# Barriers to Implementing Evidence-Based Practice in the Nursing Profession – A Systematic Review

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## HIGHLIGHTS

- Reviews barriers to implementing evidence-based practice in nursing settings
- Synthesises findings from empirical studies across multiple countries and contexts
- Identifies time constraints, limited support, and skill gaps as key challenges
- Highlights both individual and organisational factors affecting EBP uptake
- Discusses implications for strengthening evidence-informed nursing practice

## KEYWORDS

Evidence-based practice
Barriers
Nursing
Implementation
Systematic Review
Research Utilization

## ABSTRACT

Evidence-based practice (EBP) is central to the quality, safety, and efficiency of health-care delivery. By integrating clinical expertise, patient values, and the best available evidence, EBP ensures informed decision-making and optimized patient outcomes. Despite its proven benefits, global evidence shows that nurses encounter persistent challenges in adopting EBP within clinical environments. This systematic review, guided by PRISMA framework, identifies and synthesizes the barriers hindering nurses from implementing EBP in clinical settings and highlights strategies to strengthen EBP culture in nursing. Primary, peer-reviewed empirical research in English, published in CINAHL, PubMed, Medline, and the British Nursing Database, between 2018 and 2024, were used for this review. The JBI critical appraisal tool was used to assess methodological quality. Fifteen studies (n = 4,641 participants) from twelve countries met the inclusion criteria. Inductive thematic synthesis revealed four overarching themes: (1) lack of time and resources, (2) insufficient managerial and leadership support, (3) limited authority to change practice, and (4) inadequate awareness, knowledge, and skills regarding EBP. These barriers reflect both individual-level and system-level constraints that undermine nurses' ability to translate evidence into practice. Barriers to EBP are multifactorial and interlinked. Sustainable EBP integration requires leadership commitment, organizational readiness, protected time for research activities, and continuous capacity-building through education and mentorship. Embedding EBP into policy and nursing curricula is crucial for fostering a culture of evidence-informed decision-making.

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## INTRODUCTION

Clinical care and therapy were in the past, largely influenced by the personal experiences and subjective perspectives of practitioners rather than by systematically produced research. The evolution of evidence-based practice (EBP) transformed this paradigm by introducing a structured, scientific approach to clinical decision-making. Since its origins in the 1800s, EBP has become integral to nursing, shaping it into a profession grounded in research and critical inquiry. The term evidence-based emerged in the early 1980s, denoting the use of empirical evidence to determine optimal clinical actions (Zeb et al., 2018). Since then, EBP has evolved into the prevailing model for integrating research evidence into clinical practice and is recognized for its ability to enhance the quality, efficiency, and safety of health-care delivery (Shazly et al., 2018).

EBP represents a lifelong, problem-solving approach that combines clinical expertise, patient preferences, and the best available research evidence to guide care decisions. The World Health Organization (2017) emphasized the importance of embedding evidence into health-care systems, mandating the best available research to be used to guide service delivery and patient care. Despite such recognition and the wealth of empirical support for its benefits, EBP remains inconsistently practiced in nursing. Its implementation is often hindered by the gap between theory, research, and actual nursing practice (Shifaza & Hamiduzzaman, 2021).

The process of applying EBP is inherently complex and requires nurses to invest time and intellectual effort at every stage. It involves identifying clinical problems, formulating researchable questions, conducting systematic literature searches, appraising the strength and quality of the evidence, and finally translating the evidence into interventions whose outcomes are evaluated in practice (Cardoso et al., 2021). As Abu-Baker et al. (2021) explain, EBP merges clinical knowledge, recent and relevant research findings, and patient-specific values to achieve informed and contextualized decision-making. This multidimensional approach ensures that care is both scientifically sound and individually responsive, strengthening the credibility and professionalism of nursing. Therefore, EBP has emerged as the gold standard of care within the discipline and a cornerstone of professional identity, driving nursing forward as both a science and an art (Melnyk & Fineout-Overholt, 2019).

Over the past decade, the global health-care landscape has undergone rapid transformation. Technological advances, demographic shifts such as aging populations, and the growing prevalence of chronic diseases have placed new demands on health systems to deliver efficient, high-quality, and cost-effective care (Cardoso et al., 2021). These pressures have elevated the importance of EBP as a mechanism to optimize outcomes and resource use. Nursing professionals—representing the largest segment of the health-care workforce—play a pivotal role in achieving these goals (Jylhä et al., 2017). The performance and competence of nurses directly influence patient satisfaction, cost control, and institutional performance (Hosseini-Moghaddam et al., 2022). As such, their ability to apply evidence in clinical contexts is essential for the advancement of safe and effective care.

