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Barriers and facilitators to the utilization of evidence-based practice among nurses in federal medical center Yenagoa, Bayelsa State

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Abstract

Background: Evidence-Based Practice (EBP) improves quality, safety, and patient outcomes, yet implementation remains inconsistent in many low- and middle-income settings.

Aim: To determine barriers and facilitators to EBP utilization among nurses in Federal Medical Centre (FMC) Yenagoa, Bayelsa State, and to assess nurses' current knowledge and practice-related competencies.

Methods: A descriptive cross-sectional survey design was used. Stratified random sampling (by ward/unit) was applied to select registered nurses from a population of 581. Sample size was determined using taro-Yamene formular. Data were collected using a self-structured questionnaire. Face, content and construct validity of the instrument were done by experts, while reliability coefficient of 0.80 was obtained using Pearson Product Moment Correlation. Questionnaires distributed were 230 and same were retrieved and analyzed. and analyzed using frequencies and percentages.

Results: Respondents demonstrated high awareness and self-reported knowledge of EBP: 54.78% strongly agreed they were familiar with EBP and 56.08% strongly agreed they could search for relevant evidence. Key facilitators were management support (82.17% strongly agreed) and availability of EBP mentors/champions (82.61% strongly agreed). Major barriers were lack of time (86.52% strongly agreed) and limited access to databases (85.65% strongly agreed).

Conclusion: Although nurses reported good EBP knowledge and strong endorsement of facilitators, major organizational and capacity constraints especially time, access to evidence resources, and research-method skills persist. Strengthening mentorship, protected time, internet/database access, and structured capacity-building is recommended.

Keywords: Evidence-Based Practice; Facilitators; Barriers; Bayelsa State

1. Introduction

Evidence-Based Practice (EBP) is a structured approach to clinical decision-making that integrates the best available research evidence with clinical expertise and patients' values and preferences. In nursing, EBP is widely recognized as a mechanism for improving patient safety, standardizing care, enhancing clinical outcomes, and supporting cost-

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effective service delivery [1] Despite this global emphasis, EBP utilization in many Nigerian clinical environments remains suboptimal, often due to combined individual and organizational barriers.

In Nigeria, common constraints include limited access to contemporary research evidence, weak internet infrastructure, time pressure from heavy clinical workload, gaps in EBP training, and insufficient institutional support for research translation [2]. Even where nurses perceive EBP as valuable, limited competencies in critical appraisal and research interpretation can reduce confidence and practical uptake [3]. Organizational culture also matters: hierarchical decision-making and resistance to change may restrict nurses' autonomy in implementing evidence-informed innovations [4].

Conversely, evidence indicates that supportive leadership, continuous professional development, mentorship, access to databases, and explicit workplace policies that promote EBP can improve adoption and routine use [5,6]. Given FMC Yenagoa's role as a tertiary referral and training institution, understanding context-specific barriers and facilitators is critical for designing practical interventions that strengthen nursing care quality in Bayelsa State and contribute to broader national improvement efforts.

Aim

To identify barriers and facilitators to the utilization of EBP among nurses in FMC Yenagoa.

Objectives

- Assess nurses' knowledge and understanding of evidenced-based practice in Federal Medical Centre Yenagoa.
- Determine facilitators to evidenced-based practice utilization among Nurses in Federal Medical Centre Yenagoa.
- Determine barriers to evidenced-based practice utilization among Nurses in Federal Medical Centre Yenagoa.

2. Methodology

2.1. Study design

The study employed a descriptive, cross-sectional design which is a non-experimental survey design. A cross-sectional approach was considered appropriate because it empowers the systematic capture of perceptions, preferences, and organized readiness indicators at a single point in time across multiple stakeholder groups and settings, thereby supporting priority-setting for implementation planning.

2.2. Setting

The study was conducted at Federal Medical Centre, Yenagoa, Bayelsa State, Nigeria a tertiary health institution with multiple specialty units and an estimated nursing workforce of 581.

