted and respected by local residents	3.19	Agree
Is integrated while maintaining cultural identity	3.23	Agree
Overall cultural adaptation	**3.08**	**Agree**

C. Support Resources

The overall mean for perceived support resources was 3.11, classified as *agree* using the original scoring framework. The highest-rated item was maintaining regular contact with family and friends in the Philippines through telephone calls, video calls, email, or messaging applications (M = 3.85). Connection with workplace colleagues through friendships, mentorship, or peer support was also rated highly (M = 3.42). Seeking assistance from fellow Filipino nurses received a mean of 3.31. The lowest-rated item was access to housing options or assistance in finding accommodation (M = 2.46), which fell within the *disagree* range. Participation in local groups providing opportunities to share experiences and emotions (M = 2.69) and participation in expatriate groups or organizations (M = 2.81) were also among the comparatively lower-rated forms of support.

Table 3. Perceived Support Resources among Filipino Migrant Nurses

Support resource	Mean	Original interpretation
Access to formal hospital support services	3.19	Agree
Presence of a mentor or workplace buddy	3.23	Agree
Assistance or guidance from fellow Filipino nurses	3.31	Strongly Agree
Participation in local groups providing a safe space to share experiences	2.69	Agree
Access to mental health and self-care resources	2.92	Agree
Regular communication with family and friends in the Philippines	3.85	Strongly Agree
Connection with workplace colleagues, mentors, or peer groups	3.42	Strongly Agree
Participation in expatriate groups, clubs, or organizations	2.81	Agree
Access to housing or assistance in finding accommodation	2.46	Disagree
Timely performance feedback and opportunities for professional growth	3.23	Agree
Overall support resources	**3.11**	**Agree**

D. Associations with Cultural Adaptation and Support Resources

Exploratory bivariate analyses showed that cultural adaptation was positively associated with age (r = .55, p = .003), civil status (r = .64, p < .001), and length of service (r = .44, p = .026). No statistically significant associations were observed between cultural adaptation and sex (r = .16, p = .430) or clinical department (r = .19, p = .365). For support resources, statistically significant associations were observed with age (r = .40, p = .041) and civil status (r = .58, p = .002). Associations with sex (r = .23, p = .265), length of service (r = .24, p = .245), and department (r = .27, p = .190) were not statistically significant.

Table 4. Exploratory Associations of Participant Characteristics with Cultural Adaptation and Support Resources

Participant characteristic	Cultural adaptation r	p-value	Support resources r	p-value
Age	.55	.003	.40	.041
Sex	.16	.430	.23	.265
Civil status	.64	<.001	.58	.002
Length of service	.44	.026	.24	.245
Clinical department	.19	.365	.27	.190

Discussion

The present study examined cultural adaptation and support resources among Filipino migrant nurses employed in a UK hospital. The findings reveal a pattern that is more nuanced than a simple classification of participants as either successfully or unsuccessfully adapted. Overall cultural adaptation was favorable, yet substantial variation was evident across individual indicators. Participants reported their greatest confidence in managing cultural differences within the workplace, whereas participation in local community activities was markedly lower. A similarly differentiated pattern emerged for support resources: regular communication with family and friends in the Philippines was the strongest source of support, whereas access to assistance with housing was the least favorably rated. Taken together, these findings suggest that workplace cultural functioning, community integration, transnational relationships, and practical settlement support represent related but distinct dimensions of migrant adjustment.

A. Cultural Adaptation: Workplace Functioning Does Not Necessarily Equal Community Integration

Participants reported an overall cultural adaptation mean of 3.08. Their ability to manage cultural differences in the workplace received the highest rating (M = 3.35), while participation in local community events and activities received the lowest rating (M = 2.42). This difference is noteworthy because it suggests that cultural adaptation may be more advanced within the structured environment of employment than within the broader social environment of the host country.

Recent literature supports a multidimensional interpretation of integration. Kamau et al. [6] distinguished between intra-organizational, sociocultural, and professional development processes when synthesizing strategies for integrating culturally and linguistically diverse nurses. Rajpoot et al. [4] likewise emphasized that migration involves professional, cultural, and social transitions and that successful integration requires sustained support rather than a one-directional expectation that the international nurse simply conforms to the receiving system.

The current findings fit this distinction. Repeated exposure to patients, colleagues, procedures, and institutional expectations may provide nurses with continuous opportunities to learn how cultural differences operate in clinical practice. Community participation, in contrast, depends on opportunities and relationships extending beyond scheduled employment. Shift work, settlement responsibilities, limited familiarity with local organizations, transportation, family obligations, or individual preferences may affect community involvement. These explanations remain hypotheses because the present survey did not ask participants why they participated less frequently in community activities.