Despite its theoretical acceptance, empirical evidence demonstrates that nursing practice often relies more on experience, intuition, and institutional norms than on rigorous research (Tong et al., 2022). Nursing is a distinct, autonomous profession that combines scientific reasoning with compassionate practice. To uphold this dual mandate, nurses must continuously cultivate knowledge and critical-thinking skills to translate research into practical care solutions (Abu-Baker et al., 2021). Humane and Khaire (2023) argue that nursing education provides a foundation in scientific principles, yet discrepancies persist between what is taught and what is practiced. Similarly, Birken et al. (2017) observe that while numerous frameworks and funding initiatives promote EBP, their translation into routine practice remains weak. Li et al. (2019) found that nurses frequently default to experience-based decisions rather than evidence-informed choices, illustrating an enduring gap between research and bedside care.

This theory-practice divide continues to challenge nursing globally. Even with existing programs, guidelines, and quality initiatives intended to promote EBP, the pace of translation remains slow (Zhang et al., 2024). Overcoming this inertia requires a cultural shift in nursing—one that encourages active inquiry, critical reflection, and continuous professional learning (Golge et al., 2024). Implementing EBP at the workplace level is the most effective strategy to bridge this divide, ensuring that research findings inform interventions that enhance both patient and organizational outcomes.

Public expectations for quality and accountability have further amplified the necessity for EBP. Patients and health-care systems increasingly demand care that is grounded in credible evidence rather than tradition or opinion (Pitsillidou et al., 2021). Consequently, nursing as a profession is expected to demonstrate not only compassion but also intellectual rigor and responsibility. EBP thus becomes not merely a professional standard but a moral imperative to ensure that patient care decisions are justified by the best available knowledge. By

integrating EBP into daily routines, nurses strengthen their clinical reasoning, leadership, and professional autonomy (Moore & Tierney, 2019). The overarching aim of EBP is to improve patient safety and outcomes through cost-effective, evidence-driven care, reinforcing nursing's role as an indispensable pillar of the health-care system.

Within small island developing state contexts, such as the Maldives' health-care system, similar aspirations toward evidence-informed practice have been articulated. Health policy reforms emphasize research utilization as a national priority for improving care standards (Khaled, 2023). However, implementation remains limited. Studies reveal that nurses in small island developing states encounter challenges such as lack of institutional support, limited access to training, and insufficient engagement in research activities (Prill et al., 2023). This makes it imperative that ss the largest group of front-line health providers, nurses must be equipped to interpret and apply existing research findings effectively, as well as conduct research to ensure that patient care matches individual's needs and expectations. Cultivating a research-oriented culture among nurses and strengthening inter-professional collaboration are therefore crucial steps toward integrating EBP into routine clinical care.

Despite global advocacy for EBP, numerous barriers continue to hinder its adoption. These include time constraints, limited resources, resistance to change, and insufficient leadership or policy support (Fernandez-Castro et al., 2023). Many nurses struggle to modify entrenched practices or challenge hierarchical norms that restrict innovation. Understanding these barriers is fundamental to developing strategies that enhance EBP adoption and sustainability. Accordingly, this study aims to deepen understanding of the obstacles nurses face in utilizing evidence, explore the underlying factors shaping these barriers, and propose context-appropriate measures to foster EBP integration. Through this systematic review, the research seeks to bridge the gap between theory and practice, reinforcing nursing as an evidence-informed discipline dedicated to advancing patient care.

## METHODOLOGY

### *Design*

This study adopted a systematic review design, providing a comprehensive analysis of global literature examining the barriers nursing professionals face when incorporating translational research results into health-care systems. Systematic reviews are integral to evidence-based health care as they synthesize findings from multiple studies that address a common research question (Hugh et al., 2023). Such reviews enhance transparency and reproducibility by combining all available published evidence and are often considered the gold standard of evidence synthesis (Seidler et al., 2020).

Systematic reviews identify research gaps and establish future priorities by consolidating the current state of knowledge (Page et al., 2021). However, methodological weaknesses—such as inclusion of low-quality trials or lack of rigor—may compromise validity (Uttley et al., 2023). Concerns also arise from random errors, heterogeneity, and non-standardized analyses that can threaten the credibility of results (Møller et al., 2018). Many reviews have been criticized as redundant or misleading when lacking systematic conduct and transparent reporting (Chapman et al., 2023). To mitigate these concerns, this review followed structured procedures informed by the PRISMA 2020 framework to ensure rigor and replicability.

