

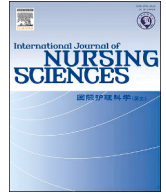
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Research Paper

Promoting evidence-based nursing through collaboration, autonomy, and agency: A qualitative case study

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ABSTRACT

Objectives: Evidence-based practice (EBP) is widely accepted as central to high-quality nursing care, yet integration into acute care settings remains uneven. Nurses play a vital role in applying evidence, but organizational hierarchies, time constraints, and limited interprofessional collaboration often restrict their ability to lead or sustain EBP. This study explored how nurses enact, adapt, and promote EBP through interprofessional collaboration, everyday clinical leadership, and access to continuing professional development.

Methods: An embedded comparative case study design was used, informed by interpretive and ethnographic principles. The research was conducted across two large hospitals in England with differing leadership and governance structures. Twenty-five participants were included, consisting of nurses, nurse managers, and physicians. Data were collected over six years through 25 semi-structured interviews, 60 h of non-participant observation, and review of policy and quality improvement documents. Data were analyzed using reflexive thematic analysis.

Results: Five key themes were identified: leadership practices and organizational support; professional identity and EBP ownership; interprofessional collaboration and communication; structural barriers and resource constraints; and capacity building through learning and feedback. Nurses enacted EBP through informal leadership, peer mentorship, and grassroots innovation. Structural barriers such as limited time, unequal access to continuing professional development, and fragmented collaboration significantly affected implementation.

Conclusions: Nurses play an active and sustained role in leading EBP through their relationships, clinical judgment, and commitment to care quality. However, their efforts are shaped by the broader organizational systems in which they work. Supporting interprofessional collaboration, distributed leadership, establishing EBP mentoring roles, and ensuring equitable access to continuing professional development are essential for consistent and inclusive evidence use. Hospital managers and policymakers should prioritize structural investment in team-based learning, inclusive governance and digital access.

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What is known?

- Nurses play a critical role in delivering evidence-based practice (EBP), but limited time, workforce pressures, and inconsistent organizational support often shape their efforts.
- Effective leadership and interprofessional collaboration are essential to embedding EBP in hospital settings, yet practical implementation remains uneven across contexts.

- Continuing professional development is widely associated with EBP capacity, though access to meaningful learning opportunities varies across and within healthcare systems globally.

What is new?

- Findings showed how nurses lead and sustain EBP through informal leadership, relational credibility, and peer support, even where formal structures are lacking.
- This study presented practical recommendations for healthcare organizations to establish EBP mentor roles, structure cross-

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professional learning forums, and integrate continuing professional development into everyday routines.

- Findings offered a transferable framework of distributed EBP leadership that captures how nurses navigate structural constraints and relational dynamics to embed evidence-based care in everyday acute clinical practice.

1. Introduction

Improving the quality and safety of patient care depends on the effective use of evidence in everyday clinical decision-making [1,2]. Evidence-based practice (EBP) integrates the best available research with clinical expertise and patient preferences and has long been recognized as essential to nursing practice [3]. Despite this, embedding EBP into routine care remains inconsistent, particularly in acute hospital settings where organizational complexity and professional hierarchies continue to affect decisions [4].

Nurses occupy a central position in healthcare systems and are often the first to identify gaps between current practice and research-informed care [5]. Their proximity to patients and continuous involvement in care delivery position them to drive the implementation of EBP [6]. However, many nurses report being excluded from clinical governance and policy-level decision-making, particularly in environments shaped by traditional hierarchies and role-based divisions of labor [7]. These conditions can limit nurses' opportunities to lead practice change, even when they possess the skills, insight, and motivation [8].

A study across the United Kingdom and elsewhere suggested that professional silos and rigid organizational structures remain significant barriers to sustained EBP integration [9]. Nurses often operate within systems where decision-making is led by senior medical professionals, leaving limited space for nursing leadership in innovation and service improvement [10]. This is especially challenging in acute care settings, where time pressures, staff shortages, and competing priorities frequently limit the ability to reflect on and apply new evidence [11].

Despite these barriers, nurses continue to lead informal, often unrecognized efforts to improve care through evidence [12]. Some initiate local projects, revise care plans based on emerging guidelines, or lead peer discussions to reflect on best practice [13]. These actions rarely attract institutional recognition but make a meaningful difference to patient outcomes and team learning [14]. The contribution of such everyday clinical leadership to EBP implementation remains underexplored in the literature.

Interprofessional collaboration has been repeatedly identified as a crucial enabler of EBP [15]. Teams that foster open communication and mutual respect across professions tend to adopt evidence-informed changes more rapidly and consistently [16]. Nevertheless, collaboration may depend on informal relationships or individual initiative, particularly where organizations lack structured systems to support shared decision-making. Nurses frequently describe collaborative practices as uneven, noting that their contributions are welcomed in some teams but dismissed in others, depending on leadership style and local culture [17].

Continuing professional development (CPD) is central to building nurses' confidence and capacity to apply research in practice. Access to high-quality, practice-relevant education enhances nurses' ability to critically appraise evidence, make informed decisions, and challenge outdated clinical routines [18]. However, CPD opportunities remain unevenly distributed across healthcare settings, with nurses in resource-limited or high-pressure environments less likely to access training or protected time for development [18]. As a result, there is a growing divide

between what is expected of nurses in terms of evidence use and what is made possible through organizational support [19].

