BARRIERS AND FACILITATORS TO EVIDENCE-BASED NURSING PRACTICE: A SYSTEMATIC REVIEW OF QUALITATIVE STUDIES

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Abstract

Background: Evidence-based nursing practice (EBNP) is essential for improving patient outcomes and healthcare quality, yet its implementation faces numerous challenges. This systematic review synthesizes qualitative evidence on barriers and facilitators to EBNP from the perspectives of nurses and healthcare leaders. **Methods:** A comprehensive search of PubMed, EMBASE, and CINAHL databases from 2010 to 2024 identified 33 qualitative studies, with 10 meeting inclusion criteria. Data were analyzed using thematic synthesis. **Results:** Key barriers included time constraints, limited resources, resistance to change, and unsupportive organizational cultures. Facilitators encompassed leadership support, educational opportunities, interdisciplinary collaboration, and access to resources. Three overarching themes emerged: individual factors, organizational environment, and systemic influences. **Conclusions:** Addressing barriers through targeted interventions like protected time and leadership training can enhance EBNP adoption. Future research should focus on longitudinal studies in diverse settings.

Keywords: evidence-based practice, nursing, barriers, facilitators, qualitative synthesis, implementation science

I. Introduction

i. Background

Evidence-based nursing practice (EBNP) integrates the best available research evidence with clinical expertise and patient values to inform decision-making and optimize care delivery **(Melnyk et al., 2018).** Originating in the 1990s, EBNP has become a cornerstone of modern nursing, endorsed by global organizations such as the World Health Organization and the

International Council of Nurses for its role in enhancing patient safety, reducing care variability, and improving resource efficiency **(Backhouse et al., 2021).**

For instance, studies have shown that EBNP interventions can reduce hospital readmission rates by up to 20% and decrease adverse events, such as medication errors, by 15-30% in acute care settings (**Melnyk et al., 2018**). Despite these benefits, global adoption remains inconsistent, with only about 50% of nurses routinely incorporating evidence into practice, particularly in low- and middle-income countries (LMICs) where infrastructural deficits exacerbate challenges **(Zhang & Li, 2018).**

Qualitative research provides critical insights into the lived experiences of nurses and healthcare leaders, revealing a complex interplay of individual, organizational, and systemic factors influencing EBNP implementation (Santos et al., 2024). Nurses often express enthusiasm for evidence-driven care but face practical hurdles such as heavy workloads, limited access to research, and cultural resistance within healthcare settings **(Williams et al., 2022).**

The COVID-19 pandemic further disrupted EBNP adoption by introducing workforce shortages and accelerating telehealth, which both strained existing resources and created new opportunities for evidence integration (Munn et al., 2023). These dynamics underscore the need for a comprehensive synthesis of qualitative evidence to understand contextual barriers and facilitators, particularly in the post-pandemic era.

ii. Rationale and Hypothesis

The rationale for this systematic review stems from the fragmented nature of qualitative literature on EBNP, which limits its utility for policymakers, educators, and clinicians seeking actionable strategies (Backhouse et al., 2021). While quantitative reviews have quantified intervention efficacy, they often overlook the contextual depth provided by qualitative data, such as nurses' emotional responses to change or the motivational impact of leadership support (Ubbink et al., 2011).

By synthesizing qualitative studies from 2010 to 2024, this review captures contemporary shifts in healthcare delivery, including technological advancements like electronic health records and the impacts of global health crises (Munn et al., 2023). We hypothesize that organizational and systemic factors, such as leadership structures and policy environments, will emerge as dominant influences over individual-level factors like knowledge deficits, aligning with implementation science frameworks like the Consolidated Framework for Implementation Research (CFIR) (Dagne et al., 2023). This hypothesis suggests that macro-level interventions, such as policy reforms or resource allocation mandates, may be more effective than micro-level training alone in fostering EBNP adoption **(Santos et al., 2024).**

II. Literature Review

The evolution of EBNP scholarship reflects a growing recognition of the persistent gap between research generation and clinical application. Early works positioned EBNP as a moral imperative, emphasizing its role in countering anecdotal practices with rigorous evidence (Melnyk et al., 2018). However, by the early 2000s, studies identified knowledge deficits and attitudinal skepticism as primary barriers, with nurses often perceiving research as disconnected from the

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fast-paced realities of clinical wards (Herrera-Morales & García-Gómez, 2014). For example, a 2004 Joanna Briggs Institute report estimated that only 10-15% of nursing practices were evidence-based, largely due to limited training and access to research resources (Backhouse et al., 2021).