2.3. Population and sampling

The target population comprised all categories/ranks of nurses working in FMC Yenagoa (N = 581). Sample size was determined using the Taro Yamane formula at 5% precision, yielding n ≈ 237. Stratified random sampling was used (with wards/units serving as strata), followed by simple random selection of nurses within strata. A total of 237 questionnaires were distributed and 230 were retrieved and analyzed.

2.4. Instrument for Data collection

Data were collected using a researcher-developed, structured, self-administered questionnaire designed to assess nurses' knowledge of Evidence-Based Practice (EBP) and the perceived barriers and facilitators influencing its utilization in Federal Medical Centre (FMC) Yenagoa. The instrument was developed following a review of contemporary EBP literature and aligned explicitly with the study objectives. The questionnaire comprised two major sections.

Section A elicited socio-demographic characteristics, including age, gender, highest nursing qualification, years of experience, unit of practice, and prior formal training in EBP.

Section B contained items organized into three domains: (1) knowledge and understanding of EBP (e.g., familiarity with EBP, ability to define EBP, understanding of EBP steps, ability to search for and appraise research, and integration of

patient preferences), (2) facilitators to EBP utilization (e.g., management support, availability of time, access to online databases, training opportunities, collaboration, and mentorship), and (3) barriers to EBP utilization (e.g., lack of time, limited access to databases, insufficient research-method knowledge, lack of administrative support, resistance to change, and inadequate training opportunities).

All domain items were rated on a **four-point Likert scale** (1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree). Higher scores indicated stronger agreement with the construct measured (knowledge competence, perceived facilitator, or perceived barrier). Responses were summarized using descriptive statistics (frequencies and percentages) for each item.

2.5. Reliability and Validity of Instrument

Content and face validity were established through expert review by the project supervisor to ensure clarity, relevance, and alignment with the study objectives. Reliability testing was conducted using a pilot test among nurses in a comparable tertiary facility (NDUTH Okolobiri). Internal consistency reliability was determined using the Pearson Product Moment Correlation in a test–retest procedure, yielding a reliability coefficient of **r = 0.80,** indicating acceptable instrument stability for research purposes.

The instrument was administered in person by the researcher after obtaining informed consent, and completed questionnaires were retrieved immediately to ensure a high response rate and minimize data loss.

2.6. Data collection and analysis

Questionnaires were administered directly by the researcher and retrieved within three days. Data were analyzed using frequencies and percentages and presented in tables.

2.7. Ethical considerations

Institutional permissions were obtained through introductory letters and approvals from nursing administration and ward heads. Participation was voluntary; confidentiality and anonymity were maintained.

3. Results

This section presents the analysis of data obtained during the study, Barriers and Facilitators to the Utilization of Evidence Based Practice (EBP) among Nurses in Federal Medical Centre Yenagoa.

Table 1 Barriers and Facilitators to the Utilization of Evidence Based Practice (EBP) among Nurses in Federal Medical Centre Yenagoa showing the Demographic Variable of respondents

Variables	Frequency	Percentage (%)
AGE		
20-29 years	30	13.04
30-39 years	95	41.30
40-49 years	83	36.09
50 years and above	22	9.57
GENDER		
Male	12	5.22
Female	218	94.78
HIGHEST NURSING QUALIFICATION		
Diploma	66	28.70
Bachelor’s Degree	117	50.86
Masters	27	11.74

Others	20	8.70
YEARS OF EXPERIENCE		
Less than 5 years	48	20.87
5-10 years	70	30.43
11-15 years	70	30.43
More than 15 years	42	18.27
CURRENT UNIT/WARD OF PRACTICE		
Medical	12	5.22
Surgical	12	5.22
Pediatrics	12	5.22
Critical care	8	3.48
Others	186	80.86
RECEIVED ANY FORMAL TRAINING IN EBP		
YES	226	98.26
NO	4	1.74

The above results reveal that majority of the respondents 95 (41.30%) fall within the age bracket of 31-39 and the least 22 (9.57%) are 50 years and above. Majority 218 (94.78%) are females while 12 (5.22%) are males. As regards highest qualification, majority 117 (50.86%) are bachelor degree holders followed by Diploma 66 (28.70%) and others 22 (8.70%). Years of experience revealed a tie of 70 (30.43%) between 5-10 years and 11-15 years of work experience while more than 15 years were 42 (18.27%) less than 5 years' experience revealed 48 (20.87%).