This study responds to calls for more practice-focused research on how nurses navigate the everyday realities of EBP in acute care. Rather than assuming EBP is driven by top-down mandates or formal training alone, this study explores how nurses engage with evidence through their day-to-day work, relationships with other professionals, and professional development pathways. The study focuses on nurses' lived experience in acute care hospitals. It seeks to understand how EBP is led, shared, and sustained in complex organizational environments.

This study aimed to explore how nurses lead and sustain EBP in acute care through interprofessional collaboration, everyday clinical leadership, and access to CPD, within the constraints of organizational structures. Specific objectives included 1) exploring how nurses lead or adapt EBP within the realities of organizational structure and team dynamics; 2) examining how collaboration across professions supports or limits the integration of evidence into routine nursing care; 3) investigating how CPD influences nurses' ability to apply evidence, lead change, and challenge outdated practice.

2. Methods

2.1. Study design

We adopted an embedded comparative qualitative case methodology [20]. Drawing on the tradition of collective case study and integrating insights from organizational ethnography and implementation science, this design enabled close analysis of local processes while facilitating structured comparison across contexts. Rather than treating cases as bounded units, the study approached each site as a dynamic health system shaped by leadership norms, institutional histories, and policy environments. The interpretive orientation focused on understanding how leadership strategies, professional networks, and local infrastructures shaped EBP's everyday practices. The study was informed by the Standards for Reporting Qualitative Research (SRQR) and adhered to principles of methodological transparency, reflexivity, and iterative engagement [21].

2.2. Study setting

The study was conducted in two large hospital trusts in the Midlands, England. Both hospitals serve diverse populations across urban and semi-rural areas and provide acute inpatient care across a range of specialties. Site 1 is a 780-bed facility with a well-established shared governance model and structured leadership development programmes. Site 2, with approximately 640 beds, adopts a more relational approach to change, supported by informal mentorship and decentralized quality improvement. These sites were selected using purposive sampling to enable exploration of contrasting organizational approaches to EBP. This approach allowed for an in-depth comparison of how differing leadership structures, team cultures, and professional networks shape the enactment and sustainability of EBP in practice. Purposive sampling is widely used in qualitative research to explore variation across relevant contexts rather than to achieve statistical generalization [22].

2.3. Participants and recruitment

Participants were recruited through purposive sampling to reflect a range of roles involved in EBP delivery and oversight. Participants were recruited through clinical leaders, departmental meetings, internal newsletters, and referrals from senior nurses.

The sample included staff nurses (SNs), nurse managers (NMs), and physicians, reflecting a range of responsibilities and experiences central to understanding how EBP is enacted within teams and across organizational levels. SNs were included for their frontline insights into the everyday enactment of EBP, particularly about patient care, peer mentorship, and informal leadership. NMs were selected for their role in translating policy into practice, leading ward-level initiatives, and supporting staff engagement with quality improvement. Physicians were included to offer interprofessional perspectives on how nursing-led EBP aligns with broader clinical governance and decision-making processes. All participants had at least two years of experience in acute care and were actively involved in implementing evidence-informed change. The sample size was determined using iterative recruitment and data saturation.

2.4. Data collection

A longitudinal, multi-method approach to data collection was used over six years, from October 2017 to October 2023. Data were gathered in three overlapping phases: preparatory engagement (October 2017 to March 2020), intensive fieldwork (January to August 2022), and follow-up validation (April to October 2023). A 13-month pause in data collection occurred between March 2020 and April 2021 due to COVID-19 restrictions, which affected site access and face-to-face research activity. This interruption, although unplanned, allowed for extended reflection and refinement of tools and priorities, consistent with the flexible designs of qualitative case research [23].

The fieldwork and analysis were led by the first author, an experienced nurse academic and qualitative researcher based at a United Kingdom-based university, with clinical experience in acute and community care. The second author, a senior academic at a United Kingdom-based University with expertise in implementation science and organizational ethnography, contributed to methodological design, data interpretation, and supervision. While only two authors are listed, the study was supported over time by internal clinical collaborators, hospital-based research facilitators, and two institutional qualitative advisors who provided oversight at key analytic stages. With a phased approach and multiple data sources, this collaborative structure enabled the research team to manage scope and ensure quality throughout the extended study period.

The phased design enabled the research team to build long-term relationships with staff, understand evolving organizational dynamics, and iteratively shape the data-collection focus. Early engagement supported the development of contextual sensitivity and methodological alignment with real-world practice, in line with methodological recommendations for prolonged field engagement and adaptive immersion [24,25]. Each method: interviews, observations, and document analysis, was selected for its capacity to capture the complex and embedded nature of EBP. Between October 2017 and March 2020, the researchers engaged in several informal activities, including site familiarisation visits, multidisciplinary team meetings, pilot observations in acute care wards, and stakeholder mapping. These activities allowed the researcher to gain insight into clinical leadership dynamics, policy-practice alignment, and the rhythm of interprofessional collaboration. During this phase, the researcher refined the observation framework and drafted a preliminary interview guide. Although these engagements were not recorded as formal data, they were central in identifying themes that would later underpin structured data collection.