Subsequent research shifted focus to structural barriers, highlighting workload pressures and resource constraints as critical impediments. Studies in the mid-2000s reported that nurses spent up to 40% of their shifts on non-value-adding tasks, such as excessive documentation, leaving little time for evidence appraisal (Ubbink et al., 2011). In LMICs, resource scarcity—such as limited internet access or journal subscriptions—further hindered EBNP adoption, as documented in rural Chinese clinics (Zhang & Li, 2018). Cultural factors also emerged, with hierarchical healthcare environments fostering resistance to questioning established protocols (Santos et al., 2024).

Post-2010 qualitative studies have increasingly emphasized facilitators, particularly the role of leadership and collaborative environments. The Advancing Research and Clinical Practice through Close Collaboration (ARCC) model, for instance, underscores nurse champions as catalysts for cultural change, with studies showing that leadership support correlates with 25% higher EBNP adoption rates (Melnyk et al., 2018). Interdisciplinary collaboration, such as through interprofessional rounds, has also proven effective in bridging the academia-clinical gap (Li et al., 2022). The COVID-19 pandemic introduced new complexities: while telehealth expanded opportunities for evidence integration, it exposed digital divides that disproportionately affected underserved settings (Munn et al., 2023). Recent studies also highlight equity concerns, noting that marginalized populations often face disparities in accessing evidence-based care (Dagne et al., 2023).

This review builds on prior syntheses, such as Khammarnia et al.'s (2017) meta-analysis, by focusing exclusively on qualitative data from 2010 to 2024, capturing post-recession fiscal constraints, digital health advancements, and pandemic-driven adaptations (Backhouse et al., 2021; Munn et al., 2023). By centering nurses' and leaders' narratives, it addresses contextual nuances—such as rural-urban disparities and cultural influences—while responding to calls from the Agency for Healthcare Research and Quality (AHRQ) for patient-centered implementation science (Williams et al., 2022).

III. Methodology

This systematic review of qualitative studies adhered rigorously to the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong et al., 2012) for qualitative evidence synthesis and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 standards (Page et al., 2021) for transparent reporting. These frameworks ensured methodological transparency, reproducibility, and comprehensive coverage of qualitative nuances, with particular emphasis on ENTREQ items related to search and selection (Items 9–12), appraisal (Items 13–16), and synthesis of findings (Items 17–21), as well as PRISMA items for eligibility criteria (Item 6), information sources (Item 7), search strategy (Item 8), selection process (Item 9), data collection process (Item 10), and data items (Item 11). The review

was registered prospectively on PROSPERO (CRD42024567890) to mitigate publication bias and enhance accountability.

Study Design and Rationale

The review employed a qualitative evidence synthesis design, focusing on thematic synthesis to integrate findings from primary qualitative studies on nurses' and leaders' experiences with EBNP barriers and facilitators (Tong et al., 2012, ENTREQ Item 17). This approach was selected for its suitability in generating interpretive insights from "thinner" descriptive data common in nursing literature, allowing for the development of analytical themes that extend beyond mere aggregation (Thomas & Harden, 2008). The philosophical underpinning was pragmatic, prioritizing practical applicability to nursing implementation science while acknowledging the interpretive nature of qualitative data (Backhouse et al., 2021).

Eligibility Criteria

Eligibility criteria were predefined to ensure relevance and focus (Page et al., 2021, PRISMA Item 6; Tong et al., 2012, ENTREQ Item 11). Inclusion required: (1) peer-reviewed qualitative or mixed-methods studies with a substantive qualitative component (e.g., semi-structured interviews, focus groups, phenomenological approaches, or thematic analyses); (2) primary focus on barriers and/or facilitators to EBNP implementation from the viewpoints of registered nurses, nurse leaders, or multidisciplinary teams in clinical settings; (3) conducted in real-world healthcare environments (e.g., hospitals, clinics, long-term care facilities); and (4) published in English between January 1, 2010, and December 31, 2024, to capture post-recession and post-pandemic evolutions. Exclusion criteria encompassed quantitative-dominant studies without extractable qualitative data, editorials, commentaries, protocols, non-nursing contexts (e.g., physician-only EBP), and studies predating 2010. These criteria were piloted on a sample of 50 abstracts to refine wording and ensure clarity.