Accordingly, the low community-participation score should not be interpreted as evidence of failed cultural adaptation. Nor should greater community participation automatically be considered the preferred endpoint for every migrant nurse. Rather, it identifies a dimension of adjustment that differs from participants' relatively strong confidence in managing workplace cultural differences. This distinction is important for both measurement and intervention: programs intended to improve clinical transition may not automatically improve social connectedness outside the hospital.

B. Adaptation while Maintaining Cultural Identity

Participants also reported relatively favorable perceptions of their ability to integrate while maintaining their cultural identity. This finding argues against interpreting successful adaptation as cultural replacement or assimilation. Contemporary research increasingly frames integration as reciprocal and context dependent rather than requiring internationally educated nurses to abandon previous professional or cultural identities.

Rajpoot et al. [4] criticized what they characterized as a “one-way integration” logic in which responsibility for successful transition is placed primarily on internationally educated nurses. Similarly, Shiju et al. [7] identified organizational and contextual barriers in addition to nurse-related factors, emphasizing that integration is shaped by the receiving environment. More recent work on support interventions has likewise concluded that effective integration requires multifaceted organizational responses and opportunities for two-way learning [12].

This perspective is particularly relevant for Filipino nurses. Migration does not necessarily dissolve cultural identity or existing relationships. Rather, nurses may develop the capacity to

work effectively within UK healthcare norms while retaining practices, relationships, and identities connected to the Philippines. Spiliopoulos and Cuban [11] demonstrate that Filipino nurse migration involves continuing negotiation between professional mobility, family expectations, cultural identity, and obligations across national boundaries.

Thus, the present finding that participants generally perceived themselves as integrated while retaining their cultural identity may represent a form of adaptive bicultural functioning rather than incomplete assimilation. Future research would benefit from examining this process using established acculturation measures and qualitative interviews capable of capturing how nurses themselves define successful adaptation.

C. Transnational Family Ties as a Central Support Resource

The highest-rated support item in the present study was regular communication with family and friends in the Philippines (M = 3.85). This was substantially higher than several formal or locally organized sources of support. The finding suggests that migration did not replace established interpersonal networks; instead, digital communication enabled these relationships to continue across national borders.

This pattern is consistent with evidence emphasizing the role of families in international nurses' migration experiences. The systematic review by Ung et al. [8], which specifically examined Asian internationally educated nurses, identified family-related considerations and workplace social support among factors relevant to retention. Pressley et al. [2], in their study of 773 internationally educated nurses during their first two years living and working in England, similarly identified family circumstances as an important component of the migration experience.

For Filipino nurses, the significance of these relationships is also supported by recent migration research. Spiliopoulos and Cuban [11] showed that the professional trajectories of Filipino migrant nurses are closely interwoven with family responsibilities, remittances, family crises, and decisions regarding return or continued migration. Filipino-specific research has therefore reinforced the argument that professional migration cannot be understood independently of transnational family life.

Recent quantitative evidence also provides support for the broader relevance of social support. Berdida et al. [9], studying Filipino internationally qualified nurses, found that social support was positively associated with job satisfaction within a broader model incorporating stress, psychological well-being, practice environment, resilience, and acculturation. Although the outcome measures and setting differ from those in the present study, the results strengthen the argument that social resources are not peripheral to migrant adjustment.

The present results therefore suggest that support for migrant nurses should be conceptualized as multi-sited. Some support is generated within the hospital, some within

migrant and local networks, and some remains physically located in the country of origin. This distinction is potentially important for future measurement: an assessment limited to organizational support could substantially underestimate the resources on which migrant nurses actually depend.

D. Local Professional Networks Remain Important

Although transnational family communication received the highest rating, locally available interpersonal support was also evaluated positively. Participants reported favorable connections with colleagues, mentors, peer groups, and fellow Filipino nurses. These relationships may perform functions that family members abroad cannot provide, particularly when assistance requires knowledge of the workplace, local healthcare practices, or immediate practical circumstances.

Evidence from contemporary reviews consistently identifies collegial support, mentorship, preceptorship, and structured orientation as important components of IEN integration. Kamau et al. [6] identified mentorship and preceptorship within professional-development strategies and peer/social support within broader organizational and sociocultural approaches. Rajpoot et al. [4] similarly recommended induction, preceptorship, mentorship, language support, and sustained organizational involvement rather than short-term adjustment measures.

The importance of organizational support has become even more explicit in recent literature. Smythe and Laing's 2026 integrative review concluded that support interventions need to address the complexity of internationally educated nurses' experiences and that isolated interventions are unlikely to address all dimensions of transition [12].