### *Eligibility Criteria*

Eligibility parameters were defined to ensure inclusion of studies most relevant to the research aim. Articles were eligible if they were primary empirical studies published in English between 2018 and 2024 within the field of clinical nursing. The Population, Intervention, Comparison, Outcome (PICO) framework guided selection (Amir-Behghadami & Janati, 2020). The target population comprised of registered nurses practicing in health-care institutions. Quantitative and mixed method research studies only were included. Although including non-English studies is often recommended to avoid language bias (Dobrescu et al., 2021; Pieper & Puljak, 2020), this review restricted inclusion to peer-reviewed, full text research papers, published in English language. Evidence suggests that English-only reviews do not necessarily introduce systematic bias when the field's dominant literature is in English (Skinner, 2023).

### *Information Sources*

The search strategy was executed across major nursing and health databases to ensure comprehensive coverage. Databases included the British Nursing Database, PubMed, and CINAHL, each offering extensive peer-reviewed nursing and health-science research.

### *Selection Process*

Study selection adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines (Page et al., 2021). The process involved four phases—identification, screening, eligibility, and inclusion—to ensure transparency and replicability

(Smith & Johnson, 2023). Titles and abstracts were independently reviewed by two evaluators (the author and research supervisor) to minimize selection bias, consistent with recommendations for two-step screening (Waffenschmidt et al., 2019; Sinha et al., 2022).

### *Data Collection Process*

Data extraction was performed by the principal investigator and verified by the second reviewer to ensure accuracy. Following the Joanna Briggs Institute (JBI, 2022) data-extraction framework, the following details were recorded for each study: author(s), year of publication, aim, participants, sample size, study design, country, data collection instruments, and main outcomes. Although structured extraction minimizes human error, biases can still arise if extraction is inconsistent (Afifi et al., 2023). Therefore, extracted data were double-checked for coherence and completeness before synthesis. All eligible articles were critically appraised using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Analytical Cross-Sectional Studies (2017). This tool evaluates eight domains including sample inclusion, exposure measurement, confounding factors, and analytical rigor (Shaheen et al., 2023; Tod et al., 2022). Each criterion was rated "yes" (1) or "no/unclear" (0). Studies scoring ≥ 80% were categorized as low risk, 50–79% as moderate risk, and < 50% as high risk (Karim et al., 2023). This standardized scoring facilitates objective comparison and reduces reviewer subjectivity. Most studies demonstrated low-to-moderate risk of bias, indicating acceptable methodological quality. The use of clear score sheets and checklist instructions further ensured transparency and rigor (Shaheen et al., 2023).

### *Synthesis Methods*

The final analytical stage involved compiling and categorizing the extracted data through inductive thematic content analysis. This approach facilitates the identification of recurring patterns, relationships, and conceptual themes across studies (Shava et al., 2021). Each article was read in full, and key findings were coded and organized into thematic clusters.

Themes were generated from empirical evidence rather than predefined categories to preserve authenticity and contextual relevance. Synthesized data are presented in a structured narrative emphasizing patterns of barriers and their implications for nursing practice. Meaningful data presentation is critical, as inadequate reporting or weak synthesis can distort review conclusions (Norman et al., 2018). The analytic process aimed to achieve conceptual saturation and ensure that all significant insights were reflected in the emergent themes.

## RESULTS

### *Study Selection*

Database searches identified 331 records. Following de-duplication and removal of ineligible items, 132 records proceeded to title/abstract screening, after which 53 were excluded. The remaining 79 full texts were assessed for eligibility, yielding 15 studies for inclusion in the final synthesis.

### *Study Characteristics*

The 15 included studies comprised 4,641 participants and were conducted across diverse health-care systems: Saudi Arabia (n=3), Egypt (n=2), and Cyprus, Pakistan, Nigeria, Ethiopia, Croatia, Iran, Portugal, UAE, China, and Indonesia (one study each). Both qualitative and quantitative designs were represented. Quality appraisal classified eight studies as strong and seven as moderate; no study was rated weak. Although not used as a selection criterion, several studies employed the Barriers Scale or closely related instruments.

