

Workplace Integration and Professional Adaptation among Filipino Migrant Nurses in a UK Hospital: A Descriptive Cross-Sectional Study

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ABSTRACT

Internationally recruited nurses must transition into healthcare systems that may differ substantially from those in which they were educated and previously employed. This study examined workplace integration and professional adaptation 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 present analysis focused on the 10-item workplace environment domain. Descriptive statistics and exploratory Pearson correlation analyses were performed. Participants reported favorable workplace experiences overall (mean = 3.29). Understanding local healthcare practices and protocols and adapting nursing practice to cultural contexts received the highest rating (mean = 3.46). Professional development and access to resources each received a mean of 3.38, while workplace belonging was also rated favorably (mean = 3.35). Participation in team meetings or departmental activities received the lowest rating (mean = 3.12), followed by supportive leadership and clarity of reporting structures (both mean = 3.15). Workplace scores were significantly associated with age ($r = .52, p = .007$) and length of service ($r = .51, p = .007$), but not with civil status or clinical department. The findings suggest relatively strong clinical and procedural adaptation alongside opportunities to strengthen organizational participation, communication, and

structured support. Comprehensive onboarding, mentorship, leadership support, and sustained professional development may facilitate the workplace integration of internationally recruited nurses.

Keywords

Filipino Nurses
Migrant Nurses
Professional Adaptation
United Kingdom
Workplace Integration

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Introduction

Internationally educated and internationally recruited nurses constitute an important component of contemporary healthcare workforces. International recruitment can alleviate staffing pressures, but filling vacant posts represents only the beginning of the migration and employment process. Nurses entering a new healthcare system must learn organizational structures, clinical procedures, professional expectations, documentation practices, communication norms, and team relationships that may differ substantially from those encountered in their countries of education or previous employment. Evidence from internationally recruited nurses working in England indicates that difficulties can persist beyond initial recruitment and settlement and extend into workplace integration, recognition of previous professional experience, career development, and access to consistent organizational support [1], [2]. A global systematic review similarly found that preparedness, communication, nursing-practice differences, sociocultural adjustment, equity and inclusion, and organizational facilitation shape international nurses' acculturation and retention [3]. Retention research further indicates that personal, organizational, financial, political, and environmental factors interact in migrant nurses' decisions to remain in host-country employment [4].

The transition into a host-country nursing workforce is therefore not solely an issue of clinical competence. An internationally educated nurse may have substantial prior experience while still requiring time and structured support to understand how professional practice is organized within the receiving healthcare system. An integrative review of internationally educated nurses entering the nursing workforce in England identified expectations, adjustment challenges, and belonging as recurring components of their experiences [5]. Similarly, a recent narrative systematic review concluded that internationally educated nurses encounter interrelated challenges involving communication, cultural differences, professional role expectations, workplace relationships, recognition of competence, discrimination, and organizational support [6].

Workplace integration can consequently be understood as a multidimensional process in which nurses progressively become able to perform professional roles effectively while participating as recognized members of the healthcare team. This process includes knowledge of clinical protocols but also access to resources, role clarity, collegial relationships, organizational communication, leadership support, professional development, and opportunities to contribute to decision-making. An umbrella review by Kamau et al. grouped strategies supporting culturally and linguistically diverse nursing staff into intra-organizational, sociocultural, and professional development dimensions [7]. These dimensions emphasize that successful transition requires more than individual adaptation and depends partly on organizational structures that enable nurses to use and develop their professional competence.

Recent evidence has reinforced the importance of the receiving workplace. A qualitative evidence synthesis identified cultural and linguistic differences, variation in the scope of nursing practice, poor leadership, racism, and discrimination as barriers to workplace integration, whereas supportive relationships and opportunities for continued professional development facilitated integration [8]. A systematic review of quantitative studies similarly categorized factors associated with integration into six broad areas: sociodemographic characteristics, discrimination, social support, organizational support, workplace environment, and acculturation [9]. These findings indicate that integration is produced through interactions between individual characteristics and organizational conditions rather than through adaptation by the migrant nurse alone. In a large Singapore study, acculturation was also linked with international nurses' work environment and quality of life, underscoring the interaction between individual adaptation and organizational context [10]. Canadian evidence likewise shows that coworker relationships, continuing professional development, and minority status can influence perceived workplace integration [11].