For the present participants, experienced Filipino colleagues may have particular value because they combine familiarity with Filipino cultural and migration experiences with practical knowledge of the UK workplace. However, organizations should avoid assuming that support for newly recruited international nurses is solely the responsibility of nurses from the same nationality. Formal institutional systems remain necessary to ensure that support is consistent, equitable, and sustainable.

E. Housing Highlights the Difference between Social and Structural Support

The lowest-rated support item concerned access to housing options or assistance in finding accommodation (M = 2.46). This finding differs conceptually from items concerning family communication, friendship, or mentorship because housing represents a structural and practical settlement resource.

Recent England-based evidence suggests that these practical dimensions deserve greater consideration in international nurse integration. Pressley et al. [1] examined arrival, settlement, and early workforce integration among 655 internationally recruited nurses in England. Their subsequent study of the first two years of nurse migration specifically identified

financial circumstances, living conditions, family considerations, and housing among issues relevant to the broader migration experience [2].

The present result should nevertheless be interpreted precisely. It does not demonstrate that Darlington Memorial Hospital failed to meet a formal obligation to provide housing, because the study did not examine contractual entitlements, employer policies, housing availability, or actual accommodation quality. The finding indicates only that participants perceived comparatively limited access to company-provided accommodation or assistance with locating housing.

This distinction matters because practical settlement needs can exist even where interpersonal relationships are favorable. A nurse may receive considerable emotional support from family, colleagues, and mentors while simultaneously facing difficulties with accommodation, transportation, immigration procedures, or other aspects of relocation. Consequently, migrant support programs that focus exclusively on emotional wellbeing or clinical orientation may overlook structural factors that influence everyday adjustment.

The emerging support literature reinforces the need for this broader approach. Contemporary reviews recommend multidimensional interventions addressing not only professional competence but also communication, cultural adjustment, organizational processes, social support, and wider transition needs [6], [12].

F. Community and Expatriate Networks Were Used Less Strongly

Participants rated participation in local support groups and expatriate organizations less favorably than communication with family or workplace colleagues. This provides additional evidence that strong social support does not necessarily imply extensive participation in organized local networks.

Several explanations are possible. Nurses may receive sufficient support through family and workplace relationships and therefore perceive less need for formal community groups. Alternatively, work schedules, access, awareness, transportation, or the availability of appropriate groups may restrict participation. The present data cannot distinguish between these possibilities.

The distinction is nevertheless useful because it cautions against assuming that all forms of support are interchangeable. Family communication may provide emotional continuity; colleagues may provide professional and immediate practical support; migrant associations may provide community belonging and shared experience; and organizations may provide institutional resources. Each operates through different mechanisms.

Rather than requiring community participation, healthcare organizations could reduce barriers by making information about local networks, professional organizations, Filipino associations, community services, and recreational opportunities readily available during

onboarding. This approach is consistent with evidence recommending sociocultural as well as workplace-based strategies for international nurse integration [6].

G. Exploratory Associations with Age, Civil Status, and Length of Service

The exploratory analyses showed that cultural adaptation was associated with age, civil status, and length of service, whereas support resources were associated with age and civil status. These relationships require substantially more caution than the descriptive results. The finding for length of service is conceptually plausible because cultural familiarity may develop through repeated exposure to the host environment. Recent research from England has emphasized that the first two years after migration constitute an important transition period during which internationally educated nurses continue to negotiate induction, professional recognition, career systems, workplace relationships, settlement, and family concerns [2].

Nevertheless, the present cross-sectional analysis cannot demonstrate that increasing length of service causes improved adaptation. Nurses with longer tenure may differ from recently recruited nurses in multiple unmeasured ways, and nurses who experienced greater difficulty may also have been more likely to leave before being included in the study.

The associations involving age and civil status should be interpreted even more cautiously. With only 26 participants, several small demographic groups, and an exploratory correlation-based analysis, these findings should not be treated as robust predictors of adaptation. Civil status, in particular, may operate as a proxy for differences in family structure, living arrangements, responsibilities, or available networks rather than exerting an independent effect.

Accordingly, these results are best presented as hypothesis-generating observations. Larger studies should test whether demographic characteristics remain associated with adaptation after accounting for migration history, time in the United Kingdom, previous overseas employment, family location, workplace support, and other potentially relevant factors.