Across studies, barriers clustered at multiple levels. Institutional barriers encompassed limited resources, restricted access to research, insufficient managerial support, and suboptimal staffing. Interdisciplinary barriers included inadequate peer/physician cooperation, limited training, time pressure, and lack of guidance. Nurse-related barriers centered on constrained authority to change practice, time scarcity, and gaps in EBP awareness/skills. Communication/access barriers reflected difficulties locating and aggregating evidence in usable formats. On the basis of frequency and salience, four cross-cutting themes were selected for detailed analysis: (1) lack of time, (2) lack of managerial/leadership support, (3) lack of authority to change patient care, and (4) lack of awareness, skills, and knowledge.

### *Lack of Time*

Lack of time was the most frequently cited barrier, appearing in all 15 studies. Nurses in Saudi Arabia (Alqahtani et al., 2022), Cyprus (Pitsillidou et al., 2021), Ethiopia (Dagne et al., 2021), Egypt (Elnaser & Mohamed, 2019), and Portugal (Pinto et al., 2023) reported that heavy workloads and staffing shortages left insufficient time to read or apply research evidence. Similar findings from Indonesia (Rahmayanti et al., 2020) and Croatia (Lai et al., 2022) reinforced that patientcare demands consistently supersede research-related activities.

Across contexts, nurses described EBP implementation as "time-consuming" and an added responsibility within already demanding schedules. Some studies, such as those by Cebohin et al. (2021) and Hosseini-Moghaddam et al. (2022), noted that documentation workload and administrative tasks further restricted opportunities for professional reading or discussion of new evidence. Collectively, these findings highlight that time constraints represent both an organizational and a systemic barrier that limits engagement in research-driven practice.

### *Lack of Managerial and Leadership Support*

Ten of the included studies—spanning Cyprus (Pitsillidou et al., 2021), Nigeria (Ezeruigbo, 2023), Croatia (Lai et al., 2022), and Saudi Arabia (Alqahtani et al., 2022; Aljezawi et al., 2019)—identified the absence of managerial or leadership support as a critical barrier. Participants from multiple settings emphasized that nursing leaders and institutional administrators rarely allocate resources or incentives for EBP activities. In several Egyptian and Middle Eastern studies (Elnaser & Mohamed, 2019; Mahmoud & Abdelrasol, 2019; Al-Yateem et al., 2019), nurses described limited supervisory encouragement and minimal investment in continuing education.

Where management commitment was weak, nurses perceived EBP as peripheral to service delivery. Studies by Pinto et al. (2023) and Hosseini-Moghaddam et al. (2022) observed that even when individual motivation existed, the lack of institutional policies or leadership guidance curtailed sustained engagement. Across the sample, managerial disengagement and insufficient mentorship consistently undermined EBP adoption.

### *Lack of Authority to Change Patient Care*

A recurring finding across nine studies—including those by Pitsillidou et al. (2021), Alqahtani et al. (2022), Zeb et al. (2018), Ezeruigbo (2023), Cebohin et al. (2021), and Mahmoud & Abdelrasol (2019)—was that nurses felt constrained by limited professional authority. In hierarchical health-care systems, nurses often lacked permission to adjust patient-care procedures even when supported by research evidence. For instance, Pitsillidou et al. (2021) reported that 83.8 percent of participants cited lack of authority as the primary impediment to EBP.

Elnaser and Mohamed (2019) and Al-Yateem et al. (2019) similarly noted that organizational structures favored physician-led decision-making, restricting nurses' autonomy in introducing new interventions. Lai et al. (2022) and Rahmayanti et al. (2020) added that institutional inertia and rigid protocols often discouraged nurse-initiated innovations. Collectively, these studies demonstrate that empowerment and shared governance remain underdeveloped in many clinical environments, hindering the translation of evidence into practice.

### *Lack of awareness, skills, and knowledge*

Limited awareness and inadequate research skills were among the most prominent personal barriers reported. Nine studies—Zeb et al. (2018), Ezeruigbo (2023), Dagne et al. (2021), Cebohin et al. (2021), Hosseini-Moghaddam et al. (2022), Aljezawi et al. (2019), Al-Yateem et al. (2019), Pinto et al. (2023), and Rahmayanti et al. (2020)—documented nurses' difficulties in locating, interpreting, and critically appraising research. Participants frequently acknowledged unfamiliarity with EBP principles and expressed uncertainty about integrating findings into patient care.