The COVID-19 pandemic-related interruption in 2020 caused significant delays. However, this period offered an opportunity for

methodological recalibration. During the pandemic, the researcher maintained remote contact with key site leads and reviewed emerging national guidelines and institutional responses to EBP. Following the resumption of fieldwork in April 2021, the focus shifted to updating recruitment strategies, confirming access, and planning for intensive data collection. Although data collection resumed in April 2021, access negotiations and shifting hospital priorities meant that sustained site-based fieldwork did not begin until January 2022. Therefore, the period from May to December 2021 was used to re-engage with research governance teams, pilot updated tools, and establish site readiness. After the intensive fieldwork phase concluded in August 2022, a second pause occurred between September 2022 and March 2023. This interval was used for initial thematic coding, internal data workshops, and planning for the follow-up validation. The final validation phase (April to October 2023) was designed to revisit earlier findings with returning participants and to examine how previously documented EBP activities had evolved. This phase supported interpretive credibility through participant sense-checking, refinement of themes, and longitudinal insight into sustainability.

2.4.1. Semi-structured interviews

A total of 25 semi-structured interviews were conducted across both hospital sites during the intensive fieldwork phase in 2022. Interviews lasted 60–120 min and were conducted in quiet, private spaces within the hospital to support focused and confidential dialogue. The lead researcher conducted all interviews, drawing on insights from earlier observation and document review to tailor the interview approach. The interview guide was structured to explore participants' experiences, perceptions, and practices related to EBP implementation. The main interview question asked participants to describe their experiences implementing EBPs in their clinical setting. The researcher used a series of open-ended prompts to elicit in-depth and reflective responses. These included the following: Can you describe your experience of implementing EBP in your clinical setting? How do you typically collaborate with other healthcare professionals to support EBP? What types of knowledge-sharing or communication practices are common within your team regarding evidence use? What challenges have you encountered in trying to implement or sustain EBP in your area of work? How has your access to, or experience of, CPD influenced your ability to promote or lead EBP? Can you share specific examples of nurse-led evidence-based activities that have improved patient care or contributed to team learning? These prompts were applied flexibly to accommodate each participant's specific context and role.

The interview approach followed established principles of reflexive qualitative interviewing, allowing participants to direct the flow of discussion while ensuring comprehensive coverage of key themes [26]. Interviews were audio-recorded with consent, transcribed verbatim, anonymized, and securely stored. Conducting interviews after sustained observation enabled the researcher to pose grounded, contextually informed questions and to explore emerging issues with greater nuance.

2.4.2. Non-participant observation

A total of 60 h of non-participant observation were conducted across the study period, with most activities occurring during the 2022 fieldwork and the 2023 follow-up phase. Observations focused on everyday leadership behaviors, informal mentorship, and interprofessional communication in routine clinical settings. Activities included ward rounds, safety huddles, governance meetings, and bedside handovers. We maintained a clearly defined observational role and were introduced to staff as an independent academic. This positioning and a consistent explanation of

purpose helped reduce social desirability bias and avoid confusion about the researcher's role. Fieldnotes were recorded in real time and elaborated through reflexive journaling, enabling continuous scrutiny of the researcher's positionality and analytic stance [27].

Observations between October 2017 and March 2020 focused on mapping leadership behaviors, understanding ward routines, and identifying potential areas of EBP engagement. These early insights informed the selection of units and guided the development of observation protocols. During the 2022 fieldwork, the observational focus shifted to how EBP was enacted through ward routines, safety briefings, and cross-professional exchanges. The 2023 follow-up observations revisited eight original participants to examine whether previously documented practices had been sustained, adapted, or deprioritized. Observational data were triangulated with interviews and documents to enhance credibility and thematic saturation [28].

2.4.3. Review of documented evidence

Documentary sources were reviewed throughout the study to trace organizational priorities, policy directives, and formal approaches to EBP implementation. These included quality improvement strategies, clinical protocols, audit dashboards, meeting minutes, and staff training logs. Documents were accessed through clinical educators, quality managers, and publicly available hospital records. Document analysis played a dual role. First, it served as a contextual backdrop that informed interview and observation protocols. Second, it was a triangulation mechanism to compare formal policies with everyday practice. Analytic memos were written to synthesize content, document interpretations, and track changes in institutional focus over time [29]. During the preparatory phase (2017–2020), document review focused on strategic plans, policy frameworks, and audit summaries. These materials helped identify priority areas for EBP and guided the identification of key informants. During 2022, document analysis focused on team-level quality reports, updated guidelines, and training records to contextualize observed practices. The 2023 review centered on follow-up documentation, including post-implementation evaluations and revised protocols. In the final phase, selected participants were invited to comment on preliminary interpretations. These reflective dialogues enabled participants to assess resonance, contest interpretations, and elaborate on institutional tensions. This feedback loop enriched the analysis and aligned with interpretive traditions emphasizing participant sense-making and researcher reflexivity [30].

2.5. Data analysis

Data were analyzed using reflexive thematic analysis, following Braun et al. [24]'s six-phase framework, which includes familiarisation, coding, theme development, reviewing, defining, and writing up findings. This approach enabled the study to identify patterns in qualitative data while preserving the complexity of the clinical and organizational contexts. Reflexive thematic analysis was particularly appropriate given the study's interpretivist stance, which views meaning as co-constructed between participants and researchers [31].