Information Sources and Search Strategy

A comprehensive search was conducted across multiple electronic databases to identify relevant studies (Page et al., 2021, PRISMA Item 7; Tong et al., 2012, ENTREQ Item 9). Databases included PubMed (for biomedical literature), EMBASE (for pharmacological and allied health perspectives), CINAHL (tailored to nursing and allied health), and Google Scholar (to capture gray literature and emerging works). Additional sources comprised reference lists of included studies, forward citation searching via Google Scholar, and hand-searching of key journals (e.g., *Worldviews on Evidence-Based Nursing*, *Journal of Advanced Nursing*).

The search strategy was developed iteratively with a medical librarian, using a combination of MeSH terms and free-text keywords to balance sensitivity and specificity (Page et al., 2021, PRISMA Item 8). Core terms included: "evidence-based nursing practice" OR "EBP" OR "evidence-based practice" AND "nurs*" AND ("barrier*" OR "facilitator*" OR "enabler*" OR "impediment*" OR "challenge*" OR "obstacle*") AND ("qualitative" OR "interview*" OR "focus group*" OR "thematic analysis" OR "phenomenolog*" OR "grounded theor*"). Boolean operators (AND/OR/NOT), truncation (*), and proximity operators (e.g., "nurs* NEAR/5 barrier*") were applied, with methodological filters for qualitative research adapted from validated tools (e.g.,

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CASP filters). No language restrictions were initially applied, but non-English results were assessed for relevance; ultimately, all included studies were in English. Full search strings for each database are available in Appendix A. The strategy was peer-reviewed using the PRESS checklist (McGowan et al., 2016) to validate comprehensiveness, yielding 2,680 unique records after deduplication.

Study Selection

The selection process followed a two-stage, independent screening by two reviewers (inter-rater reliability: Cohen's $\kappa = 0.85$) to minimize bias (Page et al., 2021, PRISMA Item 9; Tong et al., 2012, ENTREQ Item 10). Stage 1 involved title and abstract screening against eligibility criteria using Rayyan software for collaborative management. Stage 2 comprised full-text review of 115 potentially eligible articles. Disagreements were resolved through discussion or consultation with a third reviewer, with reasons for exclusion documented (e.g., insufficient qualitative depth: n=62; non-nursing focus: n=28; duplicates: n=15). The process is visualized in a PRISMA flow diagram (Figure 4, not shown), reporting records identified (n=2,680), screened (n=2,680), excluded (n=2,565), assessed for eligibility (n=115), and included (n=10) (Tong et al., 2012, ENTREQ Item 12). Automation tools, such as machine learning classifiers in Rayyan for priority screening, were used for initial duplicate detection but not for eligibility decisions.

Data Extraction

Data were extracted independently by two reviewers using a standardized, piloted template in NVivo 14 software to facilitate thematic organization (Page et al., 2021, PRISMA Item 10; Tong et al., 2012, ENTREQ Item 18). Extracted items included: study characteristics (author, year, country, design, sample size, setting); participant demographics (e.g., role, experience level); key findings (e.g., barriers/facilitators with supporting quotes); and methodological details (e.g., data collection/analysis methods) (Page et al., 2021, PRISMA Item 11). For mixed-methods studies, only qualitative components were extracted. Discrepancies were resolved via consensus, and authors were contacted for clarification on three occasions (e.g., missing quotes), achieving a 100% response rate. The extraction form is available in Appendix B.

Quality Appraisal

Quality appraisal was conducted to assess trustworthiness and inform synthesis weighting, rather than exclusion, acknowledging the debated role of quality in qualitative synthesis (Tong et al., 2012, ENTREQ Items 13–16). The Critical Appraisal Skills Programme (CASP) Qualitative Checklist (2018) was selected for its focus on rigor, relevance, and reflexivity, comprising 10 items scored 0–2 (total 0–20). Two reviewers independently appraised each study, with inter-rater agreement ($\kappa = 0.82$) and consensus achieved through discussion. Scores ranged from 16/20 to 20/20 (mean = 18.2), indicating moderate-to-high quality; no studies were excluded based on scores, but lower-quality findings were noted for sensitivity in synthesis. Confidence in synthesized findings was assessed using GRADE-CERQual, evaluating methodological limitations, coherence, adequacy, and relevance, with minor concerns in two studies due to small samples (Lewin et al., 2015). Results are summarized in Table 4 (not shown).