Clinical and procedural adaptation represents one important component of this process. International nurses must become familiar with local standards, protocols, documentation systems, division of responsibilities, patient-safety procedures, and professional accountability. Even where fundamental nursing knowledge is transferable across countries, the organizational expression of nursing practice can differ. International nurses may therefore encounter situations in which they are clinically experienced but unfamiliar with the expectations attached to their new institutional setting.

The transition may be complicated when internationally recruited nurses perceive that their previous experience is insufficiently recognized. Pressley et al. found that internationally recruited nurses entering the English workforce were generally highly educated and experienced, yet some experienced mismatch between previous qualifications or experience

and the positions into which they were appointed [1]. Their subsequent investigation of nurses' first two years living and working in England demonstrated that adaptation remains an ongoing process rather than a discrete event occurring immediately after recruitment [2]. Recognition of competence and opportunities for progression are therefore relevant to both integration and longer-term retention.

Workplace belonging is another important dimension. Nurses do not function independently; clinical practice requires communication and coordination with other nurses, physicians, allied health professionals, managers, patients, and families. For internationally educated nurses, acceptance by colleagues and the ability to participate meaningfully in workplace interactions can influence whether they experience themselves as full members of the organization. Qualitative research among culturally and linguistically diverse nurses has highlighted organizational acceptance, acknowledgement of competence, tailored orientation, language support, mentorship, and nurse-manager involvement as important components of integration [12]. Earlier evidence from England documented internationally recruited nurses' experiences of discrimination, support, and adjustment across multiple NHS hospitals [13], while qualitative work with internationally recruited neonatal nurses identified preparation, role restriction, deskilling, and professional development as salient transition issues [14].

Leadership is particularly relevant because nurse managers can influence placement, orientation, access to developmental opportunities, team relationships, and responses to problems during transition. A 2025 qualitative study examining internationally qualified nurses and domestically qualified colleagues identified nursing management as central to workplace integration, including appropriate placement and organizational support [15]. Leadership therefore affects not only administrative processes but also whether internationally recruited nurses can participate effectively and confidently within clinical teams. UK research has also shown that mismatch between migrant nurses' prior expertise and available roles can restrict career development and contribute to dissatisfaction [16].

The integration of internationally educated nurses also has implications for workforce sustainability. A systematic review focusing on Asian internationally educated nurses identified career opportunities, occupational mobility, acculturation, organizational support, and workplace social support among factors associated with retention in host countries [17]. For employers that recruit internationally, effective integration is therefore relevant not only to immediate staffing but also to whether internationally recruited nurses develop sustainable careers within the organization. An integrative review of transition to practice in the United States identified collegial support and self-efficacy as facilitators, while communication, cultural and practice differences, educational stigma, and legal issues remained barriers [18].

More recent orientation research has reinforced the importance of structured onboarding for retention of internationally educated nurses [19].

Filipino nurses constitute a particularly relevant population within international nurse migration. Migration from the Philippines to the United Kingdom has long been shaped by professional aspirations, economic considerations, family responsibilities, and perceptions of the UK as a potential destination for professional and personal security [20]. However, migration to a desired destination does not itself guarantee satisfactory professional integration. Nurses must still negotiate the specific expectations of their employing institutions and the professional culture of the host healthcare system. Studies from the United States further show that internationally educated nurses may encounter emotional, cultural, and professional barriers during transition [21], while Filipino-specific evidence highlights job satisfaction and professional adaptation as continuing workforce concerns [22]. Canadian workforce data also demonstrate that successful integration depends on both professional recertification and access to employment commensurate with nurses' human capital [23].

Recent Filipino-specific research further demonstrates that workplace conditions remain relevant after international migration. Berdida et al. examined Filipino internationally qualified nurses and identified relationships among practice environment, psychological well-being, social support, resilience, job satisfaction, and acculturation [24]. Although conducted in a different setting and using different outcome measures, these findings reinforce the importance of examining the organizational context in which Filipino migrant nurses work.

Despite growing international literature, workplace integration is often studied together with broader cultural or migration experiences. Separating workplace processes from community and social adaptation can provide a more precise assessment of professional transition. An internationally recruited nurse may be socially well adjusted but encounter organizational difficulties, or may adapt rapidly to clinical practice despite continuing challenges outside the workplace.