All data were reviewed iteratively and inductively coded. NVivo 12 software supported the organization of transcripts, observation notes, and policy documents, while manual memoing enhanced conceptual engagement and interpretation. Coding was conducted in phases across strategic timepoints in the longitudinal dataset. Thematic synthesis focused on identifying recurring narratives, structural patterns, and divergences in leadership practices and EBP adaptation. Memos were written during each phase to capture analytic decisions and evolving interpretations.

Follow-up observations and participant dialogues supported the temporal refinement of themes. Interpretive emphasis was placed on understanding how leadership, collaboration, and practice norms shaped implementation across contexts. Quotations were chosen for clarity, representativeness, and ability to illustrate relational and institutional dynamics.

2.6. Rigor and reflexivity

The researcher maintained a continuous reflexive log to record assumptions, positionality, and evolving interpretations. This process fostered transparency about how personal experiences and professional identity shape analytic choices. The lead researcher, a nurse academic with prior clinical experience, assumed a non-participant observer role during fieldwork. While familiarity with nursing practice supported rapport-building and contextual understanding, structured reflexivity helped mitigate potential biases. The extended engagement across both sites, including informal conversations and follow-up sessions, allowed immersion without over-identification. To reduce response bias, interviews were conducted confidentially, and participation was voluntary. The interview setting was non-idealized, and prompts were carefully designed to elicit experiential rather than idealized accounts. Anonymized data analysis further supported open disclosure from participants.

2.7. Quality control

Analytic quality was supported through audit trails, cross-checking coding decisions, and supervisory oversight. The coding framework was developed collaboratively and reviewed by two independent qualitative researchers with expertise in implementation science and health systems. Discrepancies in thematic categorisation were discussed until consensus was reached, strengthening analytic transparency and interpretive coherence. Repeated coding cycles enabled the research team to confirm saturation of core themes while allowing for contextual variability across sites. Saturation was reached when no new themes emerged during the final coding iterations and follow-up observations [32,33]. These steps supported the study's findings' credibility, dependability, and confirmability, thereby enhancing their transferability to similar acute care settings.

2.8. Ethical considerations

This study received ethical approval from the Research Ethics Committee (Ref: #00183). The R&D departments of both participating hospitals granted site-specific approvals. All participants provided informed written consent after receiving detailed information sheets. Verbal consent was reconfirmed before each interview and observation. Participation was voluntary, and confidentiality was emphasized throughout. Fieldwork during the COVID-19 pandemic followed the hospital's infection control guidance, including personal protective equipment (PPE) use and distancing protocols. The researcher's identity and professional background were disclosed to build trust and reduce power imbalances. Ethical safeguards were maintained across all phases, including follow-up observations, to ensure ongoing respect for participants and institutional integrity.

3. Results

3.1. Characteristics of the participants

The final sample included twenty-five participants: fifteen SNs,

six NMs, and four physicians. Participants had 13 to 32 years of clinical experience, with an average of approximately 24 across the sample. Twenty-five contributed through interviews, and seventeen were additionally involved in non-participant observation. Participant demographics are summarized in Appendix A, which includes site location, years of experience, role, and whether participants contributed via interview, observation, or both.

3.2. Main findings

Findings from this study offer a detailed picture of how EBP is understood, enacted, and sustained in acute care settings. They demonstrate that while nurses play a central role in leading and embedding EBP, their efforts are shaped by a complex interplay of interpersonal, structural, and organizational factors. Five interrelated themes were identified: leadership practices and organizational support; professional identity and EBP ownership; interprofessional collaboration and communication; structural barriers and constraints; and capacity building through learning and feedback. A conceptual framework was developed to make sense of the connections across these themes (Fig. 1). This framework illustrates how the relationships among frontline agency, organizational leadership, interprofessional collaboration, and structural constraints influence the integration of EBP. Rather than framing EBP as a product of formal directives or top-down policy, the model highlights how nurses' discretionary actions, autonomy, and local initiatives are continuously negotiated within broader systemic pressures. Appendix B provides a thematic summary that complements the framework by outlining the core themes and subthemes developed through analysis.

3.2.1. Leadership practices and organizational support

This theme explores the influence of leadership approaches and organizational support on EBP implementation. It captures formal and informal leadership practices, along with the organizational resources, structures, and cultures that enable or inhibit evidence-informed change.

3.2.1.1. Formal leadership endorsement and strategic alignment.

Participants described leadership support as a critical enabler for embedding EBP. NMs and senior physicians who promoted EBP created an environment where practice change felt possible. Staff noted that when senior leaders actively supported quality initiatives, EBP discussions became more frequent and embedded into

routine care.

“... When our director of nursing brings up EBP during the morning briefing, it sets the tone for the week [...] you know it is something we're expected to engage with ...” (S2-NM02, Interview)

Observations of ward handovers in Site 2 reinforced this point, with senior nurses encouraging staff to reflect on audit results and recent guidelines.

“... during the morning safety brief, the lead nurse reminded staff to cross-check all care plans against the NICE guidelines, making direct reference to recent audit results ...” (Fieldnote recorded during direct observation, Ward Handover, S2)

Minutes from executive team meetings in Site 1 showed explicit alignment between leadership priorities and the integration of national guidance.