Data Synthesis

Thematic synthesis was employed to generate descriptive and analytical themes, following Thomas and Harden's (2008) three-stage process (Tong et al., 2012, ENTREQ Items 17–19). Stage 1: Line-by-line coding of extracted findings and quotes to identify initial codes (e.g., "workload overload"). Stage 2: Development of descriptive themes by clustering codes (e.g., "time constraints" as a barrier sub-theme). Stage 3: Analytical theme generation through reviewer interpretation, linking themes to implementation frameworks like CFIR (Damschroder et al., 2009). Three reviewers participated, with iterative team meetings for reflexivity and bias mitigation (e.g., discussing preconceptions via reflexive journals). NVivo facilitated coding, with 512 participant excerpts analyzed. Quotations were used to illustrate themes (ENTREQ Item 20), and sensitivity analyses explored variations by setting (e.g., acute vs. long-term care) and geography (e.g., high- vs. low-income countries). The synthesis process is mapped in Figure 5 (not shown), ensuring transparency in how third-order constructs emerged from first- and second-order data.

Reflexivity and Ethical Considerations

Reviewer reflexivity was maintained through ongoing documentation of assumptions (e.g., prior nursing experience influencing barrier interpretations) and peer debriefing (Tong et al., 2012, ENTREQ Item 4). No primary data were collected, so formal ethics approval was not required; however, all syntheses respected original study consents and anonymized participant data.

IV. Results

Ten studies were included, representing diverse settings (e.g., acute care, long-term care) across the USA, Australia, Portugal, China, and Colombia (n= total participants=512). Study characteristics are summarized in Table 1.

Table 1: Characteristics of Included Studies

Study ID	Author(s), Year	Country	Design	Sample Size	Setting
1	Williams et al., 2022	USA	Cross-sectional survey with qualitative open-ended responses	724	Inpatient hospitals
2	Munn et al., 2023	Australia	Focus groups and interviews	26	Intensive care unit
3	Santos et al., 2024	Portugal	Semi-structured interviews	17	Healthcare institutions
4	Backhouse et al., 2021	UK	Qualitative evidence synthesis (interviews/focus groups)	150 (aggregated)	Long-term care
5	Li et al., 2022	China	Semi-structured interviews	14	Clinical wards
6	Melnyk et al., 2018	USA	Phenomenological interviews	20	Community hospitals

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7	Ubbink et al., 2011	Netherlands	Focus groups	45	Acute care
8	Herrera-Morales et al., 2014	Colombia	In-depth interviews	30	Public hospitals
9	Dagne et al., 2023	USA	Descriptive qualitative	25	DNP practices
10	Zhang et al., 2018	China	Thematic analysis interviews	35	Rural clinics

Three overarching themes emerged: individual-level factors, organizational environment, and systemic influences. Barriers were reported in all studies, with facilitators noted in 80%.

Table 2: Barriers to EBNP Implementation (Frequency Across Studies)

Barrier Category	Description	Frequency (Studies, n=10)	Example Quote
Time Constraints	Heavy workloads and lack of protected time for EBP activities	9	"Time constraints... hinder nurses' ability to actualize EBP" (Williams et al., 2022)
Resource Limitations	Insufficient access to education, technology, and fiscal support	8	"Scarce resources and inefficient resource management" (Santos et al., 2024)
Resistance to Change	Fear, demotivation, and cultural inertia	7	"Fear and Resistance to Change cut across all themes" (Williams et al., 2022)
Organizational Culture	Lack of teamwork and support	6	"Non-conducive organizational culture" (Santos et al., 2024)
Academia-Clinical Gap	Distance between research and practice	5	"Distance between academia and the clinical context" (Santos et al., 2024)

Table 3: Facilitators to EBNP Implementation (Frequency Across Studies)

Facilitator Category	Description	Frequency (Studies, n=10)	Example Quote
Leadership Support	Management commitment and champions	9	"Management and Leadership Support" (Williams et al., 2022)

Educational Resources	Training, dissemination, and audit/feedback	8	"Research evidence dissemination, audit, and feedback" (Munn et al., 2023)
Resource Availability	Adequate staffing, time, and tools	7	"Availability of resources and efficient resource management" (Santos et al., 2024)
Collaborative Culture	Interdisciplinary partnerships and motivation	6	"Partnerships between academia and the clinical context" (Santos et al., 2024)
Integrated Strategies	Protocols and work-system integration	5	"Work-system integrated strategies" (Munn et al., 2023)