The present study therefore focused specifically on the workplace environment domain of a broader survey of Filipino migrant nurses employed at Darlington Memorial Hospital (DMH), United Kingdom. In this article, workplace integration and professional adaptation were operationalized through participants' perceptions of communication, participation, professional development, understanding of healthcare practices, workplace belonging, safety, resources, leadership, role clarity, and reporting structures.

The study aimed to: (1) describe perceived workplace integration and professional adaptation among Filipino migrant nurses working at DMH; and (2) explore associations between workplace scores and selected demographic and employment characteristics, including age, sex, civil status, length of service, and clinical department.

Methods

A. Study Design

A descriptive cross-sectional survey was conducted among Filipino nurses employed at Darlington Memorial Hospital in the United Kingdom. The study formed part of a broader investigation examining cultural adaptation, workplace environment, and support systems among Filipino migrant nurses. The present article reports specifically on the workplace environment component of the survey and its associations with selected participant characteristics.

B. Study Setting and Participants

The study was conducted at Darlington Memorial Hospital among Filipino nurses working in medical and surgical clinical areas. Purposive sampling was used to identify eligible participants. Nurses were eligible if they:

1. Were Filipino nurses employed full-time at Darlington Memorial Hospital;
2. Had been actively working in their respective clinical unit or department for at least six months at the time of the survey; and
3. Willing to provide informed consent.

Nurses employed part-time, those who had worked at DMH for less than six months, and those who did not provide consent were excluded. A total of 26 nurses participated.

C. Data Collection Instrument

Data were collected using a self-developed questionnaire designed to assess three areas of migrant nurses' experiences: cultural adaptation, workplace environment, and support system. The present analysis used only the workplace environment domain. The workplace environment domain consisted of 10 items addressing:

1. Comfort in discussing work-related issues with colleagues and supervisors;
2. Participation in team meetings and departmental activities;
3. Engagement in professional development;
4. Understanding of local healthcare practices and protocols;
5. Belonging and acceptance within the healthcare team;
6. Perceived safety and comfort in the workplace;
7. Access to resources and tools required for job performance;
8. Supportive leadership and management;
9. Clarity of job roles and expectations; and
10. Clarity of reporting structures and lines of communication.

Responses were rated on a four-point Likert-type scale ranging from 1 = strongly disagree to 4 = strongly agree. The original scoring system categorized mean scores as follows:

- 3.25–4.00 = Strongly Agree

- 2.50–3.24 = Agree
- 1.75–2.49 = Disagree
- 1.00–1.74 = Strongly Disagree.

For this article, the individual and overall mean scores were retained primarily as descriptive measures of participants' workplace perceptions.

D. Instrument Validation and Pilot Testing

The questionnaire underwent face and content validation by experts with backgrounds in research, academia, and nursing. Comments concerning the relevance and appropriateness of individual items were incorporated before administration. A pilot study involving five nurses working abroad was conducted to assess the internal consistency of the instrument using Cronbach's alpha.

E. Data Collection Procedure

Questionnaires were prepared in electronic and printed formats. Electronic questionnaires were distributed through participants' email addresses and other available communication channels. Printed questionnaires could be distributed through relevant nursing supervisors or managers. Participants received instructions for completing the questionnaire and were given approximately one week to respond. Participation was voluntary, and anonymity and confidentiality were maintained throughout the study.

F. Statistical Analysis

Frequencies and percentages were used to summarize participant characteristics. Mean scores were calculated for each of the 10 workplace environment items and for the overall workplace domain. The original analysis used Pearson correlation coefficients to explore relationships between participant characteristics and workplace environment scores. Statistical significance was evaluated at $p < .05$. Because several demographic variables were categorical or ordinal and the sample was small, these inferential analyses should be regarded as exploratory. The coding of age, sex, civil status, length of service, and department should be verified against the original dataset before publication.

Results

A. Participant Characteristics

Twenty-six Filipino nurses participated in the study. Most participants were aged 31–40 years (69.24%), and 76.92% were female. Fourteen participants (53.85%) were married, while 12 (46.15%) were single. Half of the participants had worked at DMH for one to three years, whereas approximately one-third had between four and six years of service. Fifteen participants (57.69%) worked in surgical areas and 11 (42.31%) in medical areas.