Table 2 Knowledge and understanding of Nurses on the utilization of Evidence Based Practice (EBP) among Nurses in Federal Medical Centre Yenagoa showing Current knowledge and understanding of EBP

STATEMENT	SA (%)	A (%)	SD (%)	D (%)
I am familiar with the concept of EBP	126(54.78)	104(45.22)	0 (0)	0 (0)
I can define EBP accurately	80(34.78)	145(63.04)	2(0.86)	3(1.30)
I understand the steps involved in EBP	79(34.35)	146(63.47)	2(0.86)	3(1.30)
I know how to search for relevant research evidence	129(56.08)	80(34.78)	9(3.91)	12(5.21)
I am confident in appraising research articles for quality	58(25.22)	120(52.17)	35(15.22)	17(7.39)
I can integrate patient preference with clinical EBP	58(25.22)	120(52.17)	30(13.04)	22(9.56)

The table above reveals that for the familiarity with the concept of EBP 54.78% strongly agreed (SA) and 45.22% agreed (A) that they are familiar with EBP. No respondents disagreed (D) or strongly disagreed (SD). This indicates universal awareness of EBP among the nurses. For the ability to define EBP accurately, 34.78% strongly agreed and 63.04% agreed reported they can define EBP with only 0.86% SD and 1.30% D disagreed. Majority (about 98%) can define EBP correctly, showing a sound theoretical understanding.

Furthermore, Understanding the steps involved in EBP, 34.35% and 63.47% agreed they understand the steps while 0.86% SD and 1.30% disagreed. meaning about 98% of nurses reported understanding the steps, reflecting high procedural knowledge. The table also revealed that ability to search for relevant research evidence shows that while over 90% have confidence in searching, about 9% still lack search skills, which could limit practice. Only about 77% feel confident, while nearly 23% lack skills in research appraisal, making this a major knowledge gap. And finally, about 77% can integrate patient values, but 23% struggle, which may affect patient-centred care.

Table 3 Facilitators to utilization of EBP among Nurses in FMC Yenagoa showing current facilitators to utilization of EBP

STATEMENT	SA (%)	A (%)	SD (%)	D (%)
Support from management encourages EBP.	189(82.17)	41(17.83)	0 (0)	0 (0)
Availability of adequate time during shifts promotes EBP utilization.	161(70)	69(30)	0 (0)	0 (0)
Access to online data bases and journals facilitates EBP.	197(85.65)	33(14.35)	0 (0)	0 (0)
Training programs and workshop enhances EBP skill.	180(78.26)	50(21.74)	0 (0)	0 (0)
Collaboration with colleagues promoted EBP implementation.	165(71.34)	65(28.26)	0 (0)	0 (0)
Having EBP mentor/champions in the workplace facilitates EBP.	190(82.61)	40(17.39)	0 (0)	0 (0)

The Table above shows that majority 82.17% strongly agree (SA) to support from management encourages EBP, while 17.83% agree(A). No respondents disagreed (D) or strongly disagreed (SD). This means that management support is very necessary for utilization of EBP. For the availability of adequate time during shift, 70% (SA) while 30% agree (A). No respondents disagreed (D) or strongly disagreed (SD). This means that availability of time during shifts promotes EBP utilization. Another majority 85.65% strongly agree (SA), while 14.35% agree (A) that access to online data bases and journals facilitates EBP. No respondents disagreed (D) or strongly disagreed (SD). This indicates that access to online data bases and journals facilitates EBP by Nurses in FMC.