“... Executive board minutes from May 2022 outline the trust's aim to integrate national EBP guidance into local quality improvement targets, particularly for infection control and falls management.” (Executive Team Meeting Minutes, S1)

Despite this, inconsistencies were observed between rhetoric and implementation. Staff at both sites noted that while EBP was promoted in policy documents, operational pressures often diverted attention from it.

“The matrons talk about evidence-based care, but we end up firefighting most days. The gap between strategy and practice is huge ...” (S1-SN05, Interview)

These gaps often reflected limitations in organizational support, such as insufficient resourcing, limited protected time, or competing operational demands that diluted the impact of strategic commitments.

3.2.1.2. Informal leadership and relational influence.

Beyond formal hierarchies, many nurses acted as informal leaders by modeling EBP or guiding colleagues through change. Staff described these individuals as ‘go-to’ figures who helped translate research into everyday action.

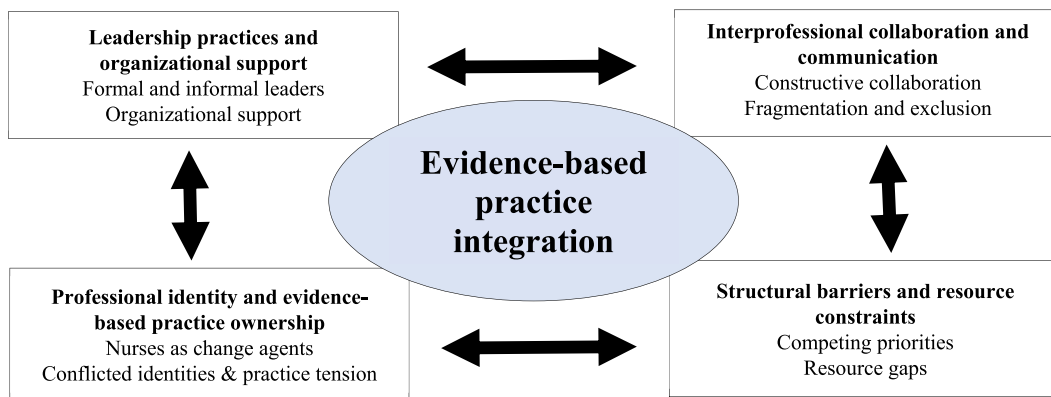


Fig. 1. Contextual framework of evidence-based practice integration in acute care. Note: This framework illustrates how a frontline agency, comprising individual initiative, discretionary action, and identity, operates within and is shaped by leadership influences, structural constraints, and interprofessional collaboration. Arrows indicate reciprocal relationships, emphasizing the dynamic conditions that support or hinder the integration of evidence-based practice in acute care settings.

“... if something new comes out, we usually ask [name withheld] first. She explains it clearly and shows how we can use it during our shifts ...” (S2-SN03, Interview)

Observation of a peer-led training session in Site 1 highlighted how such relational leadership helped reduce anxiety about adopting new practices.

“During a peer mentoring session, a senior nurse explained how to integrate new wound care guidance into shift handovers, prompting three junior staff to adjust their routines the following day.” (Fieldnote, Training Session, S1)

Documents from an internal mentoring programme in Site 2 described similar informal roles as key to embedding learning.

“The internal evaluation of the Clinical Champions Programme highlighted that informal peer support was the most cited reason for staff engagement with recent evidence updates.” (Internal Programme Evaluation, S2)

However, these individuals sometimes felt overburdened without formal recognition or protected time.

“You end up carrying a lot because people look to you, but it is not in your job plan. I do it because I care, but it can be exhausting.” (S1-NM01, Interview)

These findings underline the value of hybrid leadership models, where both formal and informal influence are acknowledged and supported.

Both forms of leadership were heavily shaped by the degree and quality of organizational support available, including protected time, recognition, access to training, and alignment with broader quality priorities. Strong organizational backing amplified leadership influence, while gaps in such support often limited the sustainability of EBP initiatives.

3.2.2. Professional identity and evidence-based practice ownership

Professional identity was seen to have shaped engagement with EBP across both sites. Nurses who saw themselves as agents of change were more likely to take initiative, challenge poor practice, and advocate for evidence-informed care.

3.2.2.1. *Nurses as change agents.* Nurses described a strong professional responsibility for improving care through evidence use. Many shared examples where they initiated change independently, driven by patient need rather than top-down instruction.

“I noticed more falls in our bay, so I reviewed the latest guidelines and suggested a new monitoring system. We trialed it for two weeks, and the falls dropped immediately ...” (S1-SN02, Interview)

This sense of initiative was mirrored in fieldnotes from Site 2, where a staff nurse adapted patient education materials based on a recent Cochrane review.

“A staff nurse altered the patient education folder after a new Cochrane review was discussed during shift handover. The update focused on fall prevention strategies for older patients.” (Fieldnote, Shift Handover, S2)

Minutes from ward meetings across both sites recorded similar grassroots initiatives.

“Minutes from ward-level quality forums show nurses initiating changes to catheter care following review of recent safety bulletins from NHS Improvement.” (Ward QI Meeting Minutes, S1)

Despite this proactive stance, some nurses hesitated to label their work as ‘EBP’, suggesting a disconnect between academic terminology and clinical reality.