For example, Dagne et al. (2021) found that only 41 percent of nurses could independently search for scientific evidence, while Pinto et al. (2023) observed that limited English proficiency impeded comprehension of international literature. Several Middle Eastern studies (Hosseini-Moghaddam et al., 2022; Al-Yateem et al., 2019) also highlighted the absence of accessible databases and insufficient IT infrastructure as contributors to poor knowledge application. The findings across all 15 studies converge on the need for targeted training, mentoring, and improved access to educational resources to enhance EBP competency among nurses.

### *Summary*

Overall, the synthesis of these 15 eligible studies indicates that barriers to EBP in nursing are both structural and personal. Time limitations and lack of managerial support form the most pervasive institutional challenges, while limited autonomy and inadequate knowledge constrain individual engagement. Although the geographic and cultural settings vary, the thematic consistency across studies suggests that these barriers are universal within the nursing profession. Addressing them requires integrated organizational strategies, educational reforms, and leadership commitment to foster a culture of evidence-informed care, and collaborative decision making.

## DISCUSSION

This systematic review consolidated findings from fifteen empirical studies exploring barriers to implementing evidence-based practice (EBP) among nurses. The analysis confirms that while EBP is widely

acknowledged as central to improving quality of care, nurses continue to experience multiple impediments at individual and institutional levels. These barriers—insufficient time, limited managerial support, restricted authority, and inadequate knowledge—mirror global trends in nursing literature, reaffirming that translating research into clinical practice is an enduring challenge (Griffiths et al., 2020; Shifaza & Hamiduzzaman, 2021).

The persistence of time constraints underscores a chronic structural problem within nursing workflows. In nearly every reviewed study, lack of dedicated time emerged as the most consistent and influential barrier. Heavy workloads, understaffing, and administrative burdens left nurses with little opportunity to search for or evaluate research evidence (Alqahtani et al., 2022; Dagne et al., 2021; Elnaser & Mohamed, 2019). This aligns with prior findings suggesting that when EBP is not embedded into the clinical routine, it becomes an optional and unrealistic addition (Naghibi et al., 2021). Studies outside the included dataset have demonstrated that time management interventions—such as workflow optimization and protected EBP time—significantly increase adoption rates (Addis et al., 2023). Therefore, addressing this barrier requires both organizational restructuring and individual capacity-building strategies.

Equally critical is managerial and leadership support, which plays a transformative role in cultivating an evidence-informed culture. Ten of the included studies reported that lack of guidance, recognition, and institutional backing discouraged EBP implementation. Broader literature confirms that supportive leadership—through mentorship, modeling, and policy advocacy—enhances EBP competency and motivation (Kueny et al., 2015; Sharplin et al., 2019; McNett et al., 2022). Leaders who create psychologically safe environments and reward evidence-driven initiatives promote innovation and improve staff retention (Swito & Sidin, 2020). In contrast, passive or hierarchical leadership styles reinforce the perception that EBP is peripheral to daily care. Building managerial competence in evidence-based leadership should thus be a strategic organizational goal.

The issue of limited professional authority was also pervasive. Nurses frequently describe decision-making hierarchies dominated by physicians, limiting their ability to introduce research-informed interventions. Such structural inequities restrict professional autonomy and slow evidence translation (Mahboube et al., 2019; Jordan et al., 2016). Shared-governance models and collaborative decision-making structures have been shown to enhance empowerment and accountability in practice (Buhaid et al., 2014). By redefining nurses as partners in evidence generation rather than passive implementers, institutions can bridge the divide between policy and practice.

A further constraint is insufficient knowledge and skill in research appraisal and interpretation. The reviewed studies revealed that many nurses lacked confidence in locating or analyzing scientific literature (Zeb et al., 2018; Cebohin et al., 2021). Broader scholarship indicates that this deficit often originates in undergraduate education, where EBP is taught theoretically but not practiced experientially (Camargo et al., 2018; Mlambo et al., 2021). Continuing professional development programs, mentorship by EBP champions, and digital learning platforms have been effective in strengthening these competencies (Mathieson et al., 2019; Zhang et al., 2024). Strengthening digital access—through institutional databases and mobile learning tools—can also facilitate real-time evidence retrieval and application.

Ultimately, the synthesis suggests that overcoming EBP barriers demands a multilevel systems approach integrating leadership, organizational culture, and lifelong learning. Nurse empowerment, coupled with leadership accountability and supportive infrastructures, can transform evidence-based nursing from aspiration into routine practice.