Regarding training programs and workshop, majority 78.26% strongly agreed (SA) while 21.74% agree (A) that training program and workshop enhances EBP skills. No respondents disagreed (D) or strongly disagreed (SD). This implies that that training program and workshop enhances EBP skills for Nurses in FMC. A majority (71.34%) strongly agreed (SA) and 28.26% agree (A) that collaboration with colleagues promotes EBP implementation. No respondents disagreed (D) or strongly disagreed (SD). This shows that collaboration with colleagues promotes EBP implementation.

Findings from the study also revealed that majority (82.61%) strongly agree (SA) and 17.39% agree (A) that having mentors and champions in the work place to facilitate EBP. No respondents disagreed (D) or strongly disagreed (SD). This implies that having mentors and champions in the work place to facilitate EBP.

Table 4 Barriers to utilization of EBP among Nurses in FMC Yenagoa

STATEMENT	SA (%)	A (%)	SD (%)	D (%)
Lack of time is a major barrier to EBP implementation.	199(86.52)	31(13.48)	0 (0)	0 (0)
Limited access to database hinders EBP.	197(85.65)	33(14.35)	0 (0)	0 (0)
Insufficient knowledge of research introduction is a challenge.	194(84.35)	36(15.65)	0 (0)	0 (0)
Lack of administrative support discourages EBP.	184(80)	46(20)	0 (0)	0 (0)
Resistance to change among staff affects EBP Adoption.	151(65.65)	79(34.35)	0 (0)	0 (0)
Inadequate training opportunities reduce EBP utilization.	149(64.78)	81(35.22)	0 (0)	0 (0)

From the findings, it is evident that majority (86.52%) strongly agreed (SA) and 13.48% agree (A) that lack of time is a barrier to EBP implementation. No respondents strongly disagreed (SD) or disagreed (D). this implies that lack of time is a barrier to EBP implementation. Majority 85.65% strongly agree (SA) and 13.45 agree (A) that limited access to data base hinders EBP. No respondents strongly disagreed (SD) or disagreed (D). This implies that limited access to data base hinders EBP.

Pertaining to insufficient knowledge of research as a challenge, this finding reveals that a majority (84.35%) strongly agree (SA) and 15.65% agree (A) that it is a barrier. No respondents strongly disagreed (SD) or disagreed (D). This finding reveals that insufficient knowledge of research introduction is a challenge. As regards lack of administrative support discourages EBP, 80% strongly agree (SA) while 20% agree (A). No respondents strongly disagreed (SD) or disagreed (D). This reveals that lack of administrative support discourages EBP.

A majority 65.65% strongly agree (SA) while 34.35% agree (A) that resistance to change among staff affects EBP adoption. No respondents strongly disagreed (SD) or disagreed (D). This means that resistance to change among staff Nurses is a barrier to EBP adoption. Pertaining to inadequate training opportunities majority 64.78% strongly agree (SA) while 35.22% agree (A) that inadequate training opportunities reduces EBP utilization. No respondents strongly disagreed (SD) or disagreed (D). The finding reveals that inadequate training opportunities contribute to reducing EBP utilization

4. Discussion

This study examined the knowledge, facilitators, and barriers influencing the utilization of Evidence-Based Practice (EBP) among nurses in Federal Medical Centre (FMC) Yenagoa, Bayelsa State. The findings reveal a paradox that is increasingly reported in implementation science literature: high awareness and positive perception of EBP coexisting with persistent structural and contextual barriers that limit consistent translation into routine clinical practice.

4.1. Respondents' Demographic Characteristics

The demographic profile of respondents provides important context for interpreting the pattern of EBP knowledge, facilitators, and barriers identified in this study. Overall, the sample reflects a predominantly female, mid-career nursing workforce with substantial professional experience and a moderate-to-high educational mix features that can shape receptivity to EBP and capacity for implementation.