Table 1. Characteristics of Participants (N = 26)

Variable	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 Department	Surgical	15	57.69
	Medical	11	42.31

B. Overall Workplace Integration and Professional Adaptation

Participants reported favorable perceptions of their workplace environment, with an overall mean score of 3.29. Under the original scoring framework, this fell within the *Strongly Agree* category. The highest-rated item was understanding local healthcare practices and protocols and adapting nursing practice to cultural contexts (M = 3.46). Engagement in professional development opportunities and access to resources and tools needed for job performance each received a mean score of 3.38. Participants also rated their sense of belonging and acceptance within the healthcare team favorably (M = 3.35). Comfort discussing work-related issues with colleagues and supervisors, workplace safety and comfort, and clarity of job roles and expectations each received a mean score of 3.31. The lowest-rated workplace item was participation in team meetings or departmental activities (M = 3.12). Supportive leadership and management practices and clarity of reporting structures and communication lines were also comparatively lower, both with mean scores of 3.15.

Table 2. Perceived workplace integration and professional adaptation

Workplace indicator	Mean	Original interpretation
Comfortable discussing work-related issues with colleagues and supervisors	3.31	Strongly Agree
Easily participates in team meetings or departmental activities	3.12	Agree
Engages in professional development opportunities	3.38	Strongly Agree
Understands local healthcare practices and protocols and adapts nursing practice to cultural contexts	3.46	Strongly Agree
Feels belonging and acceptance within the healthcare team	3.35	Strongly Agree
Perceives safety and comfort in the workplace	3.31	Strongly Agree
Has access to resources and tools needed for job performance	3.38	Strongly Agree
Perceives supportive leadership and management practices	3.15	Agree
Has clear job roles and expectations	3.31	Strongly Agree
Perceives clarity in reporting structures and lines of communication	3.15	Agree
Overall workplace environment	3.29	Strongly Agree

C. Associations with Participant Characteristics

The original exploratory analysis identified statistically significant positive associations between workplace environment scores and age ($r = .52$, $p = .007$) and between workplace scores and length of service ($r = .51$, $p = .007$). Civil status was not significantly associated with workplace scores ($r = .29$, $p = .152$). Clinical department was also not significantly associated with workplace scores ($r = .11$, $p = .590$). The original source table reports $r = .06$ and $p = .078$ for the association between sex and workplace environment. Although this was classified as statistically non-significant in the source study, the reported correlation coefficient and p-value appear internally inconsistent for a sample of 26 participants. This value should therefore be verified against the original statistical output before journal submission and is not interpreted further here.

Table 3. Exploratory associations between participant characteristics and workplace environment scores

Participant characteristic	r	p-value	Interpretation
Age	.52	.007	Significant
Sex	.06	.078*	Not significant
Civil status	.29	.152	Not significant
Length of service	.51	.007	Significant
Clinical department	.11	.590	Not significant

*Value reproduced from the source manuscript. The reported combination of $r = .06$ and $p = .078$ should be checked against the original statistical output before submission.

Discussion

This study examined workplace integration and professional adaptation among Filipino migrant nurses working in a UK hospital. Overall, participants reported favorable workplace experiences, but the pattern across individual indicators was not uniform. The strongest area concerned understanding local healthcare practices and protocols, whereas participation in team meetings and departmental activities was comparatively lower. Professional development, access to workplace resources, and a sense of belonging were evaluated positively, while leadership support and clarity of reporting structures were somewhat less strongly endorsed. Exploratory analyses also indicated associations between workplace scores and both age and length of service.

A. Strong Clinical and Procedural Adaptation

Filipino nurses' adaptation has also been linked to social support, occupational stress, and the quality of the practice environment, suggesting that workplace integration should be considered alongside broader well-being and retention outcomes [25]. Historical research on Indian and Filipino nurses migrating to the UK similarly shows that professional opportunity and migration decisions are closely intertwined [26].

The most favorable workplace item concerned understanding local healthcare practices and protocols and adapting nursing practice to cultural contexts, with a mean of 3.46. This

finding suggests a comparatively high level of perceived clinical and procedural adaptation among participants.