“... we just call it good care...I do not think of it as EBP unless someone from education points it out ...” (S2-SN06, Interview)

3.2.2.2. *Conflicted identities and practice tension.* While some embraced EBP, others expressed frustration at competing demands. Several nurses described feeling conflicted between delivering care and finding time to engage with research.

“You want to do what is best, but you are already behind on documentation, and then you are expected to read the latest paper too ... it is hard to keep up ...” (S1-SN07, Interview)

The observation of shift handovers on Site 1 showed frequent interruptions, limiting opportunities for shared reflection.

“Interruptions during medication rounds left little time for nurses to consult new sepsis pathway posters displayed in staff rooms, despite visible efforts to promote their use.” (Fieldnote, Medication Round, S1)

In Site 2, team meeting minutes documented staff concerns about unrealistic expectations for guideline adoption.

“A staff survey conducted as part of annual appraisal raised concerns about workload, leaving limited space for engaging with clinical updates and research evidence.” (Annual Staff Appraisal Report, S2)

These findings suggest that while nurses identify strongly with the values of EBP, institutional demands often erode their capacity to engage consistently.

3.2.3. Interprofessional collaboration and communication

Cross-disciplinary relationships also appeared to have shaped the implementation of EBP. Effective collaboration was seen as a catalyst for change, while siloed communication hindered uptake.

3.2.3.1. *Constructive collaboration.* Teams that engaged in open dialogue were more likely to integrate new evidence. Nurses and physicians who regularly discussed patient care and evidence-based guidelines described improved confidence in adopting change.

“We have got this Monday morning roundtable...everyone brings a case and some evidence. It has become part of our routine and it has changed how we make decisions ...” (S2-PH01, Interview)

Field observations confirmed that these structured meetings enabled mutual learning.

“During a joint ward round, physicians and nurses paused to discuss a new anticoagulation guideline. The conversation led to immediate adjustments in two patients’ care plans.” (Fieldnote, Multidisciplinary Ward Round, S1)

In Site 1, joint review of sepsis protocols led to real-time

adjustments in practice. Meeting records showed that staff reported higher satisfaction with the process when interprofessional forums were well-attended and focused on actionable evidence.

“Weekly team huddle summaries recorded increased discussion of new clinical guidance, with nursing staff actively contributing case examples for group reflection.” (Huddle Summary Notes, S2)

3.2.3.2. Fragmentation and exclusion. In contrast, some participants described limited collaboration, especially when nurses were excluded from decision-making. Lack of access to meetings or restricted input undermined their sense of professional contribution.

“... we hear after the fact that something has changed ...it feels like we are being managed, not included.” (S1-SN03, Interview)

Observation of clinical governance meetings in Site 1 showed uneven attendance, with minimal nursing representation.

“A governance meeting was held to revise delirium protocols, but none of the ward nurses were present, even though they had been involved in pilot testing the approach.” (Fieldnote, Clinical Governance Meeting, S1)

In Site 2, meeting minutes recorded repeated requests for greater nursing involvement in protocol review. This exclusion created delays in implementation and sometimes led to confusion or duplication of effort.

“Multiple entries in the feedback log noted staff dissatisfaction with exclusion from initial reviews of pressure ulcer guidance, leading to inconsistent application across shifts.” (Nursing Feedback Log, S2)

3.2.4. Structural barriers and resource constraints

Organizational barriers limited EBP integration, including staffing constraints, time pressures, and bureaucratic complexity.

3.2.4.1. Time poverty and competing priorities. Staff frequently cited a lack of time as a primary barrier. High workload and rapid patient turnover reduced opportunities to engage with evidence or attend training.

“Sometimes it feels like EBP is a luxury we cannot afford ... you are just trying to get through the shift ...” (S2-SN04, Interview)

Ward observations confirmed the pace and volume of work, especially during peak times.

“During evening rounds, staff frequently delayed documentation or skipped reflective debriefs due to back-to-back admissions.” (Fieldnote, Evening Shift, S2)

In both sites, staff skipped breaks to complete mandatory documentation, leaving little capacity for reflective practice. Documented audit feedback from both hospitals noted low compliance with EBP protocols during periods of staff shortage.

“Internal audit reports showed decreased participation in EBP education during high-demand months, correlating with increased agency staff usage.” (Internal Audit Report, S1)

3.2.4.2. Resource gaps and inconsistent support. Participants also described variability in access to EBP resources. Some wards had strong links with clinical educators or library services, while others lacked basic tools like computer access.

“... we share one desktop between six staff. If you want to look something up, you have to queue or use your phone ...” (S1-SN01, Interview)

Site 2's meeting notes showed a broken intranet portal and delayed access to updated guidelines for several weeks.

“Nurses had to wait for over 30 minutes to access the ward computer to consult a clinical decision tool, leading one staff member to rely on a printed, outdated version instead.” (Fieldnote, Ward Activity Log, S1)

In Site 1, education leads documented concerns about underutilized training due to a lack of backfill support.

“Outreach emails from the trust's EBP lead note repeated issues with intranet access and broken hyperlinks in the guideline repository.” (Internal Communication Archive, S2)

These issues highlight the infrastructural and cultural conditions that shape EBP engagement.

3.2.5. Capacity building through learning and feedback

Formal and informal learning processes helped embed EBP into daily practice across the two sites.