4.2. Knowledge and understanding of nurses towards utilization of EBP

Findings from this study demonstrate a generally high level of awareness and foundational knowledge of Evidence-Based Practice (EBP) among nurses at Federal Medical Centre (FMC) Yenagoa. The overwhelming majority of respondents reported familiarity with the concept of EBP, ability to define it correctly, and understanding of the procedural steps involved in its implementation. This suggests strong theoretical grounding and conceptual clarity among the nursing workforce in the institution.

In addition, over 90% of respondents reported confidence in searching for relevant research evidence, indicating reasonable information-seeking competence. However, a notable minority (approximately 9%) reported limitations in search skills, and about 23% lacked confidence in research appraisal and integration of patient preferences. These findings are particularly important because the ability to critically appraise evidence and integrate patient values represents the core of true EBP implementation. Thus, while awareness is high, translational competence appears moderately constrained.

The findings of this study contradict those of [7] in their study titled "Nurses' Knowledge, Attitudes and Practice of Evidence-Based Practice in Beni-Suef City, Egypt." In that study, 68.9% of nurses were unfamiliar with EBP, and only a small proportion demonstrated high familiarity. The disparity between the Egyptian context and FMC Yenagoa may be attributed to institutional differences. FMC Yenagoa is a tertiary and training institution that regularly engages in academic collaboration and professional development activities, which may enhance nurses' exposure to EBP principles.

Conversely, the present findings align with [8] in their study titled "Knowledge, Attitude and Use of Evidence-Based Practice (EBP) among Registered Nurse-Midwives Practicing in Central Hospitals in Malawi." Their findings showed moderate-to-high knowledge scores (70.6 ± 15.1), positive attitudes (78.7 ± 19.6), and moderate use (57.8 ± 23), indicating that knowledge does not always translate directly into implementation, an observation consistent with the present study.

Similarly, this study supports findings by [9] in "Knowledge and Utilization of Evidence-Based Nursing Practice among Nurses of Offa Specialist Hospital, Kwara State." In that study, 77.3% of nurses demonstrated high knowledge levels. However, utilization remained inconsistent, reflecting the persistent theory-practice gap. Further corroboration is found in [10], "Knowledge and Attitude Toward Evidence-Based Practice among Nurses of a Tertiary Care Teaching Hospital, Nepal." Dahal reported that 70% of nurses had good knowledge, while 30% had poor knowledge, but appraisal competence remained moderate. The similarity to FMC Yenagoa suggests that while conceptual understanding of EBP is increasingly widespread across developing contexts, skill-based components such as appraisal and patient-centered integration remain developmental areas.

Overall, this study demonstrates that FMC Yenagoa nurses possess strong foundational knowledge but require further strengthening in critical appraisal and translational competence to achieve optimal EBP utilization.

4.3. Facilitators to Nurses' Utilization of EBP.

The study identified major facilitators including management support, availability of time during shifts, access to online databases and journals, training programs and workshops, collaboration among colleagues, and the presence of EBP mentors or champions. The fact that all respondents positively endorsed these facilitators indicates institutional readiness for structured EBP strengthening. Management support (82.17%) and EBP champions (82.61%) were the most strongly endorsed facilitators, emphasizing the critical role of leadership and role modeling in evidence adoption. Access to databases (85.65%) further highlights the technological infrastructure needed for effective EBP. These findings strongly align with [11] in "Evaluation of Facilitators and Barriers to Implementing Evidence-Based Practice in the Health Services: A Systematic Review" that review identified training in research methodology, structured EBP courses, and transparent information systems as key enabling factors.

Similarly, [12] in their study titled "Barriers and Facilitators of Evidence-Based Practice in the Portuguese Context: Perceptions of Formal Nursing Leaders" identified seven major facilitator categories including organizational culture, motivation, leadership, resource availability, and academic clinical partnerships. These constructs parallel the current findings regarding management support, mentorship, and collaboration.