## LIMITATION OF THE EVIDENCE AND REVIEW PROCESS

Although this review offers comprehensive insights into barriers to EBP, several methodological limitations were there. Firstly, as a secondary synthesis, the review depended on published literature and is therefore susceptible to publication bias (Nair, 2019). Secondly, the predominance of cross-sectional designs limits causal inference. Sample sizes in several included studies were relatively small, and most relied on self-reported data, which may introduce response bias. Thirdly, only English-language studies were analyzed, which may have excluded relevant non-English research and introduced language bias (Rockliffe, 2022). Fourthly, restricting the publication window to 2018–2024 ensured contemporary relevance but may have inadvertently omitted earlier foundational studies (Aali & Shokraneh, 2021). Finally, the studies were conducted in countries with differing health-care systems, limiting the generalizability of findings. Future systematic reviews could benefit from multilingual inclusion criteria, broader temporal ranges, and meta-analytic integration to enhance robustness.

## IMPLICATION FOR PRACTICE, POLICY, EDUCATION, AND FUTURE RESEARCH

The findings of this review provide actionable insights for policymakers, educators, and clinical leaders. At the practice level, organizations must prioritize

structural reforms that enable nurses to incorporate EBP seamlessly into daily routines. Establishing protected time, creating interdisciplinary EBP committees, and embedding evidence appraisal within shift duties can normalize evidence use. Integrating EBP metrics into performance evaluations and accreditation systems can further reinforce accountability. At the policy level, health ministries and professional councils should institutionalize EBP through national guidelines and regulatory frameworks. Policies that incentivize EBP participation—such as recognition programs, continuing-education credits, or research grants—can accelerate adoption. Creating regional research networks linking academia and hospitals would also facilitate the co-production of locally relevant evidence. At the educational level, EBP principles must be embedded across all stages of nursing education. Undergraduate programs should adopt experiential learning methods—such as simulation-based research projects and case-based critical appraisal—to build early confidence. For practicing nurses, modular continuing-education courses focused on evidence synthesis, digital literacy, and implementation science are recommended (Mlambo et al., 2021; Zhang et al., 2024).

In terms of future research, significant gaps remain. Few studies have explored barriers specific to specialized fields such as pediatric, critical-care, or community nursing. Longitudinal studies could provide insight into how EBP behaviors evolve following targeted interventions. Comparative international studies would clarify the impact of cultural and structural contexts on EBP uptake. Furthermore, evaluating the effectiveness of emerging digital and AI-assisted tools—for evidence retrieval, appraisal, and decision support—represents a promising frontier for advancing evidence-informed nursing practice. Implementation-science approaches, such as the Iowa Model or PARIHS framework, should be applied and tested in diverse settings to determine best-fit models for sustained integration.

## CONCLUSION

This systematic review demonstrates that despite widespread advocacy for evidence-based nursing, the actual integration of evidence-based practice (EBP) into clinical settings remains limited due to persistent organizational and individual barriers. The most prominent obstacles identified across the fifteen included studies were time constraints, lack of managerial and leadership support, insufficient authority to initiate practice change, and inadequate awareness, skills, and knowledge related to EBP. These findings reflect enduring structural and cultural issues within healthcare institutions that restrict nurses' capacity to transform research evidence into daily care practices. To move forward, hospitals and nursing administrators must institutionalize EBP as an integral component of care delivery by embedding protected time for research engagement, promoting supportive leadership that values innovation, and creating mechanisms for shared governance that empower nurses to make evidence-informed decisions. Moreover, building capacity through targeted training, mentoring programs, and improved access to digital resources can enhance nurses' confidence and competence in applying EBP principles. Policy frameworks that link EBP participation to professional advancement and organizational accreditation can further encourage sustained adoption. Collectively, these actions can bridge the gap between research and clinical practice, enabling nurses to deliver safe, high-quality, and patient-centered care grounded in the best available evidence.

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## REGISTRATION AND PROTOCOL

Ethical concerns are an important part of the research project, from selecting the topic to writing the dissertation. In contrast to primary researchers, systematic reviewers do not gather personal or confidential information. However, systematic reviewers use and rely on publicly available records as evidence and in most cases, it is not necessary to get institutional ethical permission prior to initiating a systematic review (Nobile et al., 2023). However, according to Villa College research policies and protocols, ethics approval must be obtained from the Centre for Postgraduate Studies to conduct systematic reviews. Hence, the protocol was registered at the Centre for Postgraduate Studies - Ref No: VC/CPS/2024/RA-061 (Appendix 2).

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## COMPETING INTERESTS

None.