3.2.5.1. Continuous professional development. Staff who engaged in ongoing training reported feeling more confident and capable. Workshops, journal clubs, and mentorship were cited as key enablers.

“We had an in-house course on critical appraisal, and it made a real difference. Now I can read a paper and know what to do with it.” (S2-NM01, Interview)

Observation of an EBP workshop at Site 1 showed active participation, with nurses discussing recent changes in catheter care protocols. Attendance records confirmed steady uptake of optional sessions.

“Staff attending an in-house EBP seminar engaged in animated discussion on interpreting confidence intervals, with a visible increase in participation from newly qualified nurses.” (Fieldnote, Training Session, S1)

“Quarterly training records indicate that EBP workshops achieved over 80 percent attendance in wards with active mentorship programmes.” (Training Uptake Report, S2)

3.2.5.2. Feedback and reflective practice. Feedback loops, including audit reports and informal peer discussion, reinforced learning. Staff valued seeing the outcomes of their efforts, which motivated sustained change.

“... after we changed our hand hygiene approach, the infection rates dropped. Seeing the data made it real...it was not just theory.” (S1-SN06, Interview)

Documented QI summaries in Site 2 showed how feedback from small-scale tests of change informed wider rollout.

Observation of ward meetings revealed that staff used patient stories to evaluate new practices.

“Staff reviewed hand hygiene compliance data during their safety huddle and adjusted ward routines immediately to reduce missed moments of care.” (Fieldnote, Safety Huddle, S2)

“Ward newsletters included case studies demonstrating reduced falls and readmissions linked to evidence-based changes initiated by nursing staff.” (Monthly Ward Newsletter, S1)

These learning cycles helped normalise EBP and positioned staff as active improvement agents. These findings provide a nuanced account of how EBP is enacted in acute care, shaped by dynamic interprofessional relationships, structural conditions, and individual agency.

3.2.6. Post-implementation adaptation and progress

A longitudinal follow-up engagement conducted in early 2023 provided an opportunity to revisit how EBP practices had developed beyond the initial fieldwork period. These engagements, involving interviews and observations with eight returning participants across both sites, revealed both consolidation and recalibration of earlier efforts. In Site 1, NMs described adapting ward-based initiatives to align with new strategic goals introduced in late 2022. One ward team, for example, revised its falls reduction approach to integrate updated audit findings and newly introduced NICE recommendations.

“We built on what we started last year ... after the audit, we revised the checklist and made it part of the digital handover tool.” (S1-NM02, Interview, 2023 follow-up)

Staff in Site 2 emphasized how informal leadership had become more embedded. Nurses previously identified as ‘go-to’ colleagues for evidence updates had taken on mentorship roles, shaping team responses to evolving clinical guidance. Observation notes from a March 2023 safety huddle in Site 2 recorded the lead nurse prompting reflection on two recent incidents using a new decision-support checklist developed internally.

“During the morning huddle, the charge nurse reviewed two missed early warning scores and used the new checklist to guide staff discussion on protocol adherence.” (Fieldnote, Safety Huddle, S2, 2023)

Participants also reflected on continued structural constraints, including IT system delays and staff turnover, but most noted greater confidence in integrating EBP into everyday care. Executive-level interest in sustaining progress was also more visible, with several wards showcasing their initiatives at internal improvement forums.

“We presented at the Trust event last month. It was the first time the board asked for a staff-led update on evidence-based changes.” (S2-SN04, Interview, 2023 follow-up)

These follow-up findings suggest that EBP leadership and implementation were not static outcomes but evolving practices. Staff built on previous efforts while responding to changing organizational priorities, further embedding EBP through local adaptation and relational learning.

4. Discussion

This study contributes a detailed, grounded account of how

nurses in acute care settings navigate and shape EBP within the constraints and possibilities of their organizations. Findings confirm that EBP is not simply delivered through policy compliance or educational input but is actively shaped through relational leadership, interprofessional negotiation, and structural conditions. These findings resonate with previous research highlighting the complex interplay between organizational context and front-line practice [34].

The importance of both formal and informal leadership emerged strongly. While a previous study has emphasized the value of managerial support [35], this study extends that understanding by detailing how informal leaders sustain EBP through peer support and relational credibility. These findings align with earlier work showing that nurses often act as ‘hidden influencers’ in care settings [36]. The gap between policy aspirations and operational realities was also evident. This tension has been previously documented [37], but our study provides a more nuanced picture of how nurses negotiate these challenges through adaptive routines and grassroots innovation.

Professional identity also played a central role, as nurses who viewed themselves as change agents were more likely to lead local EBP initiatives, even when these efforts went unrecognized by formal structures. This supports earlier findings [38], which argued for reframing nurses as active knowledge users rather than passive implementers. However, the persistence of conflicted identities among staff also highlights ongoing ambiguity around what constitutes legitimate EBP work [39]. Interprofessional collaboration was reported as both enabling and obstructive. Where teams valued mutual respect and shared responsibility, EBP was more likely to be embedded. These accounts echo earlier findings [40]. However, this study adds weight to the observation that nurses’ contributions are often shaped by team culture and leadership style, rather than formal policy. Exclusion from decision-making forums limited the effectiveness of EBP, a concern consistent with previous research [41]. Structural barriers such as staffing shortages, limited time, and inadequate digital infrastructure further constrained implementation. These challenges are well documented [42], yet this study demonstrates how nurses develop workarounds, such as using mobile phones for information access or compressing learning into informal huddles. These improvisational strategies may reflect a resilient practice culture, although they risk normalizing unsustainable working conditions.