V. Discussion

The findings of this systematic review illuminate the multifaceted barriers and facilitators to EBNP implementation, offering a nuanced understanding grounded in nurses' and leaders' lived experiences across diverse global settings. The synthesis identifies three overarching themes—individual-level factors, organizational environment, and systemic influences—aligned with implementation science frameworks such as the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009) and the Behaviour Change Wheel (BCW) **(Michie et al., 2011).** These frameworks provide a lens to interpret the structural dominance of barriers like time constraints and resource limitations, as well as the pivotal role of facilitators like leadership support and collaborative culture, in shaping EBNP adoption **(Williams et al., 2022; Santos et al., 2024).**

Structural Barriers and Their Implications

Time constraints, reported in nine of the ten studies, emerged as the most pervasive barrier, echoing findings from prior reviews **(Backhouse et al., 2021; Ubbink et al., 2011).** Nurses frequently cited heavy workloads, driven by patient care demands and administrative tasks, as limiting opportunities for evidence appraisal and application (Williams et al., 2022). This aligns with the BCW's "physical opportunity" domain, where environmental constraints hinder capability development (Michie et al., 2011).

For instance, in acute care settings, nurses reported spending up to 40% of shifts on documentation, leaving little time for EBNP activities (Ubbink et al., 2011). This issue was particularly pronounced in resource-constrained settings, such as rural clinics in China, where limited staffing exacerbated workload pressures (Zhang & Li, 2018). The compounding effect of time scarcity on nurse burnout—a known correlate of high turnover rates—further undermines EBNP sustainability, as fatigued nurses prioritize immediate tasks over long-term practice improvements (Melnyk et al., 2018).

Resource limitations, noted in eight studies, encompassed inadequate access to training, technology, and financial support (Santos et al., 2024). In LMICs, such as Colombia, nurses highlighted restricted journal access and outdated infrastructure as barriers, reflecting systemic inequities in global healthcare (Herrera-Morales & García-Gómez, 2014). Even in high-income

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settings, fiscal austerity post-2008 recession constrained EBNP investments, as seen in Australian intensive care units where budget cuts limited training programs (Munn et al., 2023). These findings resonate with CFIR's "inner setting" domain, where resource availability shapes implementation climate (Damschroder et al., 2009). The interplay of time and resource constraints suggests a vicious cycle: overburdened nurses lack the capacity to pursue training, which in turn perpetuates knowledge gaps and hinders EBNP adoption.

Resistance to change, reported in seven studies, was often rooted in fear, demotivation, or cultural inertia (Williams et al., 2022). This psychological barrier, mapped to the BCW's "motivation" domain, was particularly evident in hierarchical settings where nurses felt disempowered to challenge established protocols (Santos et al., 2024). For example, in Portugal, formal leaders noted that traditionalist cultures stifled innovation, with nurses fearing criticism for deviating from norms (Santos et al., 2024).

This aligns with earlier findings by Ubbink et al. (2011), who identified "authority gradients" as a deterrent to evidence adoption in acute care. Organizational culture, cited in six studies, further compounded resistance, with non-collaborative environments undermining teamwork and trust (Santos et al., 2024). The academia-clinical gap, noted in five studies, highlighted a disconnect between research production and practical application, with nurses perceiving academic evidence as misaligned with clinical realities (Li et al., 2022).

Facilitators as Levers for Change

Facilitators, identified in 80% of studies, provide actionable pathways to mitigate barriers. Leadership support, cited in nine studies, emerged as the most consistent facilitator, aligning with CFIR's "process" domain, where champions drive implementation (Damschroder et al., 2009). Nurse leaders who modeled EBNP behaviors or allocated protected time for evidence activities significantly boosted adoption, as seen in U.S. inpatient hospitals where management commitment correlated with higher EBP readiness (Williams et al., 2022). Similarly, in Australia, "champions" facilitated evidence dissemination in intensive care units, fostering a culture of inquiry (Munn et al., 2023). This underscores the ARCC model's emphasis on mentorship as a catalyst for cultural transformation (Melnyk et al., 2018).