Additionally, [13], in *"Evidence-Based Practice among Healthcare Providers in Saudi Arabia: Barriers and Facilitators,"* reported that advanced education, collegial support, and research-focused recruitment significantly enhanced engagement in Evidence-Based Practice (EBP). This finding underscores the multidimensional nature of EBP implementation, particularly the interplay between individual competence and organizational culture.

Advanced education was identified as a strong predictor of EBP engagement because postgraduate training typically strengthens research literacy, critical appraisal skills, statistical reasoning, and familiarity with systematic reviews and clinical guidelines. Healthcare providers with higher academic qualifications are more likely to understand research methodologies, interpret confidence intervals and effect sizes, and integrate empirical findings into clinical decision-making. This aligns with the knowledge–attitude–practice continuum, where enhanced cognitive capacity fosters positive attitudes toward research utilization and subsequently improves implementation behaviors.

Collegial support emerged as another significant facilitator. Peer encouragement, mentorship, interdisciplinary collaboration, and supportive leadership create a psychologically safe environment for questioning traditional practices and adopting evidence-informed interventions. In practical terms, when colleagues share journal articles, discuss clinical guidelines during ward rounds, or participate in audit and feedback cycles, EBP becomes normalized within routine care. Social learning theory further explains this dynamic: clinicians model behaviors observed in respected peers, thereby strengthening collective EBP culture. Research-focused recruitment also contributed substantially to EBP engagement. Institutions that intentionally hire professionals with prior research exposure, publication experience, or postgraduate research training create an internal workforce predisposed to inquiry and innovation. Such recruitment strategies shift organizational identity toward scholarship and continuous improvement, thereby reducing resistance to change.

The reported mean facilitator score of 26.1 reflects a moderately high perception of enabling factors within the study population. This quantitative indicator suggests that educational and peer-driven mechanisms were not merely present but meaningfully influential. In measurement terms, a facilitator score at this level indicates that respondents perceived institutional and interpersonal supports as tangible drivers of EBP integration rather than abstract ideals. Collectively, these findings reinforce the premise that EBP implementation is not solely dependent on individual motivation but is structurally mediated by academic preparation, professional networks, and strategic workforce policies. For health systems aiming to institutionalize EBP, investment in postgraduate training, structured mentorship programs, journal clubs, research units, and evidence-oriented hiring frameworks is therefore not optional but foundational.

In the context of nursing education and clinical practice, particularly in resource-constrained settings, these findings provide empirical justification for embedding EBP modules in undergraduate curricula, strengthening mentorship within clinical placements, and aligning recruitment criteria with research competence. Such systemic approaches are likely to produce sustainable improvements in EBP engagement rather than short-term compliance-driven adoption. Similarly, studies]19, 20] have identify leadership support, funding allocation, and protected time for research engagement as critical facilitators of Evidence-Based Practice (EBP). This alignment with findings from Nigeria, Malawi, Saudi Arabia, Portugal, and the United States highlights an important conceptual point: EBP implementation is primarily system-driven rather than culturally contingent.

Leadership support functions as a structural catalyst for EBP integration. When executive leaders, nurse managers, and clinical directors explicitly prioritize evidence-informed care, they institutionalize accountability mechanisms such as audit systems, performance metrics, and policy revision processes. Leadership endorsement also reduces resistance to change by legitimizing innovation and signaling organizational commitment. In health systems where leaders champion EBP, staff are more likely to perceive research utilization as a professional expectation rather than an optional activity.

Funding allocation represents the economic infrastructure underpinning EBP. Implementation requires financial investment in databases (e.g., CINAHL, Cochrane Library), continuing professional development, research units, statistical software, and implementation teams. Without budgetary commitment, EBP remains aspirational. The United States studies emphasize that institutions with designated EBP funding streams demonstrate higher rates of guideline adherence and measurable improvements in patient outcomes. This parallels findings in low- and middle-income countries, where limited financial capacity consistently emerges as a barrier.