Finally, the study illustrated how CPD and feedback loops enable sustainable practice change. Nurses valued opportunities for shared learning, audit reflection, and patient stories. These mechanisms reinforced EBP knowledge and created a shared purpose and professional identity. This supports prior claims about the role of CPD in advancing EBP readiness, while also underlining the importance of regular, embedded opportunities for reflection [43]. Organizations may have to treat CPD as a structural priority to improve EBP in the future. Protected learning time may need to be written into staffing models and monitored through governance dashboards. EBP mentors could be formally appointed in each clinical area, supported by job descriptions and training pathways, and linked to roles in academic institutions. These positions would ensure EBP remains a visible, supported part of everyday clinical culture [44].

5. Implications and recommendations for practice and policy

Findings from this study suggest that healthcare organizations should formally recognize informal EBP leadership roles. Supporting these individuals through protected time, training opportunities, and inclusion in decision-making may enhance their

capacity to influence care meaningfully. Nursing leaders should adopt hybrid leadership models that value formal and relational forms of influence. Hospitals should institutionalise cross-professional forums where clinical staff from all disciplines meet regularly to review evidence, audit data, and practice guidelines. These meetings should be scheduled within clinical rosters, facilitated by senior staff, and linked to quality improvement priorities. EBP mentor roles should be introduced at the ward or department level. These mentors would provide local coaching, facilitate reflective sessions, and liaise with educators to translate new knowledge into team practice. Their contributions should be recognized within performance appraisal systems and supported with protected time.

Allocating CPD resources equitably requires more than budget allocation. Managers should map current access patterns and identify areas of under-provision. Mobile learning platforms, embedded training during handovers, and peer-led micro-teaching are all feasible solutions. Governance teams should regularly monitor EBP participation and outcomes, linking data to staff development plans and strategic goals. At the policy level, expectations for EBP must align with workforce realities. National and regional policies should incorporate implementation support measures, particularly in under-resourced settings. Allocating time within shifts for reflective practice, feedback discussion, and shared learning could be formalized through revised staffing models.

Academic institutions should partner with practice sites to co-develop CPD offerings grounded in clinical realities. These should include accessible, ward-based learning, alongside formal courses. Co-produced audit and feedback systems that involve frontline staff in sense-making would further promote learning and accountability. These strategies can also be adapted to primary healthcare and integrated community settings, where multidisciplinary teams face similar coordination, capacity, and equity challenges. Building structures honouring local knowledge, shared leadership, and routine learning will improve EBP in diverse care environments.

6. Strengths and limitations

This study benefited from longitudinal, multi-method engagement across two contrasting hospitals, allowing for sustained observation of EBP practices over time. The inclusion of interviews, observations, and document analysis enabled comprehensive triangulation and enhanced the trustworthiness of findings. Diverse participants across clinical roles and professional boundaries contributed to a rich, multi-perspective dataset.

This study was qualitative and grounded in a specific organizational context, and did not aim to produce generalizable findings. Instead, it sought to generate in-depth insights into how EBP is understood and enacted within two large hospitals in one English region. While this focus enabled a rich exploration of local practice, it may limit the transferability of findings to other settings, particularly community-based or non-English healthcare systems. Participant self-selection may have led to a sample with higher levels of engagement in EBP, potentially shaping the perspectives captured. Although follow-up observations provided insight into sustainability, wider system changes during and after the COVID-19 pandemic may have influenced how practices evolved. Future studies could build on this work by exploring smaller hospitals, community care environments, or healthcare systems in other national contexts. There is also value in examining how ongoing structural reforms in primary care and integrated services shape the conditions for EBP across diverse settings.

7. Conclusions

This study explored how nurses in acute care settings lead and sustain EBP through relational leadership, professional identity, interprofessional collaboration, and engagement with learning structures. Findings reveal that while organizational barriers continue to shape the implementation landscape, nurses adapt, negotiate, and innovate to deliver evidence-informed care. The integration of EBP is not a linear process driven solely by top-down directives. It is best understood as an ongoing, situated practice shaped by context, relationships, and professional commitment. Recognizing the contribution of everyday leadership, peer learning, and feedback mechanisms is essential for promoting sustainable EBP in acute care. Healthcare leaders and policy-makers should create environments where staff feel equipped, supported, and recognized for their contributions to evidence-informed care. Future work should examine how these dynamics unfold across varied clinical settings and professional groups, focusing on inclusion, recognition, and capacity-building.

Data availability statement

The datasets generated during and/or analysed during the current study are not publicly available due to confidentiality issues, but are available from the corresponding author upon reasonable request.

CRediT authorship contribution statement

Jude Ominyi: Conceptualization, Methodology, Validation, Formal analysis, Investigation, Data curation, Writing - original draft, Writing - review & editing, Project administration. **Adewale Alabi:** Conceptualization, Methodology, Validation, Formal analysis, Investigation, Resources, Data curation, Writing - review & editing, Project administration.

Declaration of competing interest

The authors of this study have declared no conflict of interest.

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Appendices. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijnss.2025.08.010>.

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