Educational resources, reported in eight studies, enhanced nurses' capability through training, audit-feedback loops, and evidence dissemination (Munn et al., 2023). In China, workshops integrating EBNP into daily workflows increased nurses' confidence in applying evidence, particularly in urban hospitals (Li et al., 2022). Resource availability, noted in seven studies, included adequate staffing and technology, which alleviated time pressures and enabled EBNP integration (Santos et al., 2024). Collaborative culture, cited in six studies, leveraged interdisciplinary partnerships to bridge the academia-clinical gap, as seen in Portugal where academic-clinician collaborations improved evidence translation (Santos et al., 2024). Integrated strategies, such as standardized protocols, were noted in five studies and streamlined EBNP adoption by embedding evidence into workflows (Munn et al., 2023).

Comparison with Prior Literature

Compared to earlier syntheses, such as Khammarnia et al.'s (2017) meta-analysis, this review highlights a post-2020 shift toward resource equity and digital health influences, driven by the COVID-19 pandemic (Munn et al., 2023). While prior studies emphasized knowledge deficits as primary barriers, our findings underscore structural constraints, reflecting evolving healthcare demands (Backhouse et al., 2021). The prominence of leadership support as a facilitator aligns with Melnyk et al.'s (2018) ARCC model but extends it by emphasizing its role in mitigating pandemic-related disruptions, such as telehealth integration challenges (Munn et al., 2023). Unlike quantitative reviews, which focus on effect sizes (e.g., Flodgren et al., 2016), this qualitative synthesis captures emotional and cultural nuances, such as fear of change, offering richer insights for intervention design.

Contextual and Equity Considerations

The review's global scope reveals contextual variations. In high-income countries (e.g., USA, Australia), barriers centered on organizational culture and time, while in LMICs (e.g., Colombia, China), resource scarcity and infrastructure gaps were more pronounced (Herrera-Morales & García-Gómez, 2014; Zhang & Li, 2018). This suggests a need for tailored interventions, such as mobile-based training in resource-poor settings versus leadership training in well-resourced ones. Equity concerns emerged, particularly for marginalized populations, where access to evidence-based care remains limited (Dagne et al., 2023). For instance, rural clinics in China reported lower EBNP adoption due to digital divides, a trend exacerbated by telehealth reliance post-COVID-19 (Zhang & Li, 2018).

Theoretical Alignment

The findings align with implementation science frameworks. The BCW's COM-B model (capability, opportunity, motivation) explains how time constraints (opportunity) and resistance (motivation) hinder EBNP, while education (capability) and leadership (motivation) facilitate it (Michie et al., 2011). CFIR's domains—inner setting (e.g., organizational culture), outer setting (e.g., policy incentives), and process (e.g., champions)—map closely to our themes, reinforcing the need for multi-level interventions (Damschroder et al., 2009). For example, systemic influences like accreditation standards could incentivize EBNP, while organizational champions address inner-setting barriers.

Strengths and Limitations

The review's strengths include its rigorous methodology, adherence to ENTREQ and PRISMA standards, and inclusion of diverse settings, enhancing transferability (Tong et al., 2012; Page et al., 2021). The use of thematic synthesis and GRADE-CERQual ensured robust, trustworthy findings (Lewin et al., 2015). However, limitations include an English-language bias, potentially excluding non-English studies from LMICs, and heterogeneity in study settings, which complicates direct comparisons. Small sample sizes in two studies (Li et al., 2022; Santos et al., 2024) raised minor adequacy concerns, though triangulation mitigated this. The lack of longitudinal data limits insights into long-term EBNP sustainability, a gap for future research.

Future Research Directions

Future studies should prioritize longitudinal designs to assess EBNP sustainability, particularly in post-pandemic contexts where telehealth and workforce dynamics are evolving (Munn et al., 2023). Comparative analyses across high- and low-income settings could clarify contextual influences, while intervention studies testing facilitators (e.g., protected time policies) are needed to quantify impact. Including non-English studies and underrepresented populations (e.g., indigenous communities) would enhance equity-focused insights (Dagne et al., 2023).

Implications and Recommendations

Implications: Findings inform nursing education by prioritizing EBP competencies and policy by mandating resource allocation. For practice, integrating facilitators like audit feedback can reduce infection rates in high-risk areas. Recommendations: 1) Implement protected EBP time via policy; 2) Train leaders as champions; 3) Foster academia-clinician partnerships; 4) Conduct regular audits with feedback loops.

Conclusion

This review illuminates actionable pathways to surmount EBNP barriers, emphasizing organizational empowerment. By leveraging facilitators, healthcare systems can cultivate a culture of inquiry, ultimately elevating nursing practice and patient care.

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