H. Implications for Nursing Management and International Recruitment

The findings have several implications for organizations employing internationally recruited nurses. First, cultural support should extend beyond a single pre-employment or induction session. Transition is an ongoing process, and recent systematic evidence supports sustained, multidimensional approaches that combine organizational, sociocultural, and professional-development strategies [4], [6], [12]. Second, structured mentorship or preceptorship should be regarded as part of workforce integration rather than solely as clinical supervision. Mentors can assist new nurses with understanding organizational expectations, communication norms, local professional practices, and available resources. However, mentorship should complement rather than replace accountable institutional support. Third,

social integration initiatives should recognize diversity in nurses' preferences. Opportunities for community engagement, migrant networks, and professional associations can be made visible and accessible without treating participation as an obligation or as an indicator of successful assimilation. Fourth, organizations should distinguish interpersonal support from practical settlement support. The strong family and peer-support ratings in this study did not eliminate the comparatively unfavorable rating for housing assistance. International recruitment programs may therefore benefit from providing clear, realistic information concerning accommodation, local living costs, transportation, immigration processes, and available settlement resources. Recent evidence from internationally recruited nurses in England demonstrates that these broader living conditions form part of the migration and retention experience [1], [2].

Finally, support systems should acknowledge transnational family relationships as part of migrant nurses' social ecology. The objective should not be to replace support from home with local relationships but to facilitate the development of complementary networks in which family, peers, colleagues, mentors, and organizational resources serve different functions.

I. Strengths and Limitations

The study contributes focused evidence concerning a specific group of Filipino migrant nurses working within one UK hospital. Examining cultural adaptation and support resources separately provides a more differentiated picture than combining cultural, workplace, and social experiences into a single global score. However, several limitations substantially constrain inference. The sample was small (N = 26), originated from one hospital, and was recruited purposively. The findings therefore should not be generalized to Filipino nurses throughout the NHS or to internationally educated nurses more broadly. Responses were self-reported and may be affected by social desirability or other response biases. In addition, the questionnaire was self-developed, and complete psychometric information, including numerical reliability estimates for the analyzed domains, should be reported before publication.

The inferential findings require particular caution because the original analysis used Pearson correlations for demographic variables that included categorical and ordinal characteristics. Consequently, the associations should remain secondary and explicitly exploratory until the original dataset has been reanalyzed using statistical procedures appropriate to the level of measurement and small sample size.

Future studies should use larger, multicenter samples and validated measures of acculturation, social support, organizational support, and community integration. Longitudinal designs would be particularly valuable because they could determine whether cultural adaptation and different sources of support change during the first months and years following

migration. Recent research and systematic reviews continue to identify longitudinal evaluation and assessment of support interventions as priorities in international nurse integration research [4], [12].

Limitations

Several limitations should be considered when interpreting the findings. First, the sample consisted of only 26 Filipino nurses from a single UK hospital. The findings therefore cannot be generalized to Filipino nurses across the United Kingdom or to internationally educated nurses from other countries. Second, purposive sampling was used. Participants may differ systematically from eligible nurses who did not participate, creating the possibility of selection bias. Third, all measures were based on self-report. The findings represent participants' perceptions rather than objective assessments of cultural competence, community integration, organizational support, or housing availability. Fourth, the questionnaire was self-developed. Although the instrument underwent expert validation and pilot testing, the source document does not report the numerical reliability coefficients. Psychometric properties should be reported more completely before publication. Fifth, the cross-sectional design prevents conclusions about temporal or causal relationships. Associations between length of service and cultural adaptation, for example, should not be interpreted as demonstrating that longer employment causes improved adaptation.

Finally, the original exploratory analysis used Pearson correlation coefficients for demographic and employment variables that included categorical and ordinal measures. The coding and statistical treatment of these variables should therefore be reviewed before submission. Given the small sample, results from inferential analyses should be regarded as exploratory, with primary emphasis placed on the descriptive findings.

Conclusion

Filipino nurses working at the participating UK hospital reported generally favorable cultural adaptation and access to several forms of support. However, adjustment was not uniform across domains. Participants reported relatively strong capacity to manage cultural differences within the workplace but substantially lower participation in local community activities.

Support was particularly strong through continued communication with family and friends in the Philippines, demonstrating the importance of transnational relationships after migration. Workplace colleagues and fellow Filipino nurses also represented important sources of support. In contrast, access to housing assistance was perceived less favorably, highlighting a potential gap between interpersonal support and practical settlement resources.

The findings indicate that internationally recruited nurses may become professionally and culturally functional while still experiencing limitations in community integration and structural support. Healthcare organizations employing migrant nurses should therefore consider a multidimensional approach that combines cultural orientation, mentorship, peer support, opportunities for community engagement, and practical assistance with settlement needs. Larger and longitudinal studies are required to determine how these dimensions of adaptation change over time and how organizational interventions can best support internationally recruited nurses.

Conflict of Interest

The authors declare no conflict of interest in this study

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