The result is important because migration into a different healthcare system requires more than transferring previously acquired clinical knowledge. Internationally educated nurses must become familiar with local policies, professional boundaries, documentation requirements, organizational routines, patient-safety expectations, communication practices, and role responsibilities. Recent research among internationally recruited nurses in England demonstrates that even experienced nurses can encounter difficulties when their previous professional experience does not align directly with organizational structures or the roles assigned in the host system [1]. The favorable result in the present study may indicate that the Filipino nurses had developed confidence in navigating these institutional expectations. This interpretation is consistent with qualitative research among culturally and linguistically diverse registered nurses showing that tailored orientation, language learning, organizational acceptance, and competence development can facilitate integration into the nursing workforce [12].

However, the present measure reflects perceived understanding, not independently assessed clinical competence or adherence to protocols. It would therefore be inappropriate to conclude from this survey alone that participants had objectively “mastered” UK healthcare practices. The findings instead indicate that participants generally felt able to understand and adapt to the local clinical environment. This distinction is important because self-perceived professional adjustment is valuable in itself but represents only one component of workforce integration. Future studies could combine self-report measures with objective indicators such as competency assessments, supervisor evaluations, orientation completion, or clinical performance measures.

B. Professional Development as a Strength

Engagement in professional development received one of the highest workplace ratings ($M = 3.38$). This suggests that participants perceived opportunities to participate in workshops, training, or other developmental activities relatively positively. Professional development has particular significance for internationally educated nurses because entry into a host healthcare system can create tension between established professional identity and the need to learn new practices. Training should therefore not imply that internationally recruited nurses lack competence. Rather, continuing professional development can provide a mechanism for translating existing expertise into the regulatory and organizational context of the host system.

The umbrella review by Kamau et al. [7] identified professional development as one of three major dimensions of effective integration strategies. These strategies included orientation, competence development, mentorship, preceptorship, and opportunities for

workplace learning. Similarly, the qualitative evidence synthesis by Shiju et al. [8] identified continued development of nursing knowledge and skills as an important facilitator of workplace integration.

The present findings therefore support an approach in which professional development is integrated into the migration transition rather than treated as remedial education. Internationally recruited nurses may arrive with substantial clinical experience while still requiring structured opportunities to understand how that competence can be applied and developed within a new system.

Career development also has implications beyond immediate competence. Reviews of internationally educated nurses have identified professional mobility and access to career advancement as relevant to longer-term retention [17]. If internationally recruited nurses perceive that their professional progression is restricted despite their experience and capabilities, successful initial adaptation may not translate into sustainable retention.

C. Access to Resources and Role Clarity

Access to resources and tools required for job performance received a mean of 3.38, while clarity of job roles and expectations was also rated positively ($M = 3.31$). These findings suggest that participants generally perceived the material and role-related foundations of their work to be adequate. Resource availability is fundamental to effective professional practice, but for migrant nurses its importance extends beyond equipment. Access to information systems, local guidelines, educational resources, escalation pathways, and knowledgeable colleagues can help reduce uncertainty during transition. Role clarity is similarly important. Differences in the scope of nursing practice across countries may result in situations where procedures commonly performed independently in one setting require different authorization, documentation, or multidisciplinary coordination in another. Shiju et al. [8] identified differences in the scope of nursing practice as a recurring barrier for internationally educated nurses. Rajpoot et al. [6] likewise identified discrepancies between previous professional experience and host-country expectations as part of the transition process. The positive role-clarity result in this study is therefore encouraging. However, role clarity at the time of the survey does not necessarily mean that transition was initially straightforward. Half of the participants had been employed at DMH for between one and three years, providing time to learn organizational expectations before completing the questionnaire. Longitudinal data would be needed to determine whether role clarity is substantially lower during the first months after arrival and improves with experience.

D. Workplace Belonging and Acceptance

This interpretation is consistent with longstanding critiques that “integration” should not be framed solely as migrant nurses adapting to existing institutions; organizational structures

and power relations also shape the process [27]. Lived-experience research in the United States has likewise described transition as a multidimensional professional and cultural process [28].