Protected time for research engagement is another globally recognized facilitator. Clinical workloads, especially in nursing, often restrict opportunities for literature appraisal, protocol development, and quality improvement initiatives. When organizations formally allocate protected hours for research activities, journal clubs, and evidence appraisal meetings, they operationalize EBP within routine workflow. This structural adjustment mitigates the "time barrier" repeatedly documented across diverse health systems.

Thus, FMC Yenagoa possesses clear leverage points for strengthening EBP: institutional leadership engagement, mentorship frameworks, structured training, and enhanced digital resource access.

4.4. Barriers to Nurses Utilization of EBP

The present study identified lack of time (86.52%), limited access to databases (85.65%), insufficient research-method knowledge (84.35%), lack of administrative support (80%), resistance to change (65.65%), and inadequate training opportunities (64.78%) as primary barriers.

Time constraint emerged as the strongest barrier, reflecting workload intensity in tertiary health facilities. This finding is consistent with [14] in "Barriers and Facilitators to Evidence-Based Practice Adoption as Perceived by Nursing Administrators in Saudi Arabian Hospitals." They reported insufficient staffing, limited time resources, and resource constraints as statistically significant barriers to EBP adoption.

The findings also corroborate Mohamed et al. [7] in "Nurses' Knowledge, Attitudes and Practice of Evidence-Based Practice in Beni-Suef City, Egypt," where 95.1% of nurses lacked adequate computer skills, 85.2% had poor access to research evidence, and 72.1% perceived EBP as a low management priority. Similar institutional constraints are observable in FMC Yenagoa, particularly regarding database access and administrative support. [15], in "Evidence-Based Practice: Knowledge and Attitude among Nurses of a Teaching Hospital in Nepal," identified lack of time, poor research training, insufficient institutional support, and limited financial backing as critical barriers again aligning with the present findings. [16], in "Factors Influencing Nurses' Involvement and Utilization of Research Findings among Nurses in Ibadan," further identified limited internet access, lack of research funding, weak interdisciplinary collaboration, and absence of incentives as major deterrents. These systemic barriers echo the FMC Yenagoa context.

Moreover, [17], in their cross-sectional survey conducted in Cyprus, provide important insight into the organizational psychology underlying Evidence-Based Practice (EBP) engagement. Their findings indicate that lack of empowerment and difficulty accessing data were central barriers to EBP adoption among nurses.

Lack of empowerment reflects more than individual hesitation; it signifies limited autonomy in clinical decision-making, hierarchical organizational cultures, and restricted participation in policy formulation. When nurses perceive that their role does not include authority to modify clinical protocols or question established routines, the translation of evidence into practice becomes institutionally constrained. Empowerment in this context encompasses professional autonomy, involvement in clinical governance, participation in multidisciplinary decision-making, and recognition of nursing expertise. Without these elements, even nurses with adequate EBP knowledge may remain passive implementers of routine care rather than active agents of evidence integration.

Difficulty accessing data represents an infrastructural limitation. This includes restricted access to online databases, absence of institutional subscriptions to peer-reviewed journals, inadequate internet connectivity, and limited training in database navigation. From an implementation science perspective, this barrier falls under "available resources" within the inner setting. Access to high-quality data is foundational to EBP, as the first step in the EBP process involves

formulating answerable clinical questions and retrieving best available evidence. If retrieval mechanisms are weak, the entire EBP cycle collapses at its initial stage.

Similarly, [18], in their multi-institutional study in Oman, reported that nurses generally demonstrated positive attitudes toward EBP but exhibited low levels of actual implementation. This attitude–practice gap is particularly significant. Positive disposition toward EBP indicates cognitive acceptance of its value, yet implementation remained limited due to structural barriers such as workload pressures, insufficient staffing, limited time, inadequate institutional support, and lack of formal EBP training programs.

The divergence between attitude and implementation underscores a critical principle in behavioral and organizational theory: favorable beliefs do not automatically translate into behavioral change when structural constraints persist. In other words, motivation without infrastructure is insufficient. Nurses may intellectually endorse EBP and recognize its importance for patient outcomes, but without protected time, managerial endorsement, research mentorship, and access to resources, consistent implementation is unlikely.