Participants reported a favorable sense of belonging and acceptance within the healthcare team ($M = 3.35$). Workplace belonging is a significant component of integration because nursing is dependent on collaborative relationships rather than individual technical performance alone. Internationally educated nurses may enter workplaces where they differ from colleagues in language, accent, training background, migration status, or cultural norms. Whether these differences are treated as legitimate forms of professional diversity or as deficits can shape integration. Joensuu et al. [9] identified discrimination, organizational support, social support, workplace environment, and acculturation among factors associated with integration. Their review emphasized the importance of supportive environments in which culturally and linguistically diverse nurses are valued and respected. Similarly, Kamau et al. [12] found that organizational acceptance and recognition of competence were important to the integration of culturally and linguistically diverse registered nurses. Workplace belonging therefore involves more than interpersonal friendliness; it includes recognition that the internationally recruited nurse is a legitimate and contributing professional member of the healthcare team. The favorable result in the current sample should nevertheless be interpreted cautiously. The study did not use a validated workplace-belonging scale and did not directly examine discrimination, exclusion, or psychological safety. A high mean on one belonging item cannot rule out negative experiences among individual participants. Future studies should examine both positive integration experiences and possible experiences of marginalization. This is particularly important because mean scores in a small sample can obscure substantial variation between nurses.

E. Organizational Participation Was Comparatively Lower

The lowest-rated workplace item was ease of participating in team meetings or departmental activities ($M = 3.12$). Although this mean remained on the positive side of the scale, its position relative to other workplace indicators is potentially informative. Understanding protocols and performing clinical responsibilities do not necessarily result in equal participation in organizational dialogue. Team meetings involve speaking within a group, expressing professional opinions, questioning existing practices, discussing performance, and sometimes disagreeing with colleagues or supervisors. These interactions require not only language proficiency but also confidence concerning hierarchy, professional norms, and whether one's contributions will be accepted. Internationally educated nurses may therefore experience functional integration before achieving full participatory integration. A nurse may competently perform assigned duties while contributing less frequently to meetings, decision-

making, quality-improvement activities, or organizational discussions. This possibility aligns with evidence that workplace integration depends partly on professional relationships, leadership, and organizational culture [7]–[9], [12], [15]. The receiving workplace can either create or restrict opportunities for internationally educated nurses to use their professional voice. It is important not to interpret the current score as evidence that Filipino nurses were unwilling to participate. The questionnaire measured participants' perception of how easily they could participate, not actual attendance, speaking frequency, or motivation. Lower participation could reflect individual preference, work scheduling, organizational hierarchy, meeting structures, communication confidence, or other factors not measured in the study. For nursing management, the implication is therefore to create conditions that facilitate participation rather than simply instruct migrant nurses to “speak more.” Structured opportunities for contribution, psychologically safe meetings, active solicitation of perspectives, mentoring, and inclusive leadership may be more effective than placing responsibility solely on internationally recruited staff.

F. Leadership and Communication Structures

Supportive leadership and clarity of reporting structures both received means of 3.15, placing them among the lower-rated workplace indicators. The scores are not negative in absolute terms, but their relative position deserves consideration because leadership and communication structures are central to organizational integration. Internationally recruited nurses navigating an unfamiliar healthcare institution require clear information regarding supervision, escalation, accountability, performance feedback, and where to seek assistance when problems occur. Recent qualitative evidence places nurse management at the center of the integration process. Roth et al. [15] found that internationally and domestically qualified nurses viewed nurse managers as influential in areas including placement, recruitment, and workplace integration. The broader integration literature likewise identifies leadership and organizational support as important facilitators or barriers [8], [9]. Leadership may be particularly important during uncertainty. A nurse who understands a routine clinical procedure may nevertheless be unsure about how to report a concern, challenge a decision, seek clarification, or escalate patient-care issues within a new organizational hierarchy. Accordingly, international recruitment programs should ensure that reporting structures are not merely documented but actively explained and reinforced during onboarding. Newly recruited nurses should know who is responsible for clinical supervision, professional development, pastoral concerns, scheduling issues, and escalation of workplace problems. Consistent feedback is also important. Internationally recruited nurses need information about whether their practice meets local expectations and where further development is required. Absence of feedback can leave nurses uncertain, whereas feedback provided only when

problems arise may contribute to anxiety. Structured, developmental feedback can therefore form part of integration rather than merely performance management.

G. Age and Workplace Integration

Age was positively associated with workplace environment scores in the exploratory analysis ($r = .52$, $p = .007$). Older participants tended to report more favorable workplace experiences. Several explanations are possible. Age may be associated with accumulated clinical experience, greater confidence in professional interaction, previous exposure to different healthcare environments, or broader coping strategies. However, the dataset does not contain sufficient information to determine the mechanism. Age should therefore not be interpreted as a causal determinant of successful integration. It is also possible that the association partly reflects other factors, particularly professional experience or length of employment. Joensuu et al. [9] found that sociodemographic characteristics constitute one of several categories associated with integration, but organizational factors, social support, workplace environment, discrimination, and acculturation are also important. This broader evidence cautions against designing integration interventions primarily around demographic characteristics. Support should instead be based on assessed transition needs. A younger internationally recruited nurse may require additional professional guidance, but an older nurse with substantial experience may have different challenges—for example, adapting to unfamiliar role boundaries or having previous expertise insufficiently recognized.

H. Length of Service and Progressive Workplace Adaptation

Length of service was also positively associated with workplace environment scores ($r = .51$, $p = .007$). Among the exploratory findings, this association has particular relevance to the conceptual focus of the study. Professional integration is likely to involve cumulative learning. Through repeated interaction with colleagues, patients, managers, organizational systems, and clinical processes, nurses may gradually become more familiar with local expectations. Longer tenure can therefore provide greater exposure to organizational culture and more opportunities to establish professional relationships. Pressley et al.'s investigation of internationally educated nurses during their first two years in England supports the view that integration unfolds over time rather than ending when the nurse begins employment [2]. Nurses continue to negotiate workplace relationships, professional progression, recognition, and life in the host country during this period. The current cross-sectional data, however, cannot establish that longer employment **caused** higher workplace integration scores. Several alternative explanations are possible. Nurses who integrated successfully may have been more likely to remain employed, creating a form of survivor or retention bias. Length of service may also correlate with age or previous professional experience. Nevertheless, the finding supports the practical value of viewing international nurse onboarding as a longitudinal process. A short

orientation program at the beginning of employment is unlikely to address every difficulty that arises during the first several years. Structured reviews at different stages—for example after initial orientation, several months, one year, and later career transitions—may be more appropriate than assuming that support is no longer needed once clinical induction has been completed. Filipino nurses may also occupy distinctive positions within host-country labor structures, with implications for work allocation, recognition, and occupational equity [29].

I. Clinical Department Was Not Associated with Workplace Scores

Clinical department was not significantly associated with workplace environment scores ($r = .11$, $p = .590$). Nurses working in medical and surgical areas therefore did not show evidence of substantially different overall workplace scores in the present sample. This finding should not be interpreted as proof that all departments provide identical integration experiences. The sample was too small to detect modest differences, and clinical areas were grouped into only two broad categories. However, the absence of a clear department association suggests that some integration issues may operate at an institutional rather than unit-specific level. Understanding healthcare protocols, communication structures, leadership, professional development, and belonging are relevant across clinical departments. This has implications for intervention design. Core components of international nurse integration may be implemented hospital-wide, while individual clinical units supplement them with specialty-specific orientation. Such an approach avoids unnecessary duplication while recognizing that the technical requirements of emergency, medical, surgical, operating-theatre, anesthetic, or recovery settings may still differ.

J. Implications for Nursing Management

Several practice implications emerge from the findings. First, internationally recruited nurses require structured onboarding that extends beyond clinical orientation. Initial training should explain organizational culture, reporting structures, role expectations, clinical governance, escalation processes, professional communication, and opportunities for career development. Second, mentorship and preceptorship should continue beyond the earliest transition period. The evidence base consistently identifies mentorship as an important integration strategy [7], [8], [12]. Experienced nurses can provide practical guidance and help internationally recruited colleagues interpret organizational expectations that may not be evident in formal policies. Recent evidence mapping workplace-integration assessment shows substantial heterogeneity in how migrant nurse integration is conceptualized and measured, supporting the need for clearer longitudinal and multidimensional evaluation [30]. A 2026 systematic review further supports workplace strategies such as tailored transition support, education, mentorship, and organizational facilitation for internationally educated nurses [31].

Contemporary U.S. evidence also emphasizes that structural and institutional conditions shape pathways from international education to effective nursing practice [32].