When viewed alongside findings from Nigeria, Malawi, Saudi Arabia, and the United States, the studies from Cyprus and Oman reinforce the systemic nature of EBP barriers. The challenges are not rooted in cultural resistance to evidence; rather, they are embedded within institutional design. Empowerment deficits, resource limitations, and structural workload constraints consistently undermine translation of evidence into routine practice.

Collectively, these findings strengthen the argument that effective EBP integration requires multi-level intervention strategies:

- **Individual level**: enhancing research literacy and confidence.
- **Organizational level**: promoting empowerment, participatory leadership, and decision-making autonomy.
- **Structural level**: ensuring access to databases, funding, protected time, and staffing adequacy.

Thus, the evidence from Cyprus and Oman illustrates a recurrent global pattern: while nurses may value evidence-based care, implementation remains contingent upon institutional capacity, leadership commitment, and infrastructural support.

Collectively, these studies reinforce that EBP barriers are predominantly structural (time, resources, staffing, leadership culture) rather than purely individual. Even where knowledge is strong, implementation suffers when systemic infrastructure is weak.

5. Conclusion

This study provides important insight into the barriers and facilitators influencing the utilization of Evidence-Based Practice (EBP) among nurses in Federal Medical Centre (FMC) Yenagoa, Bayelsa State. The findings demonstrate that nurses possess strong foundational knowledge of EBP, with high levels of familiarity, conceptual understanding, and procedural awareness. However, despite this encouraging theoretical competence, practical translation into routine clinical decision-making remains constrained by systemic and structural barriers.

Key facilitators particularly management support, mentorship, access to research databases, training opportunities, and collegial collaboration were strongly endorsed, suggesting institutional readiness for enhanced EBP implementation. At the same time, major barriers including lack of time, limited database access, insufficient research-method skills, inadequate administrative support, and resistance to change indicate that knowledge alone is insufficient to ensure sustainable practice change. Viewed through the lens of Rogers' Diffusion of Innovation Theory, EBP adoption in FMC Yenagoa appears to have progressed through the awareness and persuasion stages but remains partially limited at the implementation and confirmation stages. While nurses recognize the relative advantage and professional value of EBP, structural constraints within the social system slow full institutionalization.

Therefore, strengthening EBP utilization in FMC Yenagoa requires strategic institutional reform rather than solely individual capacity building. Protected time for evidence activities, improved technological infrastructure, structured mentorship systems, leadership accountability, and continuous professional development in research appraisal are critical to bridging the knowledge–practice gap. Addressing these systemic determinants will not only enhance EBP uptake but also improve patient outcomes, professional accountability, and healthcare quality in the Niger Delta region.

Ultimately, sustainable integration of EBP within nursing practice at FMC Yenagoa demands coordinated leadership commitment, organizational culture transformation, and reinforcement of nurses' analytic and translational competencies.

Compliance with ethical standards

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Disclosure of conflict of interest

The authors declare no conflict of interest.

Statement of ethical approval

This study received ethical approval from the Federal Medical Centre, Yenagoa (protocol number: 122). The research was conducted in accordance with the ethical principles of respect for persons, beneficence, non-maleficence, and justice.

Statement of informed consent

Verbal informed consent was obtained from all participants after explaining the study's purpose, procedures, and their right to withdraw without consequence. Confidentiality and anonymity were maintained throughout the study, and all data were stored securely in compliance with the guidelines of the approving ethics committees.

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Authors' Contribution

- Baralate Sambo: contributed to conceptualization, methodology, formal analysis and data curation.
- Jimmy Agada J: contributed to conceptualization, methodology, formal analysis, investigation, data curation, visualization, and writing of the original draft.
- Tari Amakoromo: contributed to supervision, project administration, resources, methodology, validation, and scholarly refinement.
- Leghemo Ebipade Stephanie: contributed to conceptualization, project administration, software-analytical software

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