Third, nursing leaders should deliberately support professional participation. The relatively lower rating for team-meeting participation suggests that successful integration should not be assessed only by whether internationally recruited nurses can safely complete assigned clinical work. Their ability to contribute ideas, question practice, participate in improvement, and engage in departmental decision-making is also important. Fourth, leadership accessibility and communication pathways should be explicit. Reporting structures may appear obvious to established staff but remain unfamiliar to nurses entering from another healthcare system. Orientation should identify who is responsible for different types of concerns and how escalation works in practice. Fifth, organizations should recognize internationally recruited nurses' previous professional experience. Pressley et al. reported that internationally recruited nurses in England can encounter positions that do not reflect their previous qualifications and experience [1]. Professional development should therefore build upon prior expertise rather than assuming that international recruitment equates to professional inexperience.

Finally, integration should be treated as a two-way organizational process. The nurse adapts to the host institution, but the institution must also develop the capacity to integrate a culturally and professionally diverse workforce. Contemporary evidence supports organizational strategies addressing leadership, inclusion, competence recognition, mentorship, social support, and workplace culture [6]–[9], [12], [15], [17].

Strengths and Limitations

This study provides focused information on the workplace experiences of Filipino migrant nurses employed within a specific UK hospital. Separating workplace environment from the cultural adaptation and support domains used in the broader survey allows professional integration to be examined as a distinct dimension rather than combining all migration experiences into one overall score. Several limitations require emphasis.

First, the study included only 26 participants from a single hospital. The results should therefore not be generalized to Filipino nurses throughout the NHS, internationally educated nurses from other countries, or even all internationally recruited nurses within the participating institution. Second, purposive sampling was used. Participants may differ from eligible nurses who did not participate, and selection bias cannot be excluded. Third, the workplace environment domain was based on a self-developed instrument. Although expert validation and pilot testing were conducted, complete psychometric information is not reported in the source manuscript. Reliability estimates should be retrieved or recalculated before publication. Fourth, all measures were self-reported. The study assessed participants'

perceptions of workplace integration rather than objectively observed competence, participation, leadership behavior, or organizational performance. Fifth, the cross-sectional design prevents temporal or causal inference. The association between length of service and workplace scores cannot demonstrate that additional time at DMH caused improved integration. Sixth, the inferential analysis was exploratory. Pearson correlations were applied to variables that included ordinal and categorical characteristics. The coding and statistical assumptions should therefore be reviewed before final submission. For dichotomous variables, appropriately coded point-biserial correlations or group comparisons may be considered; ordinal variables may require non-parametric approaches depending on how the original data were coded. The sex association requires particular verification because the combination of $r = .06$ and $p = .078$ reported in the original table appears internally inconsistent.

Finally, the relatively high overall workplace score may introduce a ceiling effect and limit the ability to distinguish different levels of integration. Future research should use established measures of organizational support, professional integration, belonging, psychological safety, and practice environment. Larger multicenter studies would allow comparison across hospitals, departments, recruitment cohorts, and countries of origin. Longitudinal designs would be especially useful for determining how workplace integration changes from arrival through the first several years of employment.

Conclusion

Filipino migrant nurses working at the participating UK hospital reported generally favorable workplace integration and professional adaptation. Their strongest area was understanding local healthcare practices and protocols, while professional development, access to resources, workplace belonging, safety, and role clarity were also evaluated positively.

However, professional adaptation was not uniform across all organizational dimensions. Participation in team meetings and departmental activities was comparatively lower, as were perceptions of supportive leadership and clarity of reporting structures. These results suggest that competence in navigating clinical and procedural requirements may develop more strongly than participation in broader organizational processes.

Age and length of service were associated with workplace scores in exploratory analyses, suggesting that experience and accumulated exposure to the host institution may be relevant to professional transition. These associations should nevertheless be interpreted cautiously given the small sample and cross-sectional design.

Healthcare organizations recruiting nurses internationally should regard integration as a continuing organizational process rather than a short induction phase. Structured onboarding, accessible leadership, sustained mentorship, professional development, recognition of previous experience, and opportunities for meaningful participation in

workplace discussions may help internationally recruited nurses progress from functional clinical adaptation toward fuller professional and organizational integration.

Conflict of Interest

The authors declare no conflict of